Asia Region Operational Plan, ROP 2019
Strategic Direction Summary

PEPFAR
U.S. President's Emergency Plan for AIDS Relief

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Abbreviations and Acronyms

ADB	Asian Development Bank
ADS	Automated Directives System
AHF	AIDS Healthcare Foundation
AIC	Airborne infection control
AIDS	Acquired immunodeficiency syndrome
AEM	AIDS Epidemic Model
AGYW	Adolescent Girls and Young Women
ANC	Antenatal clinic
APEC	Asia Pacific Economic Corporation
APN	Assisted partner notification
ART	Antiretroviral therapy
ARV	Antiretroviral drug
B-IACM	Boosted integrated active case management
CAA	Community action approach
CAOC	ART and OST Center (India)
C&T	Care and Treatment
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention
CHAI	Clinton Health Access Initiative
CHAS	Center for HIV and AIDS (Laos)
CHW	Community health worker
CIT	Community index testing
CMA	Case management assistant
CMC	Case management coordinator
COP	Country Operational Plan
CoPCT	Continuum of prevention to care and treatment
CPHL	Central Public Health Laboratory
CBO	Community-based organizations
CSO	Civil society organization
DAPCU	District AIDS Prevention and Control Unit (India)
DBS	Dried/dry blood spot
DOD	Department of Defense
DOS	Department of State
DFAT	Australian Department of Foreign Affairs and Trade
DSDM	Differentiated service delivery models
DSD	Direct service delivery
DTG	Dolutegravir
EA	Expenditure analysis
EID	Early infant diagnosis
EMR	Electronic medical record
EQA	External quality assurance

Abbreviations and Acronyms

ER	Expenditure reporting
FBO	Faith-based organization
FDA	Food and Drug Administration
FEW	Female entertainment workers
FSC	Family Support Center
FSN	Foreign Service National
FSW	Female sex workers
FTE	Full-time equivalent
FY	Fiscal year
GBV	Gender-based violence
GDP	Gross domestic product
GNI	Gross national income
GF	Global Fund (to Fight AIDS, Tuberculosis, and Malaria)
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GOB	Government of Burma
GOL	Government of Laos
GOI	Government of India/Indonesia
GoPNG	Government of Papua New Guinea
GON	Government of Nepal
HEF	Health Equity Fund
HIV	Human immunodeficiency virus
HIVTWG	HIV technical working group
HMIS	Health Management Information System
HPDB	HIV Patient Database
HSS	Health system strengthening
HTC	HIV testing and counseling
HTS	HIV testing services
HOP	Headquarters Operational Plan
IAS	International AIDS Society
IBBS	Integrated Bio-Behavioral Survey
ICTC	Integrated counselling and testing centers
ILB	International Laboratory Branch
IM	Implementing mechanism
IOM	International Office of Migration
IP	Implementing partner
IPT	Isoniazid Prevention Therapy
IPV	Intimate partner violence
JICA	Japanese International Cooperation Agency
KOICA	Korean International Cooperation Agency
KP	Key populations
KPLHIV	Key populations living with HIV/AIDS

Abbreviations and Acronyms

KP-MIS	Key populations management information system
LES	Locally engaged staff
LaosPHA	Laos Positive Health Association
LMIS	Laboratory or logistics management information system
LTFU	Loss/lost to follow up
MAT	Medication-assisted therapy
M&E	Monitoring and evaluation
M&O	Management and operations
MDR	Multi-drug resistant
MHIF	Mandatory Health Insurance Fund (Kyrgyz Republic)
MMD	Multi-month dispensing
MMS	Multi-month scripting
MoEF	Cambodia Ministry of Economy and Finance
MoPH	Ministry of Public Health
MPI	Master Patient Index (Burma and Cambodia)
MSW	Male sex workers
MTCT	Mother-to-child-transmission (of HIV)
N/A	Not available/not applicable
NAA	National AIDS Authority (Cambodia)
NAC	National AIDS Committee
NACS	National AIDS Council Secretariat
NAP	National AIDS Program
NASA	National AIDS Spending Assessment
NCASC	National Centre for AIDS and STD Control (Nepal)
NCD	National Capital District (Papua New Guinea)
NCHADS	Cambodia National Center for HIV/AIDS, Dermatology, and STDs
ND	Non-disaggregated
NDoH	National Department of Health (Papua New Guinea)
NGO	Nongovernmental organization
NHA	National health accounts
NHL	National Health Laboratory (Burma)
NHSO	National Health Security Office (Thailand)
NIH	National Institute of Health
NPHL	National Public Health Laboratory
NHIS	National health information system
NHSO	National Health Security Organization (Thailand)
NRTI	Nucleoside Reverse Transcriptase Inhibitors
NSEP	Needle and syringe exchange programs
NSP	Third National Strategic Plan for HIV: 2016-2020 (Burma)
NTP	National Tuberculosis Program
OGAC	Office of the Global AIDS Coordinator

Abbreviations and Acronyms

OST	Opioid substitution therapy
OVC	Orphans and vulnerable children
PARCU	PEPFAR Asia Region Coordination Unit
PC	Peer counselor
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHO	Provincial Health Office
PP	Priority populations
PPHA	Provincial health authority
PI	Protecting the Investment
PIF	PEPFAR Incentive Fund
PLHIV	People living with HIV
PNG	Papua New Guinea
PMRS	Patient management and registration system
PMTCT	Prevention of mother-to-child transmission
PN	Peer navigator
POC	Point of care
PP	Priority populations
PR	Primary recipient
PrEP	Pre-exposure prophylaxis
PSF	Patient Satisfaction Feedback (Cambodia)
PSM	Procurement and supply management
PWID	People who inject drugs
QA/QI/ QM	Quality assurance/improvement/management
RAC	Republican AIDS Center (Tajikistan)
RGC	Royal Government of Cambodia
ROP	Regional Operational Plan
RTCQI	Rapid Testing-Continuous Quality Improvement (Burma)
RTG	Royal Thai Government
SACS	State AIDS Control Society (India)
SAMHSA	U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration
SBIRT	Screening, brief intervention, referral to treatment
SDART	Same day ART
SDG	Sustainable Development Goals
SDS	Strategic Direction Summary
SEA-HATTC	South-East Asia HIV Addiction Technology Transfer Center
SGBV	Sexual and gender-based violence
SI	Strategic information
SID	Sustainability Index Dashboard
SNU	Sub-national unit

Abbreviations and Acronyms

SOP	Standard operating procedure
SQMS	Service Quality Monitoring System
STI	Sexually transmitted infection
SUD	Substance Use Disorders
SUFA	Strategic use of ARVs
TA	Technical assistance
TA-SDI	TA Service Delivery Improvement
TB	Tuberculosis
TG	Transgender
T&S	Test & Start
TLD	tenofovir/lamivudine/dolutegravir
TLE400	tenofovir/lamivudine/efavirenz 400 milligram
TNI	Tentara Nasional Indonesia
TPT	Tuberculosis preventive therapy
TG	Transgender
TGW	Transgender women
TRA	Transition readiness assessment
TRG	Technical resource group
TSG	Technical steering group
TVPA	Trafficking in Vulnerable Persons Act
TWG	Technical working group
U=U	Undetectable = untransmittable
UHC	Universal Health Coverage
UIC	Unique identifier code
UN	United Nations
UNAIDS	United Nations Agency for AIDS
UNICEF	United Nations Children's Fund
UNDP	United National Development Program
UNFPA	United Nations Fund for Population Assistance
US	United States (of America)
USAID	United States Agency for International Development
USG	United States Government
USPSC	United States Personal Services Contractor
VCCT	Voluntary confidential counseling and testing
VL	Viral load
WB	World Bank
WHO	World Health Organization

1.0 Goal Statement, Asia Region

PEPFAR is undertaking a major shift in Asia this year. The Regional Operational Plan (ROP) 2019 is pivotal for Asia, as PEPFAR regionalizes the seven former Strategic and Technical Alignment for Results (STAR) operating units (OU) and one Foreign Assistance Operational Plan (F-Op) country across Asia and Central Asia into one unified, 11-country Asia Region, with the aim of increasing efficiency, consolidating expertise and technical assistance, and preserving and increasing programmatic funding for effective activities using a distributed assets model. Under this model, agencies will maintain USG programmatic leadership within countries, and overall PEPFAR regional coordination will occur through an Asia Region PEPFAR Coordination Unit in Bangkok, consisting of the Asia Region PEPFAR Coordinator and two senior USAID and CDC agency representatives, who will draw upon technical expertise from across the region.
All 11 countries share the challenges of: (1) needing more effective strategies to reach key populations (KP), their partners, and their networks with effective strategies for prevention, testing, treatment, and retention, and (2) improving the use of data systems and dashboards to optimize program improvement. The region will facilitate technical exchange among countries sharing effective approaches to KP, such as pre-exposure prophylaxis (PrEP), index and self-testing, gender-affirming service delivery, differentiated service delivery models, and initiation of same-day antiretroviral treatment (ART), reducing stigma and discrimination, unique identifier codes, and improving data use.

All 11 countries have the goal of full access to viral load (VL) testing coverage, and ensuring 90% VL suppression as well as 95% retention. Countries will ensure policies and practices facilitate six-month multi-month scripting (MMS) and rapidly expand access to once-a-day, fixed-dose combination antiretroviral [tenofovir disoproxil fumarate, lamivudine, and dolutegravir (TLD)].

Throughout the Asian region, key systems barriers have been identified to ensure development of clear and measurable benchmarks of site outcomes. ROP 2019 budget allocations support the leadership and administrative infrastructure of the newly-formed region, including coordination structures, funds for multi-country meetings, funds for within-region technical assistance (TA), and other needs. It also is essential to support and ensure strong coordination at the country level with the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM).

Tier 1: Accelerate and Achieve	**Tier 2: Protect the Investment**	**Tier 3: Sustained Epidemic Control**
Burma	India	Cambodia
Kyrgyz Republic	Indonesia	
Nepal	Kazakhstan	
Tajikistan	Laos	
Thailand	Papua New Guinea	

Regionalization was launched in November 2018 in Washington, DC, where PEPFAR field-based and headquarters-based agency leadership came together to create a joint understanding of optimal staffing for the regional program, initiate discussions about how to operate as a

regional program, and prioritize PEPFAR investments to where they can make the most impact and the most significant contribution

Tier 1: Accelerate and Achieve Epidemic Control

Burma, Kyrgyz Republic, Nepal, Tajikistan, and Thailand PEPFAR teams will work intensively to achieve the UNAIDS 90/90/90 goals among KP groups in priority locations, closing the remaining gaps towards epidemic control with host country leadership. These country teams will continue to support high-impact interventions that target gaps in the prevention and treatment cascades among KP groups, reaching into high risk networks ensuring they have appropriate prevention, testing, linkage, and treatment and support services with support to measure and achieve VL suppression.

With additional funds, these countries were directed to focus on reaching 90/90/90 and achieving full PrEP access to the highest risk KP by 2020. This fast-track 2020 milestone is a shared goal between host country governments and stakeholders, with delineation of USG contributions and targets, which will support national cascade progress along with key GF and host country contributions. All countries should move toward full access to viral load coverage as well as ensuring 90% viral load suppression and 95% retention. Countries should ensure policies and practices to rapidly expand six-month multi-month scripting (MMS), access to TLD, and integration of tuberculosis preventive treatment (TPT). In addition, recency testing and index testing should be ensured for new diagnoses. Finally, programs will work with host countries to develop policies on access to prevention and treatment services for non-host country citizens.

To accelerate and achieve epidemic control, Tier 1 countries will:

- Promote scale-up of index testing with fidelity;
- Ensure they are investing in and promoting KP-differentiated case finding strategies within national programs;
- Ensure they are able to reach deeper into KP networks and consider social network strategies;
- Support linkage strategies that ensure and document at least 95% of KP who test positive are linked to ART, and reduce the time to treatment initiation;
- Articulate measurable goals for how PEPFAR support will impact national, sub-national, and/or specific KP cascades;
- Promote development and scale of differentiated service delivery models, including MMS and decentralization for stable patients with a focus on models specific to KP;
- Include clear strategies for taking successful service delivery models to scale with national governments and clear plans for service delivery models that are not successful;
- Support PrEP implementation, and promote relevant policies and programs; and
- Focus on provinces/districts with highest HIV prevalence, burden, number of new infections, and unmet ART needs.

Tier 2: Protect the Investment

India, Indonesia, Kazakhstan, Laos, and Papua New Guinea will focus on activities that support PLHIV currently on ART while continuing support for orphans and vulnerable children (OVC) and gender-based violence (GBV) activities in specific countries. These countries have a vision of optimized systems, policies, and practices to ensure ART beneficiaries achieve and maintain viral load suppression, with phased transition to a data-informed, sustainable government- and civil society-led response. All countries require the political will to address policies and programming that ensure that the most at-risk are reached with the most effective prevention and treatment interventions. To support PLHIV currently on ART, Tier 2 countries will:

- Optimize index testing with fidelity, sustained in facilities that support beneficiaries on treatment;
- Institutionalize differentiated service delivery models (DSM) with MMS for stable patients;
- Increase the use of strategic information through stronger health management information systems, case-based surveillance, and the use of unique identifier codes;
- Ensure VL testing and monitoring;
- Strengthen systems for appropriate commodities, including TLD and supply chain continuity;
- Advance gender-based violence (GBV) prevention and response (Papua New Guinea);
- Strengthen support to orphans and vulnerable children (OVC), prioritizing children of key populations (India);
- Maintain PLHIV on treatment, with Intensified focus in current PEPFAR-supported sub-national units; and
- Ensure TLD transition and integration of TPT in national protocols.

Tier 3: Sustained Epidemic Control

The PEPFAR team in Cambodia, the only Tier 3 country in ROP19, will continue its focus on sustainable financing and strengthening national systems to identify and respond to new infections, adapting or shifting activities as needed to ensure PEPFAR's investments are maximally directed to the key barriers to epidemic control. Cambodia will develop well-defined benchmarks to measure PEPFAR's specific impact on the national response during ROP 2019. In addition, Cambodia will adapt the broader sustainable epidemic control framework to local context, defining goals and indicators, and continuing to monitor progress.

The Royal Government of Cambodia (RGC) has made significant progress in addressing HIV/AIDS for the past 25 years. In 2013, Cambodia announced its intent to eliminate new HIV infections by reaching the 90-90-90 targets by 2020 and achieving 95-95-95 (and fewer than 300 new HIV infections annually) by 2025, coming close to achieving an AIDS-Free Generation. As of December 2018, Cambodia diagnosed approximately 81% of the estimated population of PLHIV, placed 99% of diagnosed PLHIV on ART, and documented VL suppression on 79% of PLHIV on ART (Figure 2.1.2: National HIV Clinical Cascade). The existing PEPFAR strategy helped to drive this progress, particularly in ensuring that PLHIV are placed on ART.

To capitalize on its previous success, Cambodia must address the primary barriers to sustained epidemic control. With stakeholders, the PEPFAR team has mapped out how these barriers threaten the foundational elements needed for a sustained response, as described in PEPFAR's Sustainability Model. The PEPFAR team identified insufficient targeted case-finding efforts, inefficient quality management systems (including efficient means to track patients through the HIV cascade) and inadequate domestic financing as the most important barriers. To guide Cambodia's response in ROP19, the Cambodia PEPFAR team has adapted the PEPFAR Framework for Sustained Epidemic Control for the Cambodia context (Figure 1). PEPFAR investments in ROP19 will focus on the following activities to expedite progress towards sustained epidemic control:

- Using micro-targeted pre-exposure HIV prophylaxis (PrEP) based on HIV testing yields through refined case-finding activities and point-of-care (POC) recency testing results; implementing case-based surveillance nationally through use of unique identifying codes (UIC) and improved inter-operability of existing HIV data systems;
- Capitalizing on the Prime Minister's commitment to increase domestic investments and funding for civil society organizations (CSOs);
- Implementing international policies aggressively, including multi-month scripting (MMS), dolutegravir-based regimens including tenofovir/lamivudine/dolutegravir (TLD) fixed-dose combination, TB preventive therapy (TPT) and same-day ART (SDART) initiation; and
- Maintaining retention above 95% and ensure 100% of eligible patients receive a VL test.

With assistance from PEPFAR and The Global Fund for AIDS, TB, and Malaria (or Global Fund, GF), Cambodia is on track to reach 95-95-95 by 2025. The greatest barrier to reaching 95-95-95 is reducing rates of LTFU and retaining patients on treatment. Failure to retain these individuals not only prevents achievement of the third 95, but also contributes to ongoing HIV transmission in Cambodia. In response, the RGC is proposing more aggressive efforts to build sustainable systems for tracking patients across the cascade and re-engaging patients who are LTFU. These efforts would likely allow Cambodia to reach the 95-95-95 goal in advance of 2025, averting hundreds of new infections and improving the quality of life for PLHIV.

Given declining resources and a rise in competing health priorities (such as nutrition, maternal and child health, tuberculosis, malaria and non-communicable diseases), the RGC, civil society, and development partners must advocate for increasing domestic investments in HIV and improve efficiency to remain an innovative leader in the global fight against HIV. The RGC has been leading these efforts, and continues to actively engage communities, civil society and other stakeholders on how best to achieve Cambodia's ambitious HIV goals. Lessons learned from Cambodia's progress will help to inform other countries with similar epidemic profiles.

2.0 Epidemic, Response, and Program Context

Tier 1: Accelerate and Achieve Epidemic Control
Burma, Kyrgyz Republic, Nepal, Tajikistan, and Thailand
Tier 2: Protect the Investment
India, Indonesia, Kazakhstan, Laos, and Papua New Guinea
Tier 3: Sustained Epidemic Control
Cambodia

Tier 1: BURMA

2.1 Summary statistics, disease burden, and country profile: Burma is a lower-middle income country with a population of 53.9 million (GOB, 2018), a GNI per capita of $1,210 (World Bank Atlas method, 2017) and total health expenditure of 4.95% GDP (WHO, 2015). With 14 states and regions, 74 districts, 330 townships, 13,602 village tracts and over 135 ethnic groups, Burma is one of 35 countries that together account for 90% of new HIV infections globally (UNAIDS, 2015). It has the fourth highest number of PLHIV in the South East Asia Region, an estimated 227,000 PLHIV (AEM, Spectrum 2017), with 0.57% adult prevalence. HIV prevalence among KP is much higher, at 34.9% in PWID (BBS 2017), 14.6% in FSW (BBS 2015), and 11.6% in MSMs (BBS 2015). The age and sex distribution of PLHIV in 2017 was estimated to be 138,000 males over 15 years (61%); 80,000 females over 15 years (35%); and 9,000 children under 15 years (4%).

KP account for over 70% of new HIV infections. At the height of the epidemic in 2000, Burma had 29,000 new HIV infections per year. Burma has made tremendous progress; in 2017 new infections were down to 11,000 (of which 28% PWID, 13% MSMs, 7% FSW, 23% clients of FSW, 24% “low- risk females” and 4% others). AIDS-related deaths have also declined from 13,000 in 2011 to 7,700 in 2017 (Spectrum) as a result of the rapidly increasing ART coverage. Seventy-four percent of new infections occur in Yangon, Mandalay, Kachin, Shan (North), and Sagaing. Kachin, Shan (North), and Sagaing face mainly PWID-driven epidemics with some heterosexual transmission. Yangon faces mainly heterosexual and MSM transmission, with mixed modes of transmission in Mandalay. In these areas, the epidemic is not declining.

Among KP, prevalence varies geographically. Although national PWID HIV prevalence is 34.9%, in Mandalay it is only 7.6%, while in Bamaw Township in Kachin State, it is 61% (PWID IBBS 2017). States and Regions that have the highest HIV prevalence rates among PWID include Kachin state (47%) and Northern Shan state (43%). PWID never tested for HIV also have relatively high HIV infection rates, such as Bamaw (64%), Hpakant (54%), and Waimaw (54%) in Kachin State. Among MSM, prevalence is highest in Yangon (27%) and Mandalay (22%) (MSM IBBS 2015). HIV prevalence among MSM in Yangon was the highest in the Asia/Pacific region in a specific geographical site. Similarly, HIV prevalence among FSW in Yangon was highest at 25% (FSW IBBS 2015).

Burma’s coverage of key services is lower than needed to reach epidemic control. Access to ART services, linkage from testing to treatment and retention among KP, especially among PWID living in remote, hard-to-reach and conflict-affected areas, remain challenging due to legal barriers, stigma and discrimination in the community and health care settings, and physical access barriers in transportation and infrastructure. Of note, once PLHIV know their status, they receive ARTs. Of those tested for viral load, VL suppression is high (93%).

Of an estimated population of 411,000 KP, 156,163 (38%) were reached with HIV prevention interventions by NAP and partners (NAP, 2018). Of these, 127,388 (82% of those reached) were tested for HIV (41,645 (63%) FSW, 48,519 (39%) MSM and 37,224 (40%) PWID) (2018 program

reports). This leaves an estimated 156,612 KP to be tested (24,355 FSWs, 76,481 MSMs and 55,776 PWIDs).

Of an estimated number of PLHIV of 227,000, 173,000 know their status (77%). Of these, 166,121 were receiving ART (73% PLHIV and 96% of those who know their status) (AEMS 2017). For the 2017 ART-initiated cohort, 12-month retention was reported as 86%. Access to VL testing is low, as only 89,868 people, or 50% of the PLHIV on ART, had VL testing in 2018. Among those tested, 83,573 PLHIV (93%) had documented VL suppression. TPT among new ART patients is estimated at 18% (2018 National TB/HIV Report).

Coverage of MAT among PWID in Burma is low. Of an estimated 93,000 PWID (PWID BBS 2017), only 17% (15,994) received methadone, a significant gap of 21,206 to reach the recommended target of 40% of PWID on MAT. Harm reduction (needle and syringe distribution) appears ineffective. While in 2017, 33.3 million needles and syringes were distributed (358 per PWID), continued high rates of transmission indicate PWID continue to share needles. This may in part because needle distribution is not concentrated where PWID are highest risk (Kachin and Shan ethnic minority areas).

Burma's Third National Strategic Plan for HIV: 2016-2020 (NSP III) aims to reach the 90-90-90 targets by 2020 and to end HIV as a public health threat by 2030. This forms the basis for HIV policy for all stakeholders in Burma. In general, the NSP III embraces the right policies. The main challenge is to operationalize and accelerate implementation of these policies. The vast majority of HIV-related services are free-of-charge. NSP III stresses the importance of maximizing HIV testing uptake among KP and linkage to treatment for PLHIV. The current national operational model emphasizes case management, peer navigation and facilitated referral approaches to improve linkage of clients. Test and Start for all PLHIV was adopted as policy in 2017. MMS up to six months was adopted as national policy with standard operating procedures in 2018. TLD was made the first line preferred regimen along with TLE per the 2018 update to national clinical management guidelines; dissemination and sensitization of clinicians to improve the uptake of the TLD regimen has not yet occurred. TPT NSP III aims for 50% of new HIV patients to receive TB preventive therapy (TPT) by 2020. TPT guidelines have been updated and stakeholder consultations are ongoing to improve patient monitoring and to identify gaps for provision of TPT for all eligible PLHIV. PrEP has been endorsed as a key prevention modality in NSP III. The NSP III also provides for index testing.

NSP III recommended unique identifier codes (UIC) to track, monitor and retain patients on ART. The Strategic Action Plan for Strengthening Health Information (2017-2021) defined a timeline to develop and implement a Client Registry and a Master Patient Index (MPI) as a unique identifier across all sites in TB and HIV programs. Public HIV facilities historically use a paper-based recording and reporting system. The national program introduced OpenMRS, an electronic open source medical record system, in ART centers and decentralized sites. By the end of 2018, OpenMRS had been expanded to 93 facilities capturing the records of around 50,000 PLHIV on ART. The transfer of legacy data of existing patient records was ongoing.

Morbidity and mortality outcomes of patients including infectious and non-infectious morbidity are not systematically and routinely monitored and reported. The HIV Sentinel Surveillance (HSS) is conducted every two years, with data reported from around 35 of 330 townships. Biobehavioral surveys among KP were also conducted in 2014-2015, 2017, and 2019 to estimate national level information and to understand the epidemic and risks among KP. Age- and sex-disaggregated data, most particularly for the age groups 15-24 and 25+, for tables 2.1.1 and 2.1.2 were not available, and recent AEM and Spectrum estimates were still using <15 and >15 age groups. Available numbers disaggregated by KP are shown in tables 2.1.1 and 2.1.2; concerns about data quality limit their use and interpretation.

Table 2.1.1 Burma Country Government Results

Table 2.1.1 Burma Host Country Government Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	53,862,000	100	7,343,000	49	7,542,000	51	4,794,000	50	4,752,000	50	15,878,000	54	13,553,000	46	Union population projections, medium variant,[1] 2018
HIV Prevalence (%)		0.57						ND		ND		ND		ND	AEM estimates for 2017
AIDS Deaths (per year)	7,700		125		136		ND		ND		ND		ND		Spectrum estimates for 2017 (NAP report)
# PLHIV	227,000		4,188		4,174		ND		ND		ND		ND		AEM estimates for 2017; PLHIV <15 years from Spectrum estimates for 2016[2]
Incidence Rate (per 1000)		0.23		NA		NA		ND		ND		ND		ND	Spectrum estimates for 2016[2]
New Infections	10,945		-		-										AEM estimates for 2017
Annual births (2015)	944,000	100													*UNICEF: State of the World's Children 2017 Statistical Tables*
% of Pregnant Women with at least one ANC visit	845,623	60.8	ND	ND			ND	ND			ND	ND			Evaluation report on 2011-2016 HIV National Strategic Plan
Pregnant women needing ARVs	5,791	0.02													AEM estimates and NAP PMTCT report for 2018
Orphans (maternal, paternal, double)	NA		NA		NA		NA		NA		NA		NA		NA
Notified TB cases (2017)	132,025		ND		ND		ND		ND		ND		ND		2018 WHO Global TB Report

[1] http://themimu.info/sites/themimu.info/files/documents/Report_Thematic_Report_On_Population_Projections_-_Census_Report_V4-F_DOP_Mar2017_ENG.pdf

Table 2.1.1 Burma Host Country Government Results															
	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
% of TB cases that are HIV infected (2017)	17,000	8.7	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	2018 WHO Global TB Report
% of Males Circumcised	NA	NA			NA	NA			NA	NA			NA	NA	
Estimated Population Size of MSM*	252,000	1.4													2015 MSM IBBS
MSM HIV Prevalence		11.6													2015 MSM IBBS
Estimated Population Size of FSW	66,000	0.3													2015 FSW IBBS
FSW HIV Prevalence		14.6					NA	1-11%			NA	7-29%			2015 FSW IBBS
Estimated Population Size of PWID	93,215	0.5													2017 PWID IBBS
PWID HIV Prevalence		34.9													2017 PWID IBBS
Estimated Size of Priority Populations (specify)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Estimated Size of Priority Populations Prevalence (specify)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	

NA = Not Applicable/ Not Available, ND = Not Disaggregate

Table 2.1.2 Burma 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*[2,3,4,5]										
Epidemiologic Data					**HIV Treatment and Viral Suppression**			**HIV Testing and Linkage to ART Within the Last Year (2017)**		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Estimated Total PLHIV (#) (2017)**	**PLHIV diagnosed (#)**	**On ART (#)**	**ART Coverage (%)**	**Viral Suppression (%)**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	53,862,000	0.57	227,000	173,800	166,121	73%	66%	299,363	30,125	28,881
Population <15 years	14,885,000	NA	9,000	NA	NA	NA	70%	NA	NA	NA
Men 15-24 years	4,752,000	0.76	138,000	NA	NA	NA	58%	NA	NA	NA
Men 25+ years	13,553,000			NA	NA	NA		NA	NA	NA
Women 15-24 years	4,794,000	0.39	80,000	NA	NA	NA	78%	NA	NA	NA
Women 25+ years	15,878,000			NA	NA	NA		NA	NA	NA
MSM	252,000	11.6% (2015)	22,517	NA	NA	NA	NA	42,167	3,483	NA
FSW	66,000	14.6% (2015)	8,892	NA	NA	NA	NA	39,748	2,402	NA
PWID	93,215	34.9% (2017)	21,212	NA	NA	NA	NA	38,424	7,935	NA
Priority Pop (specify)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

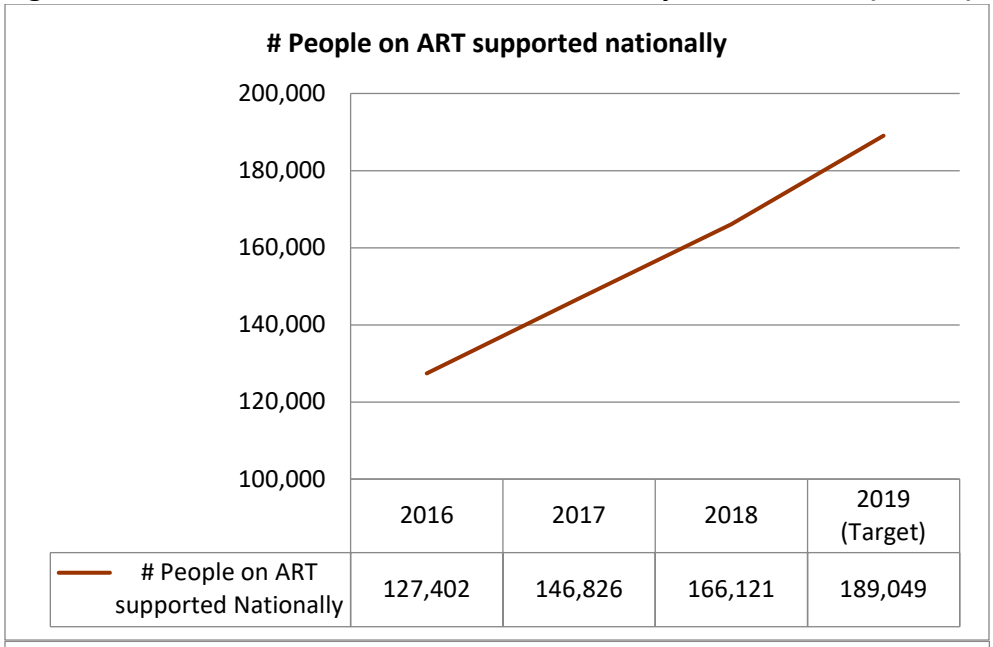
[2] 2017 AEM/Spectrum estimates
[3] PWID IBBS 2014
[4] MSM and FSW IBBS 2015
[5] Program data from 2017 Annual Review, National AIDS Program

Table 2.1.2 Burma 90-90-90 cascade: HIV diagnosis, treatment and viral suppression

Table 2.1.2 Burma 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*[6,7,8,9]										
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year (2017)		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#) (2017)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	53,862,000	0.57	227,000	173,800	166,121	73%	66%	299,363	30,125	28,881
Population <15 years	14,885,000	NA	9,000	NA	NA	NA	70%	NA	NA	NA
Men 15-24 years	4,752,000	0.76	138,000	NA	NA	NA	58%	NA	NA	NA
Men 25+ years	13,553,000			NA	NA	NA		NA	NA	NA
Women 15-24 years	4,794,000	0.39	80,000	NA	NA	NA	78%	NA	NA	NA
Women 25+ years	15,878,000			NA	NA	NA		NA	NA	NA
MSM	252,000	11.6% (2015)	22,517	NA	NA	NA	NA	42,167	3,483	NA
FSW	66,000	14.6% (2015)	8,892	NA	NA	NA	NA	39,748	2,402	NA
PWID	93,215	34.9% (2017)	21,212	NA	NA	NA	NA	38,424	7,935	NA
Priority Pop (specify)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

[6] 2017 AEM/Spectrum estimates
[7] PWID IBBS 2014
[8] MSM and FSW IBBS 2015
[9] Program data from 2017 Annual Review, National AIDS Program

Figure 2.1.3 PEPFAR trend for individuals currently on treatment (Burma)



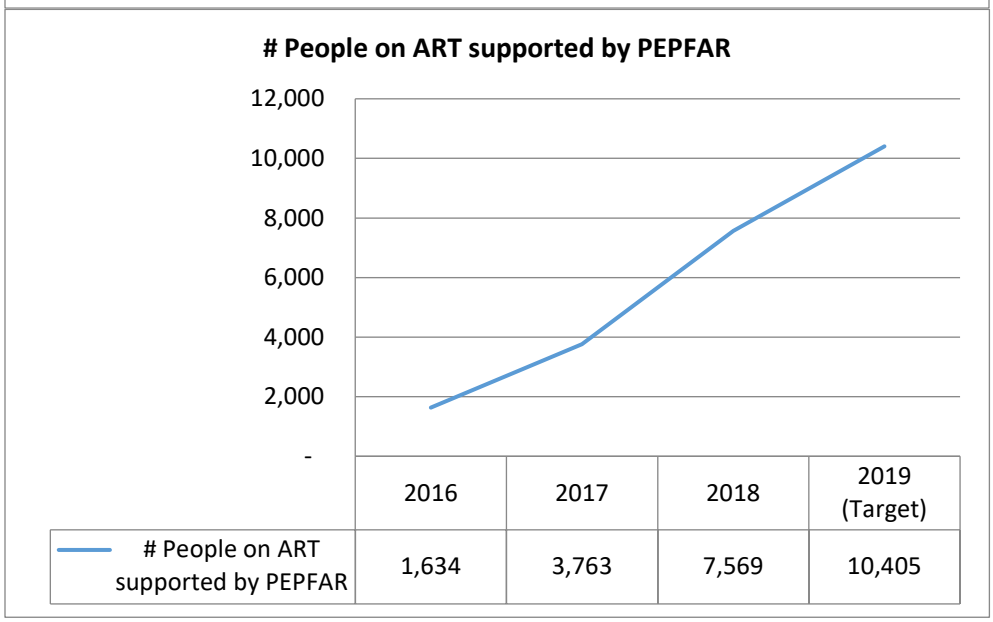
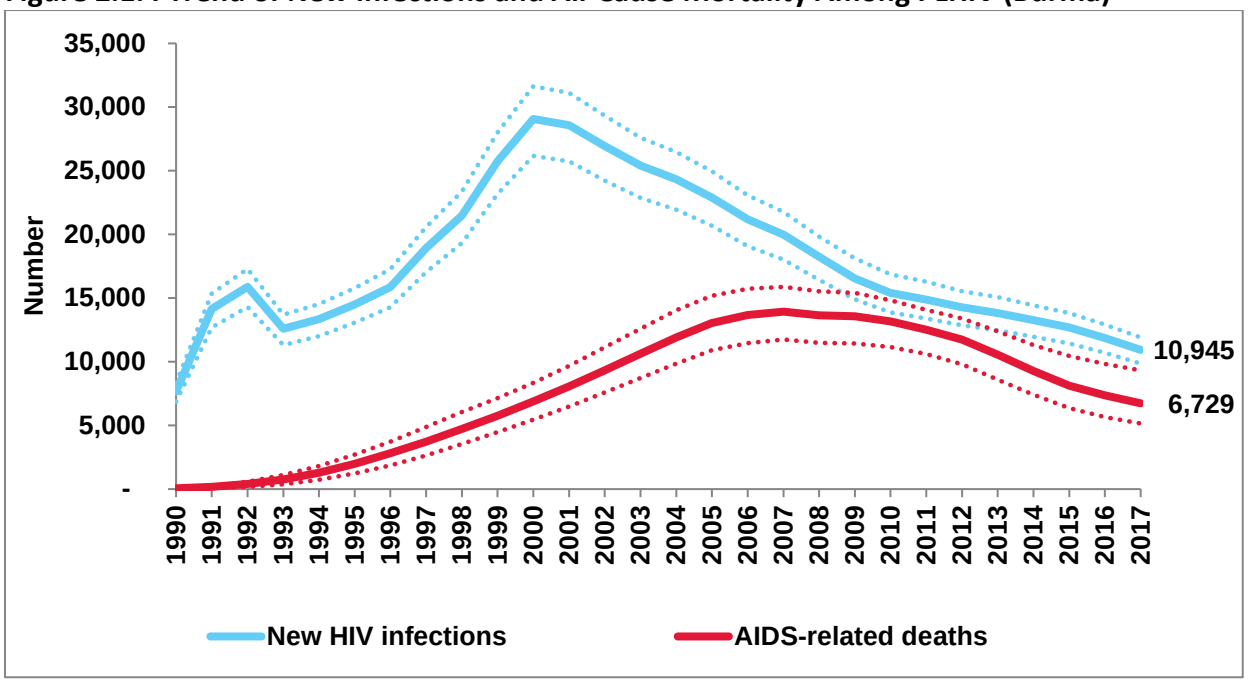


Figure 2.1.4 Trend of New Infections and All-Cause Mortality Among PLHIV (Burma)



Source: www.aidsdatahub.org based on UNAIDS 2018 HIV Estimates

2.2 Investment profile: In 2017, total HIV spending was $109.5 million (Burma NAP). The largest provider of HIV funds is the GF, which provided $52 million (48% of total HIV funds) in 2017. The second largest provider of HIV funds is the Government of Burma, at $18.5 million (17% of total funds). PEPFAR is the third largest provider of HIV funds, at $7.6 million (7% of total funds).

Since 2014, the Government of Burma has increased its commitment to funding HIV activities. According to the NASA, in 2014 the Government of Burma's contribution was $3.6 million. In 2016, the Government of Burma committed $9 million ($8 million for ARVs and $1 million for MAT). In 2018 and 2019, the Government of Burma is committed to maintaining the same contribution.

Since 2017, the GF has been decreasing its investment in Burma. The amount of funding for GF implementation in 2021 is still uncertain. Since funding for ARVs is provided from the GF and the Government of Burma, PEPFAR does not request funds for ARVs. Several international partners are decreasing their prevention activities in Burma. Both of these developments leave significant gaps in Burma's HIV response.

Thus, despite the significant GF and Burma Government investments, current funding levels are insufficient to support Burma's HIV program scale-up plans to achieve 90-90-90. The request for PEPFAR funds is $16.48 million to accelerate the HIV response in Burma to achieve 90-90-90 in the next 18 months.

Table 2.2.1 Burma Annual Investment Profile by Program Area

Table 2.2.1 Burma Annual Investment Profile by Program Area					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Clinical care, treatment and support	50,423,985	2%	41%	26%	30%
Community-based care, treatment, and support	482,226	0%	59%	0%	41%
PMTCT	2,227,547	0%	2%	96%	2%
HTS	1,737,938	54%	46%	1%	0%
VMMC	0	0%	0%	0%	0%
Priority population prevention	2,023,693	0%	26%	34%	40%
AGYW Prevention	0	0%	0%	0%	0%
Key population prevention	24,211,677	11%	55%	7%	26%
OVC	0	0%	0%	0%	0%
Laboratory	1,855,301	17%	62%	0%	21%
SI, surveys and surveillance	2,958,415	20%	60%	0%	20%
HSS	23,674,799	8%	60%	0%	31%
Total	109,595,581	7%	48%	17%	28%

Table 2.2.2 Annual Procurement Profile for Key Commodities (Burma)

Table 2.2.2 Burma Annual Procurement Profile for Key Commodities					
Commodity Category	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
ARVs	$19,713,312	0%	57%	36%	7%
Rapid test kits	-	-	-	-	-
Other drugs	-	-	-	-	-
Lab reagents	-	-	-	-	-
Condoms	$4,318,617	15%	60%	0%	26%
Viral Load commodities	-	-	-	-	-
VMMC kits	-	-	-	-	-
MAT	-	-	-	-	-
Other commodities (health equipment)	$1,536,105	0%	75%	0%	25%
Total	$25,568,034	2%	58%	28%	11%

Source: PEPFAR Expenditure Report and NASA 2017

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration (Burma)

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration (Burma)					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
USAID MCH	5,000,000				
USAID TB	7,500,000				
USAID Malaria	10,000,000				
USAID Emerging and Pandemic Threat	1,854,907				
Family planning					
NIH					
CDC (Global Health Security)	250,000				
Peace Corps					
DOD Ebola					
MCC					
Total	**24,604,907**				

Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP (Burma)

Table 2.2.4 Burma Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP						
Funding Source	**Total PEPFAR Non-COP Resources**	**Total Non-PEPFAR Resources**	**Total Non-COP Co-funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
DREAMS Innovation	0					
VMMC – Central Funds	0					
Other PEPFAR Central Initiatives	0					
Other Public-Private Partnership	0					
Total	**0**					

2.3 National Sustainability Profile Update: Sustainability of the national HIV response calls for planning and coordination; management of finances, service quality and supply chain; and legal protections. A consultative process with civil society leaders and other key stakeholders was convened to complete the 2017 Burma Sustainability Index (SID 3.0). Much remains to be done to enhance the sustainability of Burma's response, where currently planning and coordination are strong; management of finances, quality of services and the supply chain is weak; and legal protections are weak. Burma PEPFAR has concerns on current system barriers to achieve acceptable sustainability scores for: (1) performance data, (2) laboratory, (3) commodities and supply chain system, and (4) policy and governance to reduce stigma and discrimination.

Civil society and other stakeholders actively engage in the planning process at the national and local levels, including civil society oversight of the HIV response. National leaders demonstrate a commitment to use approaches Burma can sustain on its own. While the government leads periodic implementation of NASA at the national level, the country lacks health sector capacity in public financial management and health economics to work toward financial sustainability of the HIV response. Quality management is weak and requires a significant investment. Supply chain management is weak. In 2014, Burma scored 40% in a supply chain assessment, where 60% represents a minimally functional system. Procurement systems to support other elements of the HIV service cascade are incipient, in particular for VL monitoring. Legal protections are weak. The NSP III expresses a national commitment to creating a favorable environment for reduction of stigma and discrimination affecting KP. A large share of new HIV infections occur among PWID. While national drug policy has become less punitive, practice remains punitive.

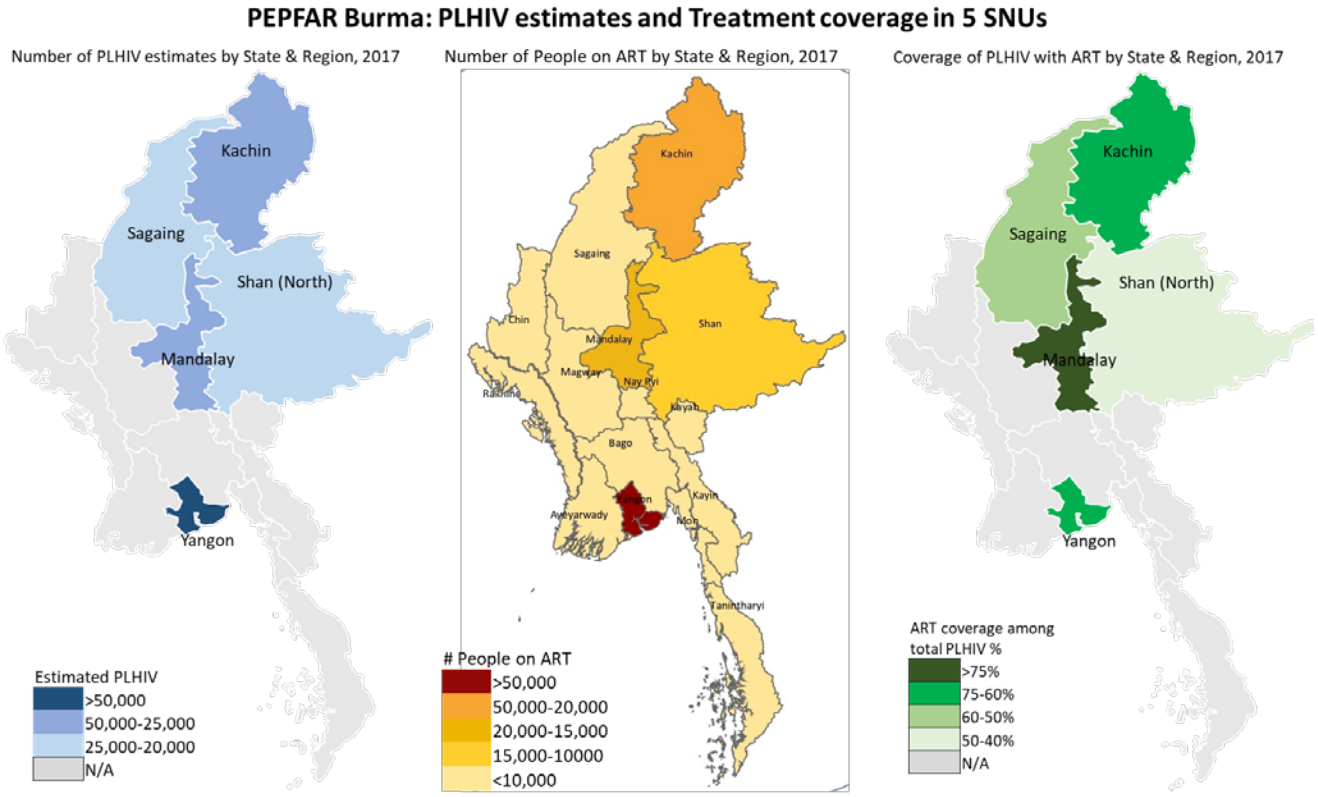
2.4 Alignment of PEPFAR investments geographically to disease burden: Township-level prioritization exercises in Burma identified Yangon, Mandalay, Northern Shan, and Kachin as priority catchment areas. Recently IBBS and program data suggested that the HIV epidemic fueled by drug use in Sagaing should not be neglected. Due to the concern on potential growth of HIV transmission through PWID in Sagaing, Burma PEPFAR plans to include Sagaing as a PEPFAR priority catchment areas in ROP19. Together Yangon, Mandalay, Northern Shan, Kachin, and Sagaing account for 80% of PWID (IBBS 2017) and 60% of FSW and MSM (IBBS 2015). Further, these five areas account for 70% of PLHIV and 75% of all new infections (AEM 2017). Seventy-five percent of all people on ART receive treatment in these five areas (NAP).

Burma Sub-National analysis on Burden of HIV Epidemic in Burma focusing on five high-burden areas

	National	Yangon	Mandalay	Kachin	Shan (N)	Sagaing	Remaining
# Population (2017 projection)	53,387,948	7,936,637	6,389,390	1,829,848	2,677,874	5,491,170	29,063,029
% contribution		*15%*	*12%*	*3%*	*5%*	*11%*	*54%*
# FSW (PSE 2015)	66,056	11,560	12,379	3,240	3,876	5,806	29,194
% contribution		***18%***	***19%***	*5%*	*6%*	*9%*	*44%*
# MSM (PSE 2015)	125,759	29,419	21,892	5,735	2,855	12,146	53,712
% contribution		***23%***	***17%***	*5%*	*2%*	*10%*	*43%*
# PWID (PSE 2017)	93,215	2,848	10,095	21,827	19,905	19,064	19,476
% contribution		*3%*	*11%*	***23%***	***21%***	***20%***	*21%*
# Adult PLHIV (15+) estimates (2017)	217,816	57,017	24,597	32,465	17,751	16,667	69,319
% contribution		***26%***	***11%***	***15%***	***8%***	***8%***	***32%***
# new infections (Adult, 2017 estimates)	10,355	2,832	595	1,702	1,150	1,347	2,729
% contribution		***27%***	*6%*	*16%*	*11%*	*13%*	*26%*
People on ART (2017)	146,826	52,410	19,547	21,154	7,867	8,506	37,342
Treatment coverage among total estimated PLHIV (2017)	66%	68%* (#People on ART adjusted by residence)	76%	62%	43%	49%	52%

1. 2017 AEM/ Spectrum estimates
2. Program data from 2017 Annual Review and Care & Treatment Technical Working Group meeting, National AIDS Program

Figure 2.4.1 Alignment of PEPFAR investments geographically to disease burden (Burma)



2.5 Stakeholder engagement: Burma PEPFAR has actively engaged key stakeholders in the development of ROP19 plans, to ensure alignment and inclusive planning, and to obtain preliminary commitments of others to ambitious PEPFAR targets. Consultations included a stakeholder meeting on January 25, and meetings by Burma PEPFAR team with MOHS officials in February, followed by full participation in the April ROP meeting by the Director of the National AIDS Program and the Chairman of the Myanmar Positives Group (as the representative selected by civil society organizations working in HIV).

The Burma PEPFAR team shared the PEPFAR planning parameters for Burma of the then $11,486 planning level, the objective of reaching 90-90-90 by 2020, and the regionalization of PEPFAR in Asia. Partners weighed in on where PEPFAR should put its emphasis among the Minimum Requirements as an Accelerate and Achieve country. In addition, PEPFAR team members consulted with leaders from the GF's two Principal Recipients—UNOPS and Save the Children—to ensure their shared commitment to TLD transition and to enlist their engagement to accelerate progress, with particular attention on accelerating enhanced case-finding and linkage to care. Following the ROP19 meeting, further consultations with GF PRs and NAP have led to a comprehensive plan for reaching the 90-90-90 goals on an accelerated timeline, and a national PrEP implementation consultation occurred in April 2019.

Tier 1: KYRGYZ REPUBLIC

2.1 Summary statistics, disease burden and country profile: Kyrgyz Republic is a former republic of the Soviet Union located in Central Asia. It is a landlocked country that borders Tajikistan and China to the South and East, Uzbekistan to the West and Southwest, and Kazakhstan to the North. The total population of the Kyrgyz Republic is 6.257 million (www.stat.kg). The 2017 GNI for Kyrgyz Republic is $1,130, which reflects a decrease from $1,250 in 2014 (World Bank data).

The adult HIV prevalence in Kyrgyz Republic is 0.18%; however, prevalence among key populations remains high [PWID (14.3%); MSM (6.6%); FSW (2.0%)] (EHCMS). The latest official SPECTRUM estimation (UNAIDS data, 2017) for total PLHIV aged 15+ in the Kyrgyz Republic is 7,473 (5,008 men and 2,465 women). In 2017, Kyrgyz Republic had 602 new HIV infections and 204 AIDS-related deaths (UNAIDS). Since 2010, new HIV infections have decreased by 27%, according to UNAIDS data.

Since 2015, Kyrgyz Republic has made steady progress towards achieving the UNAIDS 90-90-90 goals by 2020, albeit at a slower rate than needed. At the beginning of February 2019, there were 5,581 individuals diagnosed with HIV (75% of estimated PLHIV 15+); 3,362 currently on ART (60% of diagnosed PLHIV 15+); and 2,757 with documented viral suppression (82% of PLHIV 15+ on ART). The PEPFAR priority site-level sub-national units in Kyrgyz Republic (Bishkek City, Chui Oblast, Osh Oblast, and Osh City) reflect the highest-burden geographic areas in the country and account for 81% of the estimated PLHIV in the Kyrgyz Republic.

The Kyrgyz Republic has made significant progress in adopting and implementing key policies to address PEPFAR minimum program requirements, including implementation of a Test & Start strategy, scale-up of TB preventive therapy for all PLHIV, adoption of differentiated service delivery models (DSDM) and roll-out of MMS for stable patients. In June, the Republican AIDS Center (RAC) will revise the National Clinical Guidelines to make TLD the preferred 1st line ART. The RAC has a clear path to transition over 90% of PLHIV on ART to TLD within the next 18 months; the first shipment of GF-procured TLD is expected to arrive in May 2019.

Nevertheless, the Kyrgyz Republic faces several obstacles in achieving the targets set out in the UNAIDS “Fast Track – Ending the AIDS Epidemic by 2030” initiative and the 90-90-90 goals for 2020, including: labor migration; reduction in GNI and donor funding for health; punitive laws and policies toward key populations; stigma and discrimination from communities, health providers, and law enforcement officials that marginalize key populations and limit access to and uptake of HIV-related services; low Medication-Assisted Treatment (MAT) coverage of PWID; and limited epidemiological data on the size and location of key populations to help strategically target services. As a result, new case finding among KP is low and linkage and uptake of available HIV services is limited. These obstacles also impact retention throughout the continuum of care for those most in need.

Table 2.1.1 Kyrgyz Republic Host Country Government Results

Table 2.1.1 Kyrgyz Republic Host Country Government Results															
	Total		**<15**				**15-24**				**25+**				**Source, Year**
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		**Empty cells indicate no data available.**
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Total Population	6,256,730	100.0%	986,242	15.8%	1,034,673	16.5%	511,860	8.2%	532,197	8.5%	1,656,811	26.5%	1,534,947	24.5%	National Statistical Committee of the Kyrgyz Republic As of January 01, 2018 (www.stat.kg)
HIV prevalence (%)	-	0.12%	-	0.01%	-	0.01%	-	0.05%	-	0.05%	-	0.13%	-	0.31%	Estimated # PLHIV (UNAIDS data)/Total population
AIDS deaths (per year)	204		3		2		2		2		33		162		UNAIDS data, 2017, http://www.aidsinfoonline.org
AIDS deaths (per year)	195	-	2	-	4	-	2	-	1	-	60	-	126	-	EHCMS, Mar. 01 2018-Feb 28, 2019 for reported deaths
Estimated # PLHIV	7,608		65	0.9%	70	0.9%	247	352.9%	273	390.0%	2,218	29.2%	4,735	62.2%	UNAIDS data, 2017, http://www.aidsinfoonline.org
Incidence rate (Yr.)	-	0.010%	-	0.0009%	-	0.0009%	-	0.0090%	-	0.0124%	-	0.007%	-	0.023%	New infections (UNAIDS data, 2017)/Total population (2017)
New infections (Yr.)	602		9		9		46		66		122		350		UNAIDS data, 2017, http://www.aidsinfoonline.org
New Infections (diagnosed/ Yr.)	885	-	15	-	18	-	43	-	51	-	281	-	477	-	EHCMS, Mar. 01 2018-Feb 28, 2019; # of newly confirmed cases officially registered
Annual births	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
% of pregnant women with at least 1 ANC visit	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Pregnant women needing (ARVs)	52	-	0	-	-	-	5	-	-	-	47	-	-	-	EHCMS, As of Feb 28, 2019
Orphans (maternal, parental, double)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Notified TB cases (Yr.)	7,695														Global TB report WHO 2018
% of TB cases that are HIV infected	223	2.9%	2	#DIV/0!	3	#DIV/0!	1	#DIV/0!	0	#DIV/0!	49	#DIV/0!	168	#DIV/0!	EHCMS, As of Feb 28, 2019
% of Males Circumcised	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Key populations															**Source, Year**

Estimated population size of PWID	25,000	-	-	-	-	-	-	-	-	-	-	-	-	-	GFTAM report, 2013
PWID HIV prevalence	-	14.3%	-	-	-	-	-	-	-	-	-	-	-	-	RAC report. IBBS 2016
Estimated population size of MSM	16,900	-	-	-	-	-	-	-	-	-	-	-	-	-	Methods and Results of 2016 size estimation exercise in Kyrgyzstan: service multipliers to estimate the size of PLHIV, FSWs and MSM http://www.afew.kg/upload/files/Narrative_methods_results_KG_SE_03_01_2018.pdf
MSM HIV Prev.	-	6.6%	-	-	-	-	-	-	-	-	-	-	-	-	RAC report, IBBS 2016
Estimated population size of FSW	7,100	-	-	-	-	-	-	-	-	-	-	-	-	-	M-Vector, 2013
FSW HIV prevalence	-	2.0%	-	-	-	-	-	-	-	-	-	-	-	-	RAC report, IBBS 2016
Estimated size of priority population (specify)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Estimated size of priority populations prevalence (specify)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	

Table 2.1.2 Kyrgyz Republic Cascade of HIV Prevention, Diagnosis, Treatment, and Viral Suppression

Table 2.1.2 Kyrgyz Republic Cascade of HIV Prevention, Diagnosis, Treatment, and Viral Suppression											
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART			
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV+ (#)	Initiated on ART (#)	Sources
Population 15+ years	4,235,815	0.18%	7,473	5,581	3,362	45%	82%	401,750	840	586	EHCMS
Men 15-24 years	532,197	0.05%	273	128	90	33%	78%		46	31	EHCMS
Men 25+ years	1,534,947	0.31%	4,735	3,247	1,754	37%	77%		478	320	EHCMS
Women 15-24 years	511,860	0.05%	247	145	113	46%	83%		39	32	EHCMS
Women 25+ years	1,656,811	0.13%	2,218	2,061	1,405	63%	88%		277	203	EHCMS
PWID	25,000	14.3%	3,100	2,082	1,058	34%	73%	32,402	129	89	EHCMS; IBBS RAC Report 2016
MSM	16,900	6.6%	1064	184	129	12%	87%	12,072	43	38	EHCMS; IBBS RAC Report 2016
FSW	7,100	2.0%	156	53	33	21%	50%	4,797	4	2	EHCMS; IBBS RAC Report 2016

Figure 2.1.3 National ART Trend (Kyrgyz Republic)

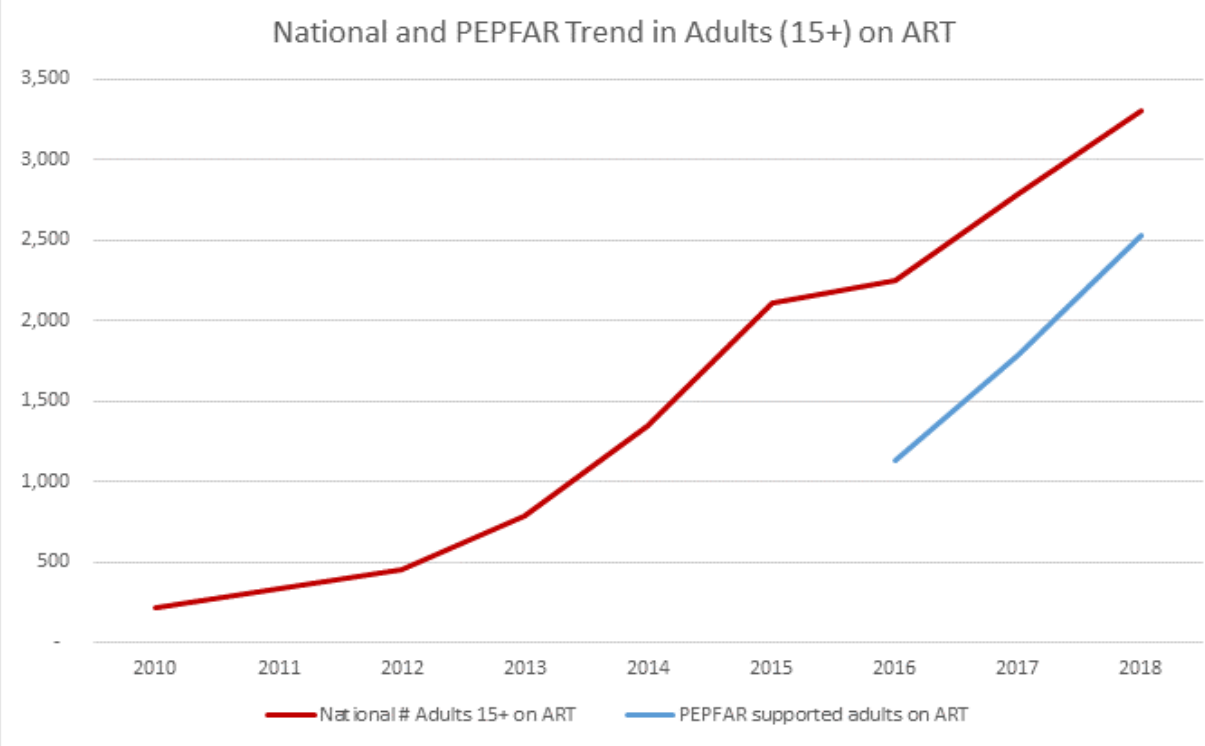
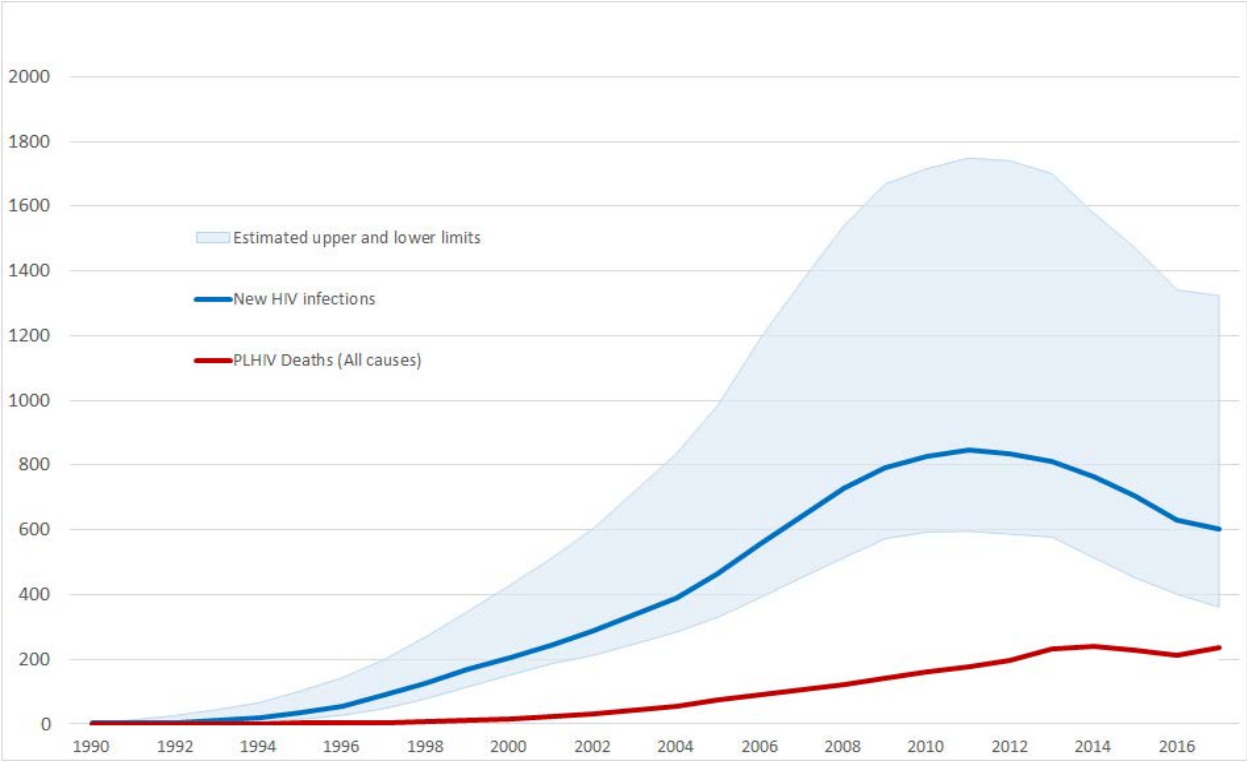


Figure 2.1.4 Trend of new infections and all-cause mortality among PLHIV (Kyrgyz Republic)



2.2 Investment profile: RAC estimates that 2020 funding needed to implement the National HIV Strategic Plan is $10,024,725. The HIV response in Kyrgyz Republic is primarily funded with external donor resources (84%), including the Global Fund and PEPFAR. However, the government has approved domestic resources of $1,574,947 (16%) for 2020. The GF allocation for the Kyrgyz Republic HIV component is $11,266,362 for the 2018 to 2020 allocation period, which is a 34% decrease from the 2015-2017 allocation. Of this 2018-2020 approved allocation, $3,217,100 was approved for 2020. This is approximately 32% of the estimated funding needs for 2020 based on the National HIV Strategic Plan.

PEPFAR continues to play an important role in providing TA as well as financing the HIV response in Kyrgyz Republic. For ROP19, PEPFAR has requested funding of $7,110,600. This is approximately 71% of the estimated funding need for Kyrgyz Republic in 2020.

[Note: Domestic and Global Fund funding information was collected from the Kyrgyz Republic Global Fund Application for 2018-2020.]

Table 2.2.1 Investment Profile by Program Area (Kyrgyz Republic)

Table 2.2.1 Kyrgyz Republic Investment Profile by Program Area					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% other**
Care & Treatment	**$7,468,872.00**	30.6%	54.2%	13.2%	2.0%
HIV Testing services	**$2,275,048.00**	67.2%	8.9%	23.9%	0.0%
Prevention	**$5,051,985.00**	10.9%	68.8%	5.9%	14.3%
AGYW beneficiary	$0.00				
Key populations beneficiary	**$4,743,240.00**	11.7%	70.1%	6.2%	12.0%
Other prevention beneficiaries	$308,745.00	0.0%	49.7%	0.4%	49.9%
Socio-economic	**$0.00**				
OVC beneficiary	$0.00				
Other socio-economic beneficiaries	$0.00				
Above-site programs	**$2,872,810.00**	38.5%	20.5%	21.8%	19.1%
HMIS, Surveillance, Research	$476,946.00	50.2%	13.1%	7.2%	29.6%
Laboratory systems strengthening	$871,225.00	38.4%	60.5%	1.1%	0.0%
Other ASP	$1,524,639.00	35.0%	0.0%	38.2%	26.8%
Total:	**$17,668,715.00**	**31.0%**	**47.1%**	**13.9%**	8.1%

Table 2.2.2 Procurement Profile for Key Commodities (Kyrgyz Republic)

Table 2.2.2 Kyrgyz Republic Procurement Profile for Key Commodities					
Commodity Category	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% other**
ARVs	$511,403.00	0.0%	100.0%	0.0%	0.0%
Rapid Test Kits	$250,286.00	18.7%	81.3%	0.0%	0.0%
Other drugs	$4,979.00	100.0%	0.0%	0.0%	0.0%
Lab reagents					
Condoms	$490,633.00	0.0%	95.9%	0.0%	4.1%
Viral Load commodities	$597,023.00	0.0%	100.0%	0.0%	0.0%
VMMC kits					
MAT	$164,013.00	0.0%	100.0%	0.0%	0.0%
Other commodities					
Total	**$1,966,448.00**	**0.0%**	**99.0%**	**0.0%**	**1.0%**

*UNAIDS GAM 2018 report

Table 2.2.3 Annual USG Non-PEPFAR Funded Interventions (Kyrgyz Republic)

Table 2.2.3 Kyrgyz Republic Annual USG Non-PEPFAR Funded					
Funding Source	**Total USG Non-PEFPAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**#Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
USAID MCH					
USAID TB	$4,300,000				
USAID Malaria					
Family Planning					
Nutrition	$1,500,000				
CDC NCD					
Peace Corps					
DOD Ebola					
MCC					
Total	**$5,800,000**				

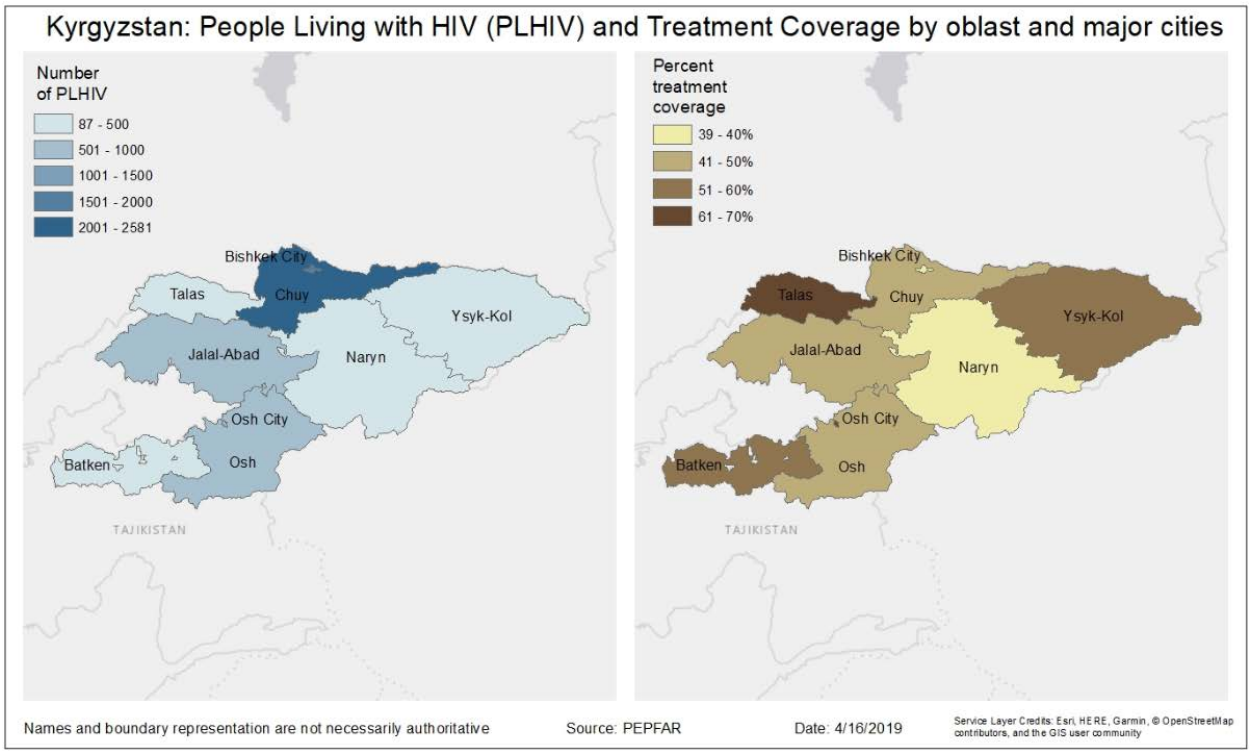
Table 2.2.4 Annual PEPFAR Non-COP Resources (Kyrgyz Republic): N/A Kyrgyz Republic does not currently receive any PEPFAR non-COP resources.

2.3 National sustainability profile update: Kyrgyz Republic has not been requested to conduct a SID and has not done one. Sustainability elements are described in more detail in the Responsibility Matrix for Kyrgyz Republic.

2.4 Alignment of PEPFAR investments geographically to disease burden: PEPFAR will support above-site national level activities to strengthen capacity throughout the Kyrgyz Republic to achieve epidemic control, and build key population and client-centered community and facility interventions that demonstrate impact towards reaching 90-90-90. In addition, PEPFAR will

continue to support site-level activities in the sub-national units (SNUs) with the highest burden of HIV. The priority SNUs for ROP19 are Bishkek City, Chui Oblast, Osh Oblast, and Osh City. These SNUs include approximately 81% of all adult PLHIV in the Kyrgyz Republic.

Figure 2.4.1 PEPFAR Sub-National Units: PLHIV and ART Treatment Coverage (Kyrgyz Republic)



2.5 Stakeholder engagement: Quarterly meetings with implementing partners and country stakeholders are used to disseminate PEPFAR program results, collect feedback, and ensure better coordination of activities among stakeholders. The PEPFAR team conducted a stakeholder meeting in Kyrgyz Republic in late January 2019 to discuss the S/GAC Planning Level Letter and program strategies for ROP19. At the stakeholder meeting, local government and Ministry of Health officials, leadership from National AIDS, and Narcology Centers, local CSOs, GF representatives, other implementing partners, and representatives of civil society and key populations discussed the PEPFAR annual progress report and the strategic direction for ROP19. Leadership from the Republican AIDS Center (RAC) of Kyrgyz Republic, as well as a Civil Society Representative and the GF Portfolio Manager, participated actively during the PEPFAR Asia Region ROP19 meetings that took place in Bangkok in April 2019. During this meeting, the PEPFAR team worked with the RAC, civil society, and Global Fund delegates to formulate new strategies to accelerate progress towards 90-90-90 by 2020. These strategies are reflected in this document in Sections 3.0 and 4.0.

Tier 1: NEPAL

2.1 Summary statistics, disease burden, and country profile: The population of Nepal is 29,880,908 (2019 World Population Review). GNI per capita was $800 in 2017 (World Bank). Since the first HIV-positive individual was reported in 1988, a total of 32,747 HIV-positive individuals have been reported (as of July 2018). National estimates indicated 29,944 PLHIV in 2018. Prevalence is greater than 5% among PWID, MSM, MSW, and TG people in certain geographic areas. Prevalence among MSM, MSWs, and transgender people (with no disaggregation by these three KP groups) was 8.2% in Terai highway districts in 2018, and 6.2% in Kathmandu valley in 2017 (IBBS). Prevalence among PWID (in 2017) was 8.5% in Kathmandu, 4.9% in Pokhara, and 5.3% in Western Teri highway districts (IBBS 2017). Among female sex workers (FSW), prevalence was 0.7% in Terai highway districts (2018), 2.2% in Kathmandu Valley (2017), and 0.3% in Pokhara (2016). For MSM, MSW, and TG, HIV prevalence was estimated at 2.2% in Pokhara (2017). Key populations (KP) comprise 49,000 FSW, 60,300 MSM, 18,300 MSW, and 21,500 TG (2016). The HIV epidemic is largely driven by KP; heterosexual transmission also is a primary driver. An estimated 74% new HIV infections occur through heterosexual transmission (NCASC, 2017). Estimated annual infections dropped by 58% from 2,093 in 2010 to 873 in 2018. Estimated annual AIDS-related deaths dropped by 38% from 1,417 in 2010 to 895 in 2018 (NCASC 2018).

The Government of Nepal (GON) National HIV Strategic Plan (NHSP) 2016 - 2021 guides the HIV response for all partners, with the goal of achieving 90-90-90 by 2020 and ending AIDS as a public health threat by 2030. There are 175 HIV testing and counseling (HTC) sites, 74 anti-retro viral therapy (ART) sites, 22 dispensing sites, and three VL testing sites across the country. Prevention of mother-to-child transmission (PMTCT) services are scaled up in all 77 districts. As of the end of 2018, out of the total estimated PLHIV, 21,388 knew their status (71%), 16,914 were on treatment (56%), and 7,603 had measurable VL suppression (25% of PLHIV on Tx). This represents 91% VL suppression among people tested for VL suppression (based on 8,357 tests performed) (NCASC 2018).

All FY19 PEPFAR Minimum Requirements are reflected in current GON policy, although MMS is endorsed only for three months rather than six. MMS is not fully implemented in Nepal, but it is expected to be expanded nationally during ROP19. During the ROP meeting in April 2019, the GON committed to updating the MMS policy to six months. Test and treat and TPT are fully implemented nationally, and quality improvement and intensification are ongoing in both USG- and GON/GF-supported districts. Index testing and the use of UICs are fully implemented in PEPFAR-supported sites. During ROP19, PEPFAR, GF, and the GON will work together to scale up a national, integrated HIV data management information system based on the District Health Information System 2 (DHIS2) and using UICs. PrEP, community-based ART, and HIV self-testing are currently implemented in one PEPFAR-supported district and will be expanded throughout Nepal in ROP19. PEPFAR and the GF will provide TA to the GON on the Tenofovir, Lamivudine, and Dolutegravir (TLD) transition during ROP19. Dolutegravir (DTG) was introduced in 2019, beginning with PLHIV not tolerating the Nucleoside reverse transcriptase inhibitors (NRTI) and protease inhibitor medicines used in first-line and second-line regimens. The

removal of Nevirapine will be completed by the end of 2019. The TLD transition is projected to be 63% completed by the end of ROP19 and 100% completed by the end of ROP20.

The GON continues to demonstrate strong political will and commitment to the HIV response. There are no user fees for HIV services. GON funding of the response has increased every year since 2016. The GON is currently funding 80% of anti-retroviral medications (ARV); this will increase to 100% during ROP19. Additionally, the GON is funding salaries of HIV and ART counselors, all costs for PMTCT, TB-HIV, diagnosis and treatment of sexually transmitted infections (STI), and strategic information systems.

To achieve 90-90-90, Nepal must identify an additional 5,562 PLHIV, put 7,311 PLHIV on treatment, maintain VL suppression above 90% (currently 91% for those tested), and triple the country's capacity to conduct VL testing. Key gaps and barriers to achieving epidemic control include:

1) Varied implementation and quality across districts supported by different donors;
2) Historically low case-finding positivity rates (Note: although case-finding strategies with higher positivity rates have been introduced over the past two quarters, they have not been fully implemented across the country);
3) Limitations in the national procurement and commodity logistics systems which have led to procurement delays and stock outs;
4) ART services are currently hospital-based, so PLHIV need to travel long distances for ART initiation as well as follow-up and pill pickup;
5) Limited capacity to conduct VL testing due to a number of issues including inadequate number of machines, sub-optimal use of existing machines, maintenance issues, stock-outs of reagents, long travel times, and geographic isolation; and
6) Lack of unified, integrated DHIS 2 data system with UICs across the country.

Table 2.1.1 Nepal Host Country Government Results

Table 2.1.1 Nepal Host Country Government Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	29,097,158	100	4,393,509	15	4,634,506	16	3,096,391	11	3,119,175	*11*	7,506,676	26	6,346,901	22	World Bank 2017
HIV Prevalence (%)		0.14		0.01		0.01		0.02		0.02		0.14		0.26	National HIV Estimates 2018
AIDS Deaths (per year)	895		15		17		11		8		168		677		National HIV Estimates 2018
# PLHIV	29,944		635		661		734		639		10,844		16431		National HIV Estimates 2018
Incidence Rate (Yr.)		0.03		0.01		0.01		0.023		0.034		0.02		0.05	National HIV Estimates 2018
New Infections (Yr.)	873														National HIV Estimates 2018
Annual births	581,600														World Population Prospects 2017
% of Pregnant Women with at least one ANC visit	85%														NDHS2016
Pregnant women needing ARVs	220														National HIV Estimates 2018
Orphans (maternal, paternal, double)	25,826														National HIV Estimates 2018
Notified TB cases (Yr.)	32,474 (2017/18)														National Tuberculosis Program Annual Report 2017/2018
% of TB cases that are HIV infected	41	2.5													National Tuberculosis Center, Sentinel Surveillance of HIV Infection among Patients with Tuberculosis in Nepal, 2018
% of Males Circumcised	NA														
Estimated Population Size of MSM*	60,333														National size estimates, 2016
MSM HIV Prevalence		4.8 2.9 6.o													IBBS, Kathmandu valley, 2017 IBBS, Pokhara valley, 2017 IBBS, Terai highway districts, 2018

Table 2.1.1 Nepal Host Country Government Results																
	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
Estimated Population Size of MSWs	18,287														National size estimates, 2016
MSWs HIV Prevalence		7.0 2.9 10.2													IBBS, Kathmandu valley, 2017 IBBS, Pokhara valley, 2017 IBBS, Terai highway districts, 2018
Estimated Population Size of TG people	21,460														National size estimates, 2016
TG people HIV Prevalence		8.6 2.9 11.5													IBBS, Kathmandu valley, 2017 IBBS, Pokhara valley, 2017 IBBS, Terai highway districts, 2018
Estimated Population Size of FSW	49,018														National size estimates, 2016
FSW HIV Prevalence		2.2 0.3 0.7													IBBS, Kathmandu valley, 2017 IBBS, Pokhara valley, 2016 IBBS, Terai highway districts, 2018
Estimated Population Size of PWID	30,868														National size estimates, 2016
PWID HIV Prevalence		8.5 4.9 3.3 5.3													IBBS, Kathmandu valley, 2017 IBBS, Pokhara valley, 2017 IBBS, Eastern Terai highway districts, 2017 IBBS, Western to Far-western Terai highway districts, 2017
Estimated Size of Priority Populations (Clients of FSWs)	800,618														National HIV Infection Estimates 2016
Priority Populations Prevalence (clients of FSWs)		0.3													IBBS, Terai highway districts, 2016

Table 2.1.1 Nepal Host Country Government Results															
	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
Estimated Size of Priority Populations (Migrants)	505,719														CBS 2011 (83.47% of absentee going to India)
Priority Populations Prevalence (Migrants)		0.4 0.3													IBBS, Western and Mid to Far Western Region of Nepal, 2017 IBBS, Eastern districts of Nepal, 2018

Table 2.1.2 Nepal 90-90-90 Cascade

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*										
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	29,097,158	0.2	29,944	21,388	16,914	56	25	253,136*** *	2,190****	*2,488***
Population <15 years	9,028,015	0.01	11,296		1,273	98		2,863****	125****	*183***
Men 15-24 years	3,119,175	0.02	639		8,044	47		18,605**	45**	*43***
Men 25+ years	6,346,901	0.026	16,431					24,229**	181**	*171***
Women 15-24 years	3,096,391	0.02	734		7,596	66		11,321**	26**	*26***
Women 25+ years	7,506,676	0.14	10,844					22,532**	121**	*121***

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*										
Epidemiologic Data					**HIV Treatment and Viral Suppression**			**HIV Testing and Linkage to ART Within the Last Year**		
MSM	60,333	4.8 (Kathmandu valley) 2.9 (Pokhara valley) 6.o (Terai highway districts)	4,345					8,704**	45**	*44***
MSWs	18,287	7.8 (Kathmandu valley) 2.9 (Pokhara valley) 10.2 (Terai highway districts)						2,583**	17**	*11***
TG people	21,460	8.6 (Kathmandu valley) 2.9 (Pokhara valley) 11.5 (Terai highway districts)						2,217**	16**	*11***
FSW	49,018	2.2 (Kathmandu valley) 0.3 (Pokhara valley) 0.7 (Terai highway districts)	264					30,743**	113**	*105***

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*										
Epidemiologic Data					**HIV Treatment and Viral Suppression**			**HIV Testing and Linkage to ART Within the Last Year**		
PWID	30,868	8.5 (Kathmandu valley) 4.9 (Pokhara valley) 3.3 (Eastern Terai highway districts) 5.3 (Western to far-western Terai highway districts)	1,287					57**	2**	*0***
Priority Pop (clients of FSWs)	800,618	0.3 (Terai highway districts)	1,723					31,393**	159**	*153***
Priority Pop (Migrants)	505,719	0.4 (Western and Mid to Far Western Region) 0.3 (IBBS, Eastern districts)						16**	1**	*3***

*These should be national data, if the data do not exist, PEPFAR data may be used if relevant. ** USAID/LINKAGES data FY 18 ***As of July 2018. ****Jan-Dec 2018

Figure 2.1.3 National trend for individuals currently on treatment (Nepal)

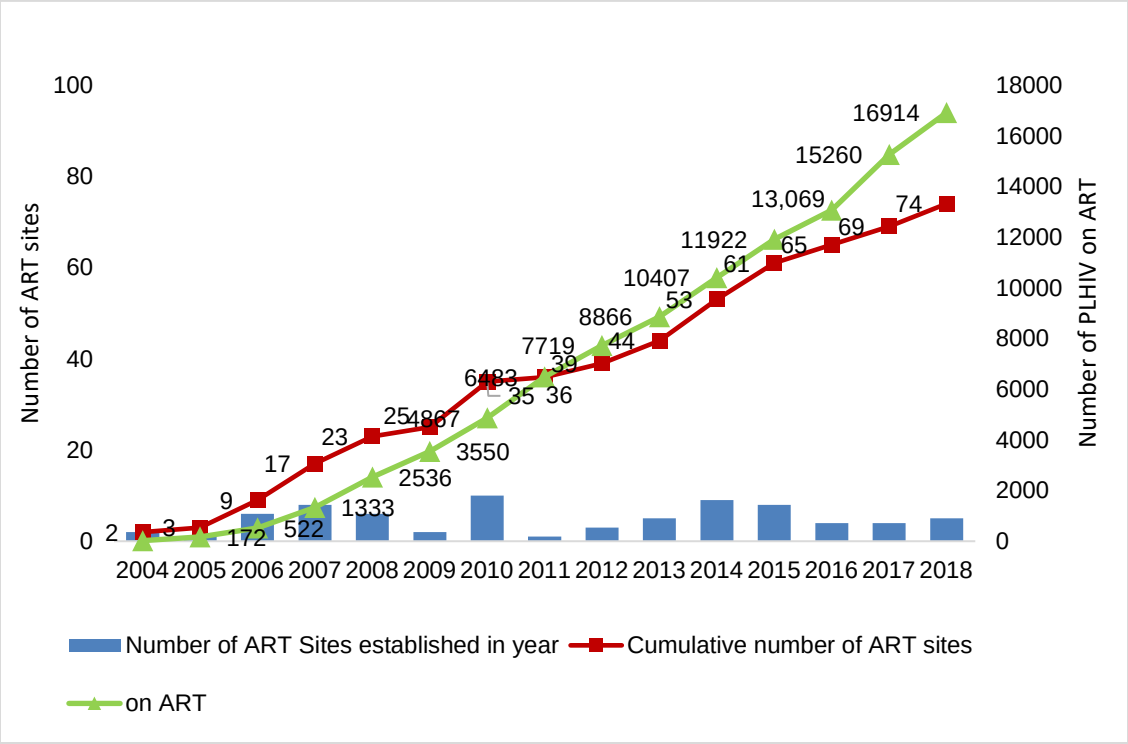
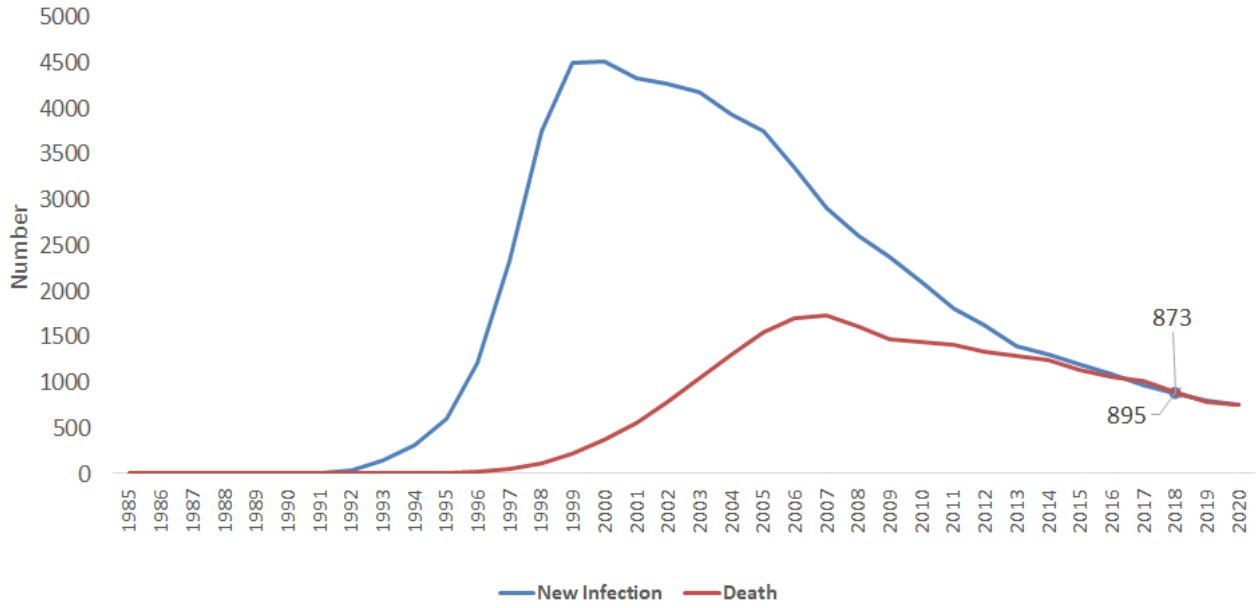
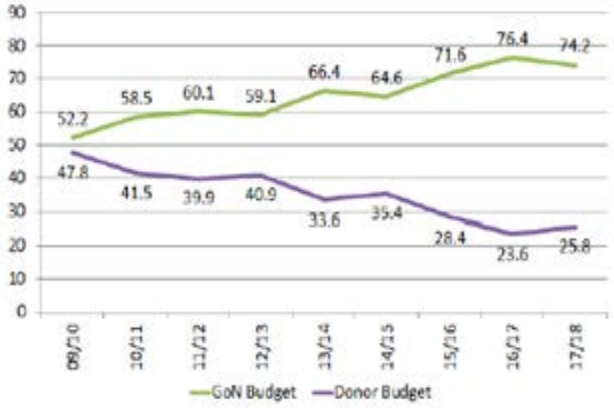


Figure 2.1.4 Trend of New Infections and All-Cause Mortality Among PLHIV (2018) (Nepal)



2.2 Investment profile: The GF and the USG are the major funders of the national HIV response in Nepal; the AIDS Healthcare Foundation (AHF), WHO, UNAIDS, and UNICEF are other contributors. In addition, the GON has committed to a significant increase in resources for the national HIV program with an average $9.4 million per year from 2019 to 2021. GON funds covered 80% of the costs of procurement of ARV drugs in 2018-19 and of salaries of HIV and ART counsellors. The government will fully cover procurement of ARV drugs in 2019-20. In 2020-21, government funding will cover other programs and services, including PMTCT, TB-HIV, STI, and SI, all of which previously received GF support (through the GF funding application of 2017). However, there is still a projected gap (around 55% in the 2020 estimated budget, prior to increased PEPFAR funding) in funding to reach the 90-90-90 targets by 2020 and to end AIDS as a public health threat by 2030. The HIV response in Nepal was still heavily funded by international donors (85%), followed by domestic government funding (8%), and private sources (out-of-pocket expenditures) (7%) in 2016 and 2017 (NASA 2018).



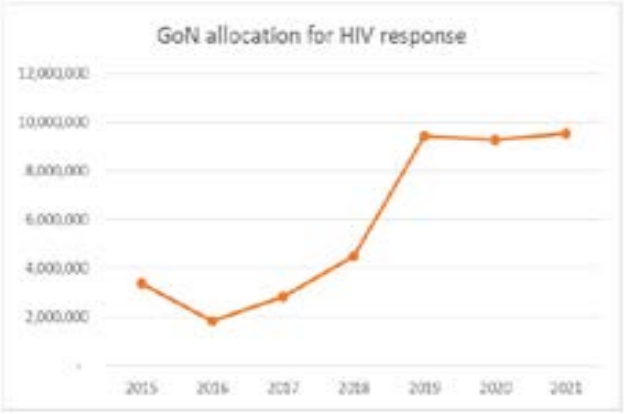


Table 2.2.1 Annual investment profile by program area (Nepal)

Program Area	Total Expenditure	% PEPFAR	% GF including other multilaterals	% Host Country	% Other
Care & Treatment	11,416,834	2	89	6	2
HIV Testing Services	see below				
Prevention including HIV testing	17,802,301	12	59	11	18
- AGYW beneficiary					
- Key populations beneficiary					
-Other prevention beneficiaries					
Socio-Economic	288,078	0	100	0	0
- OVC beneficiary					
- Other socio-economic beneficiaries					
Above site programs					
- HMIS, Surveillance, Research	508,423	2	66	31	0
- Laboratory systems strengthening					
- Other ASP	2,686,960	73	24	0	3
Total	32,702,596	14	67	8	11

Table 2.2.2 Annual Procurement Profile for Key Commodities (Nepal)

Table 2.2.2 Annual Procurement Profile for Key Commodities[10]					
Commodity Category	**Total Expenditure (US$)**	**% PEPFAR**	**% Multilateral including GF**	**% Host Country**	**% Other**
ARVs	670,3490		100		
Reagents and materials	2,011,377		100		
Other drugs	397,382		0.3%		66%
Lab reagents					
Condoms					
VL commodities					
VMMC kits					

[10] National AIDS Spending Assessment 2016-2017, all amounts in USD

MAT	NA				
Other commodities	1,118,848.00		96	1	3
Total	**10,680,517**				

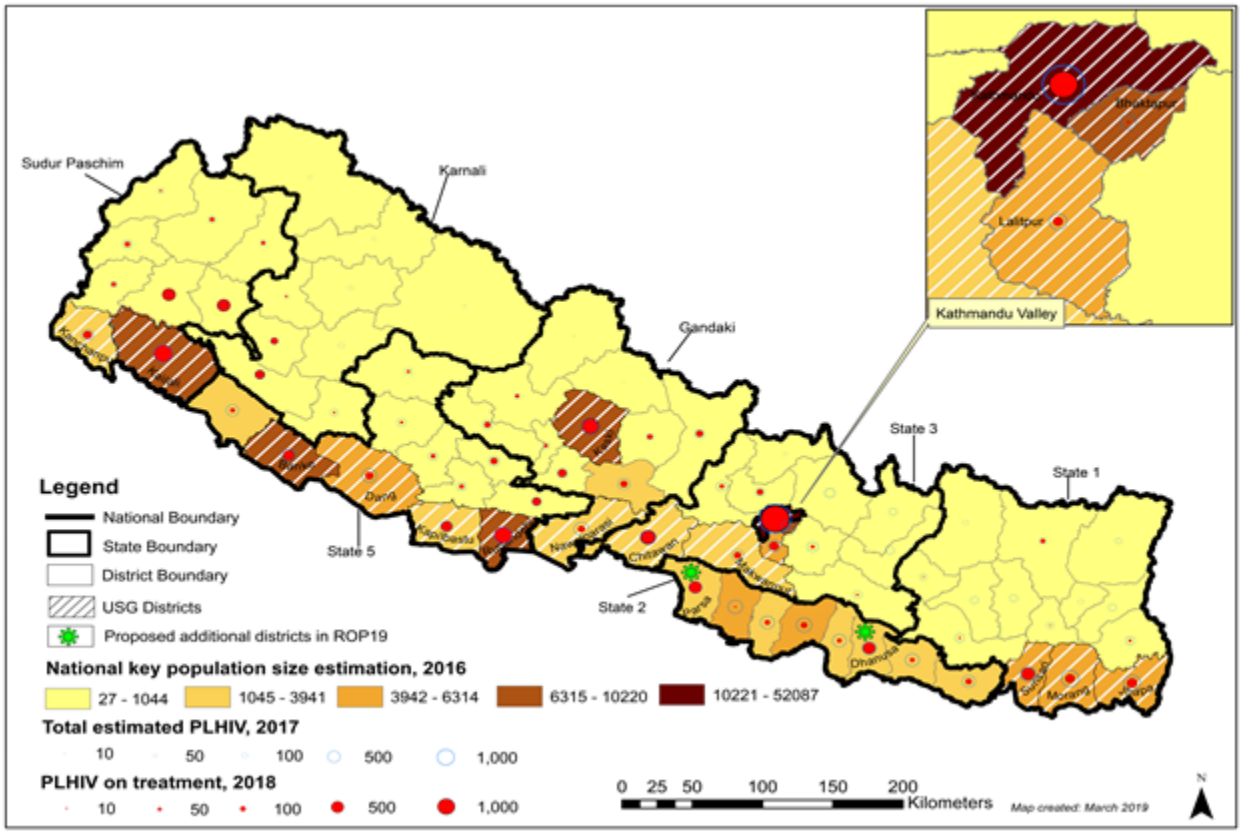
2.3 National sustainability profile update: Nepal has not yet conducted a COP or a SID, so does not have the required data to complete this section.

2.4 Alignment of PEPFAR investments geographically to disease burden: In Nepal, HIV program coverage has been divided between the USG and GF/GON by KP and by geographic area. PEPFAR has historically covered FSWs nationally and MSM, MSW, and TG people in five districts. The GF covered PWID nationally and MSM, MSW, and TG people in the non-USG-supported districts. In ROP 19, PEPFAR will work in 19 districts. These 19 districts cover 79% of the estimated KP, 52% of the estimated PLHIV, and 32% of the PLHIV not yet on treatment. (These programs represent approximately 26% of total HIV/AIDS funding). Together, the GF, GON, and PEPFAR cover 90% of KP and nearly all PLHIV. In addition to PEPFAR's 32% coverage of PLHIV not yet on treatment, the GF covers an additional 53%, for joint coverage of 85% of PLHIV not yet on treatment.

The map below shows disaggregation by SNU to the district level. Disaggregation for VL testing is not available. In ROP19, with additional acceleration funds, PEPFAR will expand to additional populations and interventions within the existing 19 districts. The USG, GF, and GON will hold a stakeholders' workshop in May 2019 to share information with the goal of improving performance across all partners nationally and realigning efforts as necessary. If agreed with the GF (tentative agreement already obtained), the USG may expand to MSM, MSW, and TG people in all of 19 PEPFAR-supported districts.

Additionally, Nepal PEPFAR will expand from zero to 28 facility-based ART sites (including 13 ART sites in collaboration with AHF) in the 19 districts. At these sites, PEPFAR will provide TA to support: treatment enrollment and retention, MMS, TPT, TB diagnosis and treatment, VL sample collection and transportation, treatment literacy, case management and follow-up, support by peer navigators, index testing by peer navigators, improved logistics management and TLD transition, improved data recording and reporting, periodic data analysis and review. Additionally, the USG will work with the GON to establish community-based ART at 11 new sites (from 1 site currently) in geographic locations with the greatest concentrations of PLHIV.

Figure 2.4.1 HIV Burden and Coverage of Program Responses Geographically (Nepal)



2.5 Stakeholder engagement: USAID/Nepal, with support from the FHI360 LINKAGES Project, organized a country consultation meeting with stakeholders in the national HIV response to share and discuss (1) PEPFAR's strategic priorities, approaches and activities, and the Asia ROP 2019 process, (2) LINKAGES' issues and challenges, and (3) the national HIV epidemic situation and response, priorities, needs, and gaps to achieve 90-90-90 targets by 2020. The meeting was attended by directors and staff from the National Centre for AIDS and STD Control (NCASC) and the National Public Health Laboratory (NPHL), representatives from Save the Children (the principal recipient of the GF in Nepal), UNAIDS, UNICEF, WHO, AHF, national networks of KP and PLHIV, FHI 360/LINKAGES Nepal, and USAID/Nepal.

As discussed during the consultation meeting, the USG will coordinate and collaborate with NCASC and NPHL, GF/Save the Children, AHF, UNAIDS, WHO, and national networks of KP and PLHIV for implementation and monitoring of PEPFAR activities. HIV test kits, reagents and supplies, condoms and lubricants will be supplied through the national logistics supply system. PEPFAR will closely work with government and other non-government stakeholders for institutionalization of HIV self-testing, index testing, and PrEP in the national HIV response, strengthening ART services, TLD transition, MMS, community-based ART service delivery, strengthening the procurement and supply management system, and development and implementation of the on-line and real-time national HIV information and management system.

Coordination and collaboration with national networks of KP and PLHIV will help to ensure provision of KP- and PLHIV-competent and friendly services.

Tier 1: TAJIKISTAN

2.1 Summary statistics, disease burden, and country profile: Tajikistan is a former republic of the Soviet Union located in Central Asia. It is a landlocked country that borders Afghanistan to the South, Uzbekistan to the West, Kyrgyz Republic to the North and China to the East. The total population of Tajikistan is 8.931 million. The 2017 GNI for Tajikistan is $990, which reflects a continued decrease from $1,340 in 2014.[11]

The national HIV prevalence (age 15+ years) in Tajikistan is 0.25%. However, prevalence among KP remains high. Among PWID, the prevalence of HIV is 11.9%, among FSW it is 3.2%, and among MSM it is 2.3% (IBBS 2017 and 2018). The latest, officially recognized Spectrum modeling estimates for total PLHIV aged 15+ in Tajikistan is 14,436 (10,662 men; 3,774 women). In 2017, Tajikistan had 1,300 (<1,000 – 2,400) new HIV infections and <1000 (<500 - <1000) AIDS-related deaths. Since 2010, new HIV infections have decreased by 2%.[12]

The World Bank estimates that almost 1 million Tajik citizens (1/3 of men aged 20-39 years) work outside of the country at any given time. These men most often work in Russia, where the HIV epidemic continues to grow at an alarming rate. Migrants are away from their families for extended periods, during which they are at increased risk of infection. Exacerbating this problem is the fact that labor migrants are inaccessible to reach with HIV-related interventions while they are outside of Tajikistan. This creates considerable barriers to reaching 90-90-90 among this population, which affects success in improving the overall national cascade as well.

Of the three PEPFAR-supported countries in Central Asia, Tajikistan is the furthest from achieving the UNAIDS 90-90-90 goals by 2020. At the beginning of January 2019, there were 6,903 individuals aged 15+ diagnosed with HIV (48% of estimated PLHIV 15+); 5,313 of were on ART (37% of estimated PLHIV 15+); and 4,144 had documented viral suppression (78% of estimated PLHIV 15+ on ART). The PEPFAR priority site-level sub-national units in Tajikistan (Districts of Republican Subordination, Dushanbe, and Sughd Province) reflect high-burden geographic areas in the country and account for 70% of the estimated PLHIV in Tajikistan.

Tajikistan has made significant progress in adopting and implementing key policies to address PEPFAR minimum program requirements, including implementation of a Test & Start strategy, scale-up of TB preventive therapy for all PLHIV, adoption of DSDM and continued roll-out and expansion of multi-month scripting (MMS) for stable patients. The Republican AIDS Center (RAC) of Tajikistan has included TLD as the preferred first-line ART in the new National Clinical Guidelines, and has a clear path to transition over 90% of PLHIV on ART to TLD within the next 12 months. The first shipment of TLD procured by the GF will arrive in September 2019.

[11] World Bank https://data.worldbank.org/country/tajikistan
[12] AIDS Info http://aidsinfo.unaids.org/

Nevertheless, Tajikistan faces several obstacles in achieving the targets set out in the UNAIDS Fast Track – Ending the AIDS Epidemic by 2030 initiative and the 90-90-90 goals for 2020. Key challenges include external migration to Russia, decreasing GNI, and reduction in donor funding for health. Another major challenge is discriminatory laws and policies toward KP that limits access to and uptake of HIV-related services. In addition, incomplete epidemiological data for some of these populations (e.g., migrants) and limited understanding of how they can best access services. As a result, new case finding among KP is lower than expected and linkage and uptake of available HIV services is limited. There also are remaining challenges with ensuring retention throughout the continuum of care for those most in need.

The Republic of Tajikistan, in close collaboration with PEPFAR, the GF, and other stakeholders, will implement new approaches to accelerate progress toward 90-90-90. These approaches include expanding effective community, peer driven and facility-based case finding and index testing strategies, and using real-time data to drive program inputs and interventions. Tajikistan will expand and strengthen index case finding activities (e.g., improved partner elicitation) and recency testing activities to find partners, networks and communities where active HIV transmission is occurring. In addition, the Republic of Tajikistan is working with PEPFAR on adopting and expanding strategies to ensure those diagnosed are linked to client centered ART services and receive interventions at the community and facility level that boost adherence and retention to achieve durable viral suppression.

Table 2.1.1 Tajikistan Host Country Government Results

TAJIKISTAN

Table 2.1.1 Key National Demographic and Epidemiological Data

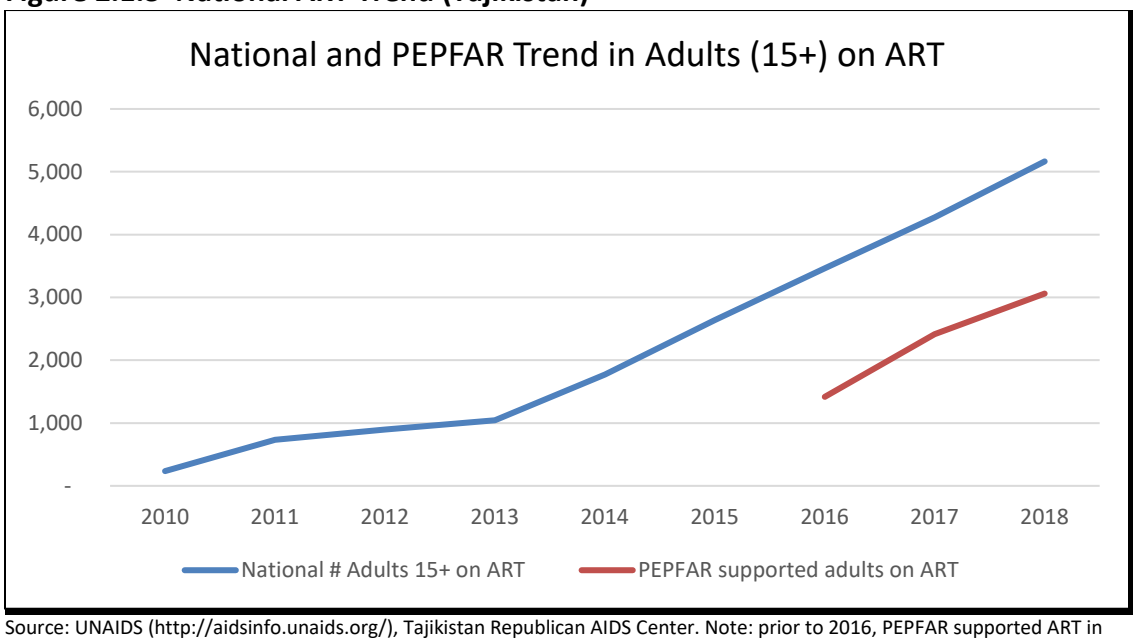
	Total		<15				15-24				25+				So
			Female		Male		Female		Male		Female		Male		Empty cell a
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	8,930,880	100.0%	1,472,800	16.5%	1,590,700	17.8%	833,300	9.3%	870,900	9.8%	2,096,550	23.5%	2,066,630	23.1%	National Sta of January 0 www.stat.tj
HIV Prevalence (%)		0.165%		0.011%		0.010%		0.049%		0.074%		0.16%		0.48%	Estimated # Spectrum da population
AIDS Death (per year)	159	-	1	-	3	-	4		0		50		101		EHCMS, Ma 28, 2019 for
AIDS Death (per year)	575	-	5	-	6	-	3	-	6	-	67	-	488	-	UNAIDS dat
Estimated # PLHIV	14,770		167		167		407		643		3,367		10,019		UNAIDS Spe
Incidence Rate (Yr.)		0.015%		0.002%		0.001%		0.011%		0.020%		0.010%		0.039%	
New Infections (Yr.)	1,327		23		23		89		178		207		807		UNAIDS dat http://www
Newly diagnosed Infections (Yr.)	1,553	-	74	-	104	-	72		43		471		789		EHCMS, Ma 28, 2019; # registered/c cases
Pregnant Women Needing (ARVs)	65														EHCMS, As
Notified TB Cases (Yr.)	6,279														2018 WHO data from 2

% of TB cases that are HIV infected	215	3.42%	9		18		3		3		37		145		EHCMS, As calculated % infected/ TB
Estimated Population Size of PWID	22,208	-													RAC, size es 2018
PWID HIV Prev.	-	11.9%													RAC, IBBS, 2
Estimated Population size of MSM	13,400	-													GF/UNDP/R
MSM HIV Prev.	-	2.3%													GF/UNDP/R
Estimated Population Size of FSW	17,591	-													RAC, size es 2018
FSW HIV Prev.	-	3.2%													IBBS, 2018

Table 2.1.2 Tajikistan Cascade of HIV Prevention, Diagnosis, Care, and Treatment

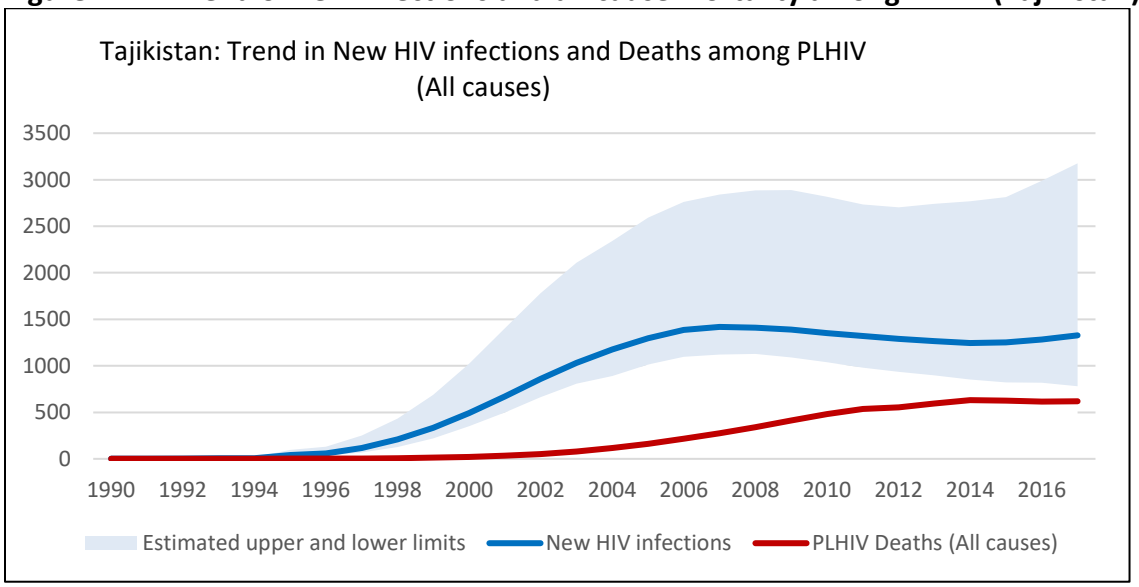
Table 2.1.2 Cascade of HIV Prevention, Diagnosis, Care and Treatment, and viral suppression (12 months) for patients 15 years old and above											
TAJIKISTAN											
	Epidemiologic Data			**HIV Treatment and Viral Suppression**				**HIV Testing and Linkage to ART**			
	Total Size Estimate (#)	**HIV Prevalence (%)**	**Estimated PLHIV (#)**	**PLHIV diagnosed (#)**	**On ART (#)**	**ART Coverage (%)**	**Viral Suppression (%)**	**Tested for HIV (#)**	**Diagnosed HIV+ (#)**	**Initiated on ART (#)**	**Sources**
Population 15+ years	5,867,380	0.25%	14,436	6,903	5,313	37%	78%	598,814	1,295	1092	EHCMS
Men 15-24 years	870,900	0.07%	643	134	116	18%	78%	NA	38	31	EHCMS
Men 25+ years	2,066,630	0.48%	10,019	3,927	2,808	28%	75%	NA	762	625	EHCMS
Women 15-24 years	833,300	0.05%	407	195	170	42%	75%	NA	75	66	EHCMS
Women 25+ years	2,096,550	0.16%	3,367	2,647	2,219	66%	82%	NA	420	370	EHCMS
PWID	22,208	11.9%	2,998	1,892	1,154	61%	75%	18,192	185	129	EHCMS; PSE 2018; IBBS, 2018
MSM	13,400	2.3%	361	95	75	79%	82%	3,173	36	32	EHCMS; PSE 2017; IBBS, 2017
FSW	17,591	3.2%	615	625	525	84%	79%	8,883	114	101	EHCMS; PSE 2018; IBBS, 2018
	1) For total population - National Statistics Agency, As of Jan 01, 2018 2) For KP - the last available PSE	Estimated PLHIV/Total population	1) UNAIDS Spectrum Data 2) For KP as calculated PSE*IBBS prev	EHCMS, diagnosed # of PLHIV still alive, As of Feb 28, 2019	EHCMS, As of Feb 28, 2019	calculated % using Estimated PLHIV as denominator	EHCMS, As of Feb 28, 2019 (calculated as TX_PVLS)	Forma 4, 2018, RAC	EHCMS, Jan 01, 2018 - Dec 31, 2018; # of newly confirmed cases officially registered	EHCMS, Jan 01, 2018 - Dec 31, 2018; TX_NEW	

Figure 2.1.3 National ART Trend (Tajikistan)



Source: UNAIDS (http://aidsinfo.unaids.org/), Tajikistan Republican AIDS Center. Note: prior to 2016, PEPFAR supported ART in a different set of HIV clinics

Figure 2.1.4 Trend of new infections and all-cause mortality among PLHIV (Tajikistan)



Source: Spectrum Estimates

2.2 Investment profile: The Republican AIDS Center (RAC) estimates that the 2020 funding needed to implement the National HIV Strategic Plan in Tajikistan is $14,993,530. External donors primarily fund the HIV response in Tajikistan, including the GF and PEPFAR. The Government of Tajikistan has approved the use of 12% domestic resources ($1,839,675) to address HIV and AIDS in 2020.

The GF allocation for the Tajikistan HIV component is $12,939,544 for the 2018 to 2020 allocation period, which is a 43% decrease from the 2015-2017 allocation. Of this 2018-2020

approved allocation, $5,288,480 is approved for 2020. This is approximately 35% of the estimated funding needs for 2020 based on the National HIV Strategic Plan. (Domestic and GF funding information was collected from the Tajikistan GF Application for 2018-2020.)

PEPFAR continues to play an important role in providing TA as well as supporting the Republic of Tajikistan to finance its HIV response.

Table 2.2.1 Annual Investment Profile by Program Area (Tajikistan)

Table 2.2.1 Tajikistan Annual Investment Profile by Program Area					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Care & Treatment	**$3,084,966**	70.1%	11.4%	2.7%	15.8%
HIV Testing services	**$2,494,016**	77.8%	22.2%		
Prevention	**$1,749,563**	29.1%	56.7%	14.2%	
AGYW beneficiary					
Key populations beneficiary	$1,358,285	37.5%	60.9%	1.6%	
Other prevention beneficiaries	$391,278		42.1%	57.9%	
Socio-economic	**$6,664**				
OVC beneficiary	$6,664				
Other socio-economic beneficiaries					
Above-site programs	**$2,957,460**	44.6%	34.3%	19.4%	1.6%
HMIS, Surveillance, Research	$822,442	59.3%	7.2%	33.5%	
Laboratory systems strengthening	$271,632	100%			
Other ASP	$1,863,386	30%	51.3%	16.1%	2.6%
Total	**$10,292,669**	**57.6%**	**28.4%**	**8.8%**	**5.2%**

Source: UNAIDS National Spending Assessments, 2018 expenditures

Table 2.2.2 Annual Procurement Profile (Tajikistan)

Table 2.2.2 Procurement Profile for Key Commodities Tajikistan					
Commodity Category	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
ARVs	$105,456	0.0%	21.1%	78.9%	
Rapid Test Kits	$147,328	32.1%	67.9%		
Other drugs					
Lab reagents	$20,689	75.8%	24.2%		
Condoms					
Viral Load commodities	249,293	16.6%	83.4%		
VMMC kits					
MAT					
Other commodities	$186,176	62.4%	37.6%		
Total:	**$708,942**	**31.1%**	**57.2%**	**11.7%**	

Source: UNAIDS National Spending Assessments, 2018 expenditures; Data on laboratory commodities was provided by Global Fund

Table 2.2.3 Annual USG Non-PEPFAR Funded Interventions (Tajikistan)

Table 2.2.3 USG Non-PEPFAR Funded Investments					
Funding Source	**Total USG Non-PEFPAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-funded IMs**	**PEPFAR COP Co-funding Contribution**	**Objectives**
USAID MCH	$2,514,772				
USAID TB	$3,842,698				
NIH	$2,839,472				
Total	**$9,196,942**				

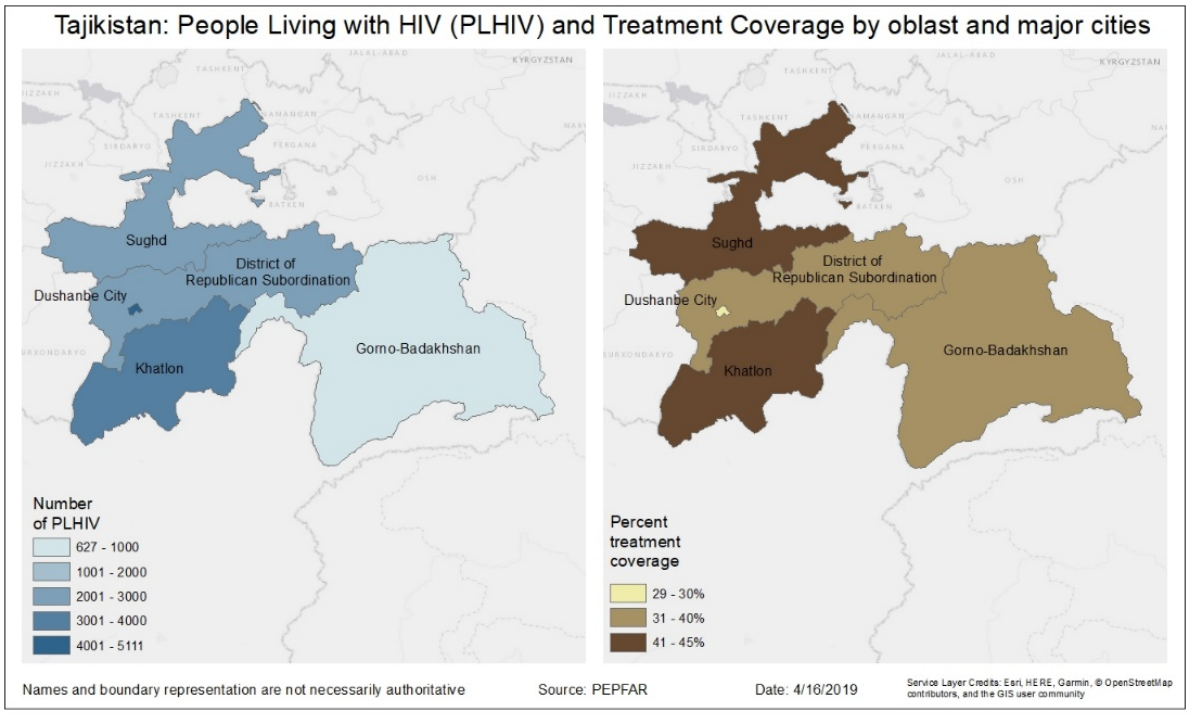
Source: US Government

Table 2.2.4 Annual PEPFAR Non-COP Resources (Tajikistan): Tajikistan does not currently receive any PEPFAR non-COP resources.

2.3 National sustainability profile update: Tajikistan did not submit a SID in 2017. The Tajikistan Responsibility Matrix includes additional information on sustainability.

2.4 Alignment of PEPFAR investments geographically to disease burden: PEPFAR will continue to support above-site national level activities to strengthen capacity throughout Tajikistan to achieve 90-90-90, and build KP and client-centered community and facility interventions that demonstrate impact towards reaching 90-90-90.
In addition, PEPFAR will continue to support site-level activities at the three SNUs that have a high burden of HIV. The priority SNUs for ROP19 are: (1) Dushanbe City; (2) Sughd Region; and (3) Districts of Republican Subordination surrounding Dushanbe. These SNUs include approximately 70% of all estimated adult PLHIV in Tajikistan.

Figure 2.4.1 PEPFAR Sub-National Units: PLHIV and ART Treatment Coverage (Tajikistan)



2.5 Stakeholder engagement: Quarterly meetings with IPs and country stakeholders disseminate PEPFAR program results, collect feedback, and ensure better coordination of activities among stakeholders. PEPFAR conducted stakeholder meetings in Tajikistan in late January 2019 to discuss the S/GAC Planning Level Letter and program strategies for ROP19.

The PEPFAR team met with local government and Ministry of Health and Social Protection officials, leadership from National AIDS and Narcology Centers, local NGOs, UNDP (Principal Recipient for the GF), other IPs, and representatives of civil society and KP to disseminate information from the annual progress report and to discuss the strategic direction for ROP19. Leadership from the RAC, as well as civil society representatives, participated actively during the PEPFAR Asia Region ROP19 meetings that took place in Bangkok in April 2019. During this meeting, the PEPFAR team worked with RAC and CSO delegates to formulate new strategies to accelerate progress towards 90-90-90 by 2020. Sections 3.0 and 4.0 of this SDS reflect these strategies.

Tier 1: THAILAND

2.1 Summary statistics, disease burden, and country profile: Under the leadership of the Royal Thai Government (RTG), Thailand PEPFAR has made significant contributions toward the national goal of achieving 90-90-90 by 2020. Thailand has been a regional leader by becoming the first Asian country to eliminate Mother-to-Child Transmission of HIV (eMTCT) and initiate PrEP—while already having achieved the "first" 90. The Thailand PEPFAR program aims to support achievement of sustainable HIV epidemic control by targeting MSM, TG, and their partners and contribute to regional responses to maximize impact and efficiency. The Thailand PEPFAR program will focus on three key areas for acceleration: institutionalizing key population-led differentiated service delivery models as an integral part of the health system

and sustainable domestic financing; strengthening policy frameworks, systems and technical capacity for evidence-based KP programming and cascade monitoring at all levels; and enhancing regional connectivity and adoption of proven KP innovations through shared expertise across the Asia region and beyond.

Thailand continues to make progress at the policy level. PEPFAR will continue to partner with the Royal Thai Government, GF, and civil society to advocate for key policies at the national level, while supporting implementation of policy at the site and community level. PEPFAR program will support improvement in service delivery and quality management for KP, including expansion of SDART, self-testing, index testing, and recency testing in 13 high-burden provinces. The focus of interventions also includes ensuring access to VL testing for viral suppression and treatment retention through KP cascade monitoring and morbidity and mortality reporting systems, and the use of granular data analysis in a timely fashion.

Thailand is the current Chair for ASEAN, and it is important that the nation continues to be at the forefront of ending HIV in the region. Although an upper-middle income country with a GNI per capita of $5,720 (2015, World Bank), Thailand's economic growth has slowed in recent years compared to other developing East Asian countries. Poverty continues to be an important challenge, particularly among the ~50% of the population that live in rural areas. Basic health systems infrastructure and access to clean water and sanitation are nearly ubiquitous.

In Thailand, overall HIV incidence has decreased, but incidence and prevalence remain high among key populations with an estimated prevalence among MSM, TG, and MSW at 7.1%, 2.1% and 10.7%, respectively (IBBS 2016). In the past decade, increased access to and coverage of prevention and ART services has resulted in a rapid decline of the epidemic. During 2015-2019, it was estimated that 41% of new infections were driven by unprotected male-to-male sex and TG women, and 31% by heterosexual discordant couples (AEM 2018).

Thailand has one of the highest rates of HIV prevalence in Asia and the Pacific, accounting for 9% of the region's total population of PLHIV. Of Thailand's population of approximately 65.5 million[13], it was estimated that 429,871 were PLHIV in 2018, while annual new infections were estimated at 5,500, and annual deaths at 15,000.

Current progress towards epidemic control: The 2017–2030 National AIDS Strategy of the RTG aims to reduce new infections to less than 1,000 per annum by supporting combination prevention and treatment strategies for KP and PLHIV, and working in partnership with community-led organizations to reach those at highest risk for HIV transmission and acquisition. The Government of Thailand is committed to ending the AIDS epidemic, and achieving the UNAIDS 90-90-90 goals by 2020. As noted below, the RTG supports more than 90% of the HIV response in country and more than 90% of the procurement of drugs and other commodities. In

[13] Population Projections for Thailand, 2010-2040, 2013 census

addition, since 2017, RTG has increasingly been providing direct funding to civil society and community-based organizations for their HIV service provision for KP.

By 2018, the HTC program in Thailand reached the first 90 of the 90-90-90 targets, as 98% of PLHIV were aware of their status.[14] However, coverage of HTC among KP remains low; only 55% of MSM and 53% of FSW were reported receiving an HIV test and result in the past year[15]. Community-based HTC that expands outreach work through peer mobilizers and partner index testing have been implemented to increase access to, and demand for, HIV testing, as well as to link KP to other services like PrEP and treatment. To augment the process, HTC outlets provide same-day results and ART is being optimized through same day (versus rapid) initiation, advocacy for TLD, and community-based navigation to re-engage those lost to follow-up. In the past years, HIV self-testing was initiated to expand HTC coverage among KP through research. As of April 9, 2019, a cutting-edge policy was pushed forward, and Thailand's Food and Drug Administration (FDA) has approved the public sale of registered HIV self-test test kits. The Thailand PEPFAR Program will support implementation of an HIV self-testing policy through diversified channels, including pharmacies and online platforms.

Thailand has a highly functional basic health system and was an earlier adopter of universal health coverage, allowing citizens and non-citizens access to essential health services. Thailand provides ART free of charge as part of the country's universal health coverage schemes. In October 2014, Thailand extended ART to all those living with HIV, regardless of their CD4 count. Since then, active case finding and the promotion of same-day ART strategy have been emphasized. At the end of 2018, there were 323,637 PLHIV receiving ART (75% ART coverage)[16] as reported by the National AIDS Program (NAP). Seventy percent receive ART through universal health insurance, 15% under the Social Security Insurance Scheme, and 5% under the Civil Servant Benefit Scheme. ART coverage among KP, however, remains low. In 2018, about 61% of MSM and TGW who were newly diagnosed received ART in the same year; while 45% of FSW, 38% of MSW, and 37% of PWID received ART in the same year as their initial diagnosis.[4]

A large number of LTFU clients and corresponding low adherence rates are the main barriers to achieving the third 90. By the end of 2018, 83% of PLHIV (268,256 of 323,637) who were on ART had VL suppression. The VL suppression rate among KP is less than 80%; 66% among MSM/TG and 70% among FSW, 73% among MSW, and 67% among PWID.[4] To address this issue the RTG, in collaboration with PEPFAR during COP18, updated and implemented the national treatment literacy and national treatment guidelines including same-day ART initiation (SDART) and MMS.

TB is the main cause of death of PLHIV and the largest number of new TB cases occurs in South-East Asia. The WHO classifies Thailand is one of the top 30 high-burden countries for TB, and in 2018 approximately 72,000 cases of TB were diagnosed, in which 81% of these people had a

[14] ART coverage and 90-90-90 cascade, National Progress Report (AZP-beta, updated by Feb 2019).
[15] IBBS among MSM and FSW (reported in GAM 2018), 2016, Bureau of Epidemiology.
[16] AEM (updated by Mar 2018) and NAP (updated by December 2018).

known HIV status. Of these, 8% were HIV-positive, of whom 59% were on ART. Additionally, there were 3,900 TB-related deaths among PLHIV. In 2018, the RTG disseminated national guidelines with recommended TB screening and TPT into routine HIV services, another demonstration of the leadership of the RTG in the response to the HIV/TB co-epidemic. Integrated TB/HIV and HIV co-infection surveillance is being established via the national HMIS platform with PEPFAR support, and is expected to obtain more reliable data to monitor HIV-related morbidity and mortality—including KP specific data.

In 2016, the National AIDS Committee (NAC) endorsed PrEP as part of the HIV prevention combination strategy and the Thai FDA approved Truvada. In 2017, supported by PEPFAR and GFATM, PrEP was initiated in public and community-based clinics. As of 2019, it is estimated that about 40,000 high-risk HIV-negative MSM are in need of PrEP in Bangkok. In FY2020, PEPFAR will accelerate PrEP services in Bangkok and high-burden sites to cover 5,000 PrEP users, contributing to approximately 25% of the estimated PrEP target in Bangkok for MSM.

Table 2.1.1 Thailand Country Government Results

Table 2.1.1 Thailand Country Government Results															
	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population (million)	65.637		5.356		5.628		2.111		2.068		26.356		24.115		National AIDS Zero Portal Dashboard, updated February 2019
HIV Prevalence (%)		0.65		0.03		0.03		0.40		0.57		0.69		0.93	
AIDS Deaths (per year)	14,032		16		18		104		138		5,351		8,406		Spectrum AEM V5.63, updated 26 March 2018, Year 2018
# PLHIV	429,871		1,393		1,442		8,047		11,304		182,471		225,214		
Incidence Rate (Yr.)		0.008		0.001		0.001		0.019		0.043		0.004		0.009	
New Infections (Yr.)	5,529		33		35		799		1,803		990		1,869		
Annual births	666,109	10.1/ 1,000[17]													Vital Statistics Report (2018), Ministry of Interior
% of Pregnant Women with at least one ANC visit	656,551	98.6													PHIMS, 2018 (DoH)
Pregnant women needing ARVs	4,048														Spectrum AEM V5.63, updated 26 March 2018
Orphans (maternal, paternal, double)															
Notified TB cases (Yr.)	72,000														2016
% of TB cases that are HIV infected		8..0													
% of Males Circumcised															
Estimated Population Size of MSM*	508,516														AEM, 2018 (BoE)

[17]Live Birth rate (per 1,000 population)

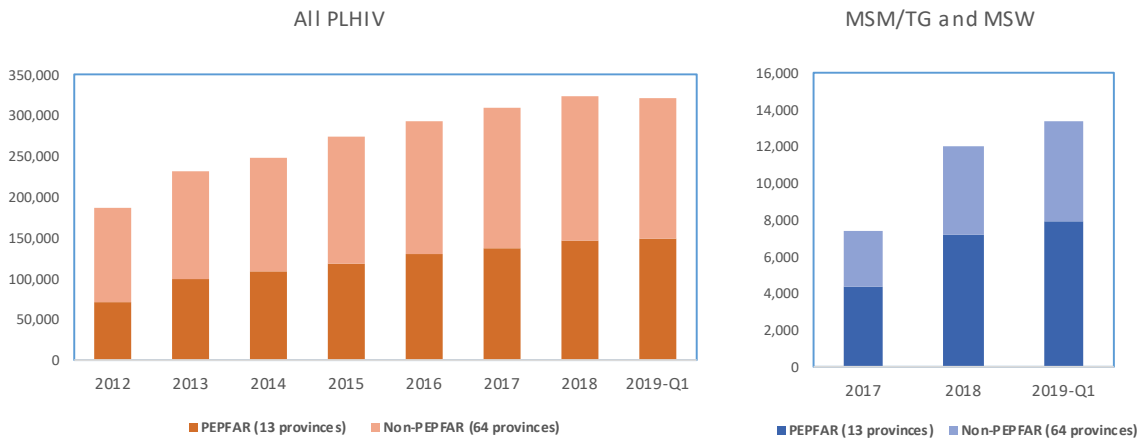
MSM HIV Prevalence		16.1							n/a	9.1			n/a	21.3	IBBS, 2016 (BoE)
Estimated Population Size of FSW	128,370														AEM, 2018 (BoE)
FSW HIV Prevalence		1.0	n/a	1.0			n/a	n/a			n/a	0.9			IBBS, 2016 (BoE)
Estimated Population Size of PWID	41,301														AEM, 2018 (BoE)
PWID HIV Prevalence		20.5							n/a	11.11			n/a	24.76	IBBS, 2014 (BoE)
Estimated Size of TG	243,018														AEM, 2018 (BoE)
Estimated Size of TG		7.4							n/a	3.8			n/a	10.2	IBBS, 2016 (BoE)
Estimated Size of MSW	15,131														AEM, 2018 (BoE)
Estimated Size of MSW		12.3							n/a	8.9			n/a	14.7	IBBS, 2016 (BoE)

Table 2.1.2 Thailand 90-90-90 Cascade

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression											
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year[18]			
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)	All TX_NEW included prior diagnosis (#)
Total population	65,700,035	0.65%	429,871	435,481	323,637	75.3%	82.9%	968,892	28,823	16,102	28,321
Population <15 years	11,350,639	0.02%	2,835	3,692	2,387	84.2%	76.7%	18,863	209	117	231
Men 15-24 years	4,517,992	0.25%	11,304	18,326	12,134	107.3%	65.8%	134,138	4,840	2,918	4,194
Men 25+ years	21,556,162	1.04%	225,214	221,588	163,372	72.5%	82.6%	385,894	15,337	8,224	15,088
Women 15-24 years	4,398,306	0.18%	8,047	11,392	7,245	90.0%	67.0%	102,688	1,493	958	1,354
Women 25+ years	23,876,937	0.76%	182,471	180,483	138,499	75.9%	85.7%	327,309	6,944	3,885	7,454
FSW	128,370	1.6%	2,024	361	220	10.9%	69.5%	4,788	75	34	55
MSM	508,516	7.1%	36,190	16,404	11,517	31.8%	66.7%	21,865	3,877	2,373	3,257
TG	243,018	2.1%	5,038	438	300	6.0%	44.3%	1,624	201	108	137
MSW	15,131	10.7%	1,616	381	230	14.2%	73.0%	486	50	19	46
PWID	41,301	16.2%	6,706	2,085	1,484	22.1%	67.0%	1,886	90	31	75

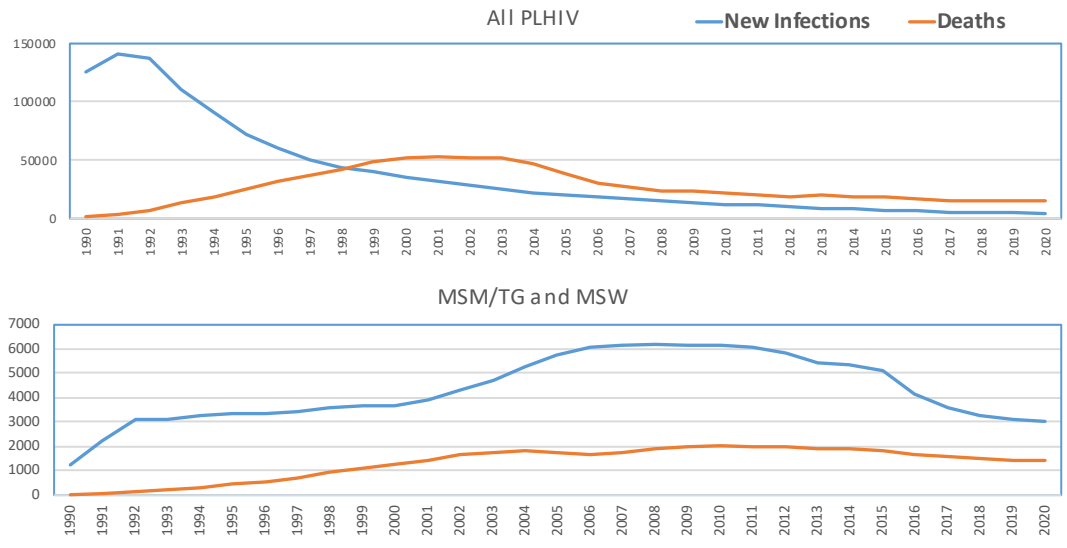
[18] Data source: AIDS Epidemic Model (AEM, March 2018) and National AIDS Program (NAP, December2018, HIV tested, HIV, positive and ART initiation in year 2018. All newly initiated ART included prior diagnosed in past years and newly positive diagnosis in year 2018 who initiated ART in 2018. The results among priority population were updated by June 2018.

Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment (Thailand)



Source: AEM-adjusted Spectrum (updated by March 2018) and NAP

Figure 2.1.4 Trend of New Infections and All-Cause Mortality Among PLHIV (Thailand)



Source: AEM-adjusted Spectrum, updated by March 2018, Bureau of Epidemiology

2.2 Investment Profile: The RTG continues to demonstrate its commitment to ending the epidemic and supports more than 90% of the HIV response in country, with PEPFAR and GF contributing about 6% and 5%, respectively, and mainly on the following areas: KP prevention, strategic information, and health system strengthening. GF resources are $37.6 million for the three-year funding cycle of 2018-2020 with the planned budget of $13.1 million for 2018, $12.8 million for 2019, and $11.7 million for 2020. The budget for the new planning cycle after 2020 has not yet been developed. PEPFAR maintains its investment in ensuring equitable access to HIV services among MSM and TG in 13 high burden geographic provinces, focusing on national-level system strengthening, provision of KP-led health services, and HIV cascade monitoring. GF has focused its investment in MDR-TB treatment; TB/HIV prevention and treatment among prisoners; PWID, MSM, and TG programming in seven additional provinces beyond PEPFAR-supported areas. Thailand PEPFAR is in discussions with the RTG, which is in the process of finalizing its budget and commitments for the coming year.

Table 2.2.1 Annual Investment Profile by Program Area (Thailand)

Table 2.2.1 Annual Investment Profile by Program Area[19,20,21]					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GFATM**	**% Host Country**	**% Other**
Clinical care, treatment and support	$175,509,453	0.75	1.12	98.13	0.00
Community-based care, treatment, and support	-				
PMTCT	$3,218,723	0.11	0.00	99.69	0.19
HTS	-				
VMMC	-				
Priority population prevention	$20,583,728	1.95	4.18	93.64	0.24
AGYW Prevention	-				
Key population prevention	$13,004,616	24.35	26.19	49.13	0.34
OVC	-				
Laboratory	-				
SI, Surveys and Surveillance	$4,623,835	19.24	19.86	59.97	0.92
HSS	$15,351,107	54.76	25.97	18.98	0.29
Other	$16,572,829	4.28	0.11	95.29	0.33
Total	**$248,864,292**	**5.98**	**4.48**	**89.44**	**0.10**

[19] (GRP, National AIDS Spending Assessment , 2012), all amounts in 2012 USD
[20]Exchange rate 33.9 THB/USD, World Bank 2017: http://wdi.worldbank.org/table/4.16
[21] Data sources: National AIDS Expenditure Report 2016-2017, updated by 18 July 2018

Table 2.2.2 Annual Procurement Profile for Key Commodities (Thailand)

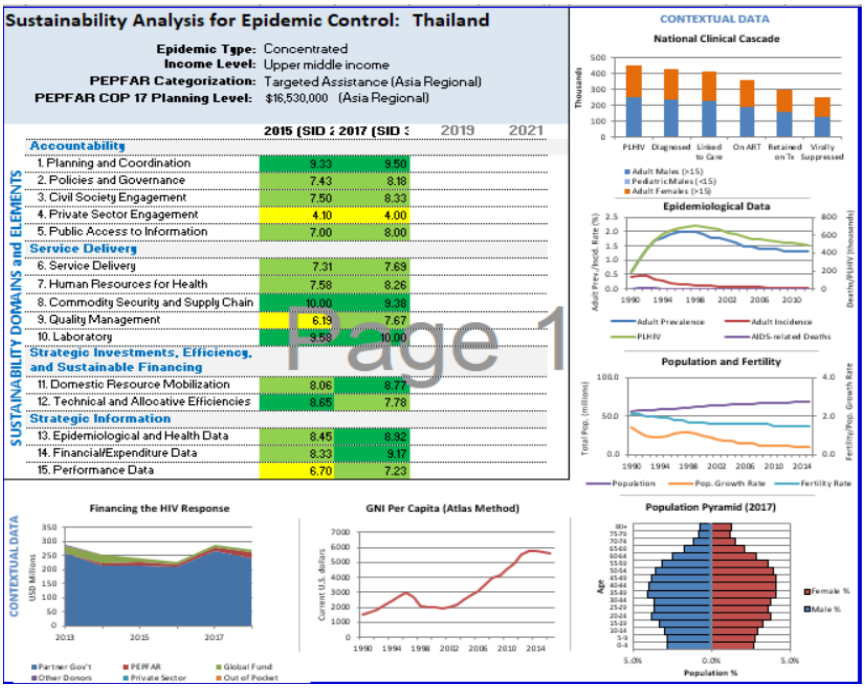
Table 2.2.2 Annual Procurement Profile for Key Commodities					
Commodity Category	**Total Expenditure**	**% PEPFAR**	**% GFATM**	**% Host Country**	**% Other**
ARVs	$118,525,734	0.42	0.86	98.71	0.00
Rapid test kits*	$6,011,778	26.90	3.36	69.63	0.11
Other drugs	$2,127,189	0.15	0.00	99.85	0.00
Lab reagents	$47,121,711	1.42	0.00	98.58	0.00
Condoms	$1,084,654	0.00	10.45	89.55	0.00
Viral Load commodities	-				
VMMC kits	-				
MAT	$982,301	0.00	0.00	100.00	0.00
Other commodities	$78,776	0.00	100.00	0.00	0.00
Total	$175,932,143	1.58	0.81	97.60	0.01

The RTG covers the procurement of 98% of ARVs and commodities; the remainder is procured by PEPFAR and the GF. PEPFAR procures a limited amount of rapid and self-test kits for Key Population-Led Health services (KPLHS) and community-led health services.

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration (Thailand)

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
USAID MCH	N/A	N/A	N/A	N/A	N/A
USAID TB	N/A	N/A	N/A	N/A	N/A
USAID Malaria	$3,000,000	0	0	0	N/A
Family planning	N/A	N/A	N/A	N/A	N/A
NIH	N/A	N/A	N/A	N/A	N/A
CDC (Global Health Security)	0	0	0	0	0
Peace Corps	N/A	N/A	N/A	N/A	N/A
DOD Ebola	N/A	N/A	N/A	N/A	N/A
MCC	N/A	N/A	N/A	N/A	N/A
Total	**$3,000,000**	**0**	**0**	**0**	

2.3 National sustainability profile update: The latest SID was prepared in 2017 through a consultative process with key stakeholders from the MOPH, CBOs, PEPFAR, and UNAIDS. Key informant interviews were conducted and a desk review was completed to assess publically reported national information and data from national HIV systems.



Thailand demonstrates leadership in terms of sustainability of its overall HIV/AIDS response. Of the 15 elements evaluated, 14 were "sustained," (light or dark green) with private sector engagement scored as yellow. Most scores increased from the 2015 assessment (SID2.0), indicating that Thailand is moving toward improved sustainability.

Considerable efforts are still needed to ensure that the challenges facing the HIV epidemic of MSM, TG, and sex workers can be addressed. PEPFAR and other international donors are currently maintaining funding levels to support the national AIDS program to achieve the 90-90-90 targets by 2020. Significant progress has been made since 2017 in the critical area of domestic financing. This is largely resulting from the PEPFAR Incentive Fund (PIF), $20 million added to the program during a three-year period, which catalyzed recognition in government and among CSOs that the KPLHS model is proven effective for increasing uptake of services among KP. The government increasingly understands the importance of the contributions made by CSOs in HIV service provision and in meeting national targets. The government committed to provide funding for PEPFAR-supported CSOs, and provided a total of $1.4 million in 2018, allowing PEPFAR to transition to focused TA support and demand-creation strategies for critical interventions. This also allows the Government of Thailand to maintain its leadership role in serving KP and grow independent, trusted partnerships with CSOs, with increased domestic financing as a fundamental element of the relationship.

To facilitate government funding of CSO delivery of health and HIV services, a system has been established to accredit the quality of services CSOs provide. This is necessary for government reimbursement of expenses incurred by CSOs in their service delivery. To operationalize this, a program of capacity strengthening has been rolled out to all PEPFAR-supported CSOs and selected GFATM partners.

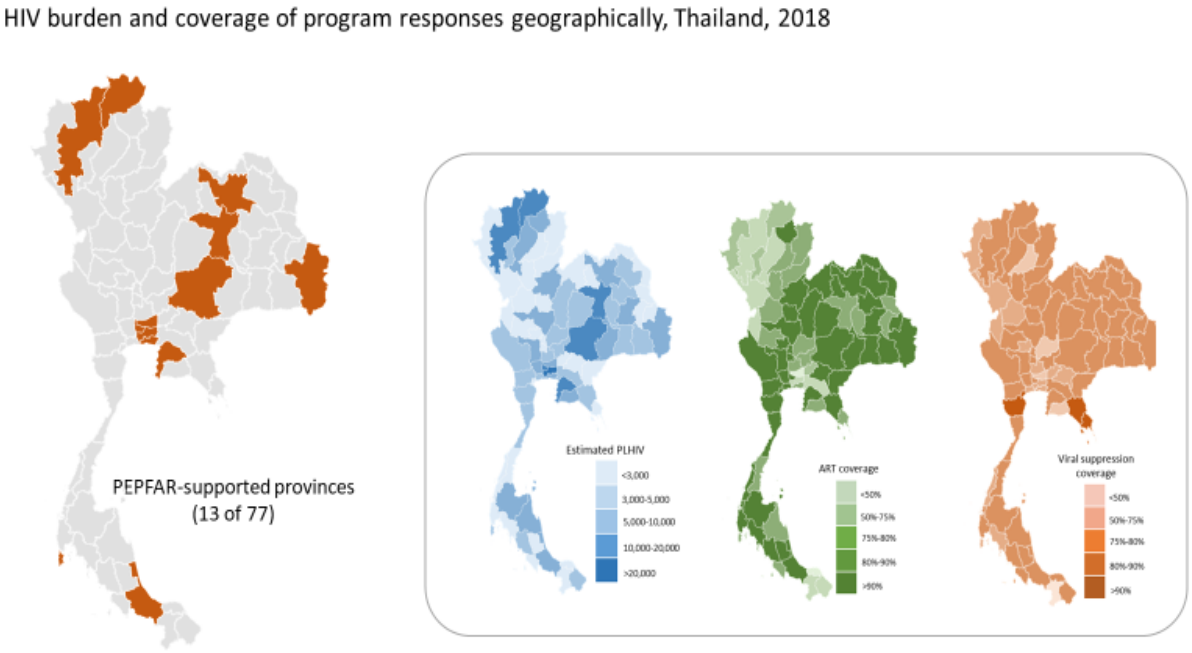
2.4 Alignment of PEPFAR investments geographically to disease burden: Thailand has a concentrated HIV epidemic, with MSM estimated to comprise over half of new HIV infections (AEM2 018). Surveillance and research show similarly high HIV prevalence among TG women. In coordination with RTG and GF, PEPFAR continues to focus its investment in the 13 highest-burden provinces, in which 75% of all new HIV-infections occur (Figure 2.4). It is estimated that 83% of new MSM and TG infections will occur in these provinces, and PEPFAR continues its plan to accelerate and achieve the 90-90-90, including PrEP expansion among most at risk MSM and TG in 6 of these provinces. There also is an increased investment in active case finding, linkage to SDART, ensuring access to VL testing, and improved data quality in these high burden areas.

PEPFAR has a proven track record of successfully investing in the right populations in the right places in Thailand. According to an analysis conducted in FY2018, PEPFAR expenditures in Thailand showed that about one-third ($1.7 million out of $6.15 million, or 28%) was applied at the national level and was primarily invested in KP-MSMTG, HSS to SI, FBCTS, and HTC. Expenditures in these areas reflect an emphasis on efforts to continue expanding coverage and quality of HIV testing and treatment, including a focus on MSM and TG women as priority populations. These areas reflect the effort to generate catalytic evidence to inform policy and improve HIV services more effectively. Other PEPFAR investments in Thailand were distributed across key areas: cross-cutting PM to SI, CBCTS, Lab, PEP, PMTCT, KP-FSW, and SURV.

More than half (65% of $6,153,940 million) of PEPFAR FY2018 expenditures were at the provincial level. In support of national-level investments, provincial-level investments were invested in the same program areas, mainly KP-MSMTG, FBCTS, HTC, CBCTS, LAB, PEP, HSS, SI, and Cross-cutting SI to HSS. Geographically, 59% of the sub-national investment was historically made in four provinces (Bangkok, Chiang Mai, Chonburi, and Songkhla), which are among the provinces with the largest estimated numbers of PLHIV, MSM, and TG women, and largest combined numbers of KP (FSW, MSM, TG women, and PWID).

In ROP19 PEPFAR is also focused on improving the low ART coverage in the 13 high-burden provinces. While Thailand has been making substantial progress towards meeting the 90-90-90 targets among PLHIV, the ART coverage among MSM and TG still requires aggressive scale up in all 13 provinces [IBBS 2018]. It is estimated that ART coverage is 80 percent among PLHIV in the country. In three provinces (Bangkok, Chiangmai, and Pathumthani), the ART coverage is much lower. These three provinces are large urban cities and/or popular tourist destinations with multiple health authorities and insurance schemes; as a result, under-reporting of ART services has been a challenge.

Figure 2.4.1 HIV Burden and Coverage of Program Responses Geographically (Thailand)



Source: National AIDS Zero Portal (Beta version) visualized from P-AEM and NAP web-report.

2.5 Stakeholder engagement: PEPFAR plans and implements all activities in collaboration with RTG departments, multilateral and international agencies, civil society, and domestic and international NGOs and advocacy groups responding to the HIV epidemic in Thailand and the Asia region. In preparation for ROP 19, PEPFAR increased its level of effort with these important stakeholders through multiple consultations before, during, and after site-level implementation. Thailand PEPFAR has strong engagement with community-based organizations representing the health needs of MSM and TGW, where in-service delivery and expertise are provided by and for KP.

Program planning and performance reviews are conducted through regular consultative meetings with stakeholders. This includes fora that are formalized routinely, ad-hoc problem solving sessions, and national- and provincial-level strategy meetings throughout the year. PEPFAR will hold twice-yearly stakeholder meetings (which used to be held annually) to: (1) discuss and gather stakeholder input on PEPFAR strategic directions and program priorities; (2) review past performance and propose mid-course corrections to ensure accelerated achievements; and (3) incorporate feedback into the PEPFAR ROP process.

As a member of the GF CCM in Thailand, the PEPFAR team is aligned to work in concert with the GF program. This involves coordination of KP coverage and geographical locations to ensure complementarity in support of the national AIDS program. Moreover, there is ongoing collaboration for capacity building of civil society organizations, and joint implementation of activities for increased domestic financing, certification and accreditation of CSOs.

The PEPFAR team works closely with UNAIDS on a number of activities. For example, PEPFAR has jointly organized several regional fora and partner to support RTG's development of social contracting mechanisms for CSOs. In 2018, the PEPFAR team worked with UNAIDS, WHO and the International AIDS Society (IAS) to convene a successful regional PrEP implementation technical exchange forum in Bangkok. The PEPFAR team also participates in the TLD national working group established recently by the Government of Thailand to accelerate the inclusion of TLD fix dose combination in the national AIDS program. This group comprises of technical experts from the Thailand MOPH, Thai Red Cross AIDS Research Centre, Thai AIDS Society, Government Pharmaceutical Organization, NHSO, Thai FDA, CSOs, and academicians.

Other key stakeholders are PLHIV and KP advocacy groups, with whom PEPFAR engages routinely in site, provincial, national meetings, and in capacity-building fora. PEPFAR plans to further engage the private sector around the distribution of HIV self-test kits and pricing of key commodities. The Thailand PEPFAR Program will seek to institutionalize a diversity of funding arrangements that include both government and civil society funding including the corporate sector. It will build on an existing partnership (Princess PrEP) with Princess Soamsawalee of the Thai Royal Family, who is also a UNAIDS Goodwill Ambassador.

Tier 2: INDIA

2.1 Summary statistics, disease burden, and country profile: India's current population is estimated at 1.3 billion.[22] India contributes 4% of new annual HIV infections globally.[2] As of 2017, an estimated 0.22% of the adult population (aged 15–49 years), or 2.14 million people, were HIV-positive[23], the third largest number of people living with HIV (PLHIV) among all countries globally. Just over 2% of all deaths, or 69,000 deaths per year, were attributed to HIV and AIDS,[2] with TB causing approximately 54% of these deaths. In 2013, AIDS-related deaths fell below new HIV infections, resulting in an approximate difference of an additional 19,000 PLHIV each year. This net positive delta demonstrates the urgency to increase ART coverage and VL suppression.

India has achieved substantial progress in reducing the spread of HIV. Since 2010, new infections have declined by 27% and mortality by 56%; at these rates, incidence and mortality are expected to converge around 2026, at which point the number of PLHIV are expected to stabilize. As of 2017, there are 1,181,129 PLHIV on treatment, representing 56% ART coverage of all PLHIV; of the 1,647,800 PLHIV that know their status, 72% are on treatment, leaving an 18% treatment gap for epidemic control. At the current pace of ART uptake, reaching the fast track second and third 90 targets for ART and VL suppression which is needed to secure rapid decline in annual new HIV infections (75%) and AIDS-related deaths (65%) by 2020 will be a challenge.

[22] U.S. Census Bureau
[23] India Technical HIV Estimations 2017, India National AIDS Control Organization

In August 2018, the Government of India (GOI) released updated state-level HIV estimates. Prevalence varies widely among the 29 states and seven union territories, and India's HIV epidemic is concentrated, with higher prevalence rates in KP groups. However, KP make up a small proportion of the total PLHIV and only 4% to 5% of new HIV cases. Twenty-eight percent of the country's PLHIV burden is found in the states of Andhra Pradesh and Maharashtra. Three states in northeastern India (Mizoram, Manipur, and Nagaland) along the border with Burma have experienced an increase in the number of new infections, where the epidemic is fueled by high rates of injection drug use. Mizoram currently has the highest prevalence of HIV in India among adults (15-49 years), followed by Manipur and Nagaland with an estimated prevalence of nine, six, and five times the national average, respectively.

On World AIDS Day 2017, India reaffirmed its commitment to addressing HIV/AIDS with the launch of the seven-year National Strategic Plan for HIV/AIDS and STIs (2017-2024), which outlines efforts to reduce new HIV infections, improve outreach and service delivery models, strengthen the generation and use of strategic information, and eliminate stigma and discrimination.

At the national level, the focus on implementation of WHO international policies has been a priority. Since April 2017, the National AIDS Control Organization (NACO) has enacted six significant HIV-related policies to advance the national HIV response, and the impact is reflected in a 9% increase in treatment coverage in two years. These policies include the launch of Test and Start in April 2017, followed with the launch of Mission Sampark in December 2017 to support the pre-ART surge and effort to track lost-to-follow-up (LTFU) patients. In 2018, the phased roll-out of routine VL testing in select priority populations began with support of the GF, and 230,000 tests had been performed nationally by April 2019. Routine testing of all PLHIV in treatment will be fully implemented by 2020, with up to 64 new VL public sector labs strategically located throughout India.

In September 2018, Section 377 of the Indian penal code, which essentially criminalized homosexuality, was ruled unconstitutional. An HIV/AIDS Prevention and Control Bill that supports the rights of PLHIV, focusing on stigma and discrimination, was passed by the Indian Parliament in April 2017. The Transgender Persons Protection of Rights Bill 2016 prohibits discrimination against transgender in areas such as education, health care, and employment, and was heralded by civil society organizations as a major step forward in the recognition of this key marginalized population in India. It directs the central and state governments to provide welfare schemes to this group in education, health care, and employment. Although nationally India has made commendable efforts to address stigma and discrimination, PLHIV stigmatization remains high throughout the country.

India's national program is primarily responsible for 538 adult and pediatric ART centers, 1,108 link ART Centers, 361 Care and Support centers, 23,400 Integrated Counseling and Testing Centers (ICTCs), and approximately 1,550 KP programs (referred to as targeted interventions) across India. Targeted Interventions of NACO are preventive interventions working with KP (MSM, FSW, TG, and PWID) in a defined geographic area, where there is a concentration of one or more KP groups. TI projects provide a package of prevention, support, and linkage services to

KP through an outreach-based service delivery model. Members from KP communities are engaged to deliver services and act as agents of change for linkage to services. In late 2018, community-based testing was adopted nationally and introduced to community-based centers. NACO, with support from India PEPFAR in the demonstration of innovative testing, committed to restructuring the TIs to include additional testing approaches such as a focus on index testing, enhanced peer outreach approach (EPOA) to enhance case-finding as well as peer navigation to increase access to services and improve linkage to treatment and adherence.

To improve service delivery and retention in care, India's NACO rolled out DSD models in July 2018. These include three-month MMS, currently being scaled-up nationally, and co-location of the ART and OST (opioid substitution therapy) Center (CAOC) for MAT dispensation to stable KP (PWID, MSM, FSW) clients. In August 2018, NACO constituted an expert group on PrEP, with the intention of developing and implementing a national PrEP policy in 2019. PrEP will be added as part of a combination HIV-prevention package of services targeted at high-risk KP.

TLD transition is a priority for NACO, and the technical resource group (TRG) recommended the adoption of TLD in October 2018. TLD is moving forward in all new patients initiating ART and those with HIV/TB co-infection, and women and adolescent girls of childbearing potential who want to become pregnant will be given an informed choice. Forecasting is currently underway, and the timeline to start transition is estimated for late 2019. An estimated 19,267 new PLHIV and women of childbearing age would be started on TLD by December of 2019, with this number increasing to 459,379 by December 2022. All PLHIV on TLN would be transitioned to TLD in the first phase. The decision for transitioning all other existing patients (on TLE for example) to TLD will be taken after all PLHIV have a documented VL test result.

India is ranked by the World Bank as a lower-middle income country. The country has a GNI of $1,800 per capita.[24] With substantial GF investment and increase in the GOI budget to address the TB/HIV response in India, NACO has adopted policies and guidelines, with technical support from PEPFAR, including a single window approach for joint dispensing of HIV and TB drugs from ART centers, the upfront use of CBNAAT (Xpert®) for faster and improved diagnosis of TB in PLHIV, TPT for PLHIV without active TB, and roll-out of airborne infection control (AIC) at ART centers. India's key challenge is the inability to follow individuals through the entire cascade, due to the separate monitoring and reporting systems used at the community, integrated counseling and testing centers (ICTC), and ART center levels. However, through the support of the GF, India is developing an integrated monitoring and evaluation system with a national unique identifier for improved linage and LTFU tracking (Project SOCH).

India PEPFAR's OVC program shifted its focus to children of KP in 2017. Efforts will focus on building a comprehensive package of services to KP addressing the critical needs of children of KP as a key target group. OVC interventions will improve the health and well-being of all enrolled children of KP through age-appropriate, tailored interventions, and linkages to critical health and social services and support based on individual needs.

[24]GNI per capita, Atlas Method, World Bank, 2017

Table 2.1.1 India Host Country Government Results

Table 2.1.1 Host Country Government Results															
	Total		<15				15-24				25+				
			Female		Male		Female		Male		Female		Male		
Indicators	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	***Source, Year***
Total Population	1,300,000,000		191,290,000	14.71	208,710,000	16.05	119,503,000	9.12	129,469,816	10.0	330,496,992	24.7	320,530,184	25.38	US Census bureau, 2017
HIV Prevalence (%)		0.22		NA		NA		NA		NA		NA		NA	India HIV Estimation 2017 report, NACO, 2017
AIDS Deaths (per year)	69,110		NA		NA		NA		NA		NA		NA		India HIV Estimation 2017 report, NACO, 2017
# PLHIV	2,140,000		NA		NA		NA		NA		NA		NA		India HIV Estimation 2017 report, NACO, 2017
Incidence Rate (Yr.)		0.07		NA		NA		NA		NA		NA		NA	India HIV Estimation 2017 report, NACO, 2017
New Infections (Yr.)	87,580														India HIV Estimation 2017 report, NACO, 2017
Annual births	25,244,000														UNICEF - The State of the World's Children, 2017
% of Pregnant Women with at least one ANC visit		79.3	NA	NA			NA	NA			NA	NA			India National Family Health Survey (NFHS-4), 2016
Pregnant women needing ARVs	22,677														India HIV Estimation 2017 report, NACO, 2017
Orphans (maternal, paternal, double)	530,000		NA		NA		NA		NA		NA		NA		Estimated Children orphaned by HIV/AIDS (2014), SOWC, UNICEF 2016

Table 2.1.1 Host Country Government Results															
	Total		<15				15-24				25+				
			Female		Male		Female		Male		Female		Male		
Indicators	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	***Source, Year***
Notified TB cases (Yr.)	1,908,371		NA		NA		NA		NA		NA		NA		Global TB Report, 2018
% of TB cases that are HIV infected	36,440	3	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	Global TB Report, 2018
% of Males Circumcised	NA	NA			NA	NA			NA	NA			NA	NA	NA
Estimated Population Size of MSM*	297,000														NACO Annual Report 2017-18
MSM HIV Prevalence		4.3													IBBS, 2015
Estimated Population Size of FSW	868,000														NACO Annual Report 2017-18
FSW HIV Prevalence		2.2					NA	NA			NA	NA			IBBS, 2015
Estimated Population Size of PWID	177,000														NACO Annual Report 2017-18
PWID HIV Prevalence		9.9													IBBS, 2015
Estimated Size of Priority Populations of TG	70,000		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NACO Annual Report 2017-18
Estimated Size of Priority Populations Prevalence of TG		7.5	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	IBBS, 2015

Table 2.1.2 India 90-90-90 Cascade

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*[25,26,27]										
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#)	HIV Prevalence (%)[25]	Estimated Total PLHIV (#)[6]	PLHIV diagnosed (#)[26]	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	1.3 bn	0.22 % [0.16-0.30]	2.14 m [1.5 – 2.8]	1,647,800	1,181,129	55.2%	No data in public domain (scale-up in progress)	35.2m	193,156	175,772
Population <15 years	400,000,000	.015%	61,000	46,970	41,120	67.4%	No data in public domain (scale-up in progress)	ND	ND	*ND*
Men >15 years	450,000,000	0.27%	1,200,000	836,643	581,405	48.5%	No data in public domain (scale-up in progress)	ND	ND	ND
Women >15 years	450,000,000	0.19 %	879,000	803,834	558,604	63.5%	No data in public domain (scale-up in progress)	ND	ND	ND
MSM	297,000	4.3% (95% CI: 3.7 – 5.1)[27]	12,771	8,276	4,676	56.5%	(scale-up in progress)	211,939	530	489
FSW	868,000	2.2% (95% CI: 1.8 - 2.6)	19,096	13,100	6,681	51%	(scale-up in progress)	622,790	623	623
PWID	177,000	9.9% (95% CI: 9.0-10.9)	17,523	11,846	4,667	53.7%	(scale-up in progress)	122,077	1099	892

[25] UNAIDS Data Hub 2017
[26] National AIDS Control Organization (2017). Sankalak: Status of National AIDS Response
[27] Integrated Bio Behavioral Survey (IBBS) 2014-15

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*[25,26,27]										
Epidemiologic Data					**HIV Treatment and Viral Suppression**			**HIV Testing and Linkage to ART Within the Last Year**		
	Total Population Size Estimate (#)	**HIV Prevalence (%)[25]**	**Estimated Total PLHIV (#)[6]**	**PLHIV diagnosed (#)[26]**	**On ART (#)**	**ART Coverage (%)**	**Viral Suppression (%)**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
TG	70,000	7.5% [95% CI 6.2-9.0].	5,250	2,604	2,275	64.1%	(scale-up in progress)	49,000	225	166

Figure 2.1.3 National and PEPFAR[28] Trend for Individuals currently on Treatment (India)

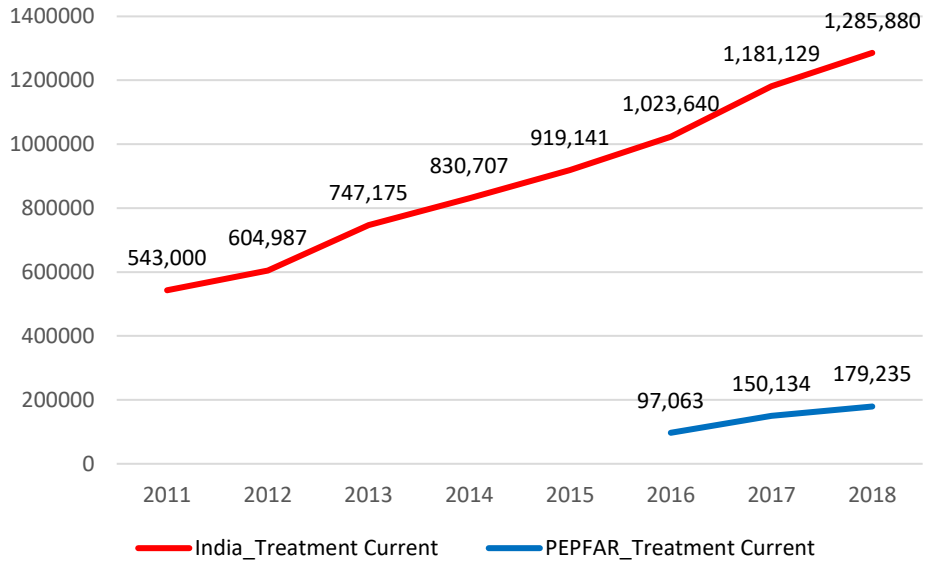
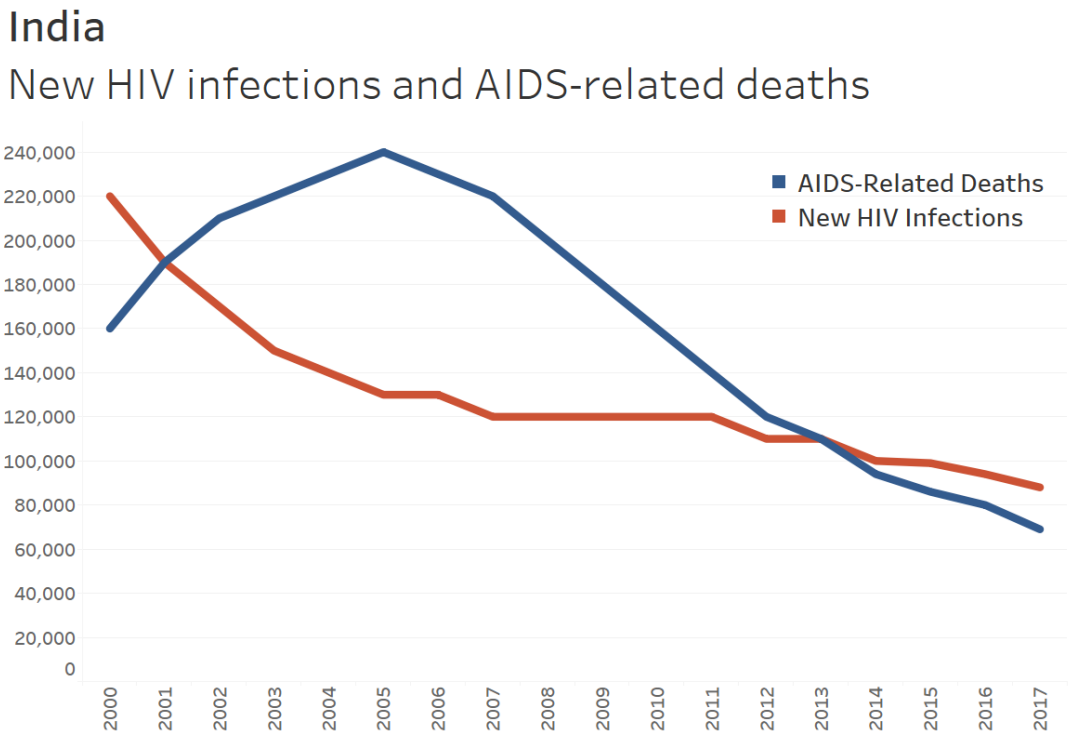


Figure 2.1.4 Trend of New Infections and All-Cause Mortality Among PLHIV (India)



2.2 Investment Profile: India's commitment to addressing HIV/AIDS was confirmed by Prime Minister Modi's support to achieving the Sustainable Development Goals (SDG), including the SDG 3 target of ending the AIDS epidemic by 2030.

[28] PEPFAR India started reporting on treatment following the programmatic shift in COP15.

In March 2019, the GOI formally approved a three-year continuation of India's National AIDS Control Program (NACP), Phase IV ending on March 31. 2020, with a total approved three-year budget of approximately $950 million. For the current Indian financial year beginning on April 1, 2019, the allocated budget for NACP is approximately $368 million. In the 2019–2020 GOI national budget, the estimate for the NACP represents a 29% increase from the previous year.[29] PEPFAR India historically provides a contribution of approximately five to six percent of the overall national HIV control budget. The U.S. government has a focus and critical role on providing TA to strengthen the GOI's response towards achieving 90-90-90 goals and demonstrating scalable innovative approaches across the HIV continuum of care to address HIV/AIDS service delivery equity and efficiency barriers.

Table 2.2.1 Annual Investment Profile by Program Area (India)

Table 2.2.1 Annual Investment Profile by Program Area					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Clinical care, treatment and support	No Disaggregated Data Available**				
Community-based care, treatment, and support					
PMTCT					
HTS					
VMMC					
Priority population prevention					
AGYW Prevention					
Key population prevention					
OVC					
Laboratory					
SI, Surveys and Surveillance					
HSS					
Total[30]	**$435 million**	**3.5% ($15m)**	**12% ($52m)**	**84.5% ($368M)**	

**** A National AIDS Spending Assessment (NASA) has not been carried out in India to date. UNAIDS and stakeholders are advocating for a NASA. Early in the discussions, NACO agreed to change the name to an "Investment Case Assessment" due to sensitivities; unfortunately, the Joint Secretary who championed the assessment moved to another department. UNAIDS continues to negotiate with current leadership.

[29] GOI Union Budget document for 2019-2020 "Outlay on Major Schemes," p. 17; February 2019
[30] The GOI budget includes a loan from the World Bank.

Table 2.2.2 Procurement Profile for Key Commodities (India)

Table 2.2.2 Procurement Profile for Key Commodities					
Commodity Category	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
ARVs		0%	50%	50%	
Rapid test kits		0%	*Expectation is that GOI is procuring 50% of ARVs, and GF is procuring the remaining 50% per previous arrangements. GF was also expected to procure 100% of test kits, condoms, and other commodities, but proportion and total expenditures are unpublished.*		
Other drugs		0%			
Lab reagents		0%			
Condoms		0%			
Viral Load commodities		0%			
VMMC kits		0%			
MAT		0%			
Other commodities		0%			
Total		0%			

India's NACO is implementing the fourth NACP (NACP IV, 2012-2017, now extended to 2020) and is preparing NACP V. Over the past seven years, the GOI has become the primary funder for HIV/AIDS. India's health sector is highly decentralized. Although annual budget disbursements for HIV/AIDS come from NACO, the authority for budget allocation and implementation of the national health policies is the responsibility of the states. The main source of financing for NACP IV was GOI resources (63%), a major increase from earlier years, when donors supported 75% of overall costs. However, domestic resources continue to be amplified by external donors, including the World Bank, GF grants, and extra-budgetary resources, including PEPFAR.

External resources available to the GOI will be reduced. In India, the Bill & Melinda Gates Foundation closed its site-level interventions and is phasing out of HIV/AIDS, and the CHAI has a limited role implementing the GF project unique identifiers systems at the national level. The World Bank loan focuses on the support of TIs, information, education, and communication, and institutional strengthening, together with supply chain management.

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration (India)

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
USAID MCH	$6,000,000				
USAID TB	$10,500,000				
USAID Malaria	$0				
Family Planning	$6,500,000				
CDC (Global Health Security)	$6,822,526				
Total	**$29,822,526**				

A major vulnerability in the HIV/AIDS budget in India is the supply of ARV drugs, test kits and other HIV commodities, which have experienced shortfalls in procurement and distribution. Currently, the GF covers the majority of the cost. India PEPFAR does not support the supply chain, but PEPFAR programs are vulnerable to shortfalls.

2.3 National sustainability profile update: India PEPFAR's ROP19 plan aims at sustaining efforts that address weaknesses which threaten sustainability. The India 2017 Sustainability Index and Dashboard (SID 3.0) was completed using an iterative consultation process with technical experts from local civil society groups, GOI, multilateral partners, and implementing partners. Stakeholders reported improvements across the elements assessed with the SID and provided recommendations on how to sustain these improvements going forward. Additional sustainability vulnerabilities were identified recently during ROP19 strategic planning consultations.

Through NACO, the GOI has demonstrated strong leadership in developing a national HIV/AIDS strategy and coordinating the response among stakeholders. NACO's leadership and funding of the HIV response in India are existing strengths that foster sustainability. Initiatives undertaken by the GOI have led to the collection and analysis of timely, quality epidemiological and behavioral data on KP utilized to inform policy, program, and funding decisions. Mainstreaming of HIV/AIDS care and treatment into the service package of private-for-profit health institutions lags behind, as engagement of the private sector has generally been difficult and unclear. In response, stakeholders and India PEPFAR will provide support to NACO to strengthen its engagement with the private sector to ensure progress in the public sector are extended to the private sector through increased private sector oversight and regulation and establishment of strategic purchasing partnerships.

Quality of services remains a challenge as it largely contributes to differential treatment outcomes. Key to quality is the deficiencies in human resources faced by the Indian health system. Recommendations from stakeholders include regular monitoring and evaluation in order to address the resource and training needs of providers as well as a call to the GOI to allocate adequate resources to hire and retain both clinical and lay service providers. In FY 2016 and 2017, India PEPFAR took a bold move to terminate agreements with certain indigenous partners due to performance issues, which have impacted results and progress in key programming areas. Still, India PEPFAR continues to prioritize responsible indigenous partners with increased focus on strengthening institutional capacity of sub-partners preparing them to quickly step into the role of prime partner. India PEPFAR continues to strive to increase partnership with indigenous local partners to sustain years of investment in HIV/AIDS along with the solid partnership with the GOI and NACO.

India PEPFAR's seat on the GF CCM ensures USG funding is complementary and not duplicative. Ongoing collaboration with CSOs is also essential to achieving sustainability. Interventions with KP and other vulnerable groups will be carried out in partnership with civil society, and implemented through community-based organizations, health workers, and peer monitors.

2.4 Alignment of PEPFAR investments geographically to disease burden: In ROP 2019, India PEPFAR will continue to focus on high-burden districts in five states: Andhra Pradesh (AP), Maharashtra (MH), Manipur, Mizoram, and Nagaland (North East states). Three districts in AP (East Godavari, Guntur, and Krishna), three districts in MH (Mumbai, Pune, and Thane), and 12 districts in the North East states have been prioritized as epidemic control[31]. The geographic focus in the North East states of India will shift as prevention activities in two districts (Phek and Kohima) in Nagaland, and one district (Ukhrul) in Manipur will be transitioned to the respective state governments due to stabilizing of the HIV epidemic and low HIV prevalence. India PEPFAR will realign program efforts to three higher burden districts (Kolasib, Mamit, and Lunglei) in Mizoram where the epidemic is evolving and changing rapidly. Thus, in the North East region, PEPFAR India works in 12 districts in prevention and 17 districts in treatment[9]. PEPFAR support in the North East focuses primarily on people who inject drugs (PWID).

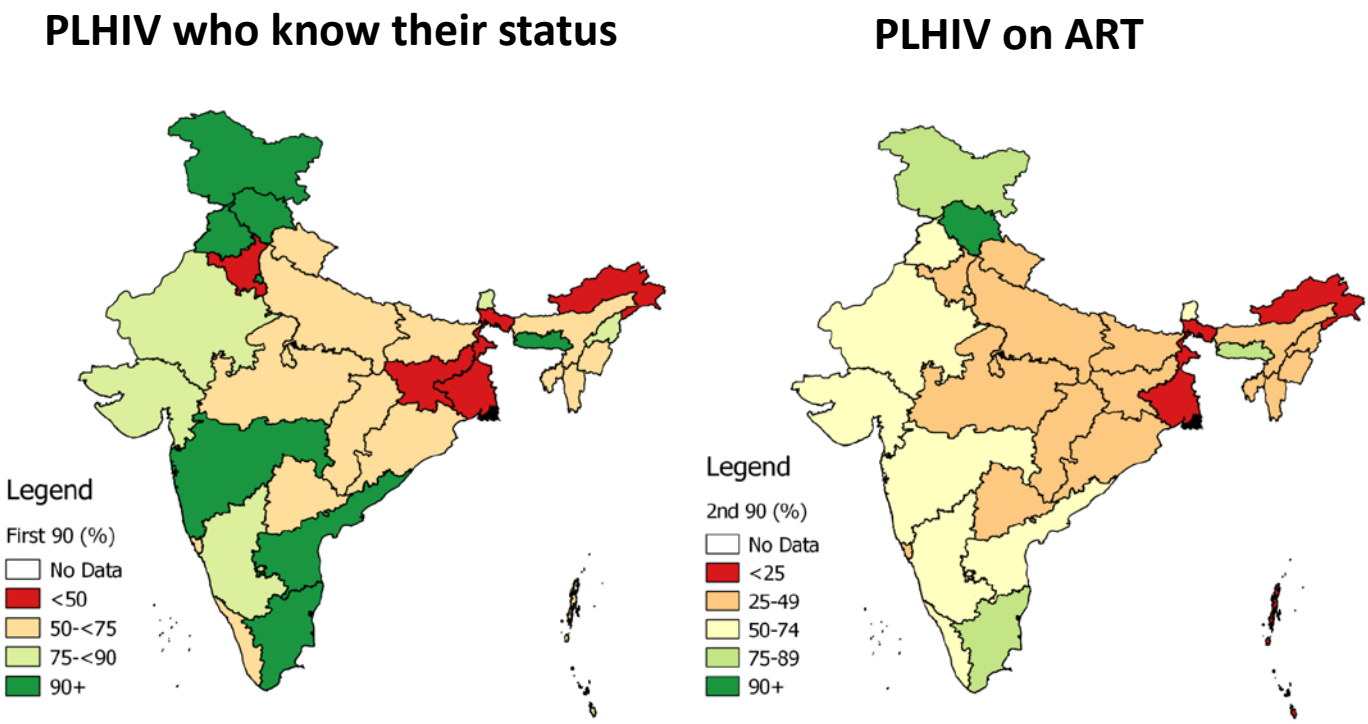
With an adult HIV prevalence of 0.33% in 2017 and an estimated 330,000 PLHIV, Maharashtra had the highest number of PLHIV, accounting for 15% of total PLHIV in the country of which 218,000 PLHIV were on ART. With an adult HIV prevalence of 0.63%, the state of Andhra Pradesh (AP) has an estimated 270,000 PLHIV (13% of total PLHIV in India), of which 154,000 PLHIV are on ART. At 2.04%, Mizoram has the highest adult HIV prevalence in the country, followed by Manipur at 1.43% and Nagaland at 1.15%.

Although the current HIV prevalence in India is 0.22%, in reality there are many different overlapping epidemics between states, regions, and risk groups. Data from the most recent population based KP survey (IBBS, 2015) show much higher prevalence among KPs: 9.9% in PWID, 2.2% in female sex workers (FSW), 4.3% in men who have sex with men (MSM), and 7.5 % in transgender (TG)[32]. The HIV prevalence among KP in the PEPFAR-supported geographic areas continues to be higher than the national level. Prevalence among FSW is 3.48% and among MSM is 4.69% in Maharashtra. In the North East states, the prevalence of HIV among PWID is 19.8% in Mizoram, 7.66% in Manipur, and 1.8% in Nagaland. The HIV prevalence among FSW is 24.6% in Mizoram, 3.6% in Nagaland, and 1.4% in Manipur. (KP HIV Sentinel Surveillance, 2017, NACO)

[31] Prevention and treatment districts in Manipur (Churachandpur, Imphal East, Imphal West, Chandel) and for treatment only (Thobal, Bisnupur, and Tamenglong); Mizoram prevention and treatment districts (Aizwal, Champai, Mamit, Kolasib and Lunglei); and Nagaland, prevention and treatment (Dimapur, Mokchung and Tuensang) and treatment only (Kohima, Kiphri).

[32] Integrated Bio-Behavioral Survey (IBBS) 2014-15

Figure 2.4.1 India State-Level 1st and 2nd 90, 2017 HIV Estimations



2.5 Stakeholder engagement: India PEPFAR regularly interacts with a wide group of stakeholders and has enjoyed a long-standing collaboration with NACO, several State AIDS Control Societies (SACS), the World Bank, the GF, UN agencies, WHO, and development partners. India PEPFAR also has strong ties with civil society, particularly organizations representing key populations. This strong engagement continued with our range of national stakeholders during the lead up months and then development of the ROP 2019, as this broad-based support and input is one of the key factors affecting the long-term sustainability of the national program. NACO also recognizes this engagement as important.

USG technical and management staff meet regularly with various technical groups at NACO to review project activities and results, discuss concerns, and provide input on policy and health systems strengthening issues. In all PEPFAR-supported districts in the five states of MH, AP, Manipur, Mizoram and Nagaland, India PEPFAR works closely with the State SACS and District AIDS Prevention and Control Units (DAPCUs), holding regular meetings with updates on activities and involving NACO and SACS staff in the progress, monitoring, and evaluation of the program activities. In more formal settings, PEPFAR implementing agencies have held partner meetings with government and community partners, quarterly meetings with implementing partners, and regular SIMS visits to demonstration sites. These consisted of discussions on findings and contributed to a joint understanding of results.

In preparation for ROP19, India PEPFAR engaged in a rigorous stakeholder consultation process. A full-day stakeholder consultation meeting was held, during which national estimates were reviewed, challenges analyzed, and programmatic solutions recommended. This meeting was convened under the leadership of the Joint Secretary of NACO, who appreciated the initiative and reiterated the importance of communication between PEPFAR and NACO. Despite the limited funding contribution from PEPFAR compared to the national budget, the meeting presented an opportunity for the NACO leadership to appreciate the USG catalytic role, which has enabled strong learning and scale up of successful models nationally.

A wide range of national stakeholders were in attendance, reflecting India PEPFAR's long-standing collaboration with each of those represented. Consultations were also held with male and female PWID, TG, FSW, MSM, and other community members to discuss gaps and elicit inputs to address the barriers and further strengthen India PEPFAR's response.

Stakeholders were given the opportunity to ask questions, comment on India PEPFAR priorities for ROP19, and make recommendations to balance prevention and treatment priorities to address barriers to services across the continuum of care. The consultation ended on a positive note with stakeholder consensus on the importance of sustainability, with the Joint Secretary advising SACS to include PEPFAR activities in their annual budget request. Stakeholders also agreed to periodic meetings throughout the implementation period as well as to consult with civil society partners on a regular basis to review, evaluate, and receive feedback on programmatic progress. PEPFAR will further involve CSOs in the development and integration of prevention and treatment services, and determine how they can be funded to do so. CSOs have the potential and willingness to be involved in supportive service delivery, but to date have not been utilized to any great extent.

Support to India to adopt policies and address domestic challenges and concerns will require strong mobilization from all stakeholders. Agreements for regular touch points among development partners were made this year during two India PEPFAR-organized consultations for periodic meetings to discuss funding, alignment of priorities, and challenges, as well as addressing in-country issues related to the accountability, transparency, and performance of GF principal recipients that impact progress.

India PEPFAR commits to strengthening cross technical collaboration through frequent interagency data collaboration meetings, and sharing a joint review of cascades including both prevention and treatment cascades.

Tier 2: INDONESIA

2.1 Summary statistics, disease burden, and country profile: Indonesia is a large and complex country with an estimated 271 million people (2020 projection) and hundreds of different ethnic groups spread across nearly 17,000 islands. It has 34 provinces, and four special regions (Jakarta, Papua, Aceh, and Yogyakarta), which are subdivided into 502 lower administrative districts (416 regencies and 98 municipalities). Local governments and municipalities became

the key administrative units responsible for the provision and budgeting of public services when the Government of Indonesia (GOI) began decentralization in 2001.

Indonesia has a GNI per capita of $3,440 (2015), is classified as a lower middle-income country by the World Bank, has an economic growth of over 5%, and has increased its investment in health from 3.7% to 5% of the national budget. Indonesia continues to struggle with fragile institutions, inadequate infrastructure, endemic corruption, terrorism, rising religious and ethnic intolerance, and the complex rollout of a national single-payer universal health coverage scheme. Indonesia is also faced with rising income inequality; 20% of the richest Indonesians hold 80% of the wealth and two-thirds of the population live on less than $3 per day.

Based on the most recent IBBS (2015), the national HIV prevalence rate among adults aged 15 years and above was estimated at 0.3% (631,635 PLHIV in 2018). With the exception of Papua and West Papua provinces, which have a low-level generalized epidemic (estimated HIV prevalence of 2.3% for males and 2.2% for females), Indonesia continues to experience a concentrated HIV epidemic. Comprehensive HIV knowledge among young people ages 15-24 years is alarmingly low, at only 10% for young males and 11% for young females. The 2015 IBBS indicated an estimated prevalence rate among direct (i.e., brothel- and/or street-based) female sex workers (DFSW) of 8.0%; 2.2% among indirect (i.e., massage- or beauty parlor-based) FSW (IDFSW); 24.8% among waria (transgender populations, or TG); 25.8% among MSM; and 28.8% among PWID.

Indonesia's 2015 AEM indicates that the number of new infections is projected to decline steadily from 49,199 in 2015 to 44,604 in 2020. It was estimated that new HIV infections in 2015 were primarily coming from non-KP women (17,117 new infections), followed by clients of FSW (12,647 new infections), and MSM (10,194 new infections). Among KP, new infections among MSM, MSW, and PWID are projected to increase, while the other groups of KP are projected to remain stable or decrease.[33] HIV disease burden among PWID, which appeared to initially ignite HIV transmission, has been on the decline nationally, while there has been a significant increase of HIV among MSM in recent years.

Nationally in Indonesia, the 2015 IBBS among MSM demonstrated a significant increase in HIV prevalence, from 8.5% in 2011 to 25.8% in 2015. The latest 2015 IBBS data show that the prevalence of HIV among MSM in Jakarta was at 32.0% in 2015, almost doubling from 17.2% in 2013. The 2014 Mode of Transmission mathematical model projects that the number of annual new HIV infections will rise most rapidly among MSM, soon surpassing the number of new infections among FSW (see Table 1.1.a). In addition, despite a national increase in prevention and testing coverage among MSM from 2009 to 2013, prevalence rates of syphilis (8% to 11%), gonorrhea (17% to 21%) and chlamydia (17% to 23%) continue to increase in this population.[34]

Table 2.1a: Estimated New Infections by Modes of Transmission (2015 AEM) (Indonesia)

[33] 2015 AEM estimates (MOH)
[34] 2015 GFATM Concept Note

Key Populations	Number of New HIV Infections					
	2015	2016	2017	2018	2019	2020
Direct Female Sex Worker	1223	1101	1057	1017	983	951
Indirect Female Sex Worker	943	915	878	843	813	785
Client of FSW	12647	11588	11338	11041	10723	10400
MSM	10194	10447	10876	11284	11669	12040
Male Sex Worker	2002	2088	2143	2197	2253	2308
PWID	616	582	660	675	691	701
Transgender	260	237	236	233	233	233
Non-KP Men	4198	3913	3887	3850	3803	3746
Non-KP Women	17117	16033	15283	14590	13980	13440
Total	49199	46905	46357	45729	45147	44604

HIV prevalence among the estimated 39,512 waria (TG) remained high in 2015.[35] Waria in Jakarta were reported to have an HIV prevalence of 30.8% (and syphilis prevalence of 31.2%) according to the 2015 IBBS.

High HIV prevalence among FSW is a major factor in the spread of HIV in Indonesia. There are significant variations in HIV prevalence among cities and districts, with prevalence of HIV among DFSW ranging from 2.5% to 17.5%. IBBS data demonstrates that in Jakarta HIV prevalence among estimated DFSW was found to be 10.5%. Although IFSW are harder to reach compared to DFSW, available data demonstrated that they had lower HIV prevalence rates compared to DFSW (Table 1.1b).

Table 2.1b: Trends in HIV Prevalence and Size Estimates among Key Populations (2007-2015) (Indonesia)

Key Population Group	HIV Prevalence 2007	HIV Prevalence 2011	HIV Prevalence 2013*	HIV Prevalence 2015	Est. Population Size 2011	Est. Population Size 2015	Est. Population Size 2016 (revision)**
PWID	52%	41.2%	39.5%	28.8%	105,784	77,286	33,492
DFSW	10%	10.4%	7.2%	8.0%	106,011	129,973	226,791
IFSW	5%	2.9%	1.6%	2.2%	108,043	109,036	
MSM	5.2%	8.5%	12.8%	25.8%	695,026	1,139,606	754,310
Waria	24%	21.9%	7.4%	24.8%	32,065	39,512	38,928

*2013 IBBS data were sampled in different sites from 2007, 2011, and 2015 IBBS
**Revised 2016 PSE based on multivariate regression model extrapolation of 2015 PSE

The US Department of Defense (DOD) provided crucial TA in Indonesia for the implementation of the military IBBS 2017 survey, and respondents with HIV-positive results were found in the

[35] 2015 IBBS Presentation, MOH, February 2016.

six survey sites located in four provinces, with a prevalence range of 0.31% to 0.35%. Based on the survey results, the population that is most vulnerable to HIV infection in the military (the Tentara Nasional Indonesia, TNI) is the population with an age range of 25-35 years old and with length of military service between two and nine years.

Since 2014, the GOI has implemented Test & Start through its Strategic Use of ARVs (SUFA) initiative, which provides immediate treatment for KP, TB patients, and pregnant women in over 100 districts, including PEPFAR-supported districts. The implementation and uptake of this policy, however, has been slower than anticipated. Indonesia PEPFAR has worked closely with the MOH in revising HK.02.02/I/1564/2018: Letter of Decree from the MOH recommendation that anyone infected with HIV should begin ART immediately within one to seven days after diagnosis, regardless of the CD4 count.

Available data and program review results suggest that, while progress has been made, national HIV program efforts lack the coverage and intervention effectiveness needed to have a major impact on the course of HIV in the country.[36] Main targets of the Indonesian response to HIV and AIDS[37] are to "achieve coverage of 80% of key affected populations with effective programs, with 60% of them engaging in safe behavior, and for 70% of funding for the targeted response coming from domestic sources."

[36] 2015 GFATM Concept Note
[37] National AIDS Strategy and Action Plans, 2010-2014 (NAC)

Table 2.1.1 Host Country Government Results

Table 2.1.1 Host Country Government Results (Indonesia)															
	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	271,066,400	100	34,579,500	12.80%	36,130,500	13.30%	21,700,700	8%	22,684,500	*8.40%*	78,643,700	29%	77,327,500	28.50%	Indonesia Bureau of Statistics, 2010 census (2020 projection)
HIV Prevalence (%)		0.32		N/A		N/A		N/A		N/A		N/A		N/A	Estimates and Projection of HIV/AIDS in Indonesia 2015-2020 (2020 projection)
AIDS Deaths (per year)	48083		1234		1289						15298*		30261*		Estimates and Projection of HIV/AIDS in Indonesia 2015-2020 (2020 projection). *Age disaggregation by below 15 and 15+ only.
# PLHIV	652349		10133		10693						229534*		401990*		Estimates and Projection of HIV/AIDS in Indonesia 2015-2020 (2020 projection). *Age disaggregation by below 15 and 15+ only.
Incidence Rate (Yr.)		0.03%													MOH EPI review, Estimates & Projections of HIV/AIDS 2015-2020
New Infections (Yr.)	48528		1915	3.90%	2009	4.10%					15176	31.30%	29428	60.60%	Estimates and Projection of HIV/AIDS in

Table 2.1.1 Host Country Government Results (Indonesia)															
	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
															Indonesia 2015-2020 (2020 projection). *Age disaggregation by below 15 and 15+ only.
Annual births	4840511														
% of Pregnant Women with at least one ANC visit	5076349	95.41%	N/A	N/A											2017 Indonesia Health Profile (no age disaggregation)
Pregnant women needing ARVs	14298														Estimates and Projection of HIV/AIDS in Indonesia 2015-2020 (2020 projection number of HIV positive pregnant mothers)
Orphans (maternal, paternal, double)	N/A		N/A		N/A		N/A		N/A		N/A		N/A		
Notified TB cases (Yr.)	446723		N/A		N/A		N/A		N/A		N/A		N/A		2018 Global TB Report
% of TB cases that are HIV infected	127432	29%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
% of Males Circumcised	N/A	N/A			N/A	N/A			N/A	N/A			N/A	N/A	
Estimated Population Size of MSM*	754310														MOH Epi review 2016 (Estimated size for KP in 2016)
MSM HIV Prevalence	119566	25.80%													MOH Epi review 2016 (HIV prevalence for MSM in 2015) and

Table 2.1.1 Host Country Government Results (Indonesia)															
	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
															Estimates and Projection of HIV/AIDS in Indonesia 2015-2020 (Estimated MSM PLHIV in 2020)
Estimated Population Size of Transgender*	38928														MOH Epi review 2016, (Estimated size for KP in 2016)
Transgender HIV Prevalence	3633	24.80%													MOH Epi review 2016 (HIV prevalence for TG in 2015) and Estimates and Projection of HIV/AIDS in Indonesia 2015-2020 (Estimated TG PLHIV in 2020)
Estimated Population Size of FSW	226791														MOH Epi review 2016, (Estimated size for FSW in 2016)
FSW (high risk) HIV Prevalence	3993	8%													MOH Epi review 2016 (HIV prevalence for Direct Female Sex Worker in 2015) and Estimates and Projection of HIV/AIDS in Indonesia 2015-2020 (Estimated Direct Female Sex Worker PLHIV in 2020)

Table 2.1.1 Host Country Government Results (Indonesia)															
	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
FSW (low risk) HIV Prevalence	3466	2.20%													MOH Epi review 2016 (HIV prevalence for Indirect Female Sex Worker in 2015) and Estimates and Projection of HIV/AIDS in Indonesia 2015-2020 (Estimated Indirect Female Sex Worker PLHIV in 2020)
Estimated Population Size of PWID	33492														MOH Epi review 2016, (Estimated size for KP in 2016)
PWID HIV Prevalence	7923	28.80%													MOH Epi review 2016 (HIV prevalence for PWID in 2015) and Estimates and Projection of HIV/AIDS in Indonesia 2015-2020 (Estimated PWID PLHIV in 2020)
Estimated Size of Priority Populations (client of female sex worker)	5254065														MOH Epi review 2016, (Estimated size for KP in 2016)
Client of Female Sex Worker HIV Prevalence	85215														Estimates and Projection of HIV/AIDS in Indonesia 2015-2020 (Estimated

Table 2.1.1 Host Country Government Results (Indonesia)															
	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
															Client of FSW PLHIV in 2020)
Estimated Size of Priority Populations Prevalence (client of transgender)	350119														MOH Epi review 2016, (Estimated size for KP in 2016)
Estimated Size of Priority Populations (military)	500000														
Military HIV Prevalence	1500	0.003													

Table 2.1.2 90-90-90 Cascade

*Estimates and Projection of HIV AIDS in Indonesia 2015 – 2020

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression* (Indonesia, National Level)													
Epidemiologic Data					HIV Treatment and Viral Suppression (until Dec 2018) ***				HIV Testing and Linkage to ART Within the Last Year (Jan - Dec 2018)***				
	Total Population Size Estimate*	HIV Prevalence*	Estimated Total PLHIV	PLHIV diagnosed	On ART	ART Coverage	Viral Suppression	Viral Suppression	Tested for HIV	Diagnosed HIV Positive	Initiated on ART	Viral Load Testing	Viral Load Suppression
	(#)	(%)	(#)	(#)	(#)	(%)	(#)	(%)	(#)	(#)	(#)	(#)	(#)
Total population	265015300**	0.33*	631635	327282	108479	17.2%	3541	89%	3077653	46659	*34559*	3985	3541
Population <15 years	70486800		19718	9412	3895	19.8%	33	67%	42924	1447	*1012*	49	33
Men 15-24 years	22475800		403150	29449	9999	16.6%	325	93%	162254	5324	*3819*	351	325
Men 25+ years	74622100			132937	57121		2504	89%	484504	23704	*18050*	2811	2504
Women 15-24 years	21590400		228485	23621	6185	16.4%	50	85%	718322	3178	*2035*	59	50
Women 25+ years	75840200			79966	31279		607	88%	1669649	13006	*9643*	692	607
Others (no ages)							22	96%				23	22
MSM	754310	25.8	119566	40186	10805	9.0%			103273	9032	*4278*		
FSW (high risk)	226791	8	3993	25439	1575	39.4%			92612	2243	*551*		
FSW (low risk)		2.2	3466										
PWID	33492	28.8	7923	12859	1939	24.5%			12119	409	*301*		
Transgender	38928	24.8	3633	8502	565	15.6%			14287	593	*181*		
Military	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*			*[REDACTED]*	*[REDACTED]*	*[REDACTED]*		

** Indonesia Bureau of Statistics, 2010 census (2018 projection). To be consistent with 2018 HIV program data

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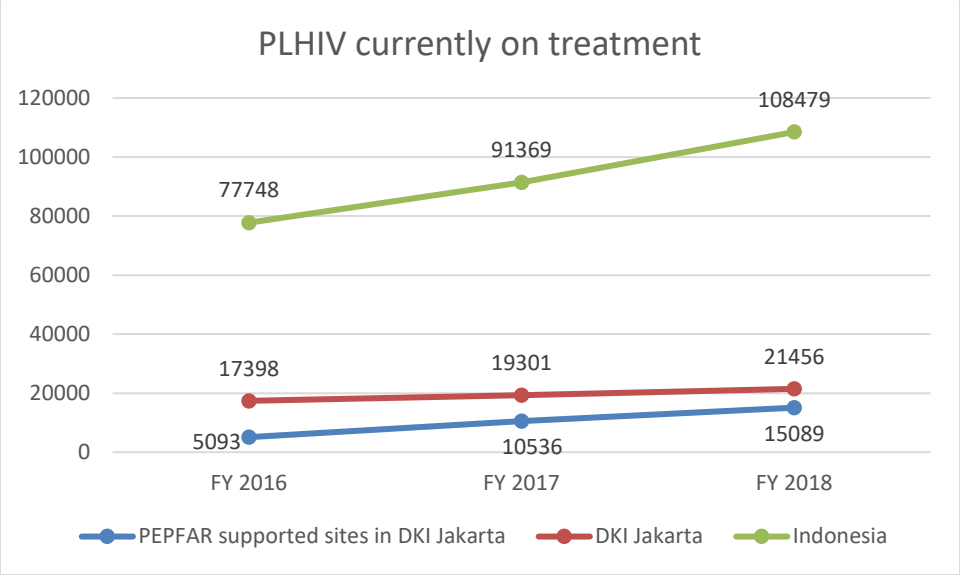
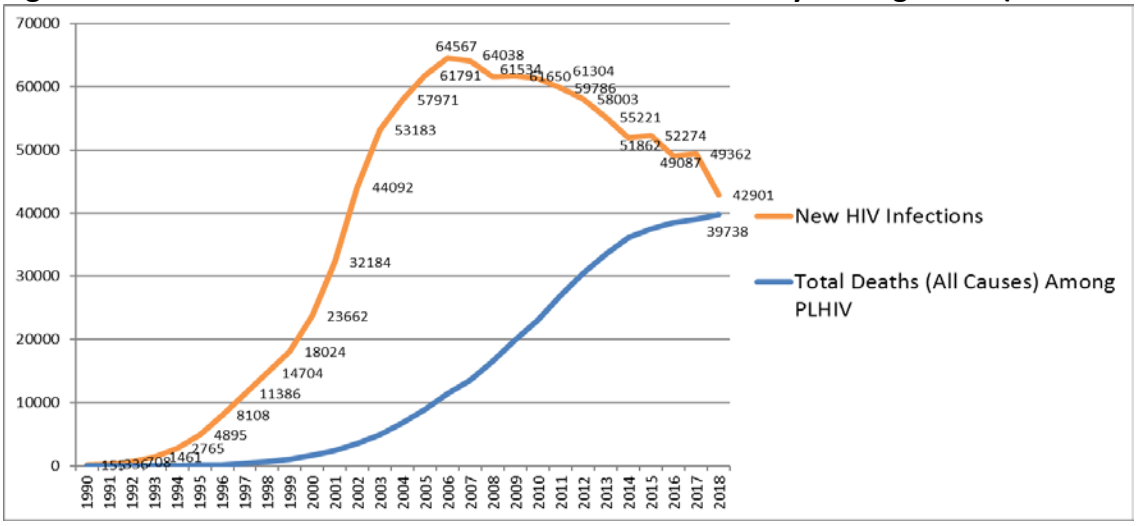
Figure 2.1.3 National and PEPFAR trend for individuals currently on treatment (Indonesia)



ART scale-up in Indonesia has been a priority for the GOI since 2005, and its commitment to increase ART coverage was demonstrated with the launch of SUFA in 2014 and GOI's pledge for Jakarta to be included in the UNAIDS Fast Track response.[38] The number of PLHIV currently on ART increased dramatically from 2,381 in 2005, to 24,410 in 2011, to 73,073 at the end of 2016[39]; in December 2018, it reached 108,479. However, despite the government's continued effort, the overall ART coverage rate in Indonesia remains low (at 15%) and VL testing is still currently not widely available.

Figure 2.1.4 Trend of New Infections and All-Cause Mortality Among PLHIV (Indonesia)



[38] 2015 UNAIDS Fast Track Cities Update http://www.unaids.org/sites/default/files/media_asset/JC2815_2015_Dec_update_Fast-track_cities_en.pdf
[39] 2016 MOH Quarter 4 HIV Program Report

New HIV infections increased by 48% from 2005 to 2013, and Indonesia's share of new HIV infections in the Asian Pacific region reached 23% in 2013, the third highest in the region.[40] However, according to AEM results in 2015, new HIV infections in Indonesia from 2015 to 2020 are projected to slightly decrease, from 49,199 to 44,604. In addition, the TB rate of infection in Indonesia is the third highest in the world, with 319 per 100,000 people. Additionally, it is estimated that there are 36,000 cases of TB-HIV comorbidity per year, which the national response has only recently begun to address.

2.2 Investment Profile: Indonesia's most recent NASA (2018) shows expenditures from domestic (75%) and external (35-25%) sources totaled $177 million in 2016. The national budget for ARVs was reduced from around $66 million in 2016 covering 77,748 PLHIV, to $40 million in 2018 for a targeted 129,490 patients.[41] Based on the 2018 NASA report, expenditures from the host country have greatly increased from $68,747,444 in 2015 to $131,711,069 in 2016. The national budget for ARVs has fluctuated from $66 million in 2016 to around $40 million in 2018. The planned budget in 2019 is $84 million for ARVs. Fluctuations are the result of better data on stock-on-hand as the result of improved data and supply monitoring, incomplete procurement processes, and fluctuations in annual funding allocations for ARVs. In late 2018 the GF approved an HIV grant of $97 million for 2018 and 2020 implementation years. Despite this envelope, Indonesia's GF PRs have historically been unable to spend close to their total annual budget. In ROP 19, Indonesia PEPFAR will work with the MOH, the GF Country Coordinating Mechanism (CCM), and PRs to strengthen and optimize existing program resources and spending. In ROP19, PEPFAR funding will continue to reach and strengthen services for targeted populations in Jakarta, as well as strengthen GF PRs, central government, and district-level investments.

Table 2.2.1 Annual Investment Profile by Program Area (Indonesia)

Table 2.2.1 Annual Investment Profile by Program Area[42]

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
Clinical care, treatment and support	$ 97,506,065	2%	1%	97%	
Community-based care, treatment, and support	$ 4,026,986		100%		
PMTCT	$ 54,896		100%		
HTS	$ 2,430,653	58%	42%		
VMMC			-		
Priority population prevention	$ 11,946,856		5%	95%	
AGYW Prevention			-		
Key population prevention	$ 25,063,774	5%	5%	90%	
OVC	$ 139,754	-	-	100%	
Laboratory	$ 161,839	-	100%	-	

[40] 2014 UNAIDS GAP Report
[41] Progress 2011-2016, Subdit HIV Indonesia
[42] (GRP, National AIDS Spending Assessment, 2018), all amounts in USD

Table 2.2.1 Annual Investment Profile by Program Area[42]					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
SI, Surveys and Surveillance	$ 1,180,775	44%	55%	1%	
HSS	$ 6,418,414	41%	8%	51%	
Total	$ 148,930,012	5%	6%	88%	

Notes: 1) PEPFAR expenditures are derived from ER 2017; 2) Global Fund expenditures provided by the GF Country Team, and include expenditures for 2 PRs: MOH, and Spritia.

Table 2.2.2 Annual Procurement Profile for Key Commodities (Indonesia)

Table 2.2.2 Annual Procurement Profile for Key Commodities					
Commodity Category	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
ARVs	40,825,282	0	11	89	
Rapid test kits	9,154,930	0	0	100	
Other drugs					
Lab reagents					
Condoms	625,426	0	100	0	
Viral Load commodities	2,356,072	0	4	96	
VMMC kits					
MAT					
Other commodities					
Total	52,961,710				

Notes: 1) expenditures for 2019; 2) amounts converted from IDR to USD at 14,200

Indonesia PEPFAR will assist the MOH to regularly review supply chain data, and use that data for logistics management decision making. Forecasting, supply planning, and monitoring functions will be strengthened to increase accountability and transparency, and ensure commodity availability for expanding programs. Focus will be placed on ensuring sufficient supplies are procured at the national level and are allocated to Jakarta to support national as well as Jakarta-specific needs. Pricing, competition, and registration issues will also be addressed, including support for a registration workshop to increase competition and the number of suppliers for TLD and other key ARV products.

ARV Commodities: The GOI has been committed to procuring ARV commodities in increasing budget amounts since 2010. In 2017 and 2018, the GOI procured more than 95% of ARVs for the country. In 2019, it is expected that the GF contribution will increase to approximately 11% in response to procurement and supply chain challenges. With the transition to TLD in 2020, the GF contribution is expected to be maintained at the 2019 level.

Rapid Test Kits: To achieve the first 90 target, the GOI has been increasing the testing of KP, as well as pregnant woman and TB patients, since 2017. In 2018, the GOI implemented a comprehensive policy to accelerate HIV testing coverage by including the HIV testing indicator in the Standard Minimum Services. Beginning in 2020, it is anticipated that 80% to 90% of the

budget for RDT procurement will be managed directly by each province and district, with the NAP procuring 10% to 20% as a buffer stock held at the central level.

VL Commodities: The policy to encourage VL testing for ARV monitoring was implemented nationwide in late 2017, and the use of GeneXpert as an alternative VL testing platform was introduced in mid-2018. Current plans are to have 70% of VL tests on Abbott platforms and 30% on GeneXpert in 2019, increasing to 60% Abbott and 40% Gx in 2020.

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration (Indonesia)

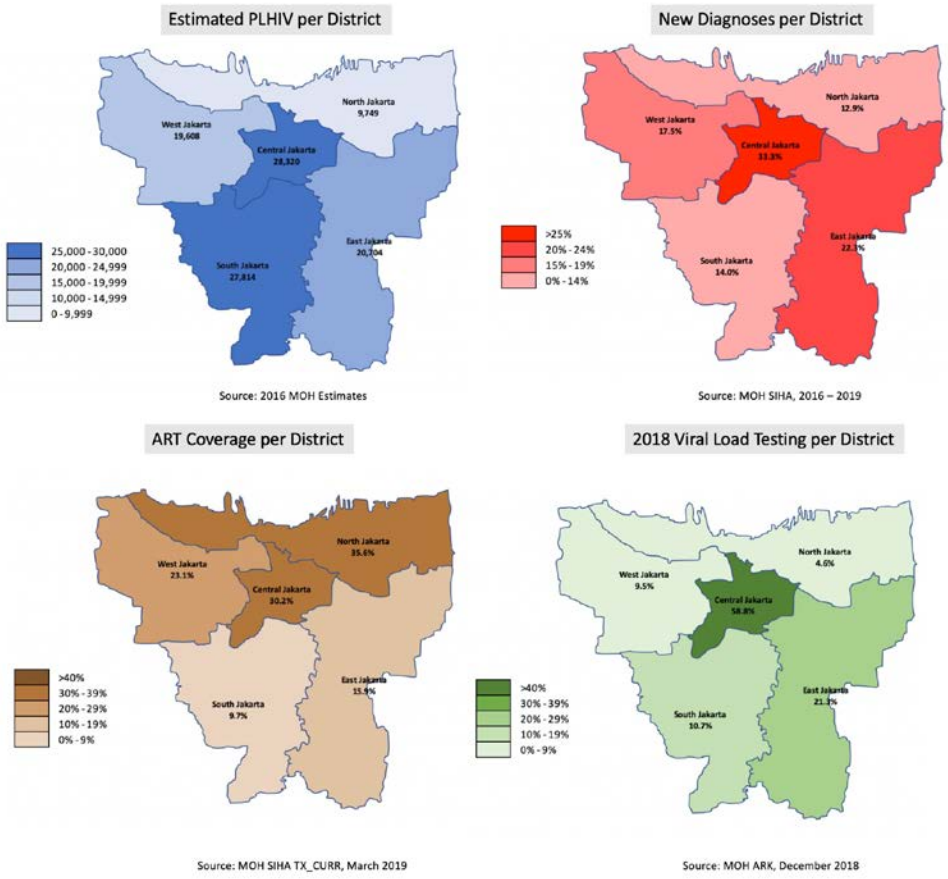
Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
USAID MCH	$7,500,000 (CBJ)	$825,000	1		
USAID TB	$20,000,000 (CBJ)	$1,685,000	2	$700,000	
USAID Malaria					
Family Planning					
NIH					
CDC (Global Health Security)					
Peace Corps					
DOD Ebola					
MCC					
Total					

2.3 National sustainability profile update: Indonesia PEPFAR's ROP19 is aimed at sustaining efforts that address weaknesses which threaten sustainability. The team engaged closely with national and local government partners to gather input on the following components deemed the most important in the management of the HIV program.

- Human resources for health: In COP17/18, Indonesia PEPFAR provided TA to conduct a two-pronged assessment to understand health workforce strengths and barriers to scaling up HIV services. In ten health centers in Jakarta, one assessment revealed 11% of staff time is dedicated for HIV. Additionally, the need for more laboratory staff was identified. Overall, the HIV policies developed at the central level and reviewed in this assessment are sufficient to support implementation of Test & Treat. Additional implementation guidance, however, is required to ensure success. Where SUFA had implications for increased workload of laboratory technicians and others, Test & Treat should serve to streamline these workflows. In ROP19, PEPFAR will continue providing crucial TA to health facilities to provide guidance to implement the Test & Start policy.
- Performance data: Performance data also had a high score in COP16. However, data collection is largely for reporting and not for programming purposes; aggregated data submitted to the national government is not being used consistently to improve service provision or quality. In ROP19, Indonesia PEPFAR will continue to intensify work with national and local governments to improve the quality and use of programmatic data at a more granular and routine level.

- Commodity security and supply chain: This area received a low score largely due to the lack of a comprehensive National Supply Chain Strategy and human resources with sufficient technical capacity to ensure the system functions at a high level. Additionally, the high price of ARVs ($740 per patient) and other essential HIV commodities place a high cost burden on the national program. In ROP19, PEPFAR will continue to advocate for more affordable prices for ARV. In addition, the decentralization of most administrative, planning, and management functions in the supply chain presents an enormous challenge in ensuring adherence to national guidelines and SOPs.

2.4 Alignment of PEPFAR investments to disease burden



In ROP19, Indonesia PEPFAR will refocus programming areas across all five Jakarta districts to make the most strategic use of PEPFAR investments and to directly respond to the Minimum Requirements outlined in the Planning Level Letter. Indonesia PEPFAR will focus on improving ART coverage through district and immediate linkage from testing to treatment. VL testing acceleration will improve district-level VL testing coverage to 40% or more of the TX_CURR totals. ART retention will be strengthened through customized community-based case management, intensive attrition monitoring, and rapid response strategies that identify clients at risk for LTFU and re-engage PLHIV in the HIV service system.

In ROP19, Indonesia PEPFAR will continue working in the same five districts in Jakarta to achieve epidemic control. In Jakarta, the sub-national government has continued a strong commitment to ensure ART coverage saturation. Indonesia PEPFAR will support up to eight CSOs or private sector partners to amplify outreach efforts to identify new PLHIV within hard-to-reach key sub-populations, with a particular focus on MSM under 35 years of age. In contrast to GF-supported or GOI outreach implementers, PEPFAR resources will be used to amplify the Enhanced Outreach and Differentiated Care Approach (EOA-DC) that differentiates the outreach contact based on the needs of each KP client, and extends support across the cascade with particular focus on index testing, linking of newly diagnosed immediately to treatment, finding those LTFU back to treatment, and achieving VL suppression.

2.5 Stakeholder engagement: To achieve control of the HIV epidemic, it is critical that PEPFAR provides support to national and local governments in Jakarta and other local institutions sharing the responsibility for building a sustainable national response. This year, the USG consulted with the head of the National AIDS Program (NAP) at the MOH and the Indonesian military's Surgeon General's Office (SG) regarding proposed activities that the USG would undertake to support the National Strategic Plan, including geographic prioritization, populations of focus, and the types of activities that would be undertaken.

Following the Bangkok ROP meetings, Indonesia PEPFAR has already increased engagement with the GF, the GOI, and UNAIDS to ensure close collaboration on accountability, targets, and performance. A comprehensive plan for strengthened partnerships to accelerate treatment coverage to move Indonesia towards epidemic control is being developed.

Indonesia PEPFAR held two consultation meetings with CSOs in the process of developing ROP19. The first meeting, held on January 23, 2019, was attended by CSOs managing PEPFAR funding, CSOs managing GF funding, and CSOs managing AIDSCare Health Foundation funding. The second meeting, on February 13, 2019, was conducted in partnership with UNAIDS and attended by national and sub-national government representatives, international development partners, representatives of the CCM, and service delivery, advocacy, and human rights CSOs.

Highlights from the discussions include concerns that reduced PEPFAR funding will result in less involvement of CSOs in active case finding. Participants acknowledged challenges in finding HIV-positive people despite the high number of tests conducted, due to a variety of reasons such as stigma and discrimination, and high mobility of KP. Participants also noted the need for innovation to differentiate service delivery for active case findings, and retaining PLHIV on treatment to reach prevention targets, especially because of the current funding-restricted environment. Participants also noted that it is important to facilitate opportunities for human rights and HIV CSOs and networks to work together to address stigma and challenge discrimination using legal recourse. Finally, participants noted that patients who have quit ART in the past who want to reenroll in treatment face several challenges; they need to pay for the pre-lab test fee again (although Test & Treat does not require a pre-lab test before starting treatment), they still fear side effects, and they feel uncomfortable because they feel like they are "scolded" by health workers for having quit ART in the first place.

Historically, the private sector has not participated actively in the National HIV Response in Indonesia due to lack of financial incentives. However, four privately run KP-friendly clinics in Jakarta provide quality HIV services for PEPFAR-targeted populations. In ROP 19, Indonesia PEPFAR will continue to engage these private clinics and will explore opportunities for increased private sector engagement in addressing the HIV epidemic in Indonesia, but this remains a challenge given the populations most affected by HIV.

Tier 2: KAZAKHSTAN

2.1 Summary statistics, disease burden, and country profile: Kazakhstan is a former republic of the Soviet Union's Commonwealth of Independent States. It borders Russia to the North, Uzbekistan, Kyrgyz Republic, and China to the South, and Mongolia to the East. Heroin produced in nearby Afghanistan is trafficked across Central Asia; injectable drug use became a major driver of the HIV epidemic. The total population of Kazakhstan is 18.157 million. The 2017 GNI per capita for Kazakhstan is 7,970 USD, which reflects a continued decrease from 12,090 USD in 2014 (World Bank).

The adult HIV prevalence in Kazakhstan is 0.20%. Prevalence among KP, however, remains significantly higher. Among PWID the rate is 7.9%; among FSW 1.9%, and among MSM 6.2%. The most recent official SPECTRUM modeling estimates for total PLHIV aged 15 years and older in Kazakhstan is 26,128 (18,130 men and 7,998 women). In 2017, Kazakhstan had an estimated 3,654 new HIV infections and fewer than 1000 AIDS-related deaths. Since 2010, however, the number of new HIV infections has increased by 106% (UNAIDS).

Of the three PEPFAR-supported countries in Central Asia, Kazakhstan is the closest to achieving the UNAIDS 90-90-90 goals by 2020. At the beginning of January 2019, there were 22,286 adults 15+ diagnosed with HIV, representing 85% of estimated PLHIV. There were 14,519 currently on ART, or 56% of PLHIV 15+. Among individuals on ART, 11,354 (43%) had documented viral load suppression. The PEPFAR priority site-level sub-national units in Kazakhstan, Pavlodar, and East Kazakhstan Provinces, reflect high prevalence geographic areas in the country and are home to 24% of the estimated PLHIV in Kazakhstan.

Kazakhstan has made significant progress in adopting and implementing key policies to address HIV and PEPFAR's program requirements, including implementation of a Test & Start strategy, scale-up of TB preventative therapy for all PLHIV, adoption of differentiated service delivery models (DSDM) and roll-out of MMS of ART for stable patients. In 2018 the Republican AIDS Center (RAC) of Kazakhstan included Dolutegravir (DTG) in the new National Treatment Guidelines, but Kazakhstan is not eligible for the Medicines Patent Pool voluntary licensing agreement. Because of the high price ($190/ month), DTG-containing regimens are prescribed as second line for patients experiencing treatment failure and as first line for some patients.

Kazakhstan faces several obstacles in achieving the targets set out in the UNAIDS Fast Track Ending the AIDS Epidemic by 2030 initiative and the 90-90-90 goals for 2020. Challenges are

numerous. They include a reduction in donor funding for health; inadequate domestic budget for HIV, and insufficient ARV supply to fully implement the Test and Start Guidelines, which were approved in 2017. In addition, there is significant HIV-related stigma and discrimination among communities, health providers, and law enforcement officials that marginalize KP and limit access to and uptake of HIV-related services. There are limited government and community services for KP including Medication-Assisted Treatment (MAT) for opioid addition.

After a protracted government review, the MOH has officially adopted MAT, using methadone as the national protocol, and only now plans to scale up access nationally, focusing on opioid-dependent PLHIV. New case finding among MSM and FSW is low; and their uptake of HIV treatment is lower than for non-KP PLHIV. There are also remaining challenges with low adherence and low viral load suppression for PLHIV on ART.

Table 2.1.1 Host Country government results (Kazakhstan)

Table 2.1.1 Host Country government results (Kazakhstan)															
Total			**<15**				**15-24**				**25+**				**Source, Year**
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		**Empty cells indicate no data available**
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Total Population	18,157,337	100	2,481,198	13.66%	2,628,328	14.48%	1,174,745	44.70%	1,224,254	46.58%	5,710,096	31.45%	4,938,716	27.20%	National Statistics Agency, As of January 01, 2018 www.stat.gov.kz
HIV Prevalence (%)	-	0.15%	-	0.01%	-	0.01%	-	0.07%	-	0.08%		0.12%	-	0.35%	Estimated PLHIV (UNAIDS, 2017) / total population (NSA, 2017)
AIDS Death (per year)	243	-	1	-	0	-	1	-	0	-	82	-	159	-	EHCMS, Jan 01, 2018 - Dec 31, 2018 for reported deaths
AIDS Death (per year)	680	-	8	-	10	-	5	-	7	-	80	-	570	-	UNAIDS data, 2017, http://www.aidsinfoonline.org
Estimated # PLHIV	26,543	0.75%	200	0.75%	215	0.81%	865	3.26%	998	3.76%	7,133	26.87%	17,132	64.54%	UNAIDS data, 2017, http://www.aidsinfoonline.org
Incidence Rate (Yr.)		0.0201%		0.0017%		0.0015%		0.0204%		0.0259%		0.0150%		0.0437%	New infections (UNAIDS data, 2017)/Total population (2017)
New Infections (diagnosed / Yr.)	3,654		41		40		240		317		858		2,158		UNAIDS data, 2017, http://www.aidsinfoonline.org
New Infections (Yr.)	3,217		18		10		93		144		1,097		1,855		EHCMS, Jan. 01 2018- Dec 31, 2018; # of newly confirmed cases officially registered
Annual Births	398,604	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	register of pregnant women, Jan 01, 2018 - Dec 31, 2018 for registered pregnancies

Table 2.1.1 Host Country government results (Kazakhstan)															
Total			<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		Empty cells indicate no data available
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
% of pregnant women with at least 1 ANC visit	382,894	98	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	register of pregnant women, Jan 01, 2018 - Dec 31, 2018 for registered pregnancies
Pregnant Women Needing (ARVs)	723	0.19	0	-	-	-	106	-	-	-	617	-	-	-	EHCMS, As of Dec 31, 2018
Orphans (maternal, parental, double)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Notified TB Cases (Yr.)	12,942	-	-	-	-	-	-	-	-	-	-	-	-	-	WHO 2018 Global TB report, data for 2017
% of TB cases that are HIV infected	745	5.76%	2		2		0		4		157		580		EHCMS, As of Dec 31, 2018; calculated % using notified cases as denominator.
% of Males Circumscribed	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Key Populations															Source, Year
Estimated Population	94,600	-	-	-	-	-	-	-	-	-	-	-	-	-	RAC, Report on Size Estimation of PWID, 2019

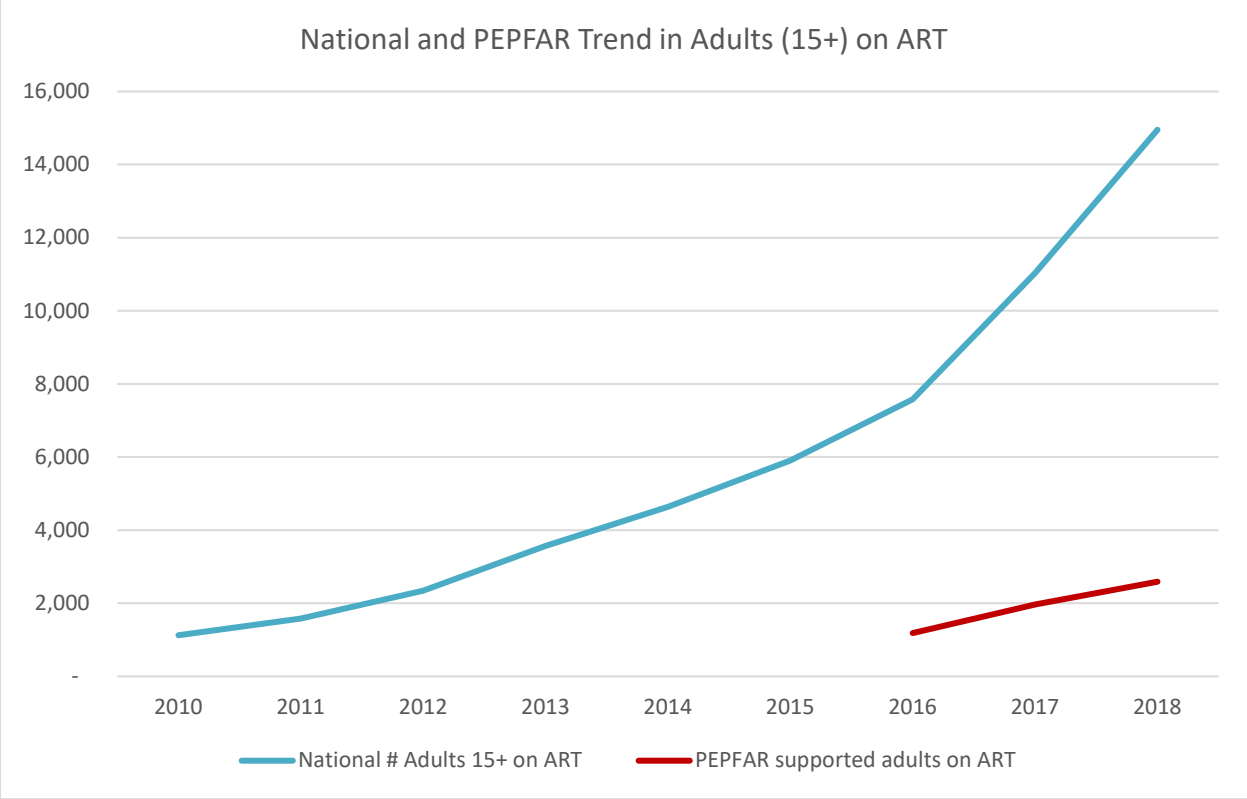
Table 2.1.1 Host Country government results (Kazakhstan)															
Total			<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		Empty cells indicate no data available
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Size of PWID															
PWID HIV Prev.	-	7.9%	-	-	-	-	-	-	-	-	-	-	-	-	e-IBBS, 2018 (RDS estimates)
Estimated Population size of MSM	62,000	-	-	-	-	-	-	-	-	-	-	-	-	-	RAC, Report on Size Estimation of PWID, 2019
MSM HIV Prev.	-	6.2%	-	-	-	-	-	-	-	-	-	-	-	-	e-IBBS, 2017
Estimated Population Size of FSW	18,350	-	-	-	-	-	-	-	-	-	-	-	-	-	RAC, Report on Size Estimation of PWID, 2017
FSW HIV Prev.	-	1.9%	-	-	-	-	-	-	-	-	-	-	-	-	e-IBBS, 2017
Estimated Size of Priority Population (specify)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Estimated Size of Priority Populations	-	-	-	-	-	-	-	-	-	-	-	-	-	-	

Table 2.1.1 Host Country government results (Kazakhstan)																
Total			<15				15-24				25+				Source, Year	
			Female		Male		Female		Male		Female		Male		Empty cells indicate no data available	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%		
Prevalence (specify)																

Table 2.1.2 90-90-90 Cascade: HIV diagnosis, treatment and viral suppression (Kazakhstan)

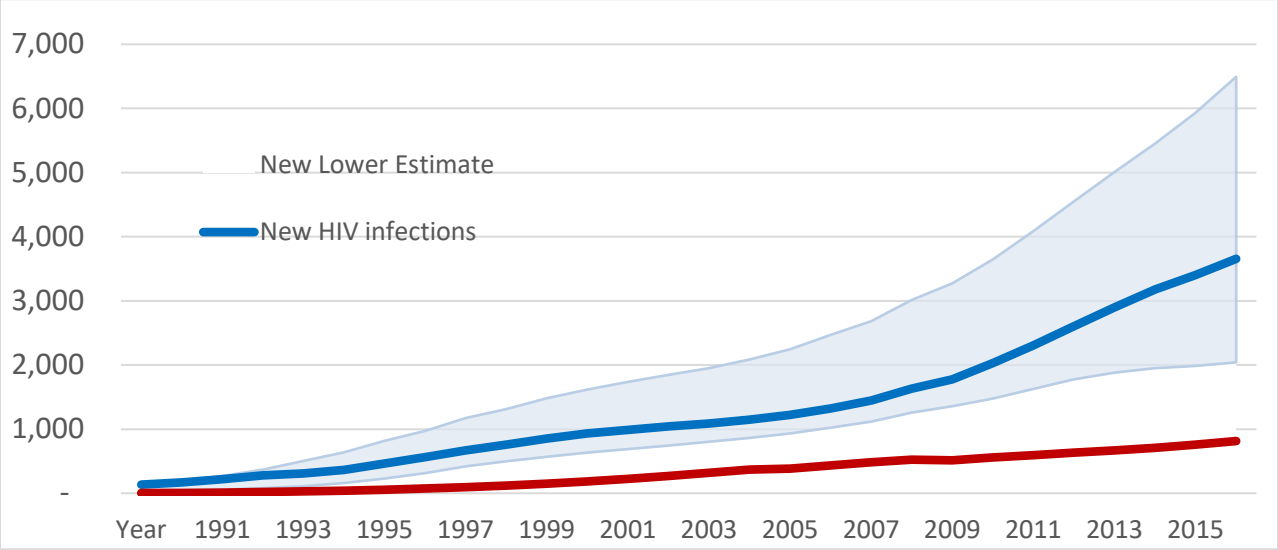
Table 2.1.2 90-90-90 Cascade: HIV diagnosis, treatment and viral suppression (Kazakhstan)											
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART			
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV+ (#)	Initiated on ART (#)	Sources
Population 15+ years	13,047,811	0.20%	26,128	22,286	14,519	55.6%	78.2%	3,005,735	3072	2429	EHCMS, Dec 31, 2018
Men 15-24 years	1,224,254	0.08%	998	324	268	26.9%	64.2%		137	97	EHCMS, Dec 31, 2018
Men 25+ years	4,938,716	0.35%	17,132	13010	7878	46.0%	61.5%		1774	1382	EHCMS, Dec 31, 2018
Women 15-24 years	1,174,745	0.07%	865	320	267	30.9%	63.7%		91	72	EHCMS, Dec 31, 2018
Women 25+ years	5,710,096	0.12%	7,133	8632	6106	85.6%	67.9%		1070	878	EHCMS, Dec 31, 2018
PWID	94,600	7.9%	8,778	9,244	5,450	62.1%	61.0%	37,654	840	660	EHCMS, Dec 31, 2018
MSM	62,000	6.2%	1959	661	455	23.2%	73.8%	3,942	156	128	EHCMS, Dec 31, 2018
FSW	18,350	1.9%	233	254	101	43.3%	49.5%	13,652	27	21	EHCMS, Dec 31, 2018

Figure 2.1.3 National and PEPFAR Trend for individuals currently on treatment (Kazakhstan)



Note: Prior to 2016, PEPFAR supported a completely different set of HIV treatment facilities.

Figure 2.1.4 Trend of new infections and all-cause mortality among PLHIV (Kazakhstan)



2.2 Investment profile: The Republic of Kazakhstan is an upper-middle income country with a GNI of $7,970 per capita (World Bank). Low oil prices and a financial recession in Russia have a negative impact on Kazakhstan's GDP. Low economic growth is projected to continue; this has a negative impact on domestic resource mobilization for health.

The Government of Kazakhstan provides 85% of the overall programmatic funding and funds 98.8% of commodities for Kazakhstan's $37-million annual HIV response. PEPFAR supports 11.9% of the country's HIV control program, and the GF funds 3.3% of the program. (Table 1.2.1). Kazakhstan has publicly made strong political and budgetary commitments in support of the social sector, including the response to HIV/AIDS. Kazakhstan developed its five-year Health Strategy, called Salamatty Kazakhstan, for 2016-2020. The strategy includes an updated section on the HIV control program. The Government of Kazakhstan procures all ARVs and pledged in the new strategy to provide $10.9 million in 2016, $12.6 million in 2017, and $12.7 million in 2018 for the procurement of ARVs. PEPFAR provides support for updating the HIV drug regimen to effective, once-daily, fixed-dose, combination drug regimens, eliminating often toxic and outdated drugs, and limiting the number of drugs for simplicity of ordering and stocking. PEPFAR will continue to advocate for and support the government to procure ARVs through UN mechanisms so that more PLHIV can access treatment. In FY19, Kazakhstan ordered enough ARVs to provide medication to all diagnosed PLHIV.

Kazakhstan is not eligible for consideration of further HIV grants under the GF's guidelines due to its economic status. The current GF HIV grant is mainly focused on prevention efforts for KP, specifically PWID, providing roughly a quarter of the overall funds in that programmatic area. The other significant portion of GF expenditures supports general health system strengthening.

Table 2.2.1 Annual Investment Profile (Kazakhstan)

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country
Care & Treatment	$22,779,952.92	4.8%	0.7%	94.5%
HIV Testing services	$3,241,898.08	22.0%	0.0%	78.0%
Prevention	$1,977,249.70	28.2%	46.2%	25.6%
AGYW beneficiary				
Key populations beneficiary	**$1,964,876.98**	28.4%	46.4%	25.2%
Other prevention beneficiaries	$12,372.72	0.0%	0.0%	100.0%
Socio-economic	**$752,487.60**	0.0%	0.0%	100.0%
OVC beneficiary	$752,487.60	0.0%	0.0%	100.0%
Other socio-economic beneficiaries				
Above-site programs	**$7,947,617.55**	25.2%	1.8%	73.0%
HMIS, Surveillance, Research	$3,105,159.92	26.9%	0.0%	73.1%
Laboratory systems strengthening	$1,423,234.97	13.9%	0.0%	86.1%
Another ASP	$3,419,222.66	28.4%	4.2%	67.4%
Total	**$36,699,205.84**	**11.9%**	**3.3%**	**84.8%**

Standard Table 2.2.2 Annual Procurement Profile (Kazakhstan)

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country
ARVs	$13,046,543.29	0.0%	0.0%	100.0%
Rapid Test Kits				
Other drugs				
Lab reagents				
Condoms	$755,398.79	0.0%	0.0%	100.0%
Viral Load commodities				
VMMC kits				
MAT	$164,013.92	0.0%	100.0%	0.0%
Other commodities				
Total	**$13,965,956.00**	**0.0%**	**1.2%**	**98.8%**

Note: Domestic and Global Fund funding information was collected from the Kazakhstan Global Fund Application for 2018-2020.

2.3 National sustainability profile update: Kazakhstan submitted its first SID in 2017. Notable vulnerabilities included:

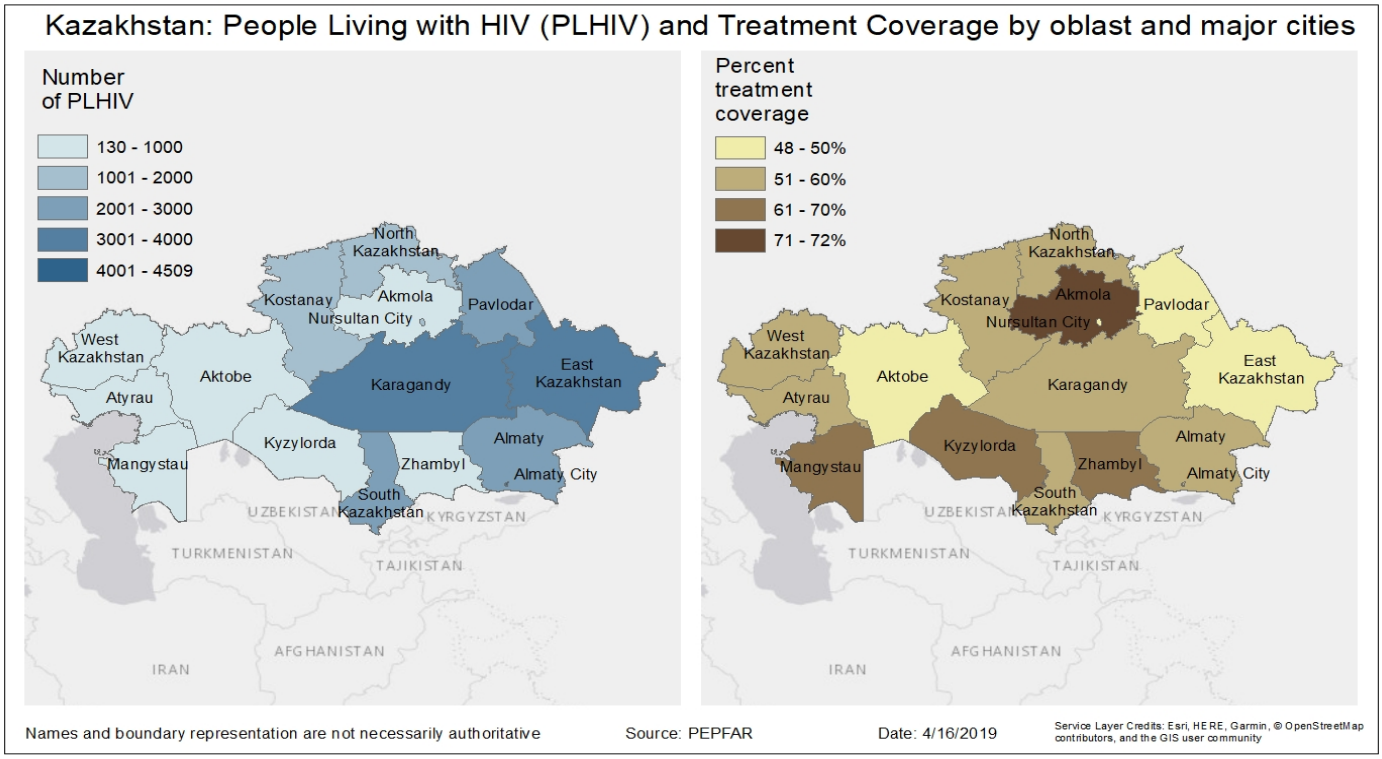
- Policies and Governance (7.72, light green): Although Policies and Governance scored as approaching sustainability, there was a robust debate about whether transgender people face discrimination, even though official policies prohibit discrimination.
- Private Sector Engagement (2.78, red): In this post-Soviet Union country, private sector health is nascent. Private health service delivery providers are currently not legally allowed to deliver HIV/AIDS services. National health reforms have been proposed to allow for more private sector engagement, but implementation is delayed until 2020.
- Service Delivery (5.97, yellow): Although the Government of Kazakhstan has shown strong leadership in policies, governance, and domestic financing, problems in procurement of ARV drugs have hampered treatment sites' ability to implement the national Test and Treat guidelines to expand ART treatment coverage for diagnosed PLHIV in care with relatively high CD4 counts.
- Human Resources for Health (2.75, red): The country's pre-service education institutions produce a sufficient number of medical workers, but providers lack motivation for working with KP. Health care providers receive low salaries and also demonstrate high levels of stigma against KP. The government provides in-service trainings infrequently. Kazakhstan collects some health workforce data, but there is no human resources for health information system.
- Laboratory (7.50, light green): There is a sufficient supply and capacity of laboratory personnel to perform HIV–related testing, a sufficient infrastructure for viral load testing, and domestic financing of HIV laboratories. However, the viral load test systems used are not WHO-prequalified. There is no national laboratory strategic plan for HIV lab services, though there is a draft national plan for viral load testing.

In ROP 19, PEPFAR will continue to work with the Government of Kazakhstan on service delivery and human resources for health for HIV services. In ROP18, PEPFAR demonstrated that a CQI and mentoring approach was effective for increasing viral load suppression and demonstrated the effectiveness of a nurse-led case management approach for improving adherence. These PEPFAR-supported interventions served as catalytic models and will now be scaled to other sites in Kazakhstan outside of the current PEPFAR sub-national units with government support. PEPFAR will continue to support the low-cost distance learning and mentoring approach for HIV clinicians called Project ECHO. PEPFAR will continue to advocate for the use of WHO-prequalified viral testing.

2.4 Alignment of PEPFAR investments geographically to disease burden: PEPFAR will continue to support above-site national level activities to strengthen capacity throughout Kazakhstan to achieve the 90-90-90 targets and build KP and client-centered community and facility interventions that demonstrate impact towards reaching these targets. Given that the major barrier to scaling up ARV coverage is national availability of government-purchased ARVs, PEPFAR will pay particular attention to procurement and supply chain strengthening.

In addition, Kazakhstan PEPFAR will continue to support site-level activities at the sub-national units. (The major implementing partner, however, is changing from ICAP to the RAC of Kazakhstan.) The priority sub-national units for ROP19 are Pavlodar and East Kazakhstan Oblasts. These units represent approximately 24% of all adult PLHIV in Kazakhstan.

Figure 2.4.1 PEPFAR Sub-National Units: PLHIV, Treatment and VL Monitoring Coverage



2.5 Stakeholder engagement: Quarterly meetings with implementing partners and country stakeholders are held to share PEPFAR program results, collect feedback, and ensure better coordination of activities among stakeholders. The PEPFAR team conducted stakeholder meetings in Kazakhstan in late January 2019 to discuss the S/GAC Planning Level Letter and review program strategies for ROP19.

The Kazakhstan PEPFAR team met with local government and MOH officials, leadership from National AIDS and Narcology Centers, local NGOs, GF representatives, other implementing partners, and representatives of civil society and KP to share information from the annual progress report and to discuss the strategic direction for ROP19.

Leadership from the Republican AIDS Center (RAC) of Kazakhstan and civil society representatives participated actively during the PEPFAR Asia Region ROP19 meetings that took place in Bangkok in April 2019. During this meeting, the PEPFAR team worked with RAC and CSO delegates to formulate new strategies to accelerate progress towards 90-90-90 by 2020. These strategies are reflected in this document in Sections 3.0 and 4.0.

Tier 2: LAOS

2.1 Summary statistics, disease burden, and country profile: Laos is considered a lower-middle income country, with a GNI per capita of $2,270 in 2017[43]. The country's economy has been steadily improving with ~7% GDP growth for several years (2019). Of the population of 6.9 million (2017)[44], more than half (55%) is below 20 years of age and more than one-third (36%) live in urban areas. Much of the population lives in poverty, with inadequate access to water, sanitation, and health care. WHO has classified Laos as a health workforce crisis country, and the lack of adequate numbers of health workers is an ongoing challenge. Other areas of health system vulnerabilities include health management information systems (HMIS), health infrastructure, and planning and management of health services. There have recently been great strides taken toward increasing domestic health financing, with the GOL spending $963,679 on HIV programming in 2018.

The HIV epidemic in Laos is classified as low prevalence (0.24% among the general population in 2018), but there are signs of an increasing epidemic among MSM, especially in the Vientiane Capital. There were an estimated 11,360 PLHIV in 2018. In the same year, the estimated HIV prevalence was 2.8% among MSM aged 15+ years, 0.6 % among female sex workers (FSW), and 7.1 % among people who inject drugs (PWID). Inadequate information is available about the impact of the HIV epidemic among TG women in Laos. For this plan, TG women are included as part of MSM due to lack of available distinguishing data. In 2018, an estimated 6,473 adult and children PLHIV were found to have been retained on ART for the previous 12 months.
The estimated number of new HIV infections in the general population has been decreasing; in

2018 there were an estimated 500 new infections in Laos and fewer than 400 HIV-related deaths are projected for 2019. Laos has 89% (10,101/11,360) of its PLHIV diagnosed. ART coverage and VL suppression are 57% and 73%, respectively. With economic growth, increasing employment opportunities, cross-border migration, and an improved transport system, the HIV epidemic in Laos continues to evolve, reflecting some trends of neighboring countries. The epidemic is increasingly concentrated in KP. A 2018 report by the International Organization for Migration (IOM) noted a potential increase in HIV among certain occupations (e.g., construction workers) in areas with enhanced infrastructure development.[45]

Starting in January 2016, Laos adopted WHO's recommendation that ART should be initiated in all adults who test positive for HIV. The government conducted a national ART Rapid Advice Guidelines Workshop in October 2016 to facilitate implementation of the new guidance across all sites. As the T&S policy is fully implemented, the GOL expects to accelerate progress toward the 90-90-90 targets.

Differentiated service delivery, including MMS, has been adopted, along with the transition of all eligible newly treated patients to TLD starting in October 2018. TLD was adopted in the national ART guidelines in 2017 and clinicians at all ART sites have been trained on TLD administration. Laos will gradually transition all eligible PLHIV to TLD and monitor the transition through the PEPFAR-supported national HIV data system. TPT in Laos has been implemented in all ART sites since the release of the 2014 national guidelines. In 2017, 53% of patients received IPT/INH within three months after eligible (IPT), according to the report from Center for HIV/AIDS and STI (CHAS). Laos has adopted and rolled out index testing nationally. Laos is a regional leader in HIV self-testing, which will be a key intervention in the HIV response in ROP19—and beyond. Laos is currently in the process of integrating its national routine monitoring morbidity and mortality systems, including HIV, into DHIS2, which also involves system-specific UIC across all sites; these systems, however, still need to be strengthened. Finally, there has been considerable progress in domestic resource mobilization in Laos. Between 2016 and 2018, there was an almost eight-fold increase in resource commitments by the GOL. The GOL is working to mainstream the ART service package into the national health insurance scheme and health financing.

National ART coverage in Laos is 65.5% with variations among different demographic groups. Major gaps in ART coverage exist among males, particularly in the 20-44-year age groups and in younger females in the 15-24-year age groups (see Table 2.1.2 and Figure 2.1.4).

[45] IOM Laos People's Democratic Republic, Health Impact Assessment, 2018

Table 2.1.1 Host Country Government Results, Laos

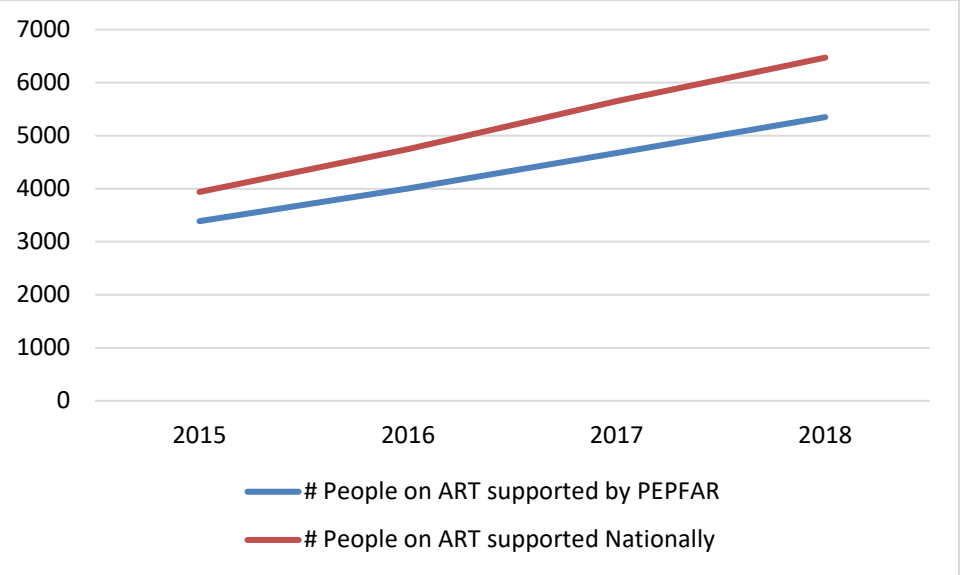
Table 2.1.1 Host Country Government Results															
	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	6,957,331		1,118,389		1,164,902		725,178		745,810		1,641,367		1,561,685		Spectrum, 2018
HIV Prevalence (%)		0.24%		0.02%		0.02%		0.18%		0.13%		0.24%		0.30%	AEM, 2018
AIDS Deaths (per year)	355		23		25		7		6		122		172		Spectrum, 2018
# PLHIV	11,360		210		220		1308		941		3968		4713		Spectrum, 2018
Incidence Rate (Yr)															
New Infections (Yr)	500														Spectrum, 2018
Annual births															
% of Pregnant Women with at least one ANC visit															
Pregnant women needing ARVs															
Orphans (maternal, paternal, double)															
Notified TB cases (Yr)															
% of TB cases that are HIV infected															
% of Males Circumcised															
Estimated Population Size of MSM*	55,666														AEM, 2018
MSM HIV Prevalence	1542	2.77%													AEM, 2018
Estimated Population Size of FSW	13,968														AEM, 2018
FSW HIV Prevalence	90	0.64%													AEM, 2018
Estimated Population Size of PWID	1630														AEM, 2018
PWID HIV Prevalence	115	7.06%													AEM, 2018

Estimated Size of Priority Populations (specify)															
Estimated Size of Priority Populations Prevalence (specify)															

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression, Laos 2018

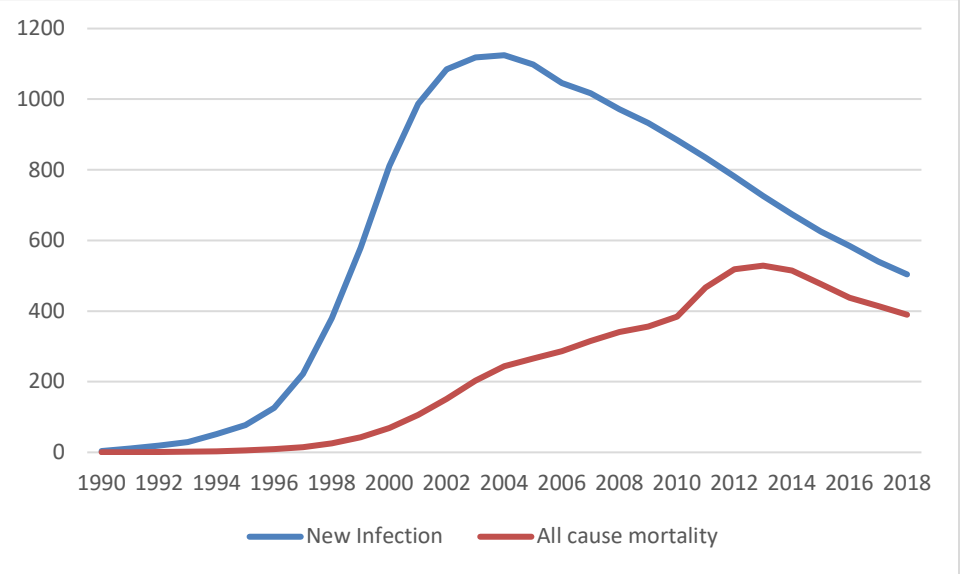
Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*										
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	6,957,331	0.16%	11,360	10101	6,473	57%	73%	89,101	1,410	1,139
Population <15 years	2,283,291	0.02%	430	382	278	65%	68%	720	45	34
Men 15-24 years	745,810	0.13%	941	837	356	38%	58%	7,265	189	86
Men 25+ years	1,561,685	0.30%	4,713	4,191	3,006	64%	73%	14,912	635	324
Women 15-24 years	725,178	0.18%	1308	1,163	288	22%	67%	30,620	143	169
Women 25+ years	1,641,367	0.24%	3,968	3,528	2,545	64%	77%	35,584	398	526
MSM	55,666	2.77%	1,542							
FSW	13,968	0.64%	90							
PWID	1630	7.06%	115							
Priority Pop (specify)										

Figure 2.1.3 National and PEPFAR Trend for individuals currently on treatment (Laos)



Data source: HIVCAM, updated Dec 2018; based on ART site

Figure 2.1.4 Trend of New Infections and All-Cause Mortality Among PLHIV (Laos)



Data source: AEM, 2018

2.2 Investment profile: In recent years, the policy and political environment in Laos has increasingly supported the national HIV response. Overall, donor funding for HIV in Laos decreased between 2016 and 2018; in 2018, the total funding for HIV programming was $4,095,361. During the same period, there was an increase in domestic resource commitments for HIV programming by the GOL from $126,625 to $963,679. The Laos national HIV program, implemented by the Centre of HIV/AIDS and STIs (CHAS), continues to rely heavily on external financial and technical support. Improving the sustainability of the country's response is a PEPFAR priority. In 2018, the majority of non-domestic resources for HIV programming came from the GF ($2,271,886), PEPFAR ($417,696), the AIDS Health Foundation ($325,000), UNAIDS ($89,100), and the Clinton Health Access Initiative (CHAI) ($28,000). In 2019, the GOL has earmarked the procurement of ARV drugs for $91,070; of OI drugs for $57,078, and of condoms for $88,235. These contributions are projected to further increase in 2020. The

government also has pledged to support the procurement of TLD supplies. The GOL is working to mainstream the ART service package into the national health insurance scheme.

Table 2.2.1 Annual Investment Profile by Program Area (Laos)

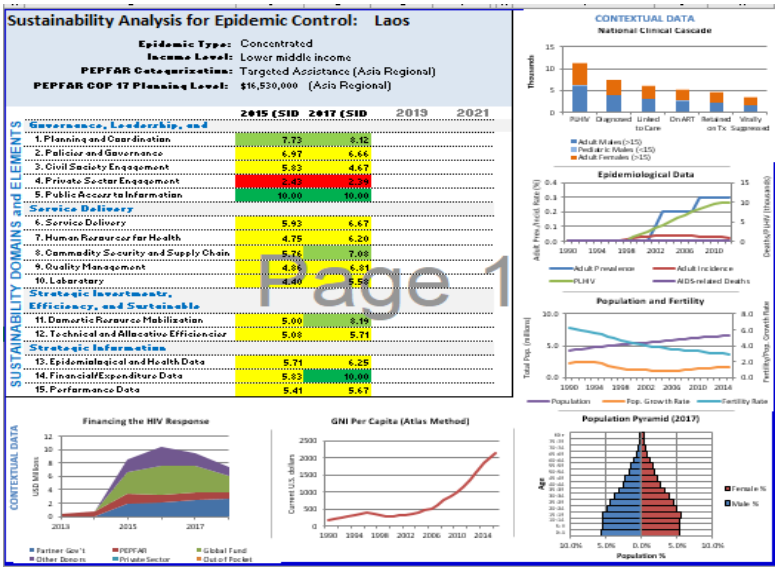
Table 2.2.1 Annual Investment Profile by Program Area[46]					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Clinical care, treatment and support	265,709	15%	0%	48%	37%
Community-based care, treatment, and support	92,933	100%	0%	0%	0%
PMTCT					
HTS	376,157	86%	0%	14%	0%
VMMC					
Priority population prevention	194,814	0%	0%	100%	0%
AGYW Prevention					
Key population prevention	674,261	33%	67%	0%	0%
OVC					
Laboratory	37,176	100%	0%	0%	0%
SI, Surveys and Surveillance	39,133	100%	0%	0%	0%
HSS	1,004,414	18%	21%	49%	12%
Total	2,684,597				

Table 2.2.2 Annual Procurement Profile for Key Commodities (Laos)

Table 2.2.2 Annual Procurement Profile for Key Commodities					
Commodity Category	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
ARVs	91,9074	0%	100%	0%	0%
Rapid test kits	159,006	0%	100%	0%	0%
Other drugs	93,831	0%	100%	0%	0%
Lab reagents	0	0%	0%	0%	0%
Condoms	98,080	0%	0%	100%	0%
Viral Load commodities	432,696	0%	100%	0%	0%
VMMC kits	0	0%	100%	0%	0%
MAT	0	0%	100%	0%	0%
Other commodities	26,386	100%	0%	0%	0%
Total	1,729,073				

[46] (GRP, National AIDS Spending Assessment , 2012), all amounts in 2012 US Dollars

2.3 National sustainability profile update: The most recent Laos SID was completed in 2017 under the leadership of CHAS in the MOH with engagement from development partners including UNAIDS, WHO, and CSOs (the Laos Positive Health Association and the Lao Red Cross). The SID results were endorsed by CHAS. Of the 15 sustainability elements evaluated, only two met the standard of "sustained": Public Access to Information (dark green) and Planning and Coordination (light green). The remaining 13 elements were identified as sustainability vulnerabilities (yellow and red).



The GOL is genuinely committed to progressive HIV policies and resources. The government's commitment to sustainable financing for epidemic control is demonstrated by its multi-ministerial consideration for inclusion of HIV services in the universal health care package and its commitment to increase domestic investment and cost-share with the GF for prevention commodities; the GOL is covering 10% in 2019 and 20% by 2021, including HIV test kits, ARV, opportunistic infection drugs, and condoms. There is limited Private Sector Engagement and private health financing schemes do not include HIV services (e.g., HIV testing). The GOL continues to receive support from GF and CHAI to strengthen supply chain management, particularly in high-burden areas. PEPFAR is supporting a costing analysis and transition readiness assessment to assist the government in quantifying investments required to continue provision of HIV/AIDS services.

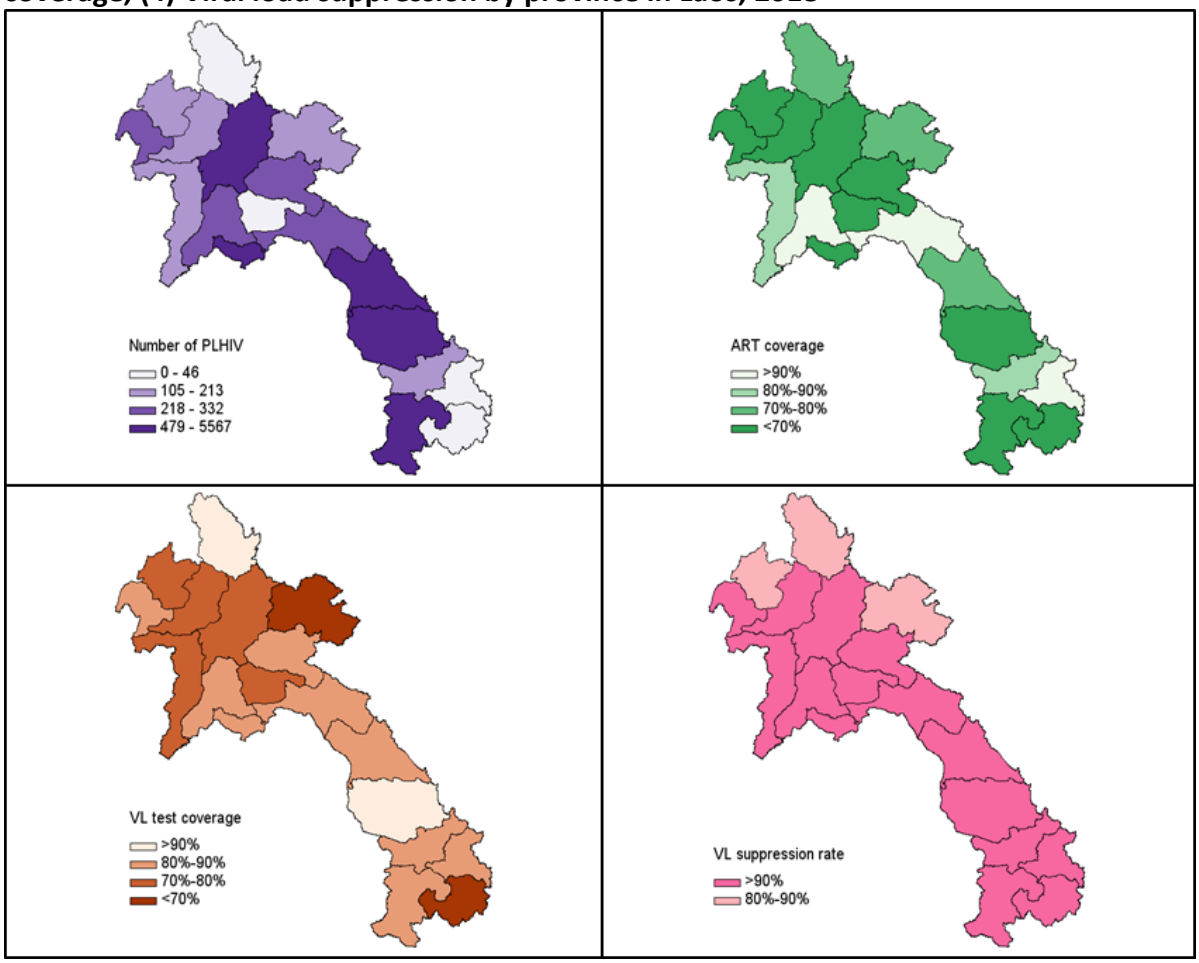
Domestic resource mobilization—including inclusion of HIV services in health financing schemes—is critical to establishing a sustained Lao HIV response. In addition, addressing the shortage of human resources for health in HIV service delivery, quality improvement, and strategic information will be integral to sustainable control of the Lao HIV epidemic. ROP19 will focus on ensuring policies and systems are strengthened for maintaining PLHIV and KPLHIV on treatment and viral load suppression through the provision of quality care and treatment services. In addition, ROP19 will focus on institutionalization of HIV health management information systems and testing policies that support PLHIV on treatment.

2.4 Alignment of PEPFAR investments geographically to disease burden: Based on analyses of epidemiological and program performance, ROP19 activities will focus on KP in three of the 18 provinces of Laos: Vientiane Capital, Savannakhet, and Champasack. These provinces have the largest estimated numbers of PLHIV, MSM, and TG women. Additionally, these three provinces have the highest HIV-positive rates and the lowest ART coverage in the country.

According to an analysis of FY2018 expenditures in Laos, approximately 20 % ($273,948) was expended at the national level. Expenditures across all program levels were primarily invested in Program Management, HTS, ASP, PREV, Care &Treatment, reflecting a focus on coverage and quality of HIV testing and treatment, and prevention among MSM and TG women as priority populations, as well as on strategic information and health systems strengthening. Other national-level PEPFAR investments in Laos were distributed across other areas, including cross-cutting human resources for health management, KP (MSM/TG), and gender/gender equity interventions.

More than half (51%) of the $689,195 in PEPFAR FY2018 expenditures in Laos were at the sub-national provincial level. As with expenditures across all program areas, the majority of the expenditures were invested in HTS, PREV, and C&T. Geographically, 100% of the sub-national investment was made in the three provinces of Laos referenced above: Champasack, Savannakhet, and Vientiane Capital.

Figure 2.4.1: (1) Number of PLHIV, (2) Coverage of total PLHIV with ART, (3) Viral load testing coverage, (4) Viral load suppression by province in Laos, 2018



2.5 Stakeholder engagement: For the past several years, the Laos PEPFAR team has planned and implemented all of its activities in collaboration with Laos government institutions, multilaterals, international agencies, civil society, and domestic and international NGOs, to respond to the HIV epidemic in the country. There also has been strong engagement with CBOs. During ROP18 implementation in FY2019, the Tier 3 classification of the Trafficking in Vulnerable Persons Act (TVPA)

made direct funding of GOL impossible, and PEPFAR-funded mechanisms to GOL had to be terminated. Laos PEPFAR will await the determination of the 2019 TVPA report on how it will affect future activities.

For ROP19, the Laos PEPFAR team consulted with national stakeholders through a variety of formal and informal meetings and discussions throughout the year. The team held special stakeholder planning sessions with civil society, domestic, and regional KP networks and communities, government, and multilaterals/international agencies. These sessions allowed stakeholders to: (1) discuss and gather stakeholder input on program priorities; (2) review past year performance and propose strategic directions and initiatives for PEPFAR ROP in FY19; and (3) review and finalize plans for future implementation, including identifying other partners who may continue case finding efforts, from which Laos PEPFAR is phasing out in ROP19 under maintenance mode. Efforts were made to actively engage stakeholders in strategy development and project design, implementation, and review efforts. The plans and priorities described in this ROP reflect the results of these fruitful exchanges and stakeholder consensus.

In Laos, regular technical quarterly meetings are conducted between the PEPFAR team and partners to review progress and challenges and identify next steps for PEPFAR-supported programs, as well as the substantial national programs responding to the HIV epidemic in the country. As a voting member of the GF CCM in Laos, the PEPFAR team ensures its plans are aligned in concert with the GF-supported work. This involves coordination with and harmonization in specific KP-led interventions and geographical locations to ensure complementarity of efforts. Ongoing collaboration strengthens the delivery of capacity building activities for CSOs as well as joint implementation of transition activities for increased domestic financing, certification, and accreditation of CSOs.

Tier 2: PAPUA NEW GUINEA

2.1 Summary statistics, disease burden, and country profile: PNG has an estimated population of 8.4 million people (World Population Review, 2018), with a GNI of $4030 in 2017, a 2.2% increase from the previous year (World Data Atlas) and currently has 95% of the reported HIV cases in the Pacific region, thus the most seriously HIV-burdened of the 22 Pacific Island countries and areas in the Western Pacific Region (WHO, 2018). There are approximately 47,412 PLHIV, of which 27,975 are receiving ART. The national HIV prevalence is 0.83% with an estimated 3,300 new infections each year. The HIV-TB co-infection rate is 7%, and treatment coverage for HIV/TB co-infected patients remains high at 95%-treatment for both HIV and TB. However, TB screening and TPT coverage among PLHIV remain low at 45% and 16%, respectively.

PNG has a mixed burden of HIV that is higher among key populations (KP) and in certain geographic regions. PNGs National Capital District (NCD) with a prevalence of 1.57% and Jiwaka at 1.32%, have the highest burden in the country, followed by Simbu (1.27%), Enga (1.26%), Western Highlands (1.21%), and Manus (1.18%) provinces.

The 2017 PNG integrated bio-behavioral surveillance (IBBS) survey in Port Moresby, Lae, and Mt. Hagen revealed HIV prevalence among female sex workers (FSW) of 14.9%, 11.9%, and 19.6%, respectively, while among MSM and TG women in Port Moresby and Lae, the prevalence was 8.5% and 7.1%, respectively. Of concern is that only one-third of FSWs and MSM/TGs have been reached

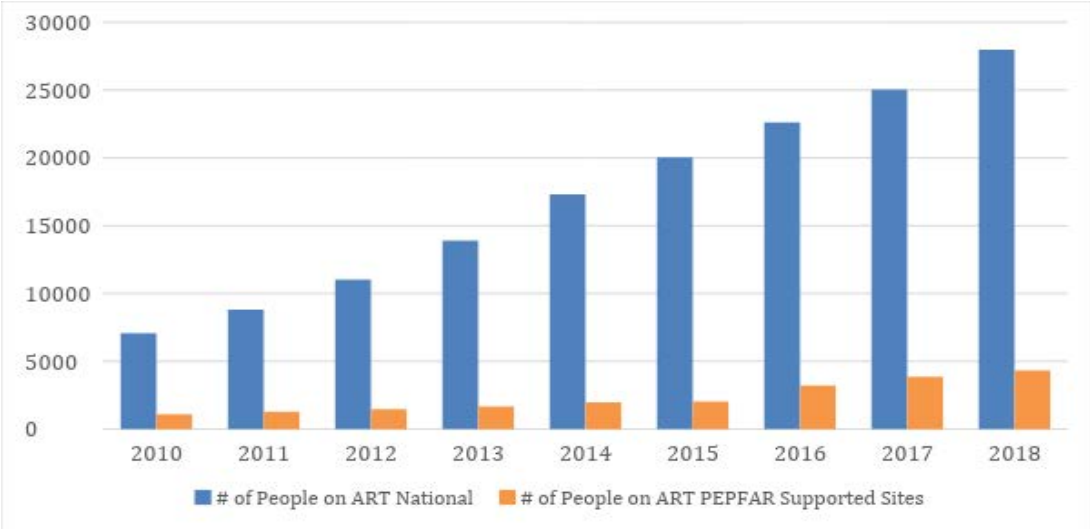
through peer outreach networks with prevention services and that condom use among KP in all three cities was found to be very low, at around 50% or less. These findings, combined with the reduction in donor funding in the KP and prevention services, presents a potential risk for the epidemic to expand to neighboring provinces as is demonstrated by the increased HIV prevalence in these provinces over the last three years.

Table 2.1.1 PNG Host Country Government Results

Table 2.1.1 Host Country Government Results			
	N	%	
Total Population	8,423,475		Spectrum Estimates (2019)
HIV Prevalence (%)		0.83	Spectrum Estimates (2019)
AIDS Deaths (per year)	454		Spectrum Estimates (2019)
# PLHIV	47,412		Spectrum Estimates (2019)
Incidence Rate (per year)		0.40	Spectrum Estimates (2019)
New Infections (per year)	3,302		Spectrum Estimates (2019)
Annual births	227,298		HIV Surveillance Database (2019)
% of Pregnant Women with at least one ANC visit		54	Annual HIV Program Report (2018)
Pregnant women needing ARVs	1,411	0.62	Spectrum Estimates (2019)
Orphans (maternal, paternal, double)	9,355		Spectrum Estimates (2019)
Notified TB cases (Yr.)	27,937		TB Profile PNG, WHO (2017)
% of TB cases that are HIV infected		7	Annual HIV Program Report (2018)
% of Males Circumcised			No Reliable Data Exists
Estimated Population Size of MSM*	7,500		IBBS Report (2017)
MSM HIV Prevalence*		8.5	IBBS Report (2017)
Estimated Population Size of FSW*	16,100		IBBS Report (2017)
FSW HIV Prevalence*		14.9	IBBS Report (2017)
Estimated Population Size of PWID			No Reliable Data exists
PWID HIV Prevalence			No Reliable Data exists
Estimated Size of Priority Populations (specify)			No Reliable Data exists

Table 2.1.1 Host Country Government Results			
	N	%	
Estimated Size of Priority Populations Prevalence (specify)			No Reliable Data exists
	**Data presented only for PEPFAR Geographic Focus –National Capital District (NCD)*		

Figure 2.1.1 National and PEPFAR trend of individuals on treatment (PNG)

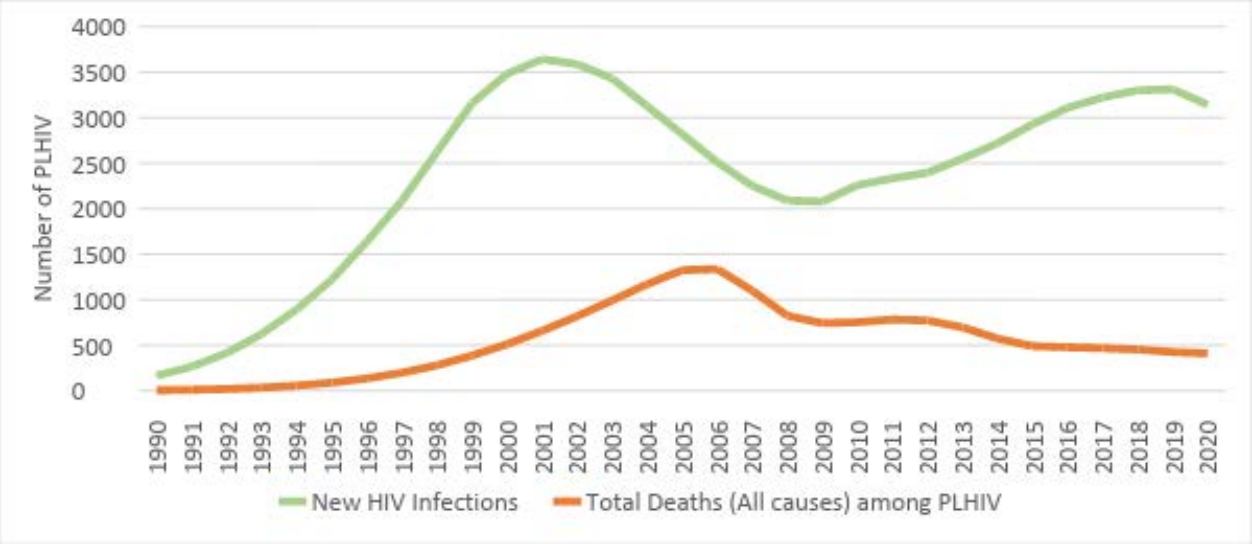


Data source: HIV Surveillance Database (SurvDB) / HIV Patient Database (HPDB)

Despite these challenges, there has been significant progress to curb the HIV epidemic in PNG, particularly in high-burden regions. ART coverage has in PNG increased by 37% from 2010 to 2018 (Figure 2.1.1), increasing the second 90 to 65.5% while AIDS-related deaths between 2010 and 2018 have declined by 40% (Figure 2.1.3). This is a result of the combined efforts of the Government of PNG (GoPNG) and key partners in rapidly scaling-up ART over the last decade, and implementation of the test and start policy.

PNG has made progress in implementing a number of key policies that address the minimum program requirements for ROP19. With Test & Start (T&S) and TPT integrated into national guidelines in 2017 and the development of an HIV UIC, the current focus is on full implementation of these at the provincial and facility level. These initiatives have yielded strong results with the proportion of patients receiving same-day ART initiation in PEPFAR-supported sites increasing from 47% to 87% between FY17 and FY19 and a national average of two days from HIV testing to start. The GoPNG is fully committed to the scale up of index testing, integration of MMS, and post-GBV clinical care to improve adherence and retention while ensuring VL testing services are available to all PLHIV.

Figure 2.1.3 Trend of New Infections and all-cause Mortality among PLHIV (PNG)



Data source: Spectrum Estimates 2019

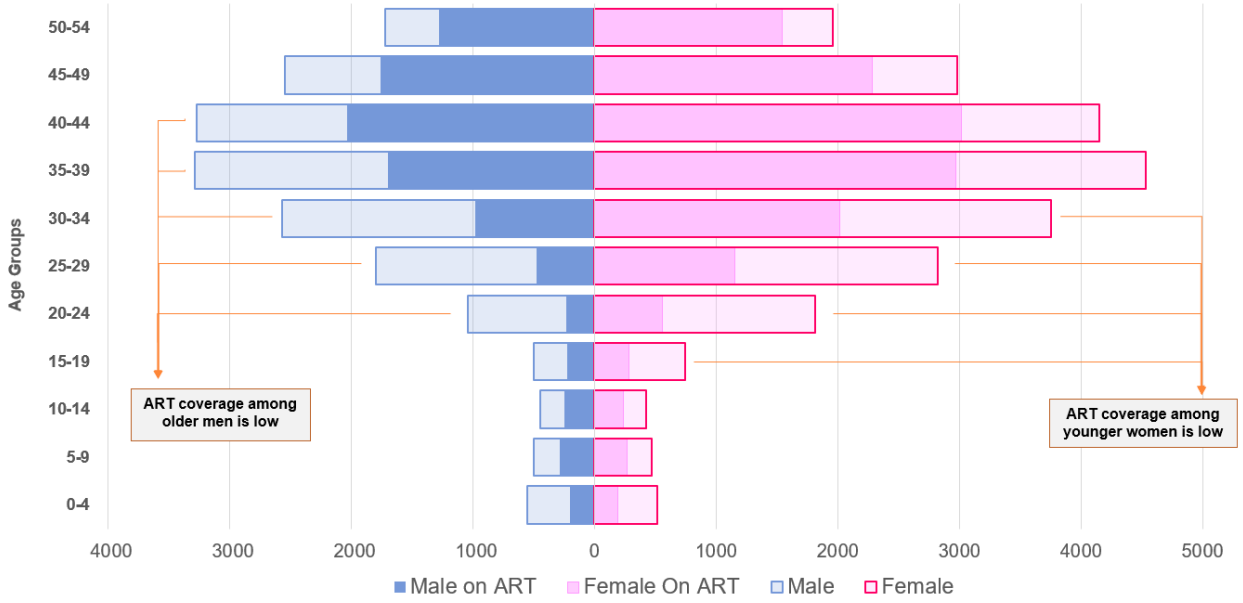
The rising number of new infections in PNG, as shown in Figure 2.1.3, indicates the need to strengthen prevention services and more aggressively scale up ART coverage. The 2011 closure of national and provincial AIDS councils, which had been responsible for coordinating prevention activities, may have contributed to this increase in new infections. In 2018, the National HIV program reinstated the National AIDS Council Secretariat (NACS) to resume coordination of prevention activities throughout the country, and to explore sustainable options, such as involvement of CSOs. One of the first tasks of the revamped NACS was the unveiling of the 2018-2022 National HIV and STI strategy that prioritizes good governance and greater provincial engagement, strengthening data systems with improved use of data for decision-making and a KP peer-led approach to prevention in high-burden provinces.

Table 2.1.2 90-90-90 Cascade

Table 2.1.2 PNG 90-90-90 cascade: HIV diagnosis, treatment, and viral suppression*										
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	8,423,475	0.83	47,412	39,169	27,975	59.0	83.1	175,329	4,645	4,794
Population <15 years	3,002,442	N/A	2,912	1455	1455	50.0	N/A	N/A	N/A	N/A
Men 15-24 years	849,678	N/A	1,543	454	454	29.4	N/A	N/A	N/A	N/A
Men 25+ years	1,888,918	N/A	17,457	13,746	9924	56.8	N/A	N/A	N/A	N/A
Women 15-24 years	801,377	N/A	2,560	9,230	845	33.0	N/A	N/A	N/A	N/A
Women 25+ years	1,887,291	N/A	22,940	15,189	15,189	66.2	N/A	N/A	N/A	N/A
MSM	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
FSW	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
PWID	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Priority Pop (specify)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Data Sources: Spectrum Estimates 2019; SurvDB; HPDB

Figure 2.1.4 Estimated PLHIV and ART Coverage Population Pyramid, 2018 (PNG)



Data source: Spectrum Estimates 2019

Sub-optimal retention rates are still a major barrier to improving ART coverage with current 12-month retention rates in PNG PEPFAR-supported sites at 69.5% in 2018 and nationally at <60%. New retention strategies have resulted in steady improvement; however, significant work is still required to improve retention nationally. Analysis of 2018 PNG ART data nationally (Figure 2.1.6) indicate that approximately 50% of ART patients who are LTFU are females in the 15-34 age group. FSW comprising 30% in the 15-24 age group. Retention strategies targeting young women could address the large ART coverage gap seen in this population group.

The recent resistance study carried out in 2018 with PNG PEPFAR support has shown NNRTI drug resistance to be 16.4% among ART naïve patients. WHO and PEPFAR have supported revision of national ART guidelines to address the drug resistance issue, now recommending the fixed dose combination TLD as the first-line ARV regimen. The first shipments of TLD will arrive in country in FY19 and a regional roll-out expected for ROP19.

Several waves of commodity stockouts in 2018 hindering effective care and treatment. This included stockouts of testing kits, laboratory supplies, condoms, and lubricants and, more recently, ARVs that resulted in emergency procurement through PEPFAR. Effective supply chain management of medical commodities is thus imperative to ensure effective control of the epidemic and will be priority for PNG PEPFAR in ROP19.

Gender-Based Violence: GBV remains a key challenge in PNG; it bears negatively on the overall development of the country. Two-thirds of women reported experiencing GBV in their lifetime (IBBS, 2017; Darko et al, 2015), and 41%-45% of FSW and MSM/TG, respectively, reported sexual violence in the last 12 months (Kelly-Hanku et al, 2017). Estimates indicate that 30% of

women over the age of 15 in PNG have experienced physical or sexual violence by an intimate partner at least once in their lifetime.

The response to GBV is coordinated with the PNG National Department of Health (NDoH), Disease Control, and Family Health Division with strong emphasis on coordination, and strengthened structural mechanisms for effective GBV response leadership at the provincial level. Integration of GBV activities into health services is at an early phase. Fear, stigma, and discrimination in relation to HIV and GBV, continue to be huge barriers to be addressed to ensure that all PLHIV who experience GBV have access to appropriate services. The possibility of increased GBV issues in relation to index testing is currently being explored and will be considered carefully when implementing index partner testing strategies in ROP19.

2.2 Investment profile: The investment landscape in PNG's health and HIV sector has not improved in the last two years, with limited incremental funding overall, both from GoPNG and donors. In its 2019 budget, the GoPNG allocated a total of $500 million to the health sector, representing 10.2% of the total budget. Although this is an increase of 3.8% from the 2018 national budget, it is still inadequate following massive cuts from prior years. Furthermore, the NACS domestic budget has flat-lined at $1.6 million, representing <1% of the health budget.

To increase its efficiency, the GF has channeled its HIV and TB activities under one recipient. Overall, total investment for HIV has decreased since 2017 with its 2018/2020 allocation further decreasing by 27% to $10.2 million.

GoPNG takes lead in all functional elements of direct service delivery of the HIV program. PEPFAR provides TA primarily in the areas of linkage, retention, adherence, and laboratory. PEPFAR's primary TA role also extends to policy formulations, strategic information and health systems strengthening.

Of note, all HIV commodities, including ARVs, are under covered through the NDoH.

Table 2.2.1 Annual Investment Profile by Program Area (PNG)

PNG Table 2.2.1 Annual Investment Profile by Program Area in US$					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Clinical care, treatment and support	4,824,209	33	26	41	0
Community-based care, treatment, and support	1,142,129	60	12	28	0
PMTCT	85,443	-		100	-
HTS	579,850	28	11	61	0
Priority population prevention	394,700	-	100	0	0
Key population prevention	994,700		40	0	60
Laboratory	484,592	56	13	31	0
SI, Surveys and Surveillance	883,749	85	11	4	0
HSS	846,267	100	0	0	0
Total	**10,235,639**				

Table 2.2.2 Annual Procurement Profile for Key Commodities (PNG)

Table 2.2.2 Annual Procurement Profile for Key Commodities in US$					
Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	2,091,816	-	-	89%	11%
Rapid test kits	173,971	-	-	100%	-
Other drugs	308,774	-	-	100%	-
Lab reagents	125,383	-	-	100%	-
Condoms	123,250	-	-	-	100%
Viral Load commodities	42,419	-	-	100%	-
Other commodities	308,716	-	-	100%	-
Total	3,174,330	-	-	-	-

Table 2.2.3 Annual USG Non-PEPFAR funded Investments and Integration (PNG)

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration in US$					
Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID Polio	$2,000,000	-	-	-	PNG is currently experiencing a polio outbreak. USAID is assisting GoPNG to respond to the outbreak through WHO
USAID TB	$585,000	-	-	-	USAID complements current measures in PNG to improve MDR-TB outcomes
CDC (Global Health Security)	$600,000	$600,000	1	-	Influenza Program - 3 years funded at $300,000 per annum TB Cost Study - $100,000 Polio Eradication Program - $200,000
Total	**$3,185,000**	**$600,000**	**1**	**-**	

2.3 National sustainability profile update: The PNG PEPFAR SID scoring in COP16 identified few poor-performing SID elements: expenditure data, commodity security and supply chain, human resources, and civil society engagement. Necessary remediation steps have been taken with the support of different stakeholders to address these issues. PNG PEPFAR will intensify its activities further by strengthening its CSO engagement and supply chain activities in ROP19.

In the last two years, severe government shortfalls in income have drastically reduced the NDoH budget. This has, in part been compounded by expenses incurred during the hosting of the 2018 Asia Pacific Economic Cooperation (APEC) event. Additionally, a recent polio outbreak has demanded a shift in funding and human resources toward vaccination programs. A risk assessment workshop undertaken by GF in March 2019 has determined that an important risk in HIV program sustainability is lack of coordination in the programming of funds.

The GoPNG revived NACS and revitalized its role in prevention and outreach activities across PNG. The GoPNG's Provincial Health Authority (PHA) policy implementation is another vehicle through which HIV services and commodities can better reach the people. The PHA also presents an opportunity for SNU-level HIV programming to mobilize resources locally from other government agencies and the private sector. As this decentralization process advances, more PHAs are expected to receive funds that can be locally programmed. The NACS is planning an HIV summit in July 2019 to bring partners together to strengthen the HIV strategy. In ROP19 PNG PEPFAR will advocate for increased budgets and support improved budgetary planning, particularly for increased activities to support HIV treatment and GBV, and to improve community interventions, riding on the PHA policy.

The Australian Department of Foreign Affairs and Trade (DFAT) funds a number of FBO-supported ART clinics. It is currently in the process of grant consolidation and downsizing of the scope of funding for those clinics that are managed by Anglicare PNG and Catholic Health Services PNG.

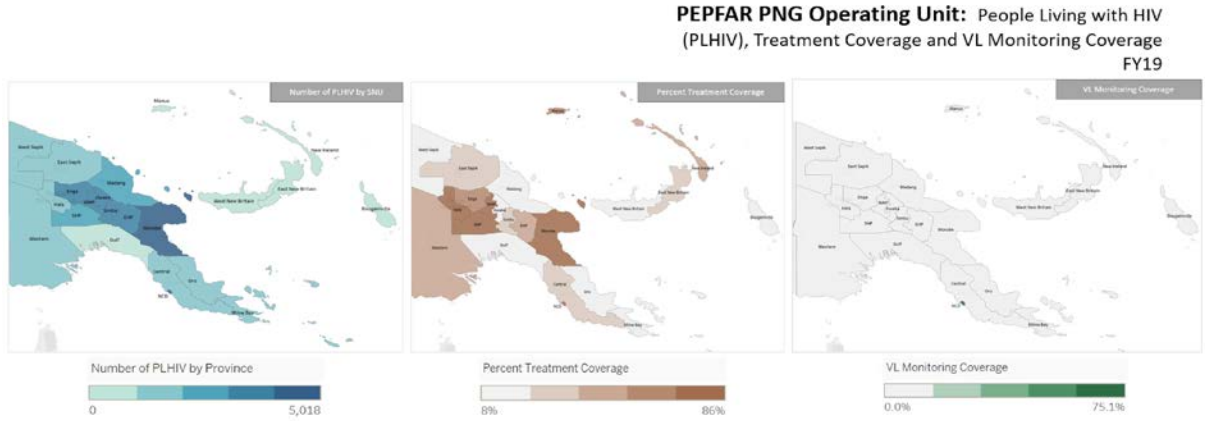
The GF PNG's allocation for 2018-2020 ($43 million) is significantly lower than the previous 2014-2016 ($83 million) allocation. Allocations for HIV dropped from $14 million to $10.2 million, while funds for TB remained the same. ROP19 will increase harmonization of interventions such that the technical assistance (TA) given will allow the primary recipient of GF, World Vision, to focus on service delivery interventions to improve outcomes. Monthly technical working group and development partners meetings are held, involving all stakeholders including PEPFAR and World Vision to ensure close collaboration and strategic implementation of program activities.

The UNAIDS Secretariat in PNG for 2019 has a program budget of approximately $600,000, of which $200,000 has been earmarked for program support through these cosponsors: WHO, UNICEF, UNFPA, and UN Women. This represents a significant increase from the 2017 budget of around $300,000. The office will reinstate an additional international post in June 2019, replacing a current national post. PNG PEPFAR is coordinating closely with UNAIDS for a more effective delivery of TA, primarily through engagement with the CSO consortium.

PNG PEPFAR DSD activities in the last two years have been successfully transferred to national indigenous organizations such as the Madang Public Hospital in Madang Province. Activities in Port Moresby have also been transferred to the Salvation Army and Four-square Church, which are national organizations that receive international funding. Both are expected to receive funds from Christian Health Services, which in turn receives funds for personnel from the GoPNG. PNG PEPFAR plans to work with these organizations and CSOs as providers of local TA as a sustainable approach to improve service delivery.

2.4 Alignment of PEPFAR investments geographically to disease burden: Available PNG national data from programs, estimates, and surveys continue to show that the NCD, together with the provinces in the highlands, remain high-prevalence areas (Figure 2.4.1). In COP18, PNG PEPFAR provided TA in Port Moresby, as well as in Lae and Mt. Hagen, areas where the IBBS study was implemented. In the above sites, specific TA focusing on KP, systems strengthening and viral load scale up, were offered. PNG PEPFAR will focus on programs and systems that support PLHIV on treatment primarily in NCD, with a priority of catalyzing national impact through relevant policy and adoption of PEPFAR's successful targeted interventions.

Fig 2.4.1 PLHIV, Treatment Coverage and VL Monitoring by SNU, FY19 (PNG)



Data source: Spectrum Estimates 2019; SurvDB; HPDB; VLSM

2.5 Stakeholder engagement: In ROP19 PNG PEPFAR will continue to work closely with NDoH, NACS, NCD PHA, CSOs, UN agencies, the GF, DFAT, and other donors and stakeholders. This is undertaken through bilateral and multilateral meetings, such as the HIV, strategic information (SI), TB, and GBV national TWG, the HIV Civil Society Forum, the GF CCM and the National STI and HIV Strategy Steering Committee. As PEPFAR increasingly focuses on maintenance and protecting the investment, coordination with GoPNG and donor partners will continue to ensure country ownership and sustainability and that such activities as outreach, counseling and testing and community involvement are adequately covered. In preparation for ROP19 planning, PNG PEPFAR engaged with stakeholders sharing the new focus, enabling feedback from all sectors of the response and continued dialogue with NDoH to further refine the strategy to address the priorities of improved retention and key policy reforms.

Stakeholders (both donor partners and CSOs) continue to be important supporters of the HIV program. As PEPFAR has withdrawn from DSD activities in favor of TA, GF has taken an increasing role in financing outreach and service delivery using PEPFAR's continuum of care and enhanced outreach approach models. It also continues to support TB activities. DFAT and UNAIDS continue to support institutional strengthening and advocacy activities of an amalgamated CSO representing key populations.

Tier 3: CAMBODIA

2.1 Summary statistics, disease burden, and country profile: In 2018, Cambodia's population reached 16.6 million, with an estimated 73,552 PLHIV (Table 2.1.1). Cambodia achieved substantial progress in reducing transmission of HIV, with an overall reduction of 96% in the estimated annual new HIV infections, from 24,900 in 1995 to 894 in 2018 [2019 Asian Epidemic Model (AEM) estimates]. By the early 2000s, the number of new HIV infections equaled the number of AIDS-related deaths, which is the definition of epidemic control.

HIV prevalence likely peaked at 1.7% in 1998 and has been declining ever since, with an overall estimated adult prevalence of 0.63% in 2018. Although the overall HIV prevalence in Cambodia is low, higher prevalence is found in KP: 2.3% among MSM, 3.2% among female entertainment

workers (FEW), 10.3% among TG women, and 15.2% among PWID. These populations are relatively small; there are an estimated 36,100 MSM, 42,100 FEW, 3,200 TG, and 1,300 PWID in Cambodia (Table 2.1.1).

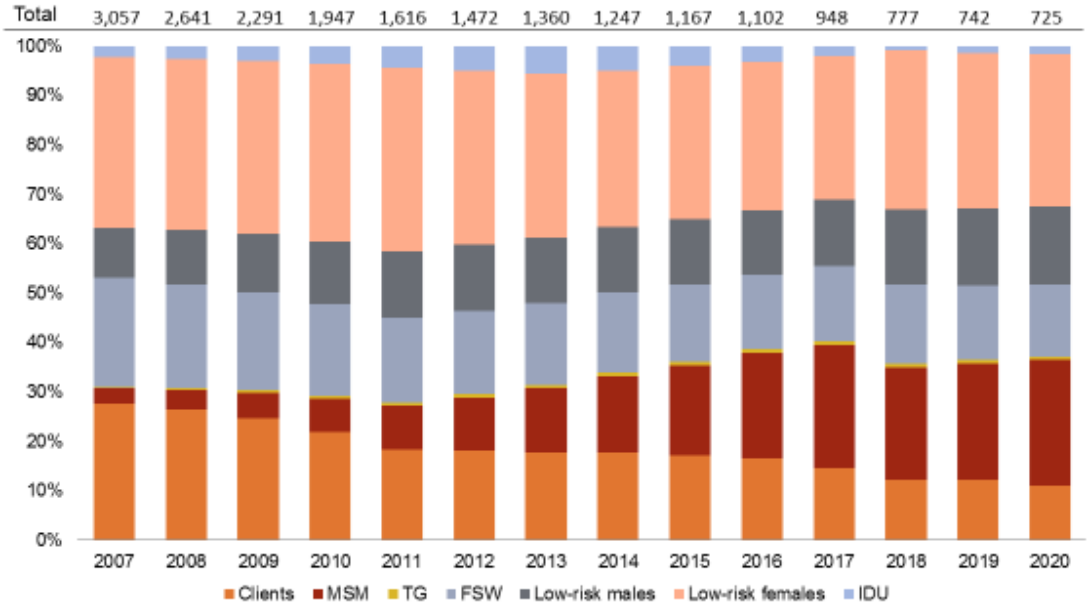
Table 2.1.1 – Cambodia Host Country Government Results

	Total		<15				>15				*Source, Year*
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Total Population	16,623,655										Unofficial 2019 Spectrum, 2018
HIV Prevalence (%)		0.61									Unofficial 2019 Spectrum, 2018
AIDS Deaths (per year)	1,322		30	2%	32	2%	618	47%	642	49%	Unofficial 2019 Spectrum, 2018
# PLHIV	73,552		1,706	2%	1,773	2%	37,109	50%	32,964	45%	Unofficial 2019 Spectrum, 2018
Incidence Rate (2018)		0.01									Unofficial 2019 Spectrum, 2018
New Infections (2018)	894		57	6%	60	7%	375		402		Unofficial 2019 Spectrum, 2018
Annual births	299,974										PMTCT progress report 2018
% of Pregnant Women with at least one ANC visit	419,535		0	0%			419,535	100%			# PMTCT LR 2018, % PMTCT Eval 2011
Pregnant women needing ARVs	735										Unofficial 2019 AEM, 2018
Orphans (maternal, paternal, double)	N/A		N/A		N/A		N/A		N/A		
Notified TB cases (Yr.)	28,757		N/A		N/A		N/A		N/A		CENAT TB/HIV 2018
% of TB cases that are HIV infected	580	2.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	CENAT TB/HIV 2018

	Total		<15				>15				*Source, Year*
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
% of Males Circumcised	N/A	N/A			N/A	N/A			N/A	N/A	
Estimated Population Size of MSM*	36,100										Unofficial 2019 AEM, 2018
MSM HIV Prevalence	2.30%										MSM IBBS 2014
Estimated Population Size of FSW	42,100										Unofficial 2019 AEM, 2018
FSW HIV Prevalence	3.20%										FEW IBBS 2016
Estimated Population Size of PWID	1,300										Unofficial 2019 AEM, 2018
PWID HIV Prevalence	15.20%										PWID IBBS 2017
Estimated Population Size of Transgender	3,200										Unofficial 2019 AEM, 2018
Estimated Transgender Prevalence	10.30%										TG IBBS 2016
	**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.* *Cite sources*										

AEM modeling in Cambodia suggests that 47% of new infections in 2018 occurred through heterosexual transmission among low-risk men and women (Figure 2.1.1).

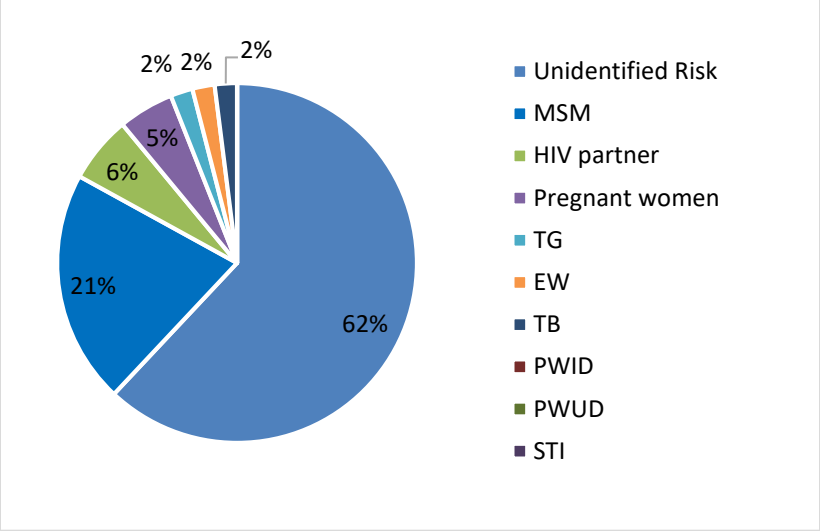
Figure 2.1.1 New HIV Infections among Adults (≥15 years) by Risk Population, 2007-2020 (Cambodia)



Estimates based on **Unofficial 2019 Asian Epidemic Model (AEM) Results**.

Data from Cambodia's case management program was unable to identify risk among 62% of newly identified PLHIV (Figure 2.1.2), while 25% self-identified as KP (MSM, FEW, PWID, or TG). However, these findings are likely underestimates.

Figure 2.1.2 New HIV Infections from the Boosted Integrated Active Case Management System by Risk Population, 2018: Improved risk elicitation will be important for refined case-finding efforts and use of micro-targeted PrEP for high-risk populations as part of ROP19 activities.



There is substantial geographic variation in HIV in Cambodia, with PLHIV largely concentrated in a small number of provinces, particularly Phnom Penh, Siem Reap, Battambang, Banteay Meanchey, and Kampong Cham (Table 2.4.1). The majority of high-risk KP live in urban centers

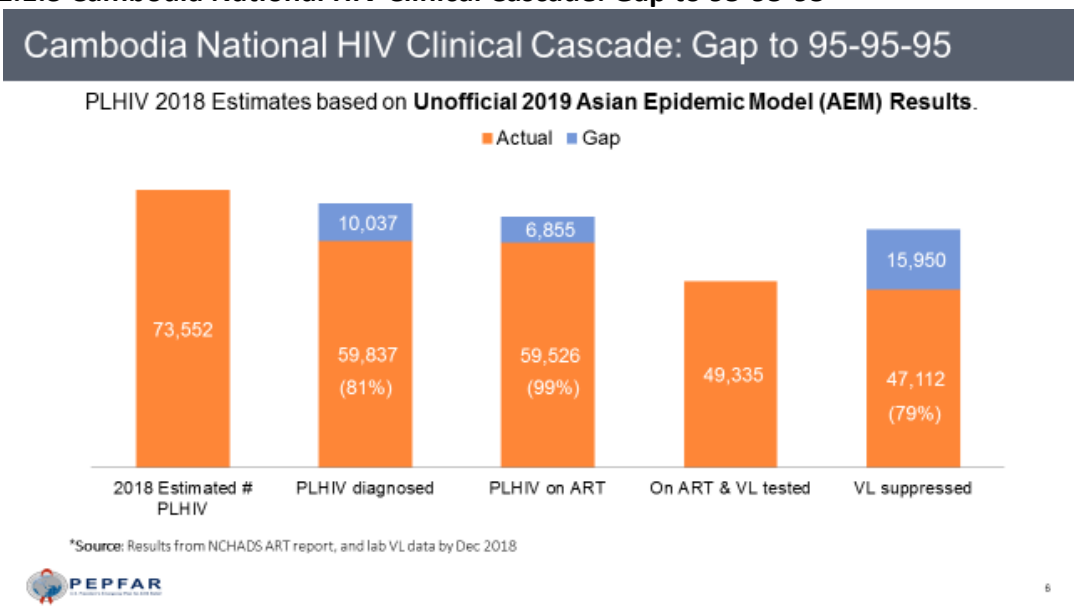
in these provinces; there also are high rates of inter-provincial migration and migration to Thailand.

As outlined in the Strategic Plan for HIV/AIDS and STI Prevention and Control in the Health Sector in Cambodia 2016-2020, Cambodia is striving for virtual elimination (<3 new infections per 100,000 population annually and mother-to-child transmission rate of ≤5%) of new HIV infections by 2025. To reach these goals, the MOH National Center for HIV/AIDS, Dermatology, and STDs (NCHADS) has outlined three main strategies for the health sector HIV response:

1) Boosted Continuum of Prevention to Care and Treatment (CoPCT): KP prevention and links to services;
2) Boosted Continuum of Care: retention and improvement of quality for patients in care;
3) Boosted Linked Response: elimination of new infections among children, while addressing the needs of their mothers.

Boosted Integrated Active Case Management (B-IACM) brings together these three strategies, along with refined activities to identify, reach, intensify, and retain KP. B-IACM tracks individuals across the cascade through case management coordinators (CMCs) and assistants (CMAs), strengthened information systems, and improved use of individual level data. To date, B-IACM has been implemented in 14 provinces with plans to scale up to the remaining 11 provinces in ROP19. In 2018, NCHADS also introduced the Community Action Approach (CAA) for B-IACM, in order to consolidate and define the implementation approach for community work. The CAA strategy will be essential for rapidly improving case finding at the community level and re-engaging LTFU PLHIV into care and on treatment.

Figure 2.1.3 Cambodia National HIV Clinical Cascade: Gap to 95-95-95



The national HIV clinical cascade suggests that Cambodia's HIV strategy has been effective toward achieving 90-90-90 targets and nearing 95-95-95 targets (Figure 2.1.3, Table 2.1.2). As

of December 2018, it was estimated 81% of PLHIV have been diagnosed, 99% of diagnosed PLHIV are on ART, 83% of those on ART have received VL testing, and 79% of PLHIV on ART have documented VL suppression. With further refinement of targeted case-finding as well as aggressive identification and re-engagement of PLHIV who were LTFU, Cambodia's promising clinical cascade statistics are likely to show further progress in 2019.

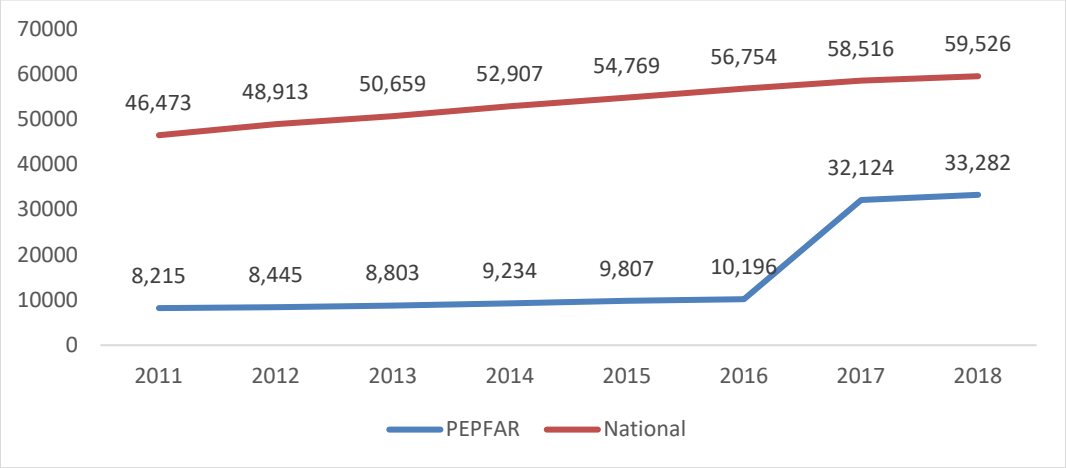
Table 2.1.2 Cambodia 90-90-90 Cascade

Table 2.1.2: 90-90-90 Cascade: HIV diagnosis, treatment and viral suppression										
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Pop Size Estimate (#)	HIV Prev (%)	Est. Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage of est. PLHIV (%)	Viral Supp 12 Months (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	16,623,655	0.61%	73,552	59,837	59,526	81%	47,112 (79%)	373,415	3,907	3,527
Population <15 years			3,479	3,111	2,983	86%	2,017 (68%)	3,332	127	138
Men >15 years			32,964	26,331	26,242	80%	20,329 (77%)	93,182	2,162	2,034
Women >15 years			37,109	30,395	30,301	82%	24,766 (82%)	276,901	1,618	1,355
MSM	36,100	2.3%	830					12,560	317	313
FSW	42,100	3.2%	1,347					18,286	59	57
PWID	1,300	15.2%	198					401	6	6
Priority Pop (Transgender)	3,200	10.3%	330					2,307	62	62

Epidemiologic data: see Table 2.1.1; PLHIV diagnosed and HIV Treatment data from NCHADS FY18 Q4 report; Viral Suppression from VL Lab Database; HIV Testing and Linkage to ART from NCHADS FY18 Q1, Q2, Q3 and Q4 reports. Key Population results from Global Fund prevention partner database.

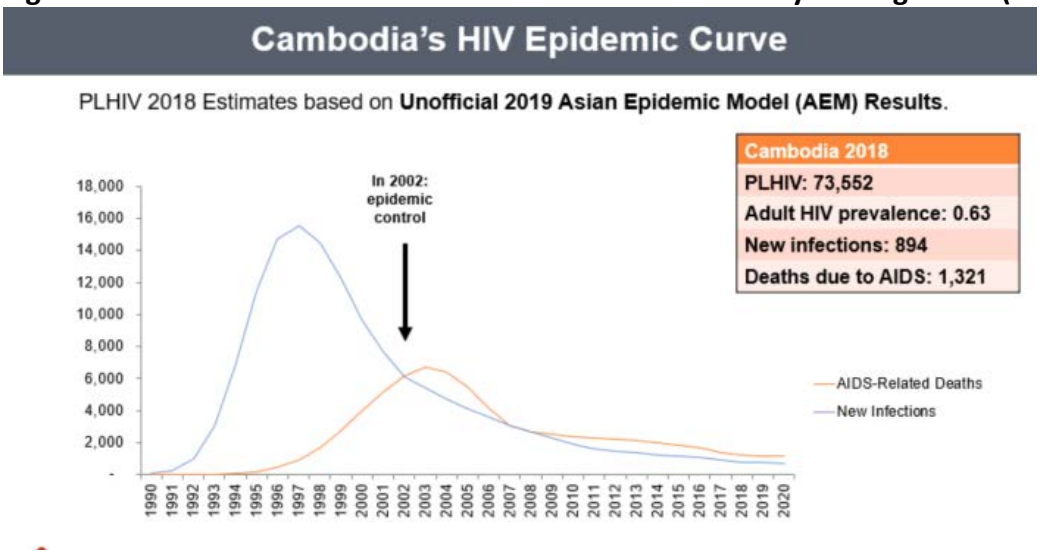
Cambodia is rapidly scaling up effective approaches such as index case testing and social networking strategies to accelerate case finding among high-risk populations. While KP are approximately a quarter of the newly identified cases, there is evidence that HIV transmission among MSM is increasing (Figure 2.1.1). Unfortunately, fear of stigma and discrimination remains a major barrier to KP accepting HIV testing, but planned expansion of HIV self-testing services and provision of multiple testing modalities through a KP-friendly clinic in Phnom Penh should enable these populations to access HIV testing services more readily in ROP19.

Figure 2.1.4 National and PEPFAR Trend for Individuals currently on Treatment (Cambodia)



PEPFAR does not support site-level activities in Cambodia. The PEPFAR trend line reflects support for four priority provinces (Banteay Meanchey, Battambang, Phnom Penh Municipality, and Siem Reap) with a substantial increase in number of PLHIV on ART in 2017, as Phnom Penh Municipality was added.

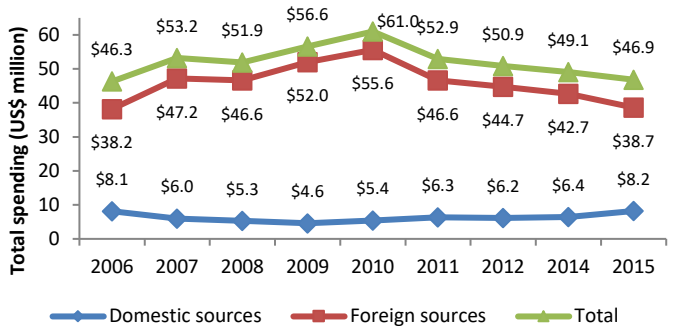
Figure 2.1.5 Trend of New Infections and All-Cause Mortality Among PLHIV (Cambodia)



2.2 Investment profile: Cambodia became a lower-middle income country in 2015, and its 2017 GNI per capita is $1,230[47]. According to the 2016 Cambodia National Health Accounts (NHA), the 2016 current health expenditure for Cambodia was 6% of GDP. Government expenditure on health increased from $199.4 million in 2012 to $268.6 million in 2016, representing a 35% increase over five years[48]. Government expenditure for health is 22% of overall health expenditures, which is below the global average for lower-middle income countries (40%)[48]. Out-of-pocket expenditures are high, at over 60% of all health expenditures, which is higher than the global average for lower middle-income countries at 40%[48]. Out-of-pocket expenditures increased among vulnerable population groups in 2016[48]. Donor spending accounts for 17% of current health expenditure, which is higher than other lower middle-income countries, which average 10%[48]. These health spending statistics demonstrate the fiscal challenges to Cambodia of increasing its contribution to the HIV response, which was 17% of the overall HIV response in 2015.

NASA VI with 2016 and 2017 data is anticipated to be completed in FY2019. The most recent comprehensive HIV/AIDS expenditure data is from the NASA V covering 2014-2015. Data from NASA V (Figure 2.2.1) shows total reported HIV/AIDS spending in Cambodia peaked at $61 million in 2010. Since that time, total spending has trended downwards, decreasing to $46.9 million in 2015. This represents an 11% decline from 2010 to 2015, or a compounded annual reduction rate of 2.3%. However, that annual decline doubled to 4.6% between 2014 and 2015.The RGC continues to increase its domestic contribution to the HIV response. In 2015, the RGC contribution increased by 21%, including approximately $1 million for the purchase of ARV drugs for the first time. Domestic government spending on HIV/AIDS has increased 78% since 2009 from $4.6 million to $8.2 million (2015). In 2018, the RGC contributed $1.5 million for ARVs as part of their current GF grant co-financing agreement.

Figure 2.2.1: Trend in Domestic and Foreign Sources of Spending for AIDS, 2006-2015 (excluding 2013)



Source: NASA, 2014-2015

The Investment Profile Table 2.2.1 has been updated to include FY18 PEPFAR and CY18 GF data. The 'RGC and Other' data are still from the 2014-2015 NASA V. Due to the drop in GF and PEPFAR expenditures, the RGC contribution to HIV will rise to 27%. The largest declines in PEPFAR expenditures were in the program areas: Clinical Care, Treatment and Support, Community-based Care, and Key Populations. PEPFAR's shift from KP direct service delivery to TA support contributes to this decline in expenditures. GF's largest declines were in Other, Laboratory, Key Population and PMTCT.

[47] http://data.worldbank.org/country/cambodia
[48] Royal Government of Cambodia National Health Accounts, 2016

Despite the modest increases in domestic funding, Cambodia's HIV response is heavily reliant on external sources of funding, which supported 73% of the response in 2018 (if one holds 'RGC and Other' constant from 2015). The USG remains the largest bilateral contributor to the HIV response in Cambodia and the GF is the largest overall contributor in the HIV sector on an annual basis. When taken together, these two development partners contribute 54% of the total resources for HIV, including 80% of costs for ARVs, and all test kits and lab reagents. PEPFAR contributes significant technical assistance (TA) to the GF program through active engagement in the CCM and TWGs, support to develop and evaluate pilot programs prior to national scale-up, and assistance to NCHADS in ongoing monitoring of the national program. In addition to the USG and the GF, other development partners active in Cambodia in the HIV sector include UNAIDS, AHF, and CHAI.

There are a number of development partners that work in health systems strengthening, not specific to HIV, including the WHO, World Bank, Australian Department of Foreign Affairs and Trade (DFAT), the German Embassy/GIZ, Korea International Cooperation Agency (KOICA), Japan International Cooperation Agency (JICA), and the French Embassy. PEPFAR, leveraging USG non-PEPFAR resources, works in coordination and collaboration with these development partners in the areas of health financing and social health protection, SI and health information systems, quality improvement, and supply chain strengthening to ensure harmonization with these broader health-related efforts.

Table 2.2.1 Annual Investment Profile by Program Area (Cambodia)

Table 2.2.1 Annual Investment Profile by Program Area[49]					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Care & Treatment (*C&T: HIV Clinical Service, Clinical care, treatment and support, Community-based care, treatment, and support, PMTCT)*	$15,988,879	17%	48%	22%	13%
HIV Testing Services (*HTS: Not Disaggregated)*	$393,498	100%	0%	0%	0%
Prevention					
- AGYW beneficiary (*AGYW prevention)*	$0	0%	0%	0%	0%
- Key populations beneficiary (*key population prevention)*	$3,252,668	43%	23%	2%	32%
- Other prevention beneficiaries (*priority population prevention)*	$0	0%	0%	0%	0%

[49] PEPFAR, FY18 Expenditure Reporting Tool; Global Fund, CY18 Reprogramming Budget; Host country and Other, NASA V 2015. Global Fund program management expenditures excluded.

Table 2.2.1 Annual Investment Profile by Program Area[49]					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Socio-Economic					
- OVC beneficiary – N/A	$0	0%	0%	0%	0%
- Other socio-economic beneficiaries - N/A	$0	0%	0%	0%	0%
Above Site Programs					
- HMIS, Surveillance, Research (*SI, Surveys, Surveillance)*	$1,896,234	64%	25%	0%	11%
- Laboratory systems strengthening (*ASP* - Laboratory)	$1,288,946	19%	81%	0%	0%
- Other ASP (*ASP – Inst Prev + ASP – Policy, planning, etc. + ASP – Not Disaggregated)*	$8,758,172	20%	1%	53%	27%
Total	**$30,169,722**	**21%**	**33%**	**27%**	**19%**

Table 2.2.2 Annual Procurement Profile for Key Commodities (Cambodia)

Table 2.2.2 Annual Procurement Profile for Key Commodities					
Commodity Category	**Total Expenditure**	**% PEPFAR**	**% GF[50]**	**% Host Country**	**% Other**
ARVs	$7,334,926	0%	80%	20%	0%
Rapid test kits	$1,196,046	1%	99%	0%	0%
Other drugs	$5,250	0%	0%	0%	100%
Lab reagents	$122,062	0%	100%	0%	0%
Condoms	$59,470	0%	100%	0%	0%
Viral Load commodities	$1,033,588	3%	97%	0%	0%
Other commodities	$155,731	5%	95%	0%	0%
Total	**$9,907,072**	**$44,401**	**$8,297,951**	**$1,500,000**	**$5,250**

[50] GF procurement of ARVs in 2018 was $1,302,988 and in 2019 it was $10,366,863. The 2018 Global Fund ARV amount is the average of 2018 and 2019.

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration (Cambodia)

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
USAID MCH	$5,500,000	$2,325,000	2	$1,100,000	Quality Improvement & Health Finance
USAID TB	$5,000,000	$2,000,000	2	$1,100,000	Quality Improvement & Health Finance
USAID Nutrition	$1,500,000	$350,000	1	$350,000	Quality Improvement & Health Finance
Total			**2**	**$1,100,00**	

These impressive achievements are driven by the strong political commitment from the RGC and the work of local and international CSOs and external donor funding. However, as Cambodia is now a lower middle-income country, donor support is declining. As the country transitions to a domestically funded response, it is vital for Cambodia to sustain the gains achieved over the last decade.

In response to declining external funding and the desire to be more self-sufficient, the Cambodian National AIDS Authority (NAA) established a sustainability TWG and developed a Sustainability Roadmap (led by UNAIDS). The Sustainability Roadmap is based on a transition readiness assessment (TRA), which identified three key risk categories to transitioning the HIV/AIDS response. The three categories include (1) service delivery and health systems, (2) CSOs, and (3) costs and financing. In 2018, a multi-stakeholder workshop validated these risk categories and separated them into 13 priority interventions. The Sustainability Roadmap provides a framework of mitigating actions for these 13 interventions and describes implementation steps to improve the sustainability of the response. ROP19 health financing activities in Table 6 are aligned with these implementation steps.

In 2017, to foster progress towards sustainability and national ownership, the GF identified the Ministry of Economy and Finance (MoEF) as the primary recipient (PR) of the 2018-2020 grant. This new arrangement allows the GF grant to move through national funding flow systems and resources can be directly disbursed to PHDs. After an initial slow start-up in 2018, the grant has ramped up to an 88% absorption rate.

In 2018, the government delivered $1.5 million of its first-year payment of its three-year commitment for ARVs and increased its contribution to salary costs of contract staff responsible for management and implementation of GF-funded grant activities. Government health facilities have taken on the management of the Health Equity Fund (HEF), though reimbursement by HEF for HIV-related services is not consistently applied throughout the health system. A logistics management information systems feasibility study in 2016 led to the MOH's decision to upgrade its current system and make it web-based to reduce drug/ARV expiry and stockouts.

All civil society HIV activities in Cambodia are currently externally funded. Given the decline in donor funding, the financing of civil society remains a key challenge to sustainability of the national response. PEPFAR is supporting the MOH and MoEF to allocate resources from the host country budget for local HIV CSOs.

2.4 Alignment of PEPFAR investments geographically to disease burden: COP15 and COP16 aligned Cambodia PEPFAR activities closely with the burden of disease through greater engagement in six of the 25 provinces. In COP18, Cambodia PEPFAR pivoted further by eliminating all site-level activities and focusing interventions in four priority provinces (Phnom Penh municipality, and Banteay Meanchey, Battambang, and Siem Reap provinces) and supporting NCHADS to scale up priority activities nationally. These four provinces have the greatest estimated number of PLHIV and are four of the five provinces with the greatest estimated number of new HIV infections annually (Table 2.4.1; Figure 2.4.1). These provinces also account for 74% of estimated KP of MSM, TG, and PWID, 57% of PLHIV, and 41% of estimated new infections. During ROP19, the RGC, with TA from Cambodia PEPFAR and implementing partners (IPs), will rapidly scale up activities such as index case testing, MMS, same-day ART, TLD, and point-of-care (POC) use of recency assay testing from the four PEPFAR priority provinces nationally.

Table 2.4.1 Key Data for Cambodia

Table 2.4.1: Key data for Cambodia by Province[51]							
Province	**Est # PLHIV 2018**	**Est # new infections 2018**	**# ART clients Q4 2018**	**% of PLHIV on ART**	**# on ART if 90/90 goals met**	**# new ART clients needed to reach 90/90 goals**	**VL Testing Rates**
Phnom Penh	16,202	115	19,555	121%	13,124	-6,431	88%
Siem Reap	6,958	83	4,569	66%	5,636	1,067	99%
Battambang	6,907	108	5,394	78%	5,595	201	84%
Banteay Meanchey	4,943	59	3,764	76%	4,004	240	81%
Kandal	4,554	30	2,698	59%	3,689	991	82%
Kampong Cham	4,188	59	2,905	69%	3,392	487	92%
Prey Veng	3,822	36	2,683	70%	3,096	413	77%
Takeo	3,561	44	2,667	75%	2,884	217	84%
Kampong Speu	2,915	56	1,714	59%	2,361	647	64%
Tbong Khmum	2,539	42	1,479	58%	2,057	578	71%
Preah Sihanouk	2,470	26	1,983	80%	2,001	18	56%
Pursat	2,172	36	1,292	59%	1,759	467	76%
Svay Rieng	2,171	26	1,381	64%	1,758	377	84%
Kampong Thom	2,001	44	998	50%	1,621	623	79%
Kampot	1,799	30	2,144	119%	1,457	-687	86%
Koh Kong	1,370	14	949	69%	1,110	161	60%
Kampong Chhnang	1,334	20	853	64%	1,081	228	78%
Oddor Meanchey	1,016	20	513	51%	823	310	55%
Kratie	812	12	564	69%	658	94	47%
Stung Treng	588	8	402	68%	477	75	61%
Pailin	459	6	410	89%	371	-39	92%
Preah Vihear	324	8	307	95%	263	-44	68%
Rattanakiri	283	6	181	64%	229	48	65%
Mondulkiri	107	3	40	37%	87	47	20%
Kep	55	3	81	147%	45	-36	85%
Total	**73,552**	**894**	**59,526**	**81%**	**59,577**	**51**	**83%**

[51] PLHIV and new infection estimates by province are based on the 2016 AEM as new SNU estimates were not available.

Figure 2.4.1: Estimated Number of PLHIV by province, 2018 (Cambodia)

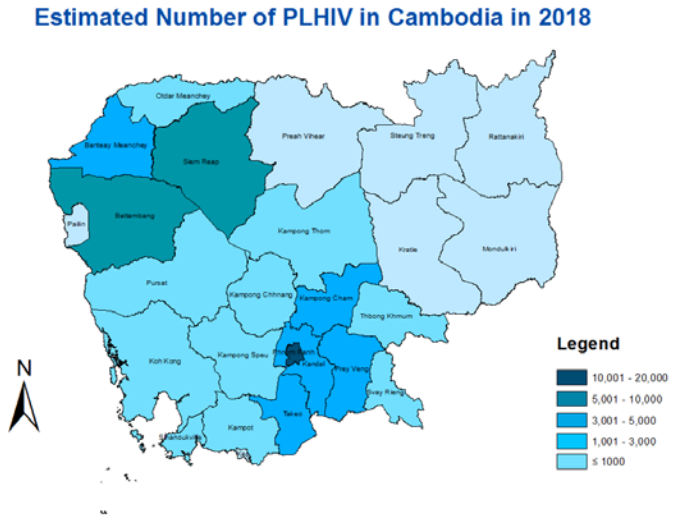


Figure 2.4.2: Number of PLHIV on ART by province, 2018 (Cambodia)

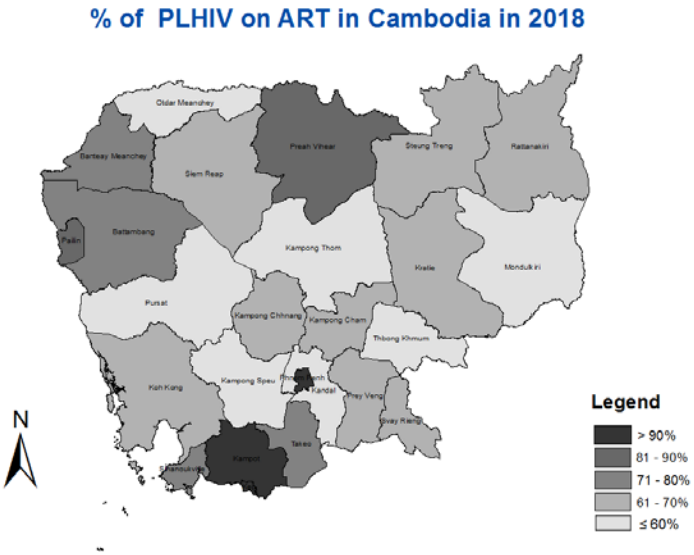
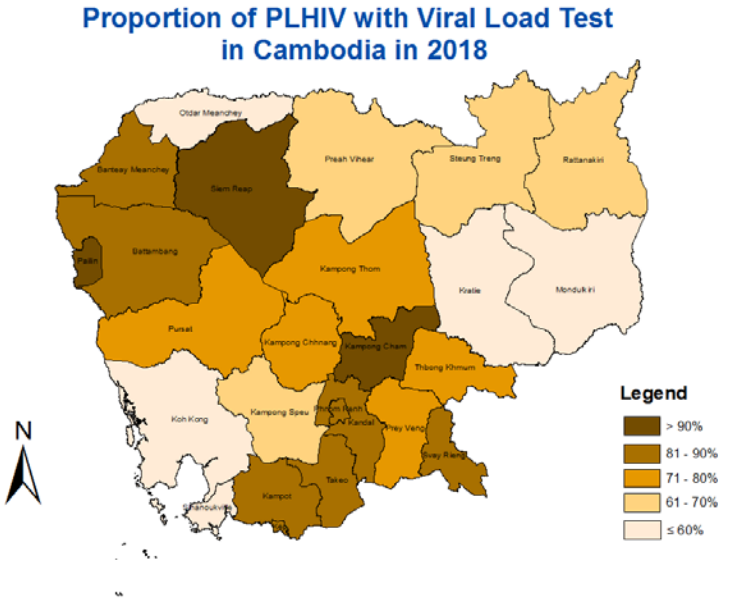


Figure 2.4.3: Number of PLHIV with VL test by province, 2018 (Cambodia)



2.5 Stakeholder engagement: Cambodia PEPFAR is committed to regular, in-depth engagement with a broad range of stakeholders. Early in ROP19 planning, PEPFAR facilitated a formal consultation with broad stakeholder participation. The USG team presented S/GAC ROP19 guidance, the overarching strategy for Cambodia PEPFAR, and data from the COP17 APR. Stakeholders stressed the importance of: supporting the implementation of the HIV/AIDS Sustainability Roadmap and the next National Strategic Plan 2021-2025; advocating to the Supreme National Economic Council and MoEF to increase domestic resources for HIV prevention and treatment; developing a strategy to integrate HIV/AIDS into the broader health care system; using innovative approaches for case detection, especially among young KP; and expanding use of TB preventive therapy. This input has been systematically addressed in ROP19 development. The PEPFAR team also shared draft activities with stakeholders for input prior to the ROP19 Bangkok Review Meeting.

The Cambodia PEPFAR team engages routinely with the host country government, the GF, other health development partners, civil society, AHF and the private sector through existing coordination structures such as the GF CCM, national TWGs on HIV, Health Partners' Meetings, and the Government-Donor Joint TWG on HIV/AIDS. Through these existing platforms, the PEPFAR team provided updates on ROP19 development and COP18 implementation.

The PEPFAR team is also heavily engaged in the implementation of the current GF grant. The USG team will remain highly active in the CCM and other coordination mechanisms over the coming cycle to ensure smooth implementation of both ROP19 and GF-funded activities.

3.0 Geographic and Population Prioritization

Tier 1: Accelerate and Achieve Epidemic Control
Burma, Kyrgyz Republic, Nepal, Tajikistan, and Thailand
Tier 2: Protect the Investment
India, Indonesia, Laos, Kazakhstan, and Papua New Guinea
Tier 3: Sustained Epidemic Control
Cambodia

Tier 1: BURMA

Given the concentrated nature of the HIV epidemic in Burma, with the highest prevalence of infection in KP, the PEPFAR strategy is to support the development of innovative service delivery models that can then be adopted, and then amplified by the national government and other stakeholders (i.e., the GF). This approach is exemplified by the successful practices related to case detection using KP-focused outreach HIV testing, index testing and other innovative testing approaches that facilitated a near doubling of testing yield (6% to 12%). These models were then adopted by a GF principal recipient (Save the Children) for scale-up and application within their KP programs.

Burma PEPFAR works at the above-site level to advocate and promote policy and guidance, grounded in the clinical realities of PEPFAR-supported and other sites. Burma PEPFAR targets are set at levels that achieve impact and allow for flexibility and space to test innovations. With this unique flexibility, PEPFAR makes an important investment in national epidemic control. Whether the innovation begins above-site or at the site-level, PEPFAR in Burma's Tier 1 role is to innovate, adopt and amplify.

The national government, GF and PEPFAR saturate the five high burden catchment areas to enhance services and accelerate HIV diagnosis yield, ART and retention of KP. The five priority catchment areas as noted above are:

- Yangon: All KP.
- Mandalay: All KP.
- Kachin: PWID support, other existing KP support maintained.
- Shan: PWID support, other existing KP support maintained.
- Sagaing: New PWID support.

Table 3.1 Current Status of ART Saturation (Burma)

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP19**	**# Current on ART (FY18)**	**# of SNU COP18 (FY19)**	**# of SNU COP19 (FY20)**
Attained	-	-	-	-
Scale-up Saturation	-	-	-	-
Scale-up Aggressive	N/A*	7,068	37	38
Sustained	-	-	-	-
Central Support	-	-	-	-

No Township (prioritized SNU) level data are available and also no KP disag data are available.

Tier 1: KYRGYZ REPUBLIC

PEPFAR will continue to support site-level activities in the SNUs with the highest burden of HIV. The priority SNUs for ROP19 are Bishkek City, Chui Oblast, Osh Oblast, and Osh City. These SNUs include approximately 81% of all adult PLHIV in Kyrgyz Republic. All four SNUs are scale-up saturation.

Long-term migration of Kyrgyz citizens abroad limits the Republic AIDS Center and PEPFAR programs' ability to reach undiagnosed PLHIV with HIV testing services conducted within Kyrgyz Republic. The estimated number of PLHIV in long term migration was calculated based on World Bank estimates of the percentage of adult population in migration (10%) [World Bank Kyrgyz Republic Economic Update Fall/Winter 2017], assuming that HIV prevalence among migrants is the same as among the general adult population. The PEPFAR team does not have direct sources of data on HIV prevalence among long term migrants. Using the most recent 2019 Spectrum estimates of adult PLHIV (15+ years), an estimated 8,000 PLHIV are within the Kyrgyz Republic, and 6,445 reside within the PEPFAR priority SNUs.

PEPFAR in Kyrgyz Republic will continue to conduct case finding among PWID and their sexual and injecting partners and MSM and will expand community-based assisted partner notification/index testing and adherence support to newly-identified non-KP PLHIV in the priority SNUs. PEPFAR will also expand case finding to: MSM (expanding to new locations to cover all SNUs) as well as their partners, including heterosexual partners; sexual partners of former PWID; sex workers and their partners; labor migrants with risky behaviors and their partners; ex-prisoners; homeless people; people with presumptive TB; and partners of people who have died of key opportunistic infections.

PEPFAR will work with the RAC to support PLHIV on ART in the PEPFAR SNU's to increase retention on treatment and VL suppression. Since PWID are a significant proportion of all PLHIV and PLHIV on ART, PEPFAR will focus on MAT for opioid addiction and other comorbidities associated with injection drug use and poor ART adherence and retention.

Table 3.1 Current Status of ART Saturation (Kyrgyz Republic)

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP19**	**# Current on ART (FY18)**	**# of SNU COP18 (FY19)**	**# of SNU COP19 (FY20)**
Attained	-	-	-	-
Scale-up Saturation	6,445/81% of national PLHIV	2,534	4	4
Scale-up Aggressive	-	-	-	-
Sustained				
Central Support	-	-	-	-

Tier 1: NEPAL

PEPFAR's geographic alignment based on disease burden is described in Section 2.4. In ROP19, the USG will focus on case finding primarily through index testing, and on reaching deeper into networks through on-line and off-line social network approaches. PEPFAR currently has only two quarters of data from these approaches, but as more data becomes available, strategies will be adjusted on an ongoing basis to focus on areas and populations with the highest potential positivity rates. The only available data on ART coverage data disaggregated by sex and age shows the highest gaps among men aged 30 to 54. PEPFAR will focus on this population

for ART enrollment and retention during the initial months of our surge. ART coverage data by district is also available and is shown on the map above. PEPFAR will intensify ART enrollment and retention activities on these districts initially.

Table 3.1 Current Status of ART Saturation (Nepal)

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP19**	**# Current on ART (FY18)**	**# of SNU COP18 (FY19)**	**# of SNU COP19 (FY20)**
Attained				
Scale-up Saturation	14,706/6%	10,766		19 districts
Scale-up Aggressive				
Sustained				
Central Support				

Tier 1: TAJIKISTAN

PEPFAR will continue to support site-level activities at the SNUs with the highest burden of HIV. The priority SNUs for ROP19 are: (1) Dushanbe City; (2) Sughd Region; and (3) Districts of Republican Subordination surrounding Dushanbe. These SNUs include approximately 67% of all estimated adult PLHIV in Tajikistan.

As previously mentioned, long-term migration of Tajik citizens abroad limits the Republican AIDS Center (RAC) and PEPFAR programs' ability to reached undiagnosed PLHIV with HIV Testing Services conducted within Tajikistan. The estimated number of PLHIV in long-term migration was calculated based on published World Bank estimates of the percent of adult population in migration (26%), assuming that HIV prevalence among migrants is the same as among the general adult population. PEPFAR does not have direct sources of data on HIV prevalence among long-term migrants.

Using the most recent 2019 Spectrum estimates of adult PLHIV (15+), an estimated 12,921 PLHIV are within Tajikistan, and 8,696 (67%) of them reside in the three PEPFAR-supported SNUs.

Table 3.1 Current Status of ART Saturation (Tajikistan)

Table 3.1 Current Status of ART Saturation				
Prioritization Area	Total PLHIV/% of all PLHIV for COP19	# Current on ART (FY18)	# of SNU COP18 (FY19)	# of SNU COP19 (FY20)
Attained	-	-	-	-
Scale-Up Saturation	8,696/67% of national PLHIV excluding migrants	3,061	3	3
Scale-Up Aggressive	-	-	-	-
Sustained	-	-	-	-

Source: EHCMS

Tier 1: THAILAND

Since ROP16, PEPFAR has focused on increasing KP access to HIV services, specifically MSM, TGW, MSW, and FSW, in 13 provinces in Thailand. It is estimated that 83% of new MSM and TG infections will occur in the 13 PEPFAR-focused provinces.

By October 2019 (after completion of ROP18 implementation) it is expected that five of the 13 PEPFAR-supported provinces will have attained at least 81% ART coverage for PLHIV (Udon Thani, Chon Buri, Nonthaburi, Songkhla, and Ubon Ratchathani). None of these five provinces however, achieved 90% VL suppression among PLHIV. None of 13 provinces achieved 81% ART coverage among MSM, TGW, and MSW.

After full ROP19 implementation (October 2020), four additional provinces will have attained at least 81% ART coverage among PLHIV (Kon Kaen, Nakhon Ratchasima, Phuket, and Samut Prakhan); Bangkok, Chiang Mai, Chiang Rai, and Pathun Thani will not. Among MSM and TG, four provinces will achieve saturation status (Nakhon Ratchasima, Phuket, Songkhla, and Udon Thani).

Table 3.1 Current Status of ART Saturation (Thailand)

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP19**	**# Current on ART (FY18)**	**# of SNU COP18 (FY19)**	**# of SNU COP19 (FY20)**
All PHIV				
Attained	87,858 (42.9%)	77,146	5	9
Scale-up Saturation	15,176 (7.4%)	11,806	4	1
Scale-up Aggressive	101,702 (49.7%)	55,922	4	3
Sustained				
Central Support				
MSM-TG-MSW				
Attained				
Scale-up Saturation	3,185 (9.1%)	1,637		4
Scale-up Aggressive	32,003 (90.9%)	5,503	13	9
Sustained				
Central Support				

Tier 2: INDIA

To achieve the greatest epidemiological impact with the available PEPFAR resources, and to demonstrate to in-country and international stakeholders that achieving epidemic control in areas of high burden is feasible, India PEPFAR investments have remained focused on scaling up services in high HIV burden states and districts.

In ROP19, India PEPFAR will continue to focus on the priority states of Andhra Pradesh (AP), Maharashtra (MH), Manipur, Mizoram, and Nagaland with the highest HIV burden or pevalanece of disease in the country. PEPFAR will focus on three districts in AP (East Godavari, Guntur, and Krishna), three districts in MH (Mumbai, Pune, and Thane), and 12 districts in the North East region which have been prioritized for epidemic control. In ROP 19, PEPFAR has shifted to three new districts with higher prevalence in Mizoram from three districts with a stabilized HIV epidemic in the state of Manipur and Nagaland. In the three North East states, PEPFAR works in 12 districts in prevention and 17 districts in treatment, due to the evolving epidemic in this region.

PEPFAR India focuses activities in the first 90 on KPs; activities in the second and third 90 are for all PLHIV, with a focus on KP. PEPFAR India will leverage tailored programs for KP and scale these in ROP19. India PEPFAR will collaborate with GF implementing partners and CSOs to prioritize scale up to 100% index testing, 95% treatment coverage and 95% VL suppression. This includes more support to guide and monitor PLHIV and KP PLHIV continuum of care. India PEPFAR will continue to work with children of KP and prioritize index testing in OVC program interventions. PEPFAR will continue to provide technical support to strengthen the district, state, and national level systems, surveillance for tracking KP prevalence, data uality, use and dissemination- with the aim of increasing access to HIV prevention,treatment and retention.

Table 3.1 Current Status of ART Saturation (India)

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP19**	**# Current on ART (FY18)**	**# of SNU COP18 (FY19)**	**# of SNU COP19 (FY20)**
Attained	86,004 (30.8%)	72,839	4	4
Scale-up Saturation	29,469 (10.5%)	22,365	2	2
Scale-up Aggressive	167,663 (58.7%)	84,031	18	17
Sustained				
Central Support				

Tier 2: INDONESIA

Site-level activities in Indonesia primarily focus on both DS and TA Service Delivery Improvement (TA-SDI) that demonstrate increased targeted population reach, HIV testing, yield/enrollment, ART initiation, treatment retention, and viral suppression in decentralized service settings across the CoPCT. In ROP19, Indonesia PEPFAR assistance will strategically fill in critical gaps and amplify results that move Indonesia toward the 95-95-95 goals highlighted in the Jakarta Fast Track approach.

Indonesia PEPFAR will further amplify international best practices, including community-based screening, SUFA/Test & Start, MMS, and systematic VL testing, in 56 (ROP 19) ART service delivery points across five districts in Jakarta. These innovative practices were highlighted in the National HIV Review conducted in January 2017 and have been approved by the MOH. Facilities have been selected based on their ability to expand CoPCT coverage, and their commitment to testing new models of care in line with PEPFAR guidance.

Indonesia PEPFAR's military-to-military engagement program will focus on increasing the number of military health facilities providing Test & Treat and will predominately be focused on scaling up VL test coverage. Through this approach, TA will be provided to strengthen the existing military health care system, build capacity, and improve data quality and the reporting system. Expected Indonesia PEPFAR achievements in working with the military include: (1) supporting five new military health facilities to start providing treatment; (2) scale up of VL testing coverage within the military; and (3) improved treatment adherence of military personnel on ART across Indonesia.

Table 3.1 Current Status of ART Saturation (Indonesia)

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for ROP 19**	**# Current on ART (FY18)**	**# of SNU COP18 (FY19)**	**# of SNU ROP 19 (FY20)**
Attained				
Scale-up Saturation				
Scale-up Aggressive				
Sustained	109676/14751(13.4%)	21456 (DKI Jakarta) /15089 (PEPFAR supported sites in DKI Jakarta)	1	1
Central Support				

Tier 2: KAZAKHSTAN

No province in Kazakhstan has yet achieved ART saturation across all age and gender bands. Specific age/genders bands (for example 15- to 19-year-old males in East Kazakhstan) have achieved 100% ART coverage, though there are very few PLHIV in this age band. In COP19, treatment coverage rates range from 48% to 72%. In COP19 in some provinces, female PLHIV generally have higher ARV coverage than males, although in most provinces, treatment coverage rates are similar for females and males.

In ROP19, Kazakhstan PEPFAR will work with the RAC to support PLHIV on ART in the PEPFAR-supported sub-national units, Pavlodar and East Kazakhstan, with the specific objectives to increase ART retention and viral load suppression. Because PWID are a significant proportion of PLHIV and of PLHIV on ART, PEPFAR support will focus on opioid addiction treatment and other

co-morbidities associated with injection drug use, as well as poor ART adherence and retention. PEPFAR will continue to support community-based index partner testing as a complementary activity to RAC's work on facility-based index testing. PEPFAR will continue its above-site work to address significant barriers to nation-wide attainment of the 90-90-90 targets and sustained epidemic control.

Table 3.1 Status of ART Saturation (Kazakhstan)

Prioritization Area	Total PLHIV/% of all PLHIV for COP19	# Current on ART (FY18)	# of SNU COP18 (FY19)	# of SNU COP19 (FY20)
Attained	-	-	-	-
Scale-up Saturation	-	-	-	-
Scale-up Aggressive	-	-	-	-
Sustained	6,479/28%	2,588	2	2
Central Support	-	-	-	-

Tier 2: LAOS

Laos has a concentrated epidemic with pockets of increasing HIV prevalence among KP. The AEM[52] projects a rising trend of new HIV infections among MSM, accounting for one-third of all new infections in 2020. This trend is corroborated by national testing data,[53] which have shown an increasing HIV-positive rate among MSM and TG at the facility level since 2015, reaching 19% in 2018. Preliminary findings of IBBS 2017 also suggest a potential increase in HIV prevalence among MSM in the capital city of Vientiane.

In 2018, 84% of new infections were in the three Laos PEPFAR-supported provinces—Vientiane Capital, Champasack, and Savannakhet. Based on national routine case reporting, 63% of PLHIV and 79% currently on ART live in these provinces.[54] Progress toward the 2nd and 3rd global 90-90-90 targets for HIV treatment scale-up is constrained by difficulties in linkage to and retention in treatment. There are currently only 11 treatment sites in eight of the 18 provinces in Laos. PEPFAR is focusing on three high-burden provinces, which have five ART sites with low ART coverage. Data collected from PEPFAR-supported sites indicated that loss-to-follow-up (LTFU) was most common among 20- to 29-year-old MSM and TG PLHIV. To protect the investment in ROP19, PEPFAR will continue to focus on the highest risk populations in the highest burden areas of Laos by increasing access to recency and index testing, ensuring 100% access to viral load testing, and ensuring and addressing barriers to 95% retention.

Table 3.1 Current Status of ART Saturation (Laos)

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP19**	**# Current on ART (FY18)**	**# of SNU COP18 (FY19)**	**# of SNU COP19 (FY20)**

[52] AIDS Epidemic Model, 2017
[53] CHAS, National VCT register, DHIS2
[54] CHAS, national ART data from HIVCAM

Sustained	63%	5,655	3	5

Tier 2: PAPUA NEW GUINEA

PEPFAR in PNG will continue to strengthen interventions through TA at the national and sub-national levels, guided by recent available HIV data. As directed by the ROP19 protecting the investment strategy, the focus will be on PLHIV on treatment in NCD; however, treatment monitoring will be done in Lae, Mt. Hagen and the rest of PNG to ensure institutionalization of best practices. PNG PEPFAR's focus in ROP19 will be on ensuring those PLHIV on treatment are retained, LFTU is reduced, and all on treatment in PEPFAR-supported SNUs have access to VL testing services, whilst catalyzing efforts through the GoPNG to scale VL testing in other non-PEPFAR sites.

To reduce LTFU and improve retention, PNG PEPFAR will prioritize 15- to 34-year-old females, who accounted for 50% of all LTFU in 2018. PEPFAR will help resolve barriers to retention experienced by FSWs, who also have a high rate of LTFU in this female age demographic. PNG PEPFAR's index partner testing strategies will target males in the 20-44-year age groups who may be partners of PLHIV females on treatment and who have yet to be linked to treatment, as shown by the large gap in ART coverage in this age group.

Finally, to address GBV as a barrier to retention, PNG PEPFAR will continue to integrate GBV case identification and clinical care into HIV testing and treatment to ensure that all PLHIV in care that experience GBV are identified and offered appropriate services.

Through this targeted approach, PNG PEPFAR intends to achieve a 30% yield in HIV+ case finding, reduce LTFU rates significantly to below 10%, and improve retention to over 95% in PEPFAR-supported SNUs. The expectation is that these interventions become integrated into national guidelines and are practiced more broadly for national impact.

Table 3.1 Current Status of ART Saturation (PNG)

Table 3.1 Current Status of ART Saturation and progress towards 95-95-95 in the NCD				
Prioritization Area	**Total PLHIV/% of all PLHIV for ROP19**	**# Current on ART (FY18)**	**# of SNU COP18 (FY19)**	**# of SNU ROP19 (FY20)**
Attained				
Scale-up Saturation				
Scale-up Aggressive				
Sustained	5,018 (95%)	4,028	1	1
Central Support				

Tier 3: CAMBODIA

In COP18, Cambodia PEPFAR eliminated all site-level support in order to focus on the four highest burden locations within Cambodia (Phnom Penh municipality, and Banteay Meanchey, Battambang, and Siem Reap provinces) and support NCHADS to scale up priority activities nationwide. While these four locations will remain a priority—given they account for 57% of PLHIV in Cambodia (Table 2.4.1)—there will be greater emphasis on national scale-up of key activities such as index case testing, MMS, same-day ART, TLD, and POC use of recency assay testing will occur during the ROP19.

4.0 Program Activities for Accelerate and Achieve Epidemic Control—by country for Tier 1

Tier 1: Accelerate and Achieve Epidemic Control
Burma, Kyrgyz Republic, Nepal, Tajikistan, and Thailand

Tier 1: BURMA

4.1 Finding the missing, getting them on treatment, and retaining them: Of an estimated total key population estimate of 411,000 MSM, FSW and PWID, Burma has an estimated 156,612 KP who have not been reached (24,355 FSWs, 76,481 MSMs and 55,776 PWIDs). OF 227,000 PLHIV, an estimated 54,000 PLHIV do not know their status. Of these, 61% are likely males over 15; 35% females over 15; and 4% children under 15. Seventy-seven thousand PWIDs (83%) lack access to MAT. Close coordination between PEPFAR and GF PRs and NAP has resulted in agreement with NAP on 2019 and 2020 targets that will allow Burma to accelerate from 79/90/50 on the 90-90-90 targets in 2018, to achieving 85/90/70 by 2019, and full 90-90-90 targets in 2020. Data on12-month retention is lacking, and there is an ongoing transition of PLHIV on ART from NGOs to public sector facilities, where high levels of stigma and discrimination prevail.

In FY20, Burma will close the gaps in the cascade of HIV prevention, testing and treatment, especially for KP affected by high HIV prevalence and limited access to HIV services by improving HIV case finding, rapid initiation of ART, maximal retention, and access to VLS testing for all. PEPFAR will work so that at least 40% PWID have access to MAT, and all have access to HIV testing and rapid initiation of ART.

Case finding: At the above-site level, PEPFAR will provide TA to the NAP on optimizing case-finding strategy, SOP development, and M&E support to promote national scale-up of an optimal mix of testing modalities including index testing with facilitated partner notification, and Social Network Testing through KP peer networks, using KP staff and civil society partnerships. TA is planned for scaling up and monitoring the quality of the KP-focused and KP peer-led outreach for HIV screening (called 'Community-Based Screening' by the NAP) and for setting up training and re-certification schemes for KP community testers. PEFPAR will support the engagement and capacity building of KP peer navigators at public facilities. PEPFAR will train clinicians and NAP teams at hospitals and public facilities in KP-friendly service delivery approaches.

PEPFAR will work with partners to test innovative and cost-efficient approaches to increase HIV testing and yields for FSW, MSM, TG and PWID KP in the five PEPFAR catchment areas of Yangon, Mandalay, Kachin, Sagaing, and Northern Shan. Site level programmatic activities will focus on KP groups (MSM, TG, FSW and PWID) in high-burden catchment areas and will include mobile outreach, community-level screening, and facility-based testing, including in private-sector sites. PEPFAR will continue to support 120 private sector clinics with PITC, with 34 providing ART as part of the government's decentralization plan. PEPFAR will support Targeted Outreach Program (TOP) centers that provide active case finding of MSM, FSW, and TG KP and their partners through peer outreach workers and social media campaigns. TOP centers will provide both HIV screening and confirmatory testing. ART clinics in high-burden areas will be implemented to enhance case finding, linkage, retention in care and routine ART adherence monitoring support, and to increase demand for VL testing.

PEPFAR will continue to support facility-based services to provide screening, confirmatory testing and ART. However, passive facility-based services are often too static to continuously find new KP and sustain KP demand. Burma PEPFAR has actively worked to change outreach tactics based on a daily/weekly review of real-time data, and this year Burma PEPFAR implementing index testing across all DSD sites. Similarly, above-site, PEPFAR will provide TA to GF SRs and NAP on incorporating index partner testing as a routine practice for all new diagnoses. PEPFAR will also introduce through training, and demonstrating in DSD sites, the power of recency testing for identifying chains of ongoing transmission.

PEPFAR will target mobile outreach to known hot spots where individuals receive health and behavior change education and voluntary screening provided by counselor and trained health personnel (such as nurses and CHWs). In Mandalay and Yangon, IPs have implemented mobile services which have been shown to be successful in expanding networks into communities as a way of accessing KP. In Kachin and Northern Shan, mobile outreach units will be used to overcome the obstacles of challenging terrain and large distances between fixed facilities and known hotspots. Mobile services will be used to "hook" community networks as a self-sustaining mechanism.

Community-based services include two types of voluntary screening: dynamic KP peer groups and static community health care workers. In Kachin and Shan, community-based service models appropriately target known hot spots using known local gatekeepers (e.g., the local area AIDS committee) to access KP. Continuous work on outreach innovations has increased HIV case finding for KP from 5% in Q2 FY16 to 17% in Q1 FY19, achieving some of the highest yields among PEPFAR countries. The success of these approaches to increase yields was adopted by the national government and then amplified by the GF principal recipient.
Above site level, Burma PEPFAR plans to provide TA for scaling up and monitoring the quality of the KP-focused and KP peer-led outreach for HIV screening (called 'Community-Based Screening' by the NAP) and for setting up training and re-certification schemes for KP community testers.

To reach the most difficult-to-reach KP through facility, mobile, and community-based outreach, advocacy and TA is planned for self-testing to be included in the next NSP. While the GOB has significant remaining overall concerns on costs and KP' ability to self-administer HIV testing, targeted implementation through secondary distribution in highest risk networks has been shown to be cost effective in other concentrated epidemics. Laboratory TA on validation and selection of self-testing kits for advising national procurement is planned, in addition to programmatic TA on operationalizing self-testing using high risk KP peer networks and recruiting newly-diagnosed index cases for secondary distribution of ST kits to hard-to-reach hidden KP.

PEPFAR TA is also planned for strengthening linkage from positive screened to confirmatory lab testing and HIV care. Advocacy for community-based diagnosis, i.e., implementation of confirmatory testing using rapid tests in the community, is planned once a streamlined testing algorithm with two rapid tests (along with repeat testing before ART initiation) is endorsed.

Retention: Burma PEPFAR will focus on providing support for maximizing retention with optimal adherence. Importantly, support for data quality analysis, epidemiologic and program reviews, and TA on case-based surveillance and UICs will address the critical unknown factor that is 12-month retention on ART.

Quality of HIV Care: Burma PEPFAR will provide TA on operationalizing DSD models: ART decentralization, Service Quality Monitoring System (SQMS), and improving facility level efficiency with MMS, to support a sustainable transition to public ART facilities. The PEPFAR program will support the national program's implementation of Service Quality Monitoring System (SQMS) tool at public ART decentralized facilities, including at ART-MAT centers. PEPFAR will support monitoring ART service quality and lab continuous quality improvement, as well as TA to national program on Incorporating ARV forecasting and procurement functions at ART sites into SQMS dashboard, to avoid stockouts and enable MMS operationalization.

In addition, Burma PEPFAR will support MOHS-run facilities in providing KP-friendly services through training and structural interventions to improve access for KP and tackle stigma and discrimination (by scaling up HCW Sensitization Curriculum) and placing KP peer navigators at public facilities. In support of scaling up MMS and monitoring of treatment retention, Burma PEPFAR will provide TA on supply chain management that will ensure that ART stockouts are minimized and that stable patients are aggressively transitioned to three- and then six-month MMS. Working with GF PR/SRs and NAP, Burma PEPFAR will provide above-site TA on developing and implementing KP peer support for adherence counselling, defaulter tracing, and assisted referral for other services like TPT.

VL Testing: PEPFAR will provide TA to optimize the work flow of VL and HIV rapid testing throughout all phases. To resolve operational challenges in transporting VL specimens, the implementation of DBS at all Abbott platforms will be rolled out with capacity building and necessary TA supports.

PEPFAR will expand above site TA investment to Burma's National AIDS Program (NAP) and National Health Laboratory (NHL) to resolve operational challenges in transporting VL specimens, the implementation of DBS at all Abbott platforms will be rolled out with capacity building and necessary TA supports. PEPFAR will augment NHL capacity to be able manage their own Proficiency Testing programs for VL and HIV serology testing. National capacity of External Quality Assurance (EQA) program for HIV serology and VL will be strengthened by implementing electronic data management tool with PEPFAR TA support.

Burma PEPFAR will support health systems needed for enhanced case finding, treatment, retention and VL suppression by addressing the significant gaps in strategic information, laboratory systems, and adoption of WHO-endorsed standards for HIV care and treatment. Burma PEPFAR will expand above-site TA investment to Burma's National AIDS Program and National Health Laboratory (NHL) to develop systematic monitoring mechanisms to close operational gaps in the laboratory and clinical facility domains, and at the laboratory-clinic interface. To address the critical gaps of KP-specific strategic information availability and use for

KP program improvement, PEPFAR will provide TA on: (1) incorporating risk classification tool at testing sites ensuring risk group/mode of transmission information is captured utilizing in standardized way and TA on harmonizing SOPs across public facilities and implementing partners for capturing risk category information; (2) estimation of 12-month retention of selected KP groups in priority SNUs as part of the upcoming PEPFAR Data Quality Analysis and national ART Program Review; (3) supporting development and operationalization of a national framework/ roadmap for case-based surveillance and scale up of UIC; and (4) advocacy and policy development for integration of HIV and overall MOH HMIS systems and utilization of Master Patient Index as UIC.

4.2 Prevention, specifically detailing programs for priority programming: Achieving epidemic control requires both the transmission-interrupting effects of ART among PLHIV through VL suppression, and PrEP scale up. PrEP has been endorsed as a key prevention modality in NSP III. Operationalization and scale-up will accelerate following the national consultation on PrEP in April 2019. PEPFAR ROP 19 and KPIF resources will make scale-up possible. PrEP will also feature prominently in the upcoming GF concept note.

Burma PEPFAR will focus on introducing PrEP for the highest risk populations in highest risk townships. PEPFAR will introduce PrEP programmatically in DSD sites. By implementing and tracking implementation and documenting and disseminating lessons about what works in practice, Burma PEPFAR will develop the basis for national expansion. PEPFAR will also help develop the PrEP national guidelines and implementation tools including a risk classification tool, clinical care SOPs, and recording and reporting tools. As part of our TA on developing and using nationally harmonized UIC, this work will extend to support for M&E of PrEP Implementation, by using UICs assigned to KP starting at the “reached” stage of the prevention cascade. Burma PEPFAR will provide TA to improve coverage and quality of condom/lubricant use among all KP, with tailored prevention counseling services. PEPFAR will provide TA to ensure that adequate STI testing and management protocols are included as part of the comprehensive HIV/STI prevention services necessary for PrEP rollout.

Burma PEPFAR will provide TA on surveillance strategies to monitor STIs, including hepatitis B/C, given the rising importance of sexually acquired hepatitis C among MSM. Burma PEPFAR has already cited successes in using social media for reaching KP and increasing HIV testing yields, and as part of PrEP rollout, PEPFAR will provide TA on comprehensive social media health education campaigns to raise awareness of STIs, HIV testing options, and how to access PrEP, tailored to each of the KP populations. Importantly, as part of the advocacy for inclusion of PrEP in the national HIV prevention package, the PEPFAR program will provide TA on costing and planning for targeting PrEP to maximize its cost effectiveness for sustaining epidemic control in the long run.

HIV prevention for PWID depends on MAT and NSEP. PEPFAR will place particular emphasis on improving coverage and quality of harm reduction services to better engage PWID. Challenges to methadone delivery arise as patients must travel far distances daily to methadone clinics. PEPFAR will work to introduce buprenorphine that can be administered for

2-3 days at a time in DSD sites to reduce clinic travel requirements. In 2017, the US FDA approved buprenorphine injections and implants that are effective for one month and six months, respectively. PEPFAR will facilitate Burma application of this potentially game-changing new technology.

4.3 Additional Burma priorities – TLD transition: To accelerate national TLD transition, Burma PEPFAR will provide TA on TLD supply chain management and TA through the Myanmar Medical Association for inclusion of TLD use in HIV care telementoring curriculum, and prioritizing TLD as the preferred first line regimen for at least all new ART initiates. In 2019, NAP executed a large procurement for TLE400, transitioning 70% of the national cohort from TLE600. Concurrently TA for switching any patients with non-suppressed VL or reporting efavirenz-related side effects to TLD regimen after adherence counseling and updating treatment guidelines and training clinicians on current best practices for using DTG-based regimens for patients on TB treatment and as part of informed choice for women of childbearing age.

4.4 Commodities: Burma PEPFAR foresees no shortages of commodities or stockout issues.

4.5 Collaboration, Integration, and Monitoring: Burma PEPFAR plans to partner with the NAP, the National Health Laboratory, the GF, the Access to Health Fund, civil society, clinicians, and NGOs to help bring the HIV epidemic under control by 2020 by playing to the strengths of various stakeholders.

Burma PEPFAR will support strategic innovations to improve targeting and impact. Managers from PEPFAR, GF, A2H and MOHS regularly meet to coordinate and collaborate through various meetings and fora, including the MOHS organized Technical Steering Group (TSG) meetings. Through TSG direction, and the MOHS guidance, a series of PSNU workplan meetings were held that used the latest epidemiological and program data to assess and map work in high priority SNUs. These workplans described work being done now, and gaps, both programmatic and funding, that need to be filled (Figure 1). PEPFAR's response is built upon the data and planning developed from this national collaborative effort.

At the site level, using the established Burma PEPFAR model of Innovate, Adopt, Amplify, PEPFAR will seek to leverage GF funding and the maturing civil society response in Burma, and coordinate with the significant GoB HIV program investments to help establish a comprehensive and sustainable HIV response.

Figure 1: PSNU Workplan (Burma)

Strategic Direction 2: Improving health outcomes for all people living with HIV							
SD 2.1 Maximize immediate enrolment, linkages and retention in ART and viral load monitoring							
Key Interventions		Sub activities	Timeline			Districts	Implementing Partner
			2018	2019	2020		
2.1.1	Rapid ART Initiation	A. Fast track counselling process, within 3 days B. Same day diagnosis & ART at mobile clinics for KPs and migrants in specified areas C. Support transport & accommodation for patients	Q3-Q4 Review feasibility of same day diagnosis & ART*	Q1-Q4 -Advocacy for transport & accommodation -Link with FBO accommodation	Q1-Q4	Bhamo*	MOHS
						Putao	MOHS, partners
						Myitkyina*	MOHS, AHRN. MDM
						Mohnyin	MOHS & AHRN, MSF-H and MDM
2.1.2	One Stop Service for PWID	A. Expand co-located ART site and MMT B. Linkage to NSEP C. ART initiation for PWID and their family at township level D. Clinical management training for health staff at ART site	Q3-Q4 Maintain existing activities	Q1-Q4 DC sites and MMT co-located (ie., Bamaw district)	Q1-Q4	Bhamo	MOHS
						Putao	
						Myitkyina	MOHS (NAP, DDTRU)
						Mohnyin	(Moegaung, Chaungwa, Lonetone, Numum, Karmine, Bangkok Tarmakhan Hupin, Namma)
2.1.3	One Stop Service for MSM (See SD1.1.3)	A. Key population service center for MSM (STI, condom, HTS, ART) B. Linkage with Peer network C. Clinical Management training for health staff at KPSC (satellite sites)	Q3-Q4 Peer Training & Team building	Q1-Q4 -Waiting Area -Reduce stigma discrimination	Q1-Q4	Bhamo	
						Putao	
						Myitkyina	MDM, PSI
						Mohnyin	PSI, MAM
2.1.4	One Stop Service for FSW (See SD1.1.3)	A. Key population service center for FSW (flexible hours) B. Awareness raising for gatekeepers/entertainment owners C. Linkage with Peer network D. Clinical Management training for health staff at KPSC (satellite sites)	Q3-Q4 Peer Training & Team building	Q1-Q4 -Waiting Area -Reduce stigma discrimination	Q1-Q4	Bhamo	FSW network
						Putao	
						Myitkyina	PSI, MDM
						Mohnyin	PSI, MAM

4.6 Targets for scale-up locations and populations

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts (Burma)

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts			
Entry Streams for ART Enrollment	**Tested for HIV (APR FY20) *HTS_TST***	**Newly Identified Positive (APR FY20) *HTS_TST_POS***	**Newly Initiated on ART (APR FY 20) *TX_NEW***
Total Men	**21,702**	**3,945**	**2,745**
Total Women	**4,949**	**904**	**683**
Total Children (<15)	**357**	**76**	**55**
Total from Index Testing	**2,765**	**832**	**N/A**
Adults			
TB Patients	***0***	**0**	**0**
Pregnant Women	***0***	**0**	**0**
VMMC clients	***0***	**0**	**0**
KPs	***18,120***	**4,115**	**2,840**
Priority Populations	***0***	**0**	**0**
Other Testing			

Previously diagnosed and/or in care	***0***	**0**	**0**
Pediatrics (<15)			
HIV Exposed Infants	***0***	**0**	**0**
Other pediatric testing	***357***	**76**	**55**
Previously diagnosed and/or in care	***0***	**0**	**0**

Standard Table 4.6.3 Target Populations for Prevention Interventions (Burma)

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	Population Size Estimate* (scale-up SNUs)	Coverage Goal (in FY20)	FY20 Target
FSW	23,939	41%	9,928
MSM/TG	51,311	19%	9,541
PWID	60,796	14%	8,483
TOTAL	136,046		27,952

*Available PSE data is State and Regional level and our PSNU are at township level and we are not working in all townships of those State and Regions. Note: FSW and MSM/TG PSE from Yangon and Mandalay Region and PWID PSE from Kachin, Shan (N) and Sagaing

Tier 1: KYRGYZ REPUBLIC

4.1 Finding the missing, getting them on treatment, and retaining them: With PEPFAR support, the Kyrgyz Republic implements several case-finding modalities, including facility index testing, assisted partner notification and testing at the community level, peer driven networks, social media outreach and community mapping. Self-testing is being initiated in ROP18, and recency testing will begin in ROP19 with PEPFAR support. There are still approximately 1,919 undiagnosed PLHIV, and many of these are likely long-term external migrants and current or former KP and their sexual partners.

Case Finding: As expected, index testing has produced the highest testing yield of the case finding modalities implemented in the Kyrgyz Republic. Index testing is done routinely at the facility as part of the epidemiological investigation shortly after HIV confirmation, with additional partner elicitation done periodically thereafter. However, partners are elicited from only around half of new PLHIV; the ratio of index cases to partners is approximately one to one. PEPFAR will assist RAC to strengthen this investigation to boost partner elicitation and notification approaches, training of health staff on client and key populations centered approaches to index testing, and standardization of partner elicitation at regular intervals after treatment initiation.

In a KP-driven epidemic with high levels of stigma, PLHIV are unlikely to divulge some partners to a facility health care worker, even in a client friendly environment. This includes MSM partners of those in heterosexual marriages, casual sexual partners, and injecting drug partners. In response, PEPFAR introduced community index testing (CIT) as an element of adherence support in ROP17. KP Peer Navigators (PN) establish a relationship with PLHIV clients as they provide ART education, assist with navigating treatment initiation, and support them over time to achieve viral suppression. As they build a trusting relationship, they are able to elicit these hidden partners and conduct Assisted Partner Notification (APN) to notify and test partners. This was a new activity for KP CSOs, and they were initially skeptical about the effectiveness

and appropriateness of the method. As they have seen the case finding results, however, PNs are now motivated to conduct CIT. The PEPFAR IP will identify high-performing PNs who will mentor their colleagues. CIT has been expanded to all PEPFAR-supported CSOs and the target for the proportion of new cases reached through index testing will be increased PLHIV CSOs which are not specifically KP oriented will be supported to conduct CIT among non-KP newly identified PLHIV. PEPFAR also will provide TA to GF-supported CSOs outside of PEPFAR SNUs to implement CIT.

Supportive policies for self-testing are being developed, and the Kyrgyz Republic, with the support of PEPFAR, is currently introducing self-testing for MSM and TG individuals on a small scale in Bishkek and Osh. PEPFAR will support expansion of self-testing among MSM and partners of PLHIV, with a focus on linkage of clients to prevention or treatment services, as appropriate.

PEPFAR introduced a peer-driven approach among PWID in Central Asia in June 2016. Although the average yield of 2.5% appears low, it is more than 10 times higher than the country's adult general HIV prevalence of 0.2%. To continue case finding among KPs, this modality will be strengthened and targeted: high performing PNs will be recognized through salary increases, and risk assessments will be strengthened in order to identify other risks associated with HIV (such as migration). Geographic areas with consistently low yield will stop PDO.

In FY19 PEPFAR introduced provider-initiated facility-based testing for patients at high risk of HIV infection, manifested by AIDS-defining illnesses such as herpes zoster or conditions associated with HIV such as viral Hepatitis infection. The national HIV clinical protocols contain a list of medical conditions considered as a subject for HIV diagnostic testing. The percent positive yield from this testing in Q1 2019 was 3.7% and will be continued in ROP19 with continuous analysis of results for high yield conditions and sites.

PNs were equipped with tablet computers using ROP18 funding. The tablets can produce geolocation of a client who tested positive through community-based rapid testing. Using geolocation, the peer navigators will conduct more targeted testing in the area. This will replace the community mapping modality which was used previously, in which PNs attempted to find and map "hotspots" of injection drug use through conversations with local people (e.g., shopkeepers, residents). The yield of community mapping was very low, but it did lead to some new networks, providing seeds for PDO. It is expected that geo-mapping will be a more efficient way to do this.

In addition to these case finding modalities, recency testing will be supported in PEPFAR SNUs in ROP19, which will allow the Republic AIDS Center and CSOs to target specific communities for HIV testing. Patients diagnosed with recent infections will be prioritized for enhanced case finding approaches. When new cases are identified, facilities will work with community partners to support index partner and network testing and target locations and populations for where increased testing approaches should be applied. Recent infections will also be geo-mapped.

All PEPFAR testing activities align with WHO's 5 Cs: informed consent, confidentiality, counseling, correct test results, and connection/linkage to prevention or treatment. As PEPFAR activities are expanded, the team will ensure that these key components are preserved and further institutionalized.

The World Bank estimates that 10% of adult Kyrgyz citizens work outside of the country at any given time. There is persistent concern about HIV incidence among labor migrants, who are thought to engage in high-risk behavior while away from their families. Migration to Russia is a particular concern due to the high HIV prevalence, lack of access to HIV services, and a policy of deportation for non-citizens who reveal their status. There is limited data available on migration, and Kyrgyz Republic's KP-focused HIV interventions are not designed to reach this population. In ROP19, PEPFAR will provide technical assistance to identify migrant men and women who engage in high-risk behaviors while abroad, including working with facility and community-based testing providers to identify migrants and partners of migrants during index case review, and collecting and analyzing risk information on migrants at the community and facility level. This risk data will allow PEPFAR and RAC to effectively work with faith-based and local community partners and IOM and utilize social media and networking strategies to reach high risk migrants. With UNAIDS support, the Kyrgyz Republic is planning a formative assessment among migrants in FY20; this survey will provide important information about the HIV risks and prevalence among this group.

Treatment Initiation: Immediate start of ART after diagnosis reduces LTFU between community testing, confirmation, and treatment initiation. High-quality standardized treatment counseling by PNs is needed as well as policies and procedures in place for immediate treatment initiation. RAC will work closely with CSOs and primary health care facilities to introduce procedures for tracking patients from diagnosis to treatment. The new PEPFAR TA Award will pilot a peer-driven intervention to improve ART initiation and retention and adherence for PLHIV with unsuppressed VL. Patients will be invited to join regular, structured sessions led by trained, facility-based peer counselors (PC). PC training will focus on ART and opportunistic infections, STIs, sexual and reproductive health and rights, HIV-related legislation, and post-diagnosis well-being. PC will support PLHIV at public health facilities and improve treatment literacy, adherence, retention, and physical and psychosocial well-being. Separate PC-led groups will be held for young PLHIV, women living with HIV, and PWID. The TA award will develop a comprehensive M&E system, including a mobile data collection application for PC for tracking the number and frequency of PC sessions for each patient, linking data on session attendance with patient outcomes. The TA award will ensure all PC training/work complements work supported by USAID/PSI in the region.

At the community level, treatment education provided by PNs to clients before providing rapid testing at the community level will be strengthened. All cases of loss to follow-up between screening at the community level, confirmatory testing and treatment initiation will be analyzed by gender, age, SNU, NGO, and PN to develop corrective actions. Advocacy for decreasing the time between initial positive test and treatment initiation will be conducted to allow for implementation of same-day initiation. Education for clients on pre-ART community care and

support will include messages about U=U, same-day treatment initiation benefits, and TLD benefits. Risk assessment for clients before testing will include questions about history of migration and plans to migrate in the future. In case of such plans, clients will be informed about possibilities of MMS for six months.

Treatment Adherence/Viral Suppression: The National Plan on Retention was developed based on the increasing need to address ART adherence issues in the country. According to the RAC (2017), 18% of PLHIV dropped out of treatment after one year, and the delay in initiating treatment was unacceptably high, from six months to three years. Drug resistance was found in 20% of patients (RAC, 2018). The National Plan on Retention for 2018-2021 was approved by MOH Order in December 2018 to address these issues and support implementation of the National HIV Strategy.

Activities on different levels (policy, service delivery) in three major areas include: (1) improvement of service delivery and access to health systems, (2) provision of case management and social support of PLHIV, and (3) building an enabling environment for HIV treatment and care programs.

At the health systems level, capacity building of health providers and social workers in case management, data quality, monitoring, and the introduction of performance-based financing are planned. Currently the Order on HIV Services Decentralization is under MOH approval. This Order ensures a full-time staff member for health care facilities covering 200 PLHIV. The plan focuses on ensuring sustainability of support programs for PLHIV through introduction of social procurement mechanisms, social worker positions in the facilities, and strengthening partnerships with local administrations. To address stigma and discrimination, the country plans to improve accountability and transparency through local level supervisory boards, education of health providers on stigma and discrimination, and documentation of human rights violations.

Kyrgyz Republic has an ambitious TLD transition plan, which will start in May 2019 with the arrival of the first shipment of TLD. In order to achieve this, they will need GF buy-in and supply chain support for forecasting, budgeting, storage and distribution of ART. PEPFAR will continue to work with the GF Portfolio Manager and GF IPs to ensure an aligned and determined strategy. Additionally, PEPFAR will engage specialized support to provide the improved supply chain strengthening needed to achieve the Minimum Requirements related to treatment and viral suppression.

Kyrgyz Republic currently has restrictions on the use of Dolutegravir among women of childbearing potential. The RAC has agreed to address this before the end of the year to align with international standards of informed choice and PEPFAR will support this policy change. PEPFAR will expand the successful models of facility and community adherence support. Nurse-led case management will be expanded to non-PEPFAR sites through provision of training and TA. At the community level, PEPFAR can assist the RAC in rolling out community-based ART, as well as engaging community-based treatment supporters to improve adherence. Non-KP PLHIV

often do not feel comfortable utilizing KP peer navigation services. PEPFAR will move beyond the currently funded local KP-led CSOs in ROP19, supporting non-KP PLHIV CSOs s and/or non-KP PNs to the current CSOs to provide community adherence and retention support to non-KP, especially those newly initiating treatment and those with poor adherence. This will be done through PLHIV PNs providing ART education based on U=U, escorting to the appropriate HIV related services, referring to additional medical (TB, STI, MAT) and social services, as needed, and community adherence support groups. Additional case management services for PLHIV on MAT will be provided by group and individual counseling.

The current RAC policy MMS strategy is to supply up to three months of ART to stable patients. RAC is committed to increasing this to six months MMS before the end of the year, in line with WHO standards. PEPFAR will support this policy change and implementation and advocate for up to 12 months' ART for those who will migrate for labor for an extended time.

Currently 86% of those on ART have access to viral load testing, with reagents being procured by the Global Fund program. In order to reach 95% access by 2020, RAC will initiate discussions with the National TB Program to expand the use of GeneXperts currently serving TB centers to include HIV VL testing in the areas not covered by GeneXperts for HIV VL testing. There are currently four GeneXperts for HIV VL testing at PEPFAR SNUs, and more GeneXperts in TB centers throughout the country. Sharing GeneXpert machines for HIV VL will greatly increase VL testing capacity. RAC will also continue strengthening the transportation system to improve access to VL testing through potential private sector partnerships.

4.2 Prevention, specifically detailing programs for priority programming: The Kyrgyz Republic will initiate PrEP among a small number of sero-discordant couples, MSM and TG in Bishkek and Osh in ROP18. In ROP19, PEPFAR will support increased availability of PrEP for all sero-discordant couples and high risk MSM and TG. Current PEPFAR MSM social media programming will be expanded to include messaging about the benefits, feasibility and availability of PrEP for high risk individuals. Additionally, PEPFAR will work with GF and other partners to advocate for community distribution of PrEP, particularly for MSM and TG individuals who are most hesitant to visit government facilities routinely.

PEPFAR will continue to ensure linkage to prevention services for those who test negative. Harm reduction, including MAT, is a critical component of keeping HIV-negative PWID uninfected, supporting HIV-infected PWID to adhere to HIV treatment, and achieving high viral suppression rates. PEPFAR will continue to coordinate with the GF and other partners to ensure that HIV negative key populations receive harm reduction services and commodities, such as needle exchange and condoms, and community-level PNs will provide MAT adherence support, referring clients to these services, escorting them when necessary. PEPFAR will continue to advocate for increased government scale up and funding of MAT services.

Coverage of PWID with MAT is still low, accounting for 4.4% of estimated PWID in the Kyrgyz Republic. There are 26 MAT sites, 24 of which are located in PEPFAR priority SNUs. The MOH has endorsed and officially approved take-home doses of methadone for up to five days for

stable MAT patients. Currently 36% of MAT patients have been prescribed these take-home doses, facilitating high retention rates (more than 95%) among those patients.

Adherence to HIV treatment among PWID/PLHIV who are on MAT has improved and now stands at 92.4%. However, there is a critical need to advocate for MAT to make it more widely available since Kyrgyz Republic is highly influenced by Russia where MAT is illegal and highly stigmatized. Site-level support by PEPFAR will fill critical gaps in services to PWID. Site-level support will also demonstrate effective models of low threshold, high-volume MAT, and new models of successful referral of PWID to MAT by strengthening community-facility collaboration and increased retention through investments in evidence-based psychosocial support models. PEPFAR will continue provision of the one-window approach and MAT sites of excellence to promote client-friendly services for PWID who are on ART/TB/MAT and to increase the coverage and retention rates among PLHIV on ART and MAT.

Key stakeholders raise serious questions about the sustainability of HIV prevention, care, and treatment services (including MAT in the community and penitentiary system) in the Kyrgyz Republic, especially as the GF significantly reduces its financial contribution to the country, and plans a gradual transition to government funding for those services. To address this challenge, PEPFAR will continue to participate in the multi-sectoral working group, which is developing a Road Map for increase of government funding in order to gradually transition from donor funding to state funding for HIV/AIDS programming.

4.3 Additional country-specific priorities listed in the planning level letter: As described above, Section 4.1., Kyrgyz Republic has developed the National Plan on ART Retention. Activities on different levels (policy, service delivery) in three major areas include: (1) improvement of service delivery and access to health systems, (2) provision of case management and social support of PLHIV, and (3) building an enabling environment for HIV treatment and care programs. At the health systems level, capacity building of health providers and social workers in case management, data quality, monitoring, and introduction of performance-based financing are planned. The plan focuses on ensuring sustainability of support programs for PLHIV through introduction of social procurement mechanisms, social worker positions in the facilities, and strengthening partnerships with local administrations. To address stigma and discrimination, the country plans to improve accountability and transparency through local level supervisory boards, education of health providers on stigma and discrimination, and documentation of human rights violations.

UNFPA recently conducted studies on STI among KP. The main finding was under-reporting of STIs, and data triangulation showed that the actual epidemiology of STIs is not reflected in the reporting system. It was agreed to update clinical protocols on STI as well as improve STI surveillance and harmonize this program with TB, HIV, reproductive health and other programs. PEPFAR will continue to be involved in and support this process.

Based on the ROP17 POART findings and ROP18 performance analysis and discussion, case finding modalities will be modified. Non-KP local CSOs will be engaged to provide community-

assisted partner notification and adherence and retention support for non-KP PLHIV. Additionally, above-site support for supply chain strengthening and financial sustainability will be introduced through engagement of specialized IPs. In particular, the Health Policy Plus project will increase its work with the RAC on finding efficiencies, increasing domestic spending, and supporting CSOs.

During the ROP19 Asia Regional OU meeting in Bangkok in April 2019, the MOH committed to reaching 90-90-90 goals by 2020. In the weeks following the Bangkok meeting, PEPFAR worked with the RAC to review the current progress towards 90-90-90. Key activities included reviewing the draft Spectrum estimates for 2019, and calculating the targets to achieve 90-90-90 in 2020 in PEPFAR SNUs and the rest of the country. As the PEPFAR program accelerates to help the country meet this ambitious goal gaps must be addressed along the cascade. 75% of currently estimated PLHIV know their status, only 60% are on ART and 82% have achieved viral suppression. The activities listed above are expected to accelerate case finding, linkage to care and adherence and retention.

Given the World Bank estimate that at any time approximately 10% of the adult population are labor migrants working outside the Kyrgyz Republic, PEPFAR and RAC adjusted the estimated PLHIV and 90-90-90 goals in the ROP19 DataPack to reflect this unreachable population. During ROP19 PEPFAR, RAC and the GF will prioritize reaching 90-90-90 for those who are not labor migrants living outside the country. PEPFAR will work with migrants that are planning to migrate or returning from migration with activities described in Section 4.1. Additional activities to address country-specific priorities are described in Sections 4.1 and 4.5.

4.4 Commodities: PEPFAR will procure additional rapid tests for confirmation to be used as an element of the updated HIV testing algorithm which will be revised by July. This will speed up confirmation and linking to care to pave the way for same-day initiation of treatment in communities. PEPFAR is also procuring tests for self-testing in Osh and Bishkek sites on a pilot basis. The Ministry Order on self-testing has just been approved and will be expanded to other sites after analysis of pilot results.

USAID supported an assessment of the existing LMIS systems for ARVs and anti-TB drugs in Kyrgyzstan, which identified an absence of officially defined reporting and requisition processes and forecasting guidelines for procurement of drugs and commodities for HIV and TB and lack of personnel trained specifically in procurement, logistics and LMIS management. PEPFAR is proposing to support TA in supply chain management for the Ministry of Health and RAC, including establishing a centralized procurement and logistics unit and information system, and training and forecasting systems tailored to MMS (six months), TLD transition, and decentralization of services--including rollout of community-based ART.

4.5 Collaboration, integration, and monitoring: The Kyrgyz Republic PEPFAR team works closely with the Global Fund Principal Recipient, UNDP. The attendance of the RAC Director and the new Fund Portfolio Manager at the ROP19 meeting in Bangkok, and high-level dialogue between S/GAC and the GF in Geneva is expected to lead to further alignment of a shared

vision of moving to 90-90-90 by 2020. Specifically, it is expected that both agencies will immediately advocate to and support the RAC in the TLD transition and meeting the Minimum Requirements. Additionally, both agencies will focus on working with RAC to find efficiencies, including targeting interventions towards key populations and decreasing remaining barriers to same-day initiation of treatment.

Beginning in ROP18, the PEPFAR team will work with IPs on improving risk assessment and reporting and analysis of resulting data. This will be added to routine data collection and review which is done in meetings with IPs. These meetings will continue to take place weekly with the largest partners and at least monthly with small IPs. The PEPFAR team will continue to ensure that IP workplans are aligned with PEPFAR program planning, targets, budgets and strategies for accelerated results at site and above-site levels.

PEPFAR will continue to support improving integration of key health system interventions, particularly lab and VL activities, across the cascade. As described above, PEPFAR will also assist RAC and other partners to improve the quality and efficiency of service delivery through improved models of care delivery across community and facility sites.

4.6 Targets for scale-up locations and populations

4.6.1 Kyrgyz Republic Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts

Entry Streams for ART Enrollment	***Tested for HIV (APR FY20) HTS_TST***	***Newly Identified Positive (APR FY20) HTS_TST_POS***	***Newly Initiated on ART (APR FY 20) TX_NEW***
Total Men	**1,821**	**329**	**920**
Total Women	**906**	**171**	**465**
Total Children (<15)	**0**	**0**	**0**
Total from Index Testing	**1,420**	**304**	**200**
Adults			
TB Patients			**75**
Pregnant Women			**5**
VMMC clients			**0**
Key populations			**200**
Priority Populations			**0**
Other Testing			**170**
Previously diagnosed and/or in care			**935**
Pediatrics (<15)			
HIV Exposed Infants	NA	NA	NA
Other pediatric testing	NA	NA	NA
Previously diagnosed and/or in care	NA	NA	NA

Table 4.6.2 is not required.

4.6.3 Kyrgyz Republic Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (scale-up **SNUs**)	Coverage Goal (in FY20)	FY20 Target
KP_PREV (PWID)			
TOTAL	**18,550**	**0.8%**	**141**

Tier 1: NEPAL

4.1 Finding the missing, getting them on treatment, and retaining them ensuring viral suppression: PEPFAR will accelerate and intensify HIV case finding, enrollment in treatment on the same day or within seven days, and support for VL testing, adherence, and retention for viral suppression. Within the cascade, PEPFAR will focus on the technical priorities that are anticipated to have the highest return for epidemic control.

To accelerate case finding, PEPFAR will continue to refine targeted, differentiated testing strategies, focusing on "low testing and high-positivity rate" approaches. This will include: (1) rapidly expanding and achieving saturation of index testing for all KP in PEPFAR-supported districts, and (2) providing TA for the intensification and improved quality of index testing in GF/GON districts, which currently has a positivity rate of 11% versus 40% in USG districts. PEPFAR will provide TA to the GON to develop index testing guidelines with steps to follow for implementation, reporting and monitoring. Based on the introduction and implementation of several new testing strategies in PEPFAR-supported districts in FY18Q4 and FY19Q1, index testing has the highest positivity rate and will help to rapidly accelerate case finding. Other new strategies include:

- Reaching new, hard-to-reach and hidden networks of KP, PP, and individuals who engage in high-risk behavior through mapping (virtual and physical) and enhanced localized/hotspot level micro-planning;
- Use of social media, online risk assessment and appointment-booking tools to reach deeper into KP networks, generating positive seeds for further index testing:
- Targeted HIV testing; community-based testing, self-testing (to be scaled up in PEPFAR-supported sites and nationally after product approval;
- Pro-positive network referrals and adaptive enhanced peer outreach approach (EPOA);
- TA for the introduction of recency testing nationally and support to select underperforming non-USG-supported sites to improve KP- and PLHIV-friendly services.

PEPFAR also will provide TA to the GON and GF to implement PrEP nationally for high-risk subgroups and will provide PrEP to high-risk subgroups in PEPFAR-supported sites. All sites will use GON-procured commodities.

For treatment enrollment, Nepal PEPFAR will focus on ensuring that as case finding accelerates, the program able to enroll new cases on treatment the same day or within seven days of diagnosis. In PEPFAR districts, PEPFAR will accelerate and institutionalize same-day ART initiation, which, while currently low, is improving (from 4% in FY18Q4 to 12% in FY19Q1). PEPFAR will work with the GF/GON to provide TA to improve same-day ART initiation, or initiation within seven days, in non-USG-supported districts. The primary strategy to achieve this is weekly partner management and monitoring of case finding and initiation on treatment per KP and per geographic area, coupled with intensified peer navigation and targeted interventions where problems are noted. In addition to linking new cases to treatment, Nepal must initiate treatment for approximately 4,400 PLHIV who know their status but are not on treatment. In PEPFAR-supported districts, peer navigators will intensify efforts to enroll PLHIV who already know their status on treatment. Furthermore, coordination and collaboration will be done with PLHIV-led CBOs and national networks of PLHIV.

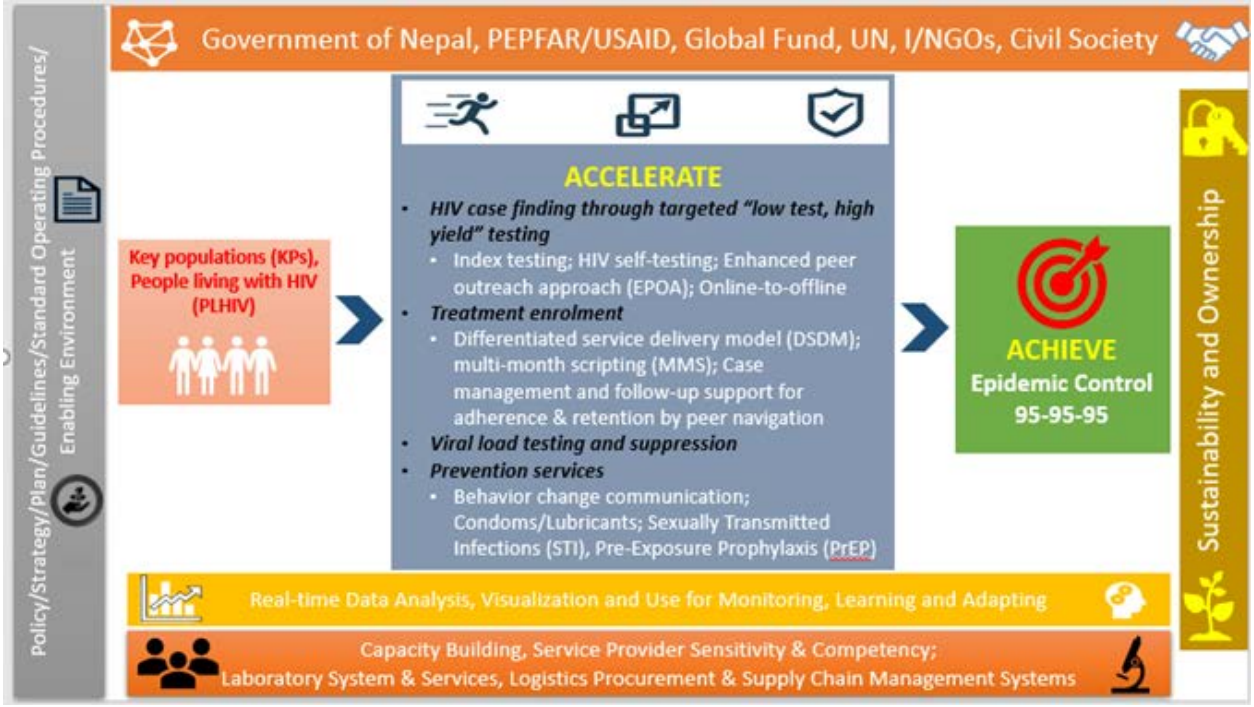
Twelve-month retention on treatment in PEPFAR-supported districts is 94%, versus 88% in other districts. VL suppression is 91% nationally among those tested. PEPFAR will continue to support enhanced peer navigation in order to maintain high levels of retention and adherence and contribute to VL suppression. PEPFAR will also advocate with the GON and provide TA to the GF/GON for the national implementation of community-based ART. PEPFAR will support community-based ART in 12 sites (compared to one site last year). Additionally, both PEPFAR and the GF will provide TA for the TLD transition. PEPFAR will advocate for six-month MMS (or 12 months for out-migrants to India or other countries) in both USG- and non-USG-supported districts and will implement MMS in USG-supported districts. PEPFAR will provide TA at 28 facility-based ART sites in 19 districts to ensure that these sites are KP- and PLHIV-sensitive and provide friendly services and support. PEPFAR will also promote treatment literacy, “Undetectable = Untransmittable” (U=U), and provide support for strengthening capacity of services providers for VL testing and use of VL data in monitoring of PLHIV on ART.

If Nepal is successful at increasing case finding and enrollment on treatment, there will be a need to triple the country’s capacity to conduct VL testing. PEPFAR, in coordination with GF, will provide TA to optimize the VL testing network and address the bottle necks. PEPFAR will also address the shortage of VL machines by coordinating with the TB program to use GeneXpert machines in isolated areas, advocating to reduce sub-optimal use of existing machines, and supporting the repair of non-functional machines, as well as ongoing maintenance. In collaboration with GF, PEPFAR will provide TA to the GON to address issues related to procurement and supply chain management. PEPFAR will provide support to the government for DBS scale-up in certain geographic areas. PEPFAR will also provide support to improve the availability of trained human resources and mobilize peer navigators and CSOs for sample collection and travel.

4.2 Prevention, specifically detailing programs for priority programming: Nepal will continue to focus on KP, including FSW, MSM, MSWs, and TG, as well as other PP, including clients of FSWs, adolescent girls and young women, spouses, and high-risk males and females (many of whom do not self-identify themselves as KP). The program will prioritize the prevention cascade

to close the gap on new infections for epidemic control. Nepal will especially target PPs with combination prevention. Nepal's PEPFAR team will reach new, hard-to-reach and hidden networks of KP, PP, and other high-risk people through virtual and physical hotspots with use of the MeroSathi (My Friend) web tool for online risk assessment, prevention messages, and links to treatment.

For both KP and PP, differentiated prevention efforts will be supported. Interventions will include SBC, including consistent correct condom use, promotion of regular HIV testing and STI check-ups, safer sexual behaviors, and orientation on diverse sexual orientation and gender identity to reduce self-stigma among KP; ART provision and adherence support; PrEP for high-risk individuals; HIV testing services (HTS); and alcohol/drug harm reduction. In addition, KP will have access to semi-annual HIV testing, syndromic STI management, and HIV self-testing.



4.3 Additional country-specific priorities listed in the planning level letter (N/A)

4.4 Commodities: The GON has committed to funding and procuring 100% of ARVs by next year, along with test kits and other commodities (previously procured by the GF). This transition has led to some delays in procurement, and a shortage of HIV test kits mainly Unigold, Statpack, rapid plasma reagent test kits and VL testing reagents in FY2019. This has been gradually improving with TA from the GF. The USG and GF have agreed to hold a stakeholder meeting in May/June 2019 to address performance issues and opportunities, and to realign if necessary. One of the identified issues to discuss is how to ensure that partners collectively provide adequate, high-quality TA on procurement and commodity logistics to the GON.

4.5 Collaboration, integration, and monitoring: The PEPFAR program works under the leadership of the NCASC, and will maintain close coordination and collaboration with NCASC, NPHL, Save the Children/Global Fund, UNAIDS, UNICEF, WHO, and other key stakeholders at national, state, and local levels for institutionalization of HIV self-testing, index testing and PrEP in the national HIV response, strengthening ART services, TLD transition, MMS, community-based ART service delivery, strengthening procurement and supply management system, development and implementation of online and real-time national HIV information and management system with UIC, and other interventions. USG and USG project staff will support and participate in national and provincial level planning, sharing, review and coordination meetings. These coordination and collaboration efforts will support NCASC, NPHL, and other local entities to manage a strong and coordinated national HIV response.

Regular supportive supervision, onsite coaching and mentoring, monitoring, performance review, and assessment across the CoPCT cascade of services will be conducted on a weekly basis in USG-supported sites.

The USG and GF in Nepal have agreed to joint program monitoring using common indicators on a quarterly basis, and joint corrective actions to address low performance and opportunities.

4.6 Targets for scale-up locations and populations

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients (Nepal)

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts			
Entry Streams for ART Enrollment	**Tested for HIV (APR FY20) *HTS_TST***	**Newly Identified Positive (APR FY20) *HTS_TST_POS***	**Newly Initiated on ART (APR FY 20) *TX_NEW***
Total Men	**23,935**	**912**	**1,155**
Total Women	**16,093**	**609**	**770**
Total Children (<15)	**966**	**30**	**36**
Total from Index Testing	**4,549**	**905**	**860**
Adults			
TB Patients			
Pregnant Women			
VMMC clients			
Key populations	**26,160**	**610**	**580**
Priority Populations	**8,551**	**300**	**285**
Other Testing (Index testing)	**4,450**	**581**	**552**
Previously diagnosed and/or in care	**NA**	**NA**	**472**
Pediatrics (<15)			
HIV Exposed Infants			
Other pediatric testing	**966**	**30**	**28**
Previously diagnosed and/or in care	**NA**	**NA**	**8**

Table 4.6.2 is not required for countries with no VMMC investments or targets.

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control (Nepal)

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate** (scale-up **SNUs**)	**Coverage Goal (in FY20)**	**FY20 Target**
FSWs (KP_PREV) MSM/MSWs and TG people (KP_PREV) Clients of FSWs, high risk male and female, migrants and prisoners (PP_PREV)	**41,562** **80,733** **NA**	**60%** **60%**	**24,754** **48,440** **20,000**
TOTAL	**122,295**		**93,194**

4.7 Cervical Cancer Program Plans: N/A

4.8 VL and Early Infant Diagnosis Optimization: GON has only three functional VL machines (in Kathmandu and Kailali), and recently installed an additional two VL machines in two districts (Kaski and Morang). Discussion at the national level is ongoing for use of GeneXpert platform (used by the TB program) for VL testing and maximizing the use of existing machines. EID service is available from districts laboratories with sample collection and PCR testing is done at NPHL, Kathmandu. In PEPFAR districts, PEPFAR supports the collection of DBS at the district level, as well as sample transport to NPHL.

Tier 1: TAJIKISTAN

4.1 Finding the missing, getting them on treatment, and retaining them ensuring viral suppression: Tajikistan has made limited progress towards the first 90, with only about half (6,903) of total estimated PLHIV 15+ (12,291/2019 Spectrum estimate) receiving an HIV diagnosis (EHMCS data as of February 2019). The country still has not yet diagnosed an estimated 6,018 PLHIV 15+, and many of these are likely long-term external migrants, current or former KP, and their sexual partners.

Tajikistan has implemented multiple service delivery models for HIV case finding among KP, including community and facility-based testing, index partner testing, social network and mapping strategies, and enhanced peer outreach approaches. While some of these models have yielded higher (5% to 20%) positivity than the general population HIV prevalence (0.23%), they have not achieved positivity yields approaching the HIV prevalence we see in the PWID (11.9%) population in Tajikistan.

Tajikistan will work with PEPFAR in ROP19 to improve case finding using more effective outreach and testing strategies for KP including PWID, their partners, and migrants. PEPFAR will assist the RAC to enhance the epidemiologic investigation of newly diagnosed PLHIV in order to tailor case finding through an improved understanding of the local epidemiology and identification of pockets of unfound cases. The enhancements include better risk elicitation to identify probable mode of transmission, improved partner elicitation and use of recency testing to identify newly infected PLHIV.

Tajikistan will also review and revise its strategies for voluntary index partner testing, a primary focus of PEPFAR support in ROP19. PEPFAR will support new approaches to implement index testing at community and facility level that identify and reach more partners, especially in cases where recency testing shows recent infection.

PEPFAR will support sites to improve partner elicitation and notification approaches at the facility level, and training of health facility staff on client and KP-centered approaches to index testing. In addition, PEPFAR will work with Tajikistan on improved methods for facility-based health care workers to assess and record risk behaviors. PEPFAR will also support partner self-testing strategies where feasible for those unwilling or unable to access current HIV testing services (e.g., MSM partners). PEPFAR will support Tajikistan to implement client-centered and KP-tailored index testing approaches focused on the needs and safety of the index client and his or her partner(s). All index testing services supported by PEPFAR will meet WHO's 5C minimum standards, including consent, counseling, confidentiality, correct test results, and connection to HIV prevention (for both HIV-positive and HIV-negative individuals).

PEPFAR will work with the RAC to recognize and formalize the roles of community organizations and civil society partners to implement and execute index partner testing. RAC facilities and community-based partners will be encouraged to develop local joint action plans and strategies to promote shared responsibility for index partner testing, adopting client-centered and KP focused approaches for epidemiological investigation, partner elicitation, and HIV prevention and testing to index partners and linkage to ART services for HIV-positive partners.

Tajikistan PEPFAR also will support recency testing in priority SNUs in ROP19, and patients diagnosed with recent infections will be prioritized for enhanced case-finding approaches. When new cases are identified, the facilities will work with community partners to support index partner and network testing and also target locations and populations where increased testing approaches should be applied.

PEPFAR will increase monitoring of index testing at supported sites in Tajikistan, including implementing monthly review of the percentage of index clients who accept index testing and the positivity rate of those tested through index testing at the facility and community testing sites. PEPFAR will support continuous quality improvement methods to ensure high-performing, high-yield index case finding sites are prioritized, and low-performing, low-yield sites are either remediated or eliminated.

In ROP19, PEPFAR will work with Tajikistan to strengthen several other HIV testing approaches, including expanding and strengthening risk assessments of social networks for partners of PWID and using social networking platforms to increase uptake of testing and index case finding among MSM populations.

Temporary labor migration of Tajik men to Russia remains a significant concern for Tajikistan due to the high HIV prevalence in Russia and the increased risk behaviors that are sometimes

associated with migration. In ROP19, PEPFAR will provide TA support to Tajikistan to better identify migrant men that engaged in high-risk behaviors while abroad. Key support strategies will include working with facility and community-based testing providers to identify migrants or partners of migrants during index case review, and collecting and analyzing data on migrants to understand the size and HIV prevalence in this population.

PEPFAR also will work with faith-based and local community partners to reach migrant men, and support the development and rollout of tailored social media and networking strategies to reach these men. HIV-positive migrants will be immediately enrolled in treatment and provided with six-month supply of ART to ensure they have access while abroad.

Tajikistan has made significant progress towards the second 90 since 2015, with nearly 80% of those diagnosed on ART as of February 2019. However, the current rate of progress will be insufficient to reach the second 90 by 2020 without several adjustments to program priorities. PEPFAR will continue to work with Tajikistan to adopt and utilize models that are more effective for initiating PLHIV, especially KP and their partners, on treatment.

While Tajikistan has adopted Test & Start and included it in the national clinical guidelines, several challenges remain to its implementation. Key barriers include inadequate and incomplete referral and linkage of KP at community outreach/testing sites, and health facilities and providers that do not sufficiently support KP needs.

To address inadequate and incomplete referrals from community sites, PEPFAR will review linkage data from PEPFAR- and GF-supported community-based IPs that use peer navigation strategies for KP to assess the success these organizations are having in linking and initiating newly diagnosed clients on ART. PEPFAR will support TA to improve the quality and capacity of these partners to achieve complete linkage and initiation on ART for individuals newly diagnosed through KP-focused community testing and index testing.

Tajikistan PEPFAR also will work with these partners to ensure that peer navigators and other CHWs are implementing a comprehensive and client-centered package of linkage services, including:

- Escort to HIV care facility;
- Treatment education/navigation;
- Peer-delivered case management;
- Telephone follow-up and/or text messaging;
- Psychosocial support and informational and motivational counseling on the benefits of disclosure and testing of sexual and injecting partners and ART initiation and adherence;
- Assessment and mitigation of real and perceived barriers to HIV care; and
- Systematic monitoring and evaluation of enrollment in HIV care and ART initiation outcomes.

PEPFAR will work to ensure the RAC is fully implementing Test & Start across all ART sites. This includes providing TA to health care providers on approved testing HIV algorithms, addressing stigma and discrimination barriers, and increasing awareness and understanding of the Undetectable=Untransmittable (U=U) message. PEPFAR will work with supported community IP to incorporate U=U in KP programs so those populations can understand treatment as prevention and seek HIV testing and ART treatment that will allow them to prevent HIV transmission to their partners.

Tajikistan made significant progress towards the third 90 since 2015; nearly 80% of those on ART have documented viral suppression as of February 2019. Key retention and adherence strategies that PEPFAR will prioritize in Tajikistan will focus on KP, especially PWID, and will incorporate differentiated service delivery models that best support these populations.

Currently, 90.1% (2,910) of patients are picking up their ART drugs on a quarterly basis, and 9.9% (320) on a semi-annual basis. In ROP19, PEPFAR will support Tajikistan to shift to six-month provision of ART among stable, virally suppressed patients. PEPFAR will support Tajikistan to complete the transition of most patients to TLD to improve retention and adherence outcomes going forward. In ROP19, PEPFAR will continue working with the Republican Narcology Centers to support medication assisted therapy (MAT) interventions for PWID PLHIV to improve retention and adherence.

Tajikistan PEPFAR also will support enhanced case management approaches at the facility and community level. At local RAC sites, PEPFAR will expand its nurse-led case management program, Support4Health, which has improved both new initiation of ART and viral load suppression among newly diagnosed PLHIV and those already receiving ART treatment but unsuppressed. The local RAC sites will also adopt a tracking log for missed appointments, and work with community organizations to bring LTFU patients back to treatment.

At the community level, PEPFAR will support enhanced peer navigation and case management strategies, including bolstering partner notification and disclosure activities that will help clients disclose HIV status to their sexual and injecting partners. PEPFAR-supported community partners will identify and locate PLHIV who fail to link and initiate ART, miss appointments, or fail to return to treatment.

During ROP19 stakeholder engagement processes, community and CSOs emphasized the need for the RAC to view them not only as service providers, but also as decision-makers critical to ensuring high-quality, client-centered ART services. As a result, PEPFAR will work with the RAC to recognize and formalize the roles of peer navigators and CHWs in supporting ART initiation, retention and adherence services. PEPFAR will work with facility and community-based partners to develop joint action plans and strategies to promote shared responsibility for linkage and initiation on HIV care and treatment services and adherence. PEPFAR also will work with the RAC and CBOs to use their electronic case registries to better evaluate the quality of linkage and ART initiation of HIV-infected individuals.

4.2 Prevention, specifically detailing programs for priority programming: In ROP19, Tajikistan PEPFAR will work with the RAC, IPs, and other stakeholders to prioritize locations/districts for prevention activities (syringe/needle exchange and condom distribution program) currently funding by PEPFAR and will develop a transitional plan for a smooth transition of funding for these programs to national or other donor funding. PEPFAR will support RAC to conduct a facility-level performance and demand analysis to determine which sites to retain in ROP19 and ROP20.

Tajikistan plans to rollout PrEP for up to 300 clients during 2020. In ROP19, PEPFAR will work with the RAC to revise national guidelines to include PrEP for discordant couples and KP. PEPFAR will use the USG/UNAIDS PrEP target-setting guide for KP to help Tajikistan estimate the number of individuals among KP who are at "substantial risk." PEPFAR will work with Tajikistan to assess potential for community-based PrEP among KP that do not want to use government facilities for this service.

In ROP19, PEPFAR will also continue to work with the Republican Narcology Centers to support MAT activities for PWID in PEPFAR-supported sites. However, PEPFAR's primary focus of MAT support will be for PLHIV PWID.

PEPFAR will work with facility and community IP to incorporate U=U into KP programs so those populations can understand treatment as prevention and seek HIV testing and ART treatment that will allow them to prevent HIV transmission to their partners.

4.3 Additional country-specific priorities listed in the planning level letter: Tajikistan has demonstrated progress over the last few years by updating and approving critical policies and guidelines to create the legal and policy framework to achieve 90-90-90. In December 2018, Tajikistan's MOH approved new national guidelines for immediate start of HIV treatment of all PLHIV regardless of CD4 count. PEPFAR will continue to support Tajikistan to roll out these policies and guidelines in ROP19, including those related to index testing, recency testing, and PrEP.

PEPFAR also will work with Tajikistan to rapidly transition most patients to TLD in 2020, including supporting supply chain and forecasting technical needs to ensure sufficient quantities of ART are procured by the GF.

As described in Section 4.1, PEPFAR will prioritize evidence-based approaches to index case finding, as well as work with Tajikistan to address barriers KP face in linkage and ART initiation and adherence.

Based on the ROP18 performance analysis, Tajikistan and PEPFAR will assess and modify case-finding modalities, as described in Section 4.1. Non-KP local NGOs will be engaged to provide community-assisted partner notification, adherence, and retention support for non-KP PLHIV. Additionally, above-site support for supply chain strengthening and financial sustainability will be introduced through engagement of specialized technical IPs.

During the ROP19 Asia Regional Operating Unit April 2019 meeting in Bangkok, the MOH committed to reaching the 90-90-90 goals by 2020. In the weeks following the Bangkok meeting, PEPFAR worked with the RAC to review current progress. Key activities included reviewing the draft Spectrum estimates for 2019 and calculating the annual targets to achieve 90-90-90 in 2019 and 2020 in both the PEPFAR SNUs and the rest of the country.

Given the World Bank estimate that at any given time, nearly one-third of men aged 20-39 are labor migrants that are working outside of Tajikistan, PEPFAR and the RAC adjusted the estimated PLHIV and 90-90-90 goals in the ROP19 Data Pack to reflect that this unreachable population. During RO19, PEPFAR, the RAC, and the GF will prioritize reaching 90-90-90 for those who are not labor migrants living outside of Tajikistan. PEPFAR will work with migrants that are planning to migrate or returning from migration with activities described in 4.1, below. Additional activities to address country-specific priorities are presented in Sections 4.1 and 4.5.

4.4 Commodities: Ensuring that patients have continuous access to ART and timely testing requires complex projections and calculations by program staff. It is becoming more challenging to make these predictions because new diagnostic devices rapidly increase the number of individuals diagnosed or followed up, which impacts the quantity of medicines needed. In addition, when treatment regimens change because new medicines (e.g., TLD) or guidelines (e.g., MMS) are introduced, national programs must carefully plan how to phase medicines in and out to minimize stock-outs or expiries. Frequent quantification and vigilant stock management are vital to ensuring that appropriate types and quantities of medicines are available to meet the evolving needs of HIV programs as they scale up treatment.

The GF has supported a series of workshops to provide Tajikistan with technical knowledge and skills in various areas of the procurement and supply management (PSM) cycle, Tajikistan periodically still faces to stock out of commodities, particularly for ARV drugs, laboratory commodities and test kits. In ROP19, PEPFAR jointly with IPs will review current Logistics Management and Information System for supply of ARVs for treatment and laboratory commodities for HIV/AIDS. PEPFAR also will support continued TA in forecasting and supply chain management. In addition, PEPFAR continues to develop and implement an electronic quantification and early warning system designed to improve procurement processes, ordering, and supply planning for HIV testing and treatment.

4.5 Collaboration, integration, and monitoring: The PEPFAR team works closely with UNDP, the GF implementing partner in Tajikistan. The attendance of the RAC Director and the GF at the PEPFAR Asia Region meeting in Bangkok and increased dialogue between S/GAC and the GF in Geneva will lead to further alignment of a shared vision of moving to 90-90-90 by 2020. Specifically, PEPFAR and the GF will immediately advocate to and support the RAC in the TLD transition and meeting the Minimum Requirements. Additionally, both agencies will focus on working with RAC to find efficiencies, including targeting interventions towards KP and decreasing remaining barriers to same day initiation of treatment.

The PEPFAR team will continue working with IPs on improving risk assessment and reporting and analysis of resulting data. This will be added to routine data collection and review, which is done in quarterly meetings with the IPs. Additionally, the PEPFAR team will continue to ensure that partner work plans are aligned with PEPFAR program planning, targets, budgets and strategies for accelerated results at site and above-site levels.

4.6 Targets for scale-up locations and populations

Table 4.6.1 Entry Streams for Adults Newly Initiating ART Patients (Tajikistan)

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts			
Entry Streams for ART Enrollment	**Tested for HIV (APR FY20) *HTS_TST***	**Newly Identified Positive (APR FY20) *HTS_TST_POS***	**Newly Initiated on ART (APR FY 20) *TX_NEW***
Total Men	7,939	1,452	1,685
Total Women	5,816	1,063	1,214
Total Children (<15)			
Total from Index Testing	7,054	1,512	1,436
Adults			
TB Patients			377
Pregnant Women			64
VMMC clients			0
Key populations			503
Priority Populations			0
Other Testing			1,318
Previously diagnosed and/or in care			637

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate (scale-up SNUs)**	**Coverage Goal (in FY20)**	**FY20 Target**
KP_PREV ***(PWID)***	6,823	6.5%	408
TOTAL			

(**Note: Standard Tables 4.6.2 and 4.6.4 are not required for Tajikistan**.)

Tier 1: THAILAND

4.1 Finding the missing, getting them on treatment, and retaining them ensuring viral suppression: Under the leadership of the Royal Thai Government (RTG), in partnership with strong CBOs, PEPFAR has contributed to increasing ART initiation trends for MSM and TGW over the past 5 years, notably in the 13 PEPFAR-supported provinces. ART initiation among HIV-positive MSM in the 13 provinces increased from 58% in 2017 to 88% in Q1 of FY19 and from 56% in 2017 to 77% among TGW. While the improvement is promising, there remain challenges with HIV case finding, SDART initiation, and VL coverage in these provinces and nationally. With accelerated PrEP and same-day ART, mostly led by KP at both facility and community level,

Thailand PEPFAR will actively employ evidence-based interventions to reach 90-90-90 in select high burden provinces, with the introduction of recency testing and intensification of index testing to close gaps within the cascade among PLHIV, TG, and MSM.

HIV case finding among MSM and TG will be strengthened in priority provinces through an intensified enhanced targeted outreach model that focuses on HIV-positive networks. PEPFAR continues to advocate for the inclusion of HIV self-testing in the national strategy in 2019, and continues to employ the use of HIVST within MSM and TG networks. With the addition of recency testing in ROP19, PEPFAR will be able to further narrow its focus on recent infections within its case finding efforts to identify geographic hot spots of ongoing transmission for rapid target responses. Another area of focus will continue to be on young MSM, those with STI, and those using amphetamine type substances—with demonstrated higher risk of acquisition and transmission. Other case finding strategies include on-line engagement, chat rooms, and dating apps with HIV testing promotion, on-line reservation systems linking to testing, and risk network and index testing where newly diagnosed HIV-positive individuals refer sexual partners and members of their social networks to HIV testing. These interventions will be offered through a KPLHS and KP competent facility-based approach and link HIV-positive individuals through peer navigators to facilities where clients obtain free ART.

In an increasing number of sites nationwide, many through PEPFAR support, SDART and extra hour MSM, TG friendly VCT clinics are offered to improve access to HIV testing and improved rates of ART initiation among newly diagnosed HIV-positive individuals. ART clients are supported for adherence through multiple modalities: counseling and toolkits, information to increase ART and VL literacy including U=U; escort, if necessary, for routine VL monitoring; telephone follow-up; SMS reminders; and 6-month MMS for stable PLHIV.

In COP19, PEPFAR will also support Case Managers within health facilities (or community organizations) to facilitate and strengthen linkage to treatment, re-engaging LTFU cases to treatment. Additionally, Thailand PEPFAR will ensure laboratory results are available by improving communication among laboratories and health care providers, and will introduce and implement VL electronic data exchange tools to facilitate the specimen request and result reporting process. The tools will decrease turnaround time, reduce missing data, and provide rapid results and alerts to health care providers and laboratory staff to follow up with patients. In addition, PEPFAR will ensure accurate and complete cascade data are available to providers and RTG stakeholders to ensure routine and joint program monitoring.

Although the Bangkok Metropolitan Authority (BMA) provides domestic funding support to non-Thai migrants, allowing equal access to ART for this vulnerable population in Bangkok, and the Thai government set up fast track one-stop service migrant registration to allow documented migrants to purchase migrant health insurance to benefit from health care services including ART, there are still high numbers of undocumented migrants, especially in Bangkok. PEPFAR will work with BMA, MOPH, and other partners to promote purchasing of the migrant health insurance card with low premium cost, and facilitate discussions on long-term plans to support this population. PEPFAR will also work with the local government of Bangkok

to improve retention in care by enhancing the quality of HIV and STI services, laboratory systems, and establishing effective referrals in the Bangkok health care system. Tracking of these migrants will continue to be challenging due to lack of effective unique identifiers.

4.2 Prevention, specifically detailing programs for priority programming: In addition to promoting core interventions critical to filling the gaps across the KP cascade of prevention and care services, consistent condom and lubricant usage is promoted among MSM and TGW. Since 2015, PrEP has been a major focus of PEPFAR and the RTG, as can be seen by the rapid uptake, and the Thai Ministry of Public Health commitment to making free PrEP available for all under the universal health care coverage (UHC) scheme by the end of 2020. Through a unique public-private partnership between PEPFAR and the Thai Red Cross, Tenofovir was provided by the Princess of the Thailand Royal family. This "Princess PrEP" collaboration has resulted in more than 3,000 individuals obtaining PrEP from KPLHS providers, contributing to over 50% of all new PrEP users in the country and serving as a catalyst for this critical intervention among MSM and TG. In addition, PEPFAR supports the Thai government and GF partners to integrate and expand PrEP in the routine facility-based HIV prevention services. The PEPFAR team expects that by 2020, at least one hospital in each province will be able to provide PrEP, and PrEP uptake will be monitored through national web-based monitoring system, which provide regular uptake reports and feedback for improvement to implementation sites.

Recognizing the unmet health needs of TG populations, PEPFAR supported Thailand's first TG - specific sexual health and wellbeing clinic in 2015, and has accelerated the expansion of this model, which offers a comprehensive, fee-based health service package. PEPFAR will invest further in this model to more than double PrEP coverage with the additional funding, and leverage other private contributions to ensure a differentiated service delivery package--including gender-affirmative hormone treatment, testing, management of STIs, vaccination for viral hepatitis A, hepatitis B and HPV, ART, and PEP.

As a result of additional funding made available to Thailand during the April 2019 ROP meeting, PrEP implementation will be further intensified in FY20 through the addition of new sites offering PrEP in KP-led facilities and additional TA to GF-supported sites, leveraging PEPFAR's investment in existing provinces. To further accelerate uptake, PEPFAR will support a targeted on- and off-line PrEP campaign as well as a national media campaign to socially norm PrEP in the MSM and TG communities, and introduce a focused "Standup Teen PrEP" intervention that will provide self-testing and PrEP to young MSM and TG, who are at greatest risk.

4.3 Additional country-specific priorities listed in the planning level letter: While already a regional leader in the national response to the HIV epidemic, the HIV policy environment in Thailand has improved even further in recent years, especially as it relates to the ROP19 Minimum Requirements as outlined in Appendix D. Following the results of a catalytic PEPFAR-supported HIV self-testing pilot, the Thailand MOPH approved self-testing for wider use starting in mid-2019. As mentioned earlier, as of April 2019, a cutting-edge policy was pushed forward and Thailand's FDA has approved the public sale of home HIV test kits via pharmacies. In ROP19, PEPFAR and other partners will be able to accelerate this HIV testing strategy and it is

hoped that Thailand will be the third country in Asia (after Vietnam and Laos) to endorse HIV self-testing as a national policy.

Additionally, the Thailand National Health Security Organization (NHSO) has substantially increased its reimbursements to local KPLHS organizations, replacing some of the PEPFAR support of the past several years. These additional investments of approximately $1.5 million in 2018 now support over 50% of the operational costs of several CSOs, allowing PEPFAR to transition to targeted TA support and demand-creation strategies. This also allows the Government of Thailand to grow independent, trusted partnerships with CSOs, with increased domestic financing as a fundamental element of the relationship. The partnership with CBOs is seen as mutually beneficial, with CBOs also capacitating larger "umbrella" organizations with community intelligence and expertise.

Thailand PEPFAR is advocating for a more rapid transition to TLD. The NHSO and the Thailand Government Pharmaceutical Organization (GPO) are reviewing the current ARV stocks, manufacturing plan, and timeline of TLD availability. The generic DTG will be registered to the Thai FDA in June 2019 and TLD in January 2020. It is anticipated that DTG and TLD will be registered in the national essential drug list and available in NAP system around January 2020 and July 2020, respectively.

In ROP 19, Thailand PEPFAR is also implementing the following key program approaches, as highlighted in the planning level letter. These key approaches include:

- Accelerated HIV case finding through index and self-testing, with greater focus on risk-referral network testing;
- Enhanced targeted outreach that focuses outreach in HIV-positive networks;
- Optimized HIV community-based index testing that includes an accelerated approach to self-testing in high-burden provinces with increased demand through on- and off-line promotions, pharmacy distribution points, and KPLHS;
- Pairing recency with index testing in order to identify and intervene with those most likely to transmit;
- Enhanced peer navigation to re-engage PLHIV LTFU to regular ART and VL monitoring; differentiated service delivery, particularly MMS and tailored TG services in an increased number of sites;
- Expanded PrEP uptake among most-at-risk HIV-negative MSM and TG in community and government clinic settings;
- Intensified PrEP adoption among MSM and TG through a targeted on- and off-line campaign to normalize PrEP;
- A focused PrEP service that will provide self-testing and PrEP to young MSM and TG; expanded SDART into an increased number of sites, and
- Continued advocacy for the "same-day" terminology instead of "rapid" (within seven days) in revised ART guidelines to ensure site-level implementation.

PEPFAR routinely holds meetings and data reviews with implementing partners. In addition, Thailand PEPFAR will immediately initiate biweekly data reviews and establish subsequent remediation plans with partners to ensure that acceleration areas are based on performance and achievements.

4.4 Commodities: Due to the strong coordination function of the RTG, Thailand PEPFAR projects no commodity concerns or stockouts.

4.5 Collaboration, integration, and monitoring: RTG is in a unique role this year as the ASEAN chair, and Thailand PEPFAR plans to leverage this regional leadership role. Thailand has multiple areas of expertise and will support the region and beyond in the following areas: SDART; index testing; PrEP expansion through private partnerships; facilitation of the ASEAN network to leverage price negotiation for ART and commodities; establishment of TA platform for TG health and HIV; initiation of a dialogue on regional HIV financing through World Bank.

Thailand PEPFAR will continue to support the MoPH to hold quarterly meetings with all HIV stakeholders. A PEPFAR representative sits on the CCM, where issues related to priorities and coordination are addressed. Furthermore, PEPFAR implementation partners meet regularly with the PR of the GFATM grants, Thailand MOPH and Raks Thailand Foundation, to share innovation successes, guidelines, and training materials. As per recent discussions with GFATM, PEPFAR and GFATM will plan in closer coordination during ROP19 to ensure quantifiable and synergistic coverage for maximum impact in the country.

To improve integration of key health system interventions, including HRH and laboratory VL activities across the cascade, PEPFAR plans to support implementation of the following approaches: building capacity of KPLHS sites resulting in the accreditation of selected sites, thus allowing reimbursement by the National Health Security Organization; supporting the placement of point-of-care machines in selected high-volume KPLHS sites for STI testing and VL monitoring; and supporting human resources at the community level to ensure the successful management of program data and fiscal information from KP-led community-based services.

To improve quality and efficiencies of service delivery through differentiated models of care across community and facility sites, PEPFAR supports the following approaches:

- Support CSOs that implement peer navigation as an integral component of the referral system to treatment in high-burden provinces;
- Ensure that clients initiating SDART gain adequate health literacy regarding ART and VL, are informed about U=U and its implications for their own health and the health of their sexual partners, and reach VL suppression;
- Ensure TG-competent services are expanded;
- Promote MMS.

To note, currently, over half of all facilities in PEPFAR-supported provinces now offer MMS for three or six months, as per national guidelines and the NAP system allows ARV dispensing for the maximum of six months.

To ensure that above-site activities are mapped to key barriers and measurable outcomes related to reaching epidemic control, Thailand PEPFAR works closely with the MoPH to update guidelines and advocate for policy change so that optimized HIV cascade interventions can be nationally institutionalized, implemented, and financed. Key barriers that have been recently solved or for which a solution or strategy now exists include:

- HIV self-testing: Self-testing is widely recognized as safe and effective as a result of the PEPFAR-supported catalytic pilot, which demonstrated high acceptance by MSM and TG, no adverse events, and the potential to reach highest risk KP. PEPFAR will monitor yield on a biweekly basis from this modality in ROP19.
- PrEP: Through PEPFAR support, affordable pricing of PrEP (50 US cents per day or free, at selected sites) is already available through a unique partnership with the Princess of the Thai Royal Family. PEPFAR and other donors continue to advocate for PrEP in the universal health coverage insurance scheme, and will closely monitor uptake of subsidized and free PrEP.
- TLD transition: The lack of TLD in Thailand has become an urgent priority for PEPFAR, and negotiations with the MOPH have secured a timeline for TLD introduction. As stated above, the Thailand FDA anticipates that DTG will be registered in June 2019 and TLD in January 2020. PEPFAR will closely monitor the rapid uptake of TLD in ROP19.

The Thailand Government has implemented HIV-related program monitoring, both facility and community, and HIV Case Reporting Surveillance. The national identification code has been used a standard UIC for vital registration, social welfare, and health services. The MoPH, supported by PEPFAR, has initiated an informatics system to harmonize data from these systems and is expected have access to comprehensive service delivery data along the community-to-facility cascade. In addition, an on-line dashboard has been established to summarize key indicators, ensuring timely and accurate program monitoring. In ROP19, UICs will be used by facilities and peer navigators to track testing, ART initiation, VL monitoring and suppression. These UICs and associated data are managed in eCascade, a system supported by PEFPAR, which allows the local organizations who serve clients to monitor performance.

4.6 Targets for scale-up locations and populations: The proposed targets (submitted in the DataPack) were developed based on OGAC guidance, program data, and previous performance, and are provided below.

Table 4.6.1 Entry Streams for Adults Newly Initiating ART Patients (Thailand)

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts			
Entry Streams for ART Enrollment	**Tested for HIV (APR FY20) *HTS_TST***	**Newly Identified Positive (APR FY20) *HTS_TST_POS***	**Newly Initiated on ART (APR FY 20) *TX_NEW***
Total Men	31169	3813	4,092
Total Women	8593	933	1,116
Total Children (<15)	-	-	-
Total from Index Testing	3520	1,021	-
Adults			
TB Patients			
Pregnant Women			
VMMC clients			
Key populations	32,102	3,969	4,269
MSM	24,804	3,456	3,677
TG	5,242	313	378
FSW	2,056	200	215
Priority Populations	-	-	-
Other Testing[55]	37,263	3,725	-
Previously diagnosed and/or in care	-	-	920
Pediatrics (<15)			
HIV Exposed Infants			
Other pediatric testing			
Previously diagnosed and/or in care			

[55] This row displays men and women and subtracts index testing.

5.0 Program Activities for Epidemic Control in Protect the Investment Countries—by country, Tier 2

Tier 2, Protect the Investment

India, Indonesia, Kazakhstan, Laos, and Papua New Guinea

Tier 2: INDIA

5.1 Finding the missing, getting them on treatment, and retaining them, ensuring viral suppression: PEPFAR India provides technical assistance to strengthen the GOI's response towards achieving the 90-90-90 goals. In ROP 19, PEPFAR India will focus on adoption of fundamental evidenced-based activities across the care continuum in PEPFAR-supported districts to achieve epidemic control. In this regard, key to ROP19 planning is an immediate laser focus on case finding through index testing, linkage of identified positives to treatment, ART coverage, retention, and viral suppression among all PLHIV including KP. PEPFAR India will consolidate gains from COPs 17 and 18 and use data in real time to efficiently and effectively microtarget programmatic activities across the prevention to treatment cascade.

To accomplish these outcomes, India PEPFAR will scale strategies for rapid site-level focus on ART initiation activities, ART adherence/retention strategies, and VL testing coverage and suppression, and above site support for national guideline development and adoption to ensure optimal impact. PEPFAR India seeks to scale, accelerate, and saturate access to treatment, linkage ART coverage, retention, and viral load suppression for all PLHIV, with specialized strategies for KP in PEPFAR supported districts.

To improve ART initiation, India PEPFAR will continue to support the GOI in implementing test and start and to increase coverage on ART by improving quality of care. Specific strategies to increase coverage include implementing same-day initiation, community starter packs for remote communities, community ART initiation and dispensation, and scale up of KP-focused strategies for ART initiation and dispensation (including scale up of co-location strategies such as OST/ART centers). Critical among these strategies is the linkage programming. PEPFAR India will continue to scale peer navigation, especially for KP, to achieve 95% linkage to treatment. To improve ART adherence and retention, PEPFAR will continue to scale a host of strategies implemented in PEPFAR-supported districts and now undergoing scale up nationally.

Differentiated ART service delivery options of treatment services will be prioritized to improve service delivery, access to quality treatment, and the efficiency of ART centers. Implementation of differentiated models of ART distribution at the facility and community level will be scaled to enhance retention and lower attrition and loss to follow up (LTFU). Community-based ART dispensation started in COP18 at selected TI sites and moving forward, both ART initiation and dispensation at high load TIs (more than 100 KP PLHIV) will be implemented and facilitated by an in-house medical officer to support integrated care. The community site has the capacity to draw laboratory tests, further increasing efficiencies for KP PLHIV receiving care. In remote locations, the GOI has agreed to scale community ART adherence groups, whereby PLHIV can pick up medications as a proxy. Differentiated care for unstable patients is also being scaled with strategies for advanced disease management in process. Multimonth scripting (MMS) is a cornerstone of the differentiated care delivery system. PEPFAR India will continue to implement three-month MMS and advocate for further scale up of six-month MMS. PEPFAR India advocates for expanded MMS eligibility with wrap around adherence counseling to ensure low MMS attrition.

Programming for PLHIV retention will be a critical focus in ROP19. To further bolster retention, PEPFAR India will focus and scale a differentiated package of services for retention which will include specialized services for those new to ART (< 1 year) with intensive peer support for tracking and tracing. A second package of services for patients deemed unstable will be scaled up. Both strategies leverage and adapt activities PEPFAR India utilized in the pre-ART surge for tracking and tracking pre-ART patients in 2017-2018. Other strategies for retention leverage successful government-scaled adherence and retention strategies. One example of this is known as 99 dots. This approach is being scaled up nationally for TB and currently being adapted for HIV service. Self-verified adherence for PLHIV is of interest to the GOI for scale up. ART medication is packaged in customized envelopes which have dosage instructions and a series of hidden numbers behind the pills. Each time a patient takes a dose of medication, a hidden number is revealed to the patient. The patient then makes a call when they take the medication. The numbers are packaged in an unpredictable way to the patient, where the only way for them to call the correct number is through removing the pill. This information is tracked in real time, and the ART center will package reminders, incentives, and additional counseling for patients that display low adherence. Critical to scale up is input and guidance from civil service orientations to ensure real time feedback and improvements toward better efficiency and equity.

To bolster viral load coverage and suppression, PEPFAR India seeks to accelerate routine viral load testing beyond the current prioritized groups. Accelerating VL coverage and suppression is a critical pillar for PEPFAR India and frames the principle of Undetectable = Untransmittable (U=U). Lab activities in COPs 17 and 18 included laboratory network optimization and rapid scale up of routine VL testing through a phased-in approach starting with priority populations, with the goal of administering one million VL tests annually by 2020. By the end of 2019, 500,000 tests will have been performed in the prioritized populations, including those with immunological/clinical failure, those on second- or third-line therapy, pregnant and breastfeeding women, KP, children < 15 years, those who have been on ART for more than five years. KP-focused programming will continue to be scaled up such that KP are peer-navigated for VL in PEPFAR-supported districts. VL utilization and data management supports VL suppression, and thus a key area of activity is to fast track VL results for enhanced adherence counseling or referral for second or third line therapy.

Moving forward, PEPFAR India will continue to accelerate routine VL testing, VL test utilization, suppression and programming for enhanced adherence counseling, and referral for ARV optimization. Using a package of services for VL testing and utilization (involving patient calls, navigation, testing, result delivery, and follow up on utilization) will ensure rapid testing, follow up, and data use. India is moving toward routine, annual VL for all PLHIV, and PEPFAR India will work to implement routine VL in PEPFAR-supported districts in ROP19. Specific programming in ROP19 will focus on programming for KP, adolescents and young adults with poor viral suppression rates. PEPFAR India will use real-time data to offer microtargeted programming to gender and age bands with poor VL suppression. PEPFAR India will continue to provide

continuous quality improvement support for the ongoing scale up of the 64 public sector labs throughout the country and continue to strengthen the lab-clinical interface.

ARV optimization impacts adherence, retention, and viral load suppression. PEPFAR India continues to support the GOI toward adoption of TLD, and there has been significant progress with an updated roll out schedule (planned for December 2019). PEPFAR India provided TA to the GOI in COP 18 and will continue to provide TA during TLD roll out in ROP 19.

To find the missing and get them on treatment, PEPFAR India will leverage achievements in COPs 17 and18 and implement 100% use of index testing to achieve 95% linkage in all PLHIV including KP. Moving forward in ROP19, PEPFAR India will aggressively scale and saturate index testing services among high-risk populations and link those who test negative to prevention services, ensuring standardized partner notification requirements (including IPV screening and the 5 C's – consent, confidentiality, counseling, correct test results and connection/linkage to prevention care and treatment). The GOI has adopted many of the innovative active case finding strategies demonstrated in COPs 17 and 18 in the national restructured TI guidelines (targeted community based screening and EPOA), thus PEPFAR India has the opportunity to transition many of the case finding strategies to NACO and SACS, DACS, and focus the case-finding strategy on index testing.

Site-level implementation of index testing will be reinforced at targeted intervention sites (KP-focused), ICTCs, and ART centers (general population and KP). To ensure KPs within and outside the TI are offered index testing, KP who are not in the TI will continue to be reached for index testing at community convening sites such as secondary needle and syringe sites (SDNS), OST, and satellite OST sites. Once the PLHIV is identified, the peer navigator accompanies the PLHIV to the nearest government ART center for rapid initiation of treatment.

PEPFAR India will provide technical assistance to develop operational guidelines to fully scale and saturate the prevention cascades. To complete the prevention to linkage cascades, PEPFAR India will support the GOI in the development of PrEP policy and operational guidelines, with the goal of having PrEP available for high-risk KP by ROP19. Implementation of PrEP among high-risk persons with community-led solutions for KP access to PrEP will be critical and community input will be sought. PEPFAR India will provide above-site support in planning for the efficient use of recency testing for targeting of prevention services and harm reduction strategies, with PrEP targeting of seronegative clients, and rapid linkage of seropositive clients to ART centers. In this regard, PEPFAR India will advocate for recency testing to focus programmatic resources towards identification of high transmission networks for both PrEP availability and ART linkage. Lastly, PEPFAR India will continue to advocate and support the GOI in the adoption of HIV self-testing in ROP19.

Overarching strategies in data availability and use are cross cutting and impact all efforts for PEPFAR India's strategic objectives. PEPFAR India will continue to improve data sharing and access to strengthen the cascade. Updated district estimations will help to track the epidemic and target resources.

5.2 Prevention, specifically detailing programs for priority programming: PEPFAR India will focus on saturating index testing in all PEPFAR-supported districts to ensure 100% use of index testing and 95% linkage to treatment. PEPFAR India will leverage the success of targeted programs for KP during COPs 17 and 18 and scale these programs to ensure targeted prevention services for high-risk KP are widely available. Prevention activities will support the full prevention cascade, with the GOI taking over many of the scaled up harm reduction strategies such as SDNS, OST, and satellite OST. PEPFAR India will focus on identifying sexual and injecting partners and their high risk networks to ensure testing and linking all HIV-positive individuals to treatment, as well as linking all HIV-negative individuals to government prevention services. The program will continue to advocate for PrEP and will support its introduction into the prevention cascade along with recency testing. As discussed above, PEPFAR India will provide above-site support to implement the efficient use of recency testing for targeting of prevention services and harm reduction strategies, with PrEP targeting of seronegative clients, and rapid linkage of seropositive clients to ART centers. PEPFAR will implement targeted strategies to reach out to young and adolescent KP, implement index testing, and support linkage to prevention and treatment services. Prevention services will be tailored to the context and burden of HIV in the PEPFAR-supported districts.

5.3 Additional country-specific priorities listed in the planning level letter: The last two years have seen remarkable progress in policy adoption, starting with Treat All, passage of the HIV Act that bans all stigma and discrimination toward all PLHIV, and Mission Sampark to track back LTFU, all in 2017. In 2018 there were more policy advances, with the routine VL testing launch, Section 377 ruled unconstitutional[56], HIV estimates released, and the restructuring of the TIs. Office memos have been signed by NACO for three-month MMS for those on tenofovir-lamivudine-efavirenz and zidovudine-lamivudine-nevirapine, and TLD transition has started for all new initiations, those on second- and third-line regimens, and all those on tenofovir-lamivudine-nevirapine. TPT has been implemented for the past three years, but full implementation has not been achieved due to drug shortages. This area will be a focus in ROP 19. The Indian government has expressed an intention to pass PrEP policy guidance in 2019, with clinical and implementation guidelines. PrEP policy will advance toward implementation in PEPFAR-supported districts for MSM, TG, and PWID, specifically micro-targeting of those in high-risk networks.

NACO plans to rapidly expand MMS up to 300,000 PLHIV on ART by September 2019. Further policy progress will be achieved alongside political will for MMS six-monthly scripting. Lastly, PEPFAR India will gather evidence and share experience on how to use HIV recency assays in the national testing protocols to prioritize populations for index testing.

5.4 Collaboration, Integration, and Monitoring:

[56] In September 2018, Section 377 of the Indian penal code, which essentially criminalized homosexuality, was ruled unconstitutional.

Collaboration: PEPFAR India participates in various national Technical Working Groups (TWGs) to enhance collaboration and improve program outcomes. Collaboration has led to the review of national program guidelines to incorporate new policies like test and treat, differentiated care models, OVC programming, case finding and prevention approaches, revamping of the national TI approach, plans for adoption of PrEP, MMD, and transition to TLD.

TWGs are platforms for program performance reviews and provide the opportunity to address program and policy challenges. PEPFAR India uses these platforms to share outcomes of the quarterly Program Oversight and Accountability Review Team (POART) meeting and to mobilize stakeholder participation and inputs for the ROP development process and collaborative efforts such as the development of the SID.

PEPFAR India also collaborates closely with the GOI and multilateral organizations to provide support in strengthening the National Laboratory Network System, the national supply chain system, and the national health Information system. PEPFAR participates in the GF CCM, and the World Bank Joint Implementation Review of the NACP. These are opportunities to advocate for increased frequency of program monitoring, increased linkages, and wraparound across programs for enhanced collaboration.

Future collaboration and engagement with stakeholders such as the GF, UNAIDS, WHO, and CSOs will focus on the Advocacy Action Plan for India to adopt and implement pending critical policies to reach epidemic control by 2030. PEPFAR India will continue to engage the GOI on implementing the revamped National TI model to move to efficient utilization of resources to target those most at risk and hidden populations and respond to gaps in the national response in a catalytic and sustaining investment effort to reach epidemic control targets.

Integration: To improve integration of health system interventions, PEPFAR will consolidate planning and funding of systems strengthening activities focused on service delivery systems gaps across implementing partners. PEPFAR India will engage NACO and the Ministry of Health and Family Welfare to ensure implementation of the National Health Mission integrates HIV/AIDS services and that gaps in system readiness are addressed. This will reduce fragmentation, improve accountability, and allow for system investments to target documented gaps. System priorities will be established and activity implementation will be monitored by cross-cutting working groups to ensure that all program priorities are considered in allocating system resources.

Monitoring: Continued strengthening of partner management will be required to achieve ROP19 targets and fill programming gaps. Processes include reporting and monitoring; data analysis; data interpretation and use for decision making; and rapid course-correction. PEPFAR India conducts these steps as an interagency to ensure optimal sharing of best practices, challenges, and remediation steps across all partners.

PEPFAR India will use a rigorous reporting and monitoring system to assess partner performance by examining data on program achievements (through PEPFAR Monitoring,

Evaluation, and Reporting), quality (through SIMS), and financials (through expenditure analysis), all of which are currently available quarterly. Data will be collected on the clinical cascade, as well as site-level indicators required to measure implementation of high-priority activities, including index testing, true linkage, retention, and MMS. In addition, quality improvement and quality assurance processes will be applied to further strengthen scale-up and fidelity of priority interventions.

PEPFAR India will also continue to gather and act on information about the impact of different community service delivery approaches on performance across the treatment cascade, evaluation of community-facility outreach models, and impact of various lay cadres and peer support mechanisms on linkage, adherence, and retention. PEPFAR India will continue to refine and roll out service delivery models that will include training to health care providers for various factions of stable patients.

PEPFAR will engage with CSOs to continue to foster a grassroots network of indigenous organizations to drive more local investment. This strategy will include building the capacity of grassroots indigenous organizations with the goal of helping to position CSOs to play increasingly larger implementation roles in PEPFAR programming. PEPFAR will prioritize engagement with KP and PLHIV communities and organizations to build on their experience carrying out peer support, outreach, awareness raising, and treatment literacy to ensure program success.

5.5 Targets for scale-up locations and populations (India)

Table 5.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts

Entry Streams for ART Enrollment	Tested for HIV (APR FY20) *HTS_TST*	Newly Identified Positive (APR FY20) *HTS_TST_POS*	Newly Initiated on ART (APR FY 20) *TX_NEW*
Total Men	9,462	2,052	11,214
Total Women	9,741	2,101	11,645
Total Children (<15)	-	-	1,075
Total from Index Testing	19,203	4,153	-
Adults			
TB Patients	-	-	-
Pregnant Women	-	-	-
VMMC clients	-	-	-
Key populations	-	-	-
Priority Populations	-	-	-
Other Testing	-	-	-
Previously diagnosed and/or in care	-	-	-
Pediatrics (<15)			
HIV Exposed Infants			
Other pediatric testing			
Previously diagnosed and/or in care			

Table 5.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control													
State	District	Population Size estimate	Coverage Goal in FY 20	FY 20 target in Data pack	Population Size estimate	Coverage Goal in FY 20	FY 20 target in Data pack	Population Size estimate	Coverage Goal in FY 20	FY 20 target in Data pack	Population Size estimate	Coverage Goal in FY 20	FY 20 target in Data pack
		FSW (KP_PREV)			MSM(KP_PREV)			TG (KP_PREV)			PWID (KP_PREV)		
Mizoram	Aizawl	410	95%	391	477	105%	503	NA	NA	NA	4658	97%	4529
	Champhai	59	119%	70	0		0	NA	NA	NA	1763	76%	1335
	Kolasib	111	88%	98	0		50	NA	NA	NA	640	106%	681
	Lunglei	110	89%	98	55	0%	0	NA	NA	NA	1310	89%	1168
	Mamit	74	92%	68	0		0	NA	NA	NA	682	95%	650
Mizoram total		764	95%	725	532	104%	553	NA	NA	NA	9053	92%	8363
Nagaland	Dimapur	1425	95%	1347	706	107%	757	NA	NA	NA	2764	87%	2415
	Mokokchung	415	97%	401	364	99%	359	NA	NA	NA	3604	88%	3177
	Tuensang	213	79%	169	53	130%	69	NA	NA	NA	2446	87%	2134
Nagaland total		2053	93%	1917	1123	106%	1185	NA	NA	NA	8814	88%	7726
Manipur	Chandel	982	99%	975	15	0%	0	NA	NA	NA	1408	115%	1613
	Churachandpur	1011	108%	1089	30	497%	149	NA	NA	NA	1020	107%	1092
	Imphal East	669	101%	675	41	0%	0	NA	NA	NA	5608	86%	4821
	Imphal West	879	104%	910	114	555%	633	NA	NA	NA	4094	97%	3974
Manipur total		3541	103%	3649	200	391%	782	NA	NA	NA	12130	95%	11500
Maharashtra	Mumbai	21805	85%	18500	13534	83%	11250	3410	95%	3250	683	59%	400
	Pune	6815	93%	6350	1569	121%	1900	182	220%	400	56	268%	150
	Thane	17664	88%	15500	3752	98 %	3700	2277	94%	2150	346	87%	300
Maharashtra total		46284	87%	40350	18855	89%	16850	5869	99%	5800	1085	78%	850
Andhra Pradesh	East Godavari	12000	60%	7200	3844	34%	1300	772	45%	350	270	0%	0
	Guntur	13805	74%	10200	4807	43%	2050	808	31%	250	270	0%	0
	Krishna	13327	86%	11500	5085	52%	2650	712	28%	200	771	58%	450

Andhra Pradesh total	39132	74%	28900	13736	44%	6000	2292	35%	800	1311	34%	450
Total	91774	82%	75541	34446	74%	25370	8161	81%	6600	32393	89%	28889

Table 5.6.4 Targets for OVC (India)

Table5.6.4 Targets for OVC and Linkages to HIV Services			
SNU	**Estimated # of Orphans and Vulnerable Children[57]**	**Target # of active OVC (FY20Target) OVC_SERV**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY20 Target) OVC[58]***
Andhra Pradesh	Not Available	11,291	2,882
Maharashtra	Not Available	18,585	4,958
Manipur	Not Available	4,798	1,283
Mizoram	Not Available	10,153	2,696
Nagaland	Not Available	5,232	1,397
TOTAL		50,059	13,217

Tier 2: INDONESIA

5.1-5.3 ROP19 Programmatic Priorities for Epidemic Control: Following dissemination of the July 2018 MOH's circular letter (Surat Edaran No. HK. 02.02/I/1564/2018 - PLHIV Management for AIDS Elimination in 2030), which formalized the practice of Test & Treat All and introduced provisions for Test & Start (same-day up to seven days) and regular VL reporting, PEPFAR Indonesia has supported the Jakarta Provincial Health Office (PHO) to implement Test & Start across all 42 sub-district public facilities (puskesmas), four direct service delivery clinics, and 14 hospitals (approximately 50% of HIV testing service delivery points and 62% of HIV treatment service delivery points in Jakarta).

PEPFAR's TA currently focuses on: (1) development and roll out of Test & Start SOPs and associated job aides; (2) development and roll out of the Test & Treat All tracker that documents Test & Start performance; and (3) strengthening of community-based navigation and customized case management interventions to support ART retention. Quarter 1/COP18 data showed that 77% of enrolled PLHIV in Central Jakarta and 66% of enrolled PLHIV in East Jakarta are receiving immediate ART at PEPFAR-supported facilities. PEPFAR site-level analyses, however, illustrate unsystematic Test & Start interventions that are not yet reaching 80% or more of diagnosed and enrolled PLHIV at targeted facilities.

[57] There are no estimates for Children of KP available at national/state levels. The program has based the coverage estimates on the number of KPs reached through national program and taking into account the marital status (IBBS 2015) and an average of 1.5 children for every married KP.

[58] The targets for OVC_HIV_STAT are lower as they has been calculated on the basis of two assumptions: children of positive KPs who have chance of vertical transmission from parents as well as 20% of adolescents aged 15-18 estimated to be showing risk behavior. The project will document the status against both indicators for each child.

In ROP19, PEPFAR will assist the Jakarta Provincial Health Office to fully implement Test & Start among all facilities within the province, "leaving no site behind" as outlined in the Planning Level Letter. Facility-based TA will ensure systematic Test & Start performance (e.g. more than 80% of new PLHIV), with the proportion of same-day ART patients making up a substantial portion (at least 40%) of Test & Start clients during the ROP19 period. Personalized community-based case management for ART clients during the first 6 months will support ART retention, navigate transfer out to other sites, and limit LTFU or treatment stoppage.

Test & Start patients will be disaggregated by age and gender, using PEPFAR's Test & Treat tools. All trackers will be integrated within the MOH national cohort application (or SIHA NIK) during COP18 and ROP19. PEPFAR-developed Test & Start training materials and tools also will be transitioned to the MOH in an effort to strengthen, systematize, and track Test & Start across highest burden districts prioritized for the 95-95-95 targets within the national program.

While policy provisions enable six-month MMS within the national program, MMS scale up has been extremely limited due to both perceived and real ARV commodity shortfalls, insufficient VL testing coverage, suboptimal MMS reporting within the national HIV information system, and the lack of provider and patient readiness due ART retention challenges and reported lack of clarity in the national clinical guidelines.

PEPFAR will support the Jakarta PHO to roll out six-month MMS among virally suppressed PLHIV that meet the WHO MMS-eligibility criteria. PEPFAR will ensure site-level application of MMS SOPs (developed with PEPFAR assistance in COP18); intensive MMS socialization among providers and patients, and personalized case management for MMS clients; ARV commodity availability for all ART patients; and MMS recording within the MOH cohort application or the HMIS (SIHA) system. PEPFAR will also track barriers to MMS implementation, including policy and programmatic limitations that affect full scale up.

Scale up of index testing, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established. From April 2018 onwards, PEPFAR Indonesia has assisted the MOH to develop and roll out a national partner notification (index testing) framework that includes standard operating procedures, job aides, and reporting/recording tools. Facility-based index testing interventions are in the process of roll out across Jakarta facilities, with 42 health centers ("puskesmas"), four DSD clinics, and targeted hospitals expected to implement and report index testing interventions with fidelity by the end of COP18. In ROP19, PEPFAR will assist the MOH to ensure (1) systematic site-level implementation of index testing procedures following WHO guidance; (2) sharing of programmatic best practices and lessons learned across the national program for national scale up; and (3) protection of patient confidentiality and full activation of linkages to intimate partner violence services, as appropriate. PEPFAR will also support scale up of index testing interventions for 95-95-95 aims, through strategic above-site assistance.

Over the course of ROP19, PEPFAR will support 4,160 people to avail HIV index testing services across targeted facilities and CBOs. The yield from these tests will be 22%. Among the new HIV-

positive cases identified through index testing services, at least 90% (40% by 2020) of them will be linked to care and initiate HIV treatment.

Direct and immediate (more than 95%) linkage of clients from testing to treatment across age, sex and risk groups. PEPFAR Test & Start procedures; diagnosis – enrollment SOPs, community-based navigation interventions; and transfer in/out and LTFU ICT client tracking tools are in the process of implementation across Jakarta facilities. Quarter 1/COP18 data illustrate community-based navigation linkages of 90% and overall facility-based diagnosis/enrollment linkages at above 95%. Site-level linkages, however, are more variable, with 14 out of 42 sub-district facilities reporting sub-optimal linkages over 2018. In ROP19, PEPFAR will intensify site-level assistance and monitoring to ensure direct and immediate linkages of clients from testing to treatment. Use of cohort data will foster more granular site and partner monitoring for continual quality improvement and biweekly meetings for course correction throughout the programmatic period.

Monitoring and reporting of morbidity and mortality outcomes. In ROP19, PEPFAR will support PHO, District Health Offices (DHOs), and targeted ART treatment facilities to monitor and report PLHIV morbidity and mortality through the national cohort application. PEPFAR also will assist the PHO to coordinate site-level clinical mentoring to ensure quality ART patient clinical outcomes and will closely monitor patient ARV regimens among individuals exhibiting treatment failure and/or death.

At least 14,751 PLHIV will be retained on treatment in ROP19, with 88% of them achieving viral suppression. PEPFAR will ensure optimal patient retention through (1) site-level attrition monitoring and rapid response actions; (2) differentiated service delivery models, including MMS; (3) personalized client case management services, based on the length of time on ART; (4) face-to-face and e-clinical mentoring to ensure adherence to evidence-based practices, policies and SOPs; (5) more granular data relating to missed appointment, LTFU and transfer in/out tracking; and (6) activation of patient facility- and community-based service feedback mechanisms. PEPFAR is also working with the MOH and Jakarta PHO to: (1) increase VL test kit allotments for Jakarta in 2019 and 2020 by refining forecasting assumptions; (2) leverage the private sector (Abbott) and local government for additional VL testing commodities and subsidized VL testing fees; (3) strengthening laboratory VL testing quality assurance mechanisms for GenXpert and Abbott; and (4) introducing routine VL testing VL testing, promoting U=U, and systematizing processes for assessing VL testing eligibility and interpreting VL test results.

Clear evidence of agency progress toward local, indigenous partner prime funding. PEPFAR is playing a critical role helping the national program strategize and sustainably finance the response through strategic purchasing and evidence-based budgeting. CSO organizational development and financing–particularly of implementers directly supported by PEPFAR–remains key and will continue to be a focus in ROP19.

Scale up of unique identifier codes (UICs) for patients across all sites. Since PEPFAR initiated Jakarta's surge strategy in 2016, the program has highlighted data quality and data management issues as the key factors that are making it difficult for the national program to show who is receiving immediate ART, being retained in the system, and availing VL testing. PEPFAR has repurposed the national cohort application (ARK) so that, for the first time, patient clinical outcomes can be collected, reported, and analyzed. The MOH is working now on the development of a national patient records system that is tied to national insurance reimbursements. PEPFAR has offered a suite of ICT tools, called Jak Track, which is helping Jakarta track retention, reduce attrition, and monitor linkages among individual clients.

PEPFAR is also assisting the MOH to introduce the new version of SIHA (SIHA NIK), in which patient national ID numbers will be used to document individual-level testing and treatment uptake and reduce double-counting of the transfer-in and -out individuals.

Indonesia's progress on policy and technical guidelines is as follows:

- MOH formalization (in early quarter 4/COP17) of Test & Treat All and the replacement of the Strategic Use of Anti-Retrovirals (SUFA) across the national program; included within this formalization were provisions for Test & Start and regular VL reporting due to advocacy efforts from PEPFAR. Results were accelerated after the policy was formalized.
- Updated HIV testing regulations, including the (a) streamlining of HIV testing procedures; (b) introduction of new testing algorithms; and (c) offering of assisted and unassisted lay testing modalities in 2018.
- National Partner Notification strategy developed by MOH, with PEPFAR identified as the lead TA partner in Jakarta.
- Lay person and self-testing action plan was developed by the MOH, with up to three implementation research projects in the process of preparation and early implementation.
- The MOH PrEP modeling exercise for PrEP introduction and scale up was conducted, with scenario recommendations and action plan forthcoming.
- The MOH procured RDT based on Fast Track aims, with 1.2 million test kits provided to Jakarta in December 2018.
- The Government of Indonesia commits to reduce the ceiling price of ARV medications and to substantially increase allotments of VL testing supplies through GFATM and national resources and the initiation of TLD transition plans and actions.
- The Jakarta Provincial Health Office endorsed MMS for at least 10% of stable PLHIV.
- PEPFAR's ICT data utilization tools and platforms are helping Jakarta track retention, reduce attrition and monitor quality, while a more robust national patient records system is in development. A suite of ICT tools, called Jak Track, is now fully integrated into Jakarta's SMARTcity server. PEPFAR's Fast Track dashboards, cascade generator, and SIHA data verification tools have been introduced to 290 facilities across four Indonesia provinces.
- PEPFAR's face-to-face and virtual differentiated outreach approaches offer personalized PLHIV case management and PLHIV index case finding services in community settings.
- The MOH is currently rolling out a national index testing framework, with technical support from WHO, UNFPA, UN Women and PEPFAR. PEPFAR has developed the national SOPs, job

aides, and recording tools that are in alignment with WHO Five C's of HTS. The program is also introducing PLHIV risk network referral interventions to capitalize on peer-driven testing referrals that extend the coverage of index testing among key populations and other vulnerable individuals who may not be able or willing to name their injecting or sexual partners in traditional index testing encounters.

5.4 Commodities

TLE: The MOH is currently struggling to ensure the availability of TLE stock in the country using domestic resources allocated for the purchasing of TLE. Although there are two registered suppliers for this product, the procurement process through GOI funding has been delayed, and the government faces a deadlock in price negotiation with these suppliers. Additional suppliers have been identified, however, due to barriers to competition, efforts to register these suppliers have been stalled. It is anticipated that this situation will continue throughout 2019 and into 2020 unless additional suppliers are able to register and participate in the tender process, thus encouraging competition in the procurement process. To avert stockouts, in November 2018, the GOI placed an order with the GF for approximately 553,000 bottles; this order is expected to arrive in country in May 2019. This quantity should be sufficient to cover approximately 10 months of consumption, through February 2020. With the introduction of TLD for new patients expected in late 2019 or early 2020, TLE provision will begin to decline, increasingly accelerating with the anticipated full transition to TLD in the future.

TLD Transition: The GOI has recently agreed to transition to TLD for new patients in Jakarta Province beginning in December 2019 or January 2020, with initial estimates of around 3,000 to 4,000 new patients. In addition, approximately 20% of existing patients will be transitioned to TLD, using EFV600 treatment failure as the criteria. As part of the USD 55 million in Incentive Funding, PEPFAR and the Global Fund will advocate and negotiate with the MOH to increase the percentage of patients who transition to TLD. Orders for TLD will be placed with the GF in June/July 2019 and the product is estimated to arrive in country by December 2019. This GF procurement is expected to equal 10 to 12 months of stock, with ongoing supply planned to continue under GOI procurements using national budget funding. Currently there is no approved TLD supplier in country, thus the initial shipments will be brought in under waivers. The final implementation plan for TLD transition is pending a WHO-led expert panel meeting scheduled for mid-May 2019. The annual multi-year ARV forecasting/quantification exercise will be conducted in September and October 2019 and will include TLD needs.

Rapid Test kits: Indonesia currently has sufficient resources to fulfill the demand for HIV testing in 2019 and 2020, using GOI funding for 100% of procurement needs. Projected needs for 2020 is approximately 9,300,000 tests.

Viral Load Commodities: Indonesia is projecting approximately 54,000 VL tests will be conducted in 2020, with 60% coming from the Abbott platform and 40% from GeneXpert. 100% of reagents for Abbott and 80% of Gx cartridges will be purchased with GOI funding, with the balance of funding for Gx cartridge procurement coming from the GF. In addition, there is a pending request with Abbott for an additional donation of 3,000 to 5,000 tests under the

USAID/Abbott PPP collaboration; it is anticipated these donated commodities will support Jakarta Province VL targets.

5.5 PEPFAR's Plan to Solve Challenges across the Clinical Cascade

Strengthening cross technical collaborations and implementation across agencies and with external stakeholders, including the GF and MOH. PEPFAR is currently working in close collaboration with the GF and MOH to intensify AIDS elimination interventions in 10 highest-burden provinces and to introduce or scale programmatic or systems-level interventions across the national program. PEPFAR TA includes (1) the use of granular strategic information for improved case finding, linkages, and ART retention; (2) facility and community-based stigma and discrimination reduction frameworks and modules; (3) CSO financing and organizational development; (4) commodity forecasting, supply chain logistics and laboratory system strengthening; and (5) district-level planning and budgeting.

Strengthening IP management and monitoring and the implementation of innovative strategies across the cascade, with fidelity and at scale, to improve impact within shorter time periods. PEPFAR's Fast Track dashboards, cascade generator, SIHA data verification tool, and national cohort application (ARK) have been introduced to 290 facilities across four Indonesian provinces in an effort support more granular monitoring and adaptive programmatic management for impactful and scalable AIDS elimination strategies.

Improving quality and efficiencies of service delivery through improved models of care delivery across community and facility sites. By isolating programmatic interventions (e.g. differentiated outreach approaches) and using granular data for adaptive programmatic management in facility and community-based settings, PEPFAR is supporting a culture of continual quality improvement at provincial, district, facility, and community levels. Technical performance thresholds are currently being used to rationalize or direct TA resources, while models of care delivery are being tested to maximize impact and efficiencies.

Improving integration of key health system interventions, including human resources for health (HRH) and laboratory activities across the cascade. In collaboration with other the GF and other partners, PEPFAR is prioritizing key improvements to the national laboratory network. These ongoing efforts are focused on data connectivity and improved laboratory information systems, quality assurance, network optimization, and supervision and training.

Solving TLD transition, phase out from Nevirapine and commodities challenges through:

- Support to the MOH, with a focus on Jakarta province, in the transition to TLD. A key priority will be forecasting and procurement planning to ensure an adequate and uninterrupted supply of commodities for all new patients in Jakarta province, in addition to the 20% of existing patients that will initially transition to TLD.
- Coordination with planned GF activities for nationwide expansion of VL coverage, focusing on data connectivity for diagnostic platforms and increased reliance on GeneXpert for VL testing.

- Collaboration with Abbott Laboratories under the recent public-private partnership (PPP) agreement with USAID/Indonesia to leverage Abbott's $1.2 million commitment of goods and services to the MOH.
- Ongoing efforts to strengthen the national laboratory network, including data connectivity, quality assurance, network optimization, etc.
- Support for recent achievements in improving data-based commodity forecasting and procurement planning at the central level.

5.6 Targets for scale-up locations and populations

Table 5.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts (Indonesia)

Table 5.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts			
Entry Streams for ART Enrollment	**Tested for HIV (APR FY20) *HTS_TST***	**Newly Identified Positive (APR FY20) *HTS_TST_POS***	**Newly Initiated on ART (APR FY 20) *TX_NEW***
Total Men	**2,846**	**626**	**563**
Total Women	**1,314**	**289**	**258**
Total Children (<15)	**115**	**25**	**24**
Total from Index Testing	**4,160**	**915**	**821**
Adults			
TB Patients			
Pregnant Women			
VMMC clients			
Key populations	***1,516***	**387**	**510**
Priority Populations			
Other Testing			
Previously diagnosed and/or in care			
Pediatrics (<15)			
HIV Exposed Infants			
Other pediatric testing			
Previously diagnosed and/or in care			

In ROP19, the HIV military program will continue to increase the number of military health facilities to provide treatment and will predominately be focusing on scaling up VL coverage. The Indonesian military Surgeon General's Office will urge the military health facilities to advance same-day approaches as part of "Test & Start" implementation to improve linkage to treatment for military personnel. To achieve the ambitious third 90 goal in the military, continuous commitment and political will are needed.

Tier 2: KAZAKHSTAN

5.1 Finding the missing, getting them on treatment, and retaining them: In Kazakhstan, 85% of the estimated 26,128 adult PLHIV are diagnosed, though only 16,143 (62% of estimated PLHIV) had a clinic visit (with WHO staging or CD4 testing) in the past six months. A large portion of diagnosed PLHIV were not recently engaged in care because: (1) patients tested anonymously and are now untraceable (538); (2) there were many unrecognized or undocumented deaths (lacking an official death certificate); and (3) migration to other countries.

Last year, Kazakhstan performed over three million HIV tests and newly diagnosed 3,072 adult PLHIV, of whom 2,429 initiated ART. In PEPFAR sub-national units, 86% of the estimated 6,479 PLHIV have been diagnosed. Though the vast majority of HIV testing is among the general population, over 90% of new diagnoses come from HIV testing services among KP (60% of total positive), partners of index patients (30%), and TB patients (15%). (These categories are not mutually exclusive.)

PEPFAR has not focused on case finding in Kazakhstan given the high proportion of PLHIV already diagnosed, the country's ability to fund case finding, and the lack of sufficient ARVs to treat all currently diagnosed PLHIV. In ROP18, PEPFAR introduced community-assisted partner notification and index partner testing to complement the facility-based epidemiologic investigation. The epidemiologic investigation is a process in which each newly diagnosed PLHIV is asked a series of standard questions to identify the likely mode of HIV transmission, timing of transmission, and partners/ biological children who may also be HIV infected. At the above-site level, Kazakhstan's PEPFAR assisted RAC to approve the use of rapid testing in community settings and helped to field a sample tracking and reporting electronic database for HIV tests supported by government funds. Under the partner indexing strategy, PEPFAR will continue support to community index partner testing in priority areas, because the model finds partners and new cases not disclosed to the facility health care workers. In addition to case finding, disclosure of HIV-positive status to partners is associated with improved patient retention and adherence to treatment.

Kazakhstan's PEPFAR and RAC will continue to improve retention and immediate start of ART after diagnosis in ROP19. Current barriers include ARV supply, stigma against KP and PLHIV, and the current testing algorithm requiring Immunoblot testing for diagnosis, as well as other treatment delays within the facilities. In FY19, Kazakhstan purchased a sufficient supply of ARVs to treat all eligible patients currently diagnosed and engaged in care, removing ARV availability as a barrier. PEPFAR will support RAC to update the HIV diagnostic algorithm and allow for start of ART prior to Immunoblot confirmation, working at sites to improve education about ART during HTC prior to and just after diagnosis, and removing facility barriers to immediate ART initiation. PEPFAR-supported peer navigators will continue to work with clients to retain them in treatment and support adherence through community-based case management. Peer navigators will provide additional services such as referral to STI management and treatment

for clients and their families and MAT education to increase enrollment and retention on MAT and ART.

In ROP18, PEPFAR demonstrated a new nurse-led case approach to increase viral load suppression among patients newly initiating ART. Evaluation of this nurse-led case management approach showed that patients graduating after six months of case management attained high levels of viral load suppression (98%), which is significantly higher than previous viral load suppression among new starts and those not enrolled in the program. In addition, the nurse case management was offered to patients without viral load suppression after six months on ART. After six months, 77% of these patients had a suppressed viral load. Given the positive outcomes from PEPFAR's catalytic investments, RAC plans to scale up nurse case management to sites outside of PEPFAR-supported areas. Kazakhstan is trying to optimize its treatment regimens, phasing out older ARVs associated with toxic side effects and purchasing newer Dolutegravir (DTG)-containing regimens. The Government of Kazakhstan purchases all of its ARVs, and PEPFAR provides support for logistics and supply management. As an upper-middle income country, Kazakhstan has been unable to negotiate reduced prices for DTG-containing regiments, making progress on the TLD transition difficult. PEPFAR will continue to work with RAC and other partners on this issue.

5.2 Prevention, specifically detailing programs for priority programming: As a Tier 2 country, PEPFAR will phase out its support for prevention programming in Kazakhstan. Over the course of FY20, PEPFAR will phase out support for MAT for HIV-negative PWID and will not renew its cooperative agreement with the Republican Mental Health Center, which oversees the national MAT program. We expect that the Government of Kazakhstan will continue to support these MAT programs using state budget. MAT is important for opioid-addicted PLHIV to remain on ART; therefore, PEPFAR plans to continue supporting the "one window" integrated ART/ MAT/ TB approach for opioid-addicted PLHIV who also may have TB. PEPFAR will also end its prevention work in prisons and with post-prison release clients.

5.3 Additional country-specific priorities listed in the planning level letter: None.

5.4 Commodities: N/A

5.5 Collaboration, Integration and Monitoring: PEPFAR's collaboration with MOH's RAC. is described above. The GF focuses on different geographical areas than PEPFAR, and assists the Government of Kazakhstan to implement social contracting for NGOs to work with KP in community settings. Columbia University has an NIH grant and Elton John Foundation funds to work with MSM in Almaty, Astana, and Shymkent. UNAIDS provides assistance with SPECTRUM estimates and is also involved with the ARV procurement and supply issue. PEPFAR communicates and collaborates regularly with all stakeholders to ensure that its works complements, but does not duplicate, efforts.

For monitoring the HIV epidemic and response, the RAC uses the PEPFAR-supported EHCMS system, which is an Electronic Medical Record used in all HIV treatment sites nationally. RAC

uses the information from the EHCMS to improve quality of services in sites by using a Continuous Quality Improvement (CQI) approach. Clinical indicators of morbidity and mortality such as viral load suppression and death are monitored on a monthly basis by looking at reports automatically generated from EHCMS. PEPFAR supports a RAC Quality Management unit, which communicate remotely and through physical monitoring visits about the monitoring indicators and encourages the sites to improve patient-level care. This CQI approach was fielded initially in PEPFAR SNUs and demonstrated an improvement in viral load suppression after six months of the CQI process. As a result of PEPFAR's support of this successful strategy, RAC is scaling up this CQI process to other non-PEPFAR sites.

5.6 Targets for scale-up locations and populations: Kazakhstan targets for TX_CURR were calculated in PEPFAR sub-national units by projecting progress until the beginning of ROP19. This was calculated based on an assumption of a five percent net growth in the number of people on ART based on a steady case finding without PEPFAR acceleration. It was assumed that 90% of newly diagnosed individuals would initiate ART, and 95% PLHIV would remain on ART. Current national clinical protocols recommend viral load testing after six months on ART; therefore, we targeted that 50% of TX_NEW would have a viral load test and 100% of TX_CURR by October 1, 2019 would have a viral load test. Of those, the TX_PVLS target was set at 90%. In ROP18, ICAP reported MER indicators as a direct service delivery (DSD) indicator. The ICAP award ends in ROP18; therefore, RAC will report the MER indicators in PEPFAR sub-national units as technical assistance indicators based on PEPFAR-supported CQI monitoring.

Table 5.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts (Kazakhstan)

Table 5.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts			
Entry Streams for ART Enrollment	***Tested for HIV (APR FY20) HTS_TST***	***Newly Identified Positive (APR FY20) HTS_TST_POS***	***Newly Initiated on ART (APR FY 20) TX_NEW***
Total Men	**854**	**68**	**202**
Total Women	**605**	**48**	**144**
Total Children (<15)	**0**	**0**	**0**
Total from Index Testing	**1459**	**116**	**104**
Adults			
TB Patients			**52**
Pregnant Women			**4**
VMMC clients			**0**
Key populations			**208**
Priority Populations			**0**
Other Testing			**0**
Previously diagnosed and/or in care			**10**
Pediatrics (<15)			
HIV Exposed Infants	NA	NA	NA

Other pediatric testing	NA	NA	NA
Previously diagnosed and/or in care	NA	NA	NA

Tier 2: LAOS

5.1 Finding the missing, getting them on treatment, and retaining them ensuring viral suppression: The HIV cascade trends in Laos for MSM and TG have improved, but challenges remain. Disaggregated data between MSM and TG are difficult to access due to information system limitations at the national level. In Laos, an estimated 90 % of all HIV-positive individuals, but only 78 % of MSM and TG, are estimated to know their status. Significant loss-to-follow-up is apparent after testing and before ART initiation, with only 64 % of PLHIV initiating ART (70 % for MSM and TG). Because MSM are estimated to comprise over 30% of new HIV infections in the country, it is critical to improve retention at all levels of the HIV cascade.

HIV case finding among PLHIV, MSM, and TG will be focused on in the three highest burden provinces through intensification of index testing at facilities. (MSM and TG case finding will be phased out of two provinces due to the Tier 2 pivot.) With the addition of recency testing in ROP19 in potential hot-spot areas, PEPFAR will be able to further narrow its focus on recent infections within index case finding. This will support risk-referral network testing in Vientiane Capital, where surveillance and program data indicate the highest HIV infection rates. Gaps in ART initiation and adherence to viral load monitoring will be filled by community-based peers who will identify cases lost-to-follow-up and will re-engage them with treatment. Peers will engage in ART and viral load literacy improvement so that clients understand the manifestation of U=U and are then encouraged, and escorted if necessary, for routine viral load monitoring.

5.2 Prevention, specifically detailing programs for priority programming: Key Populations: Prevention strategies supported by PEPFAR in Laos will focus on MSM, especially those age 20 to 29, and TG. In addition to regular HIV testing and early access to ART, consistent condom usage is promoted among all subpopulations. While PrEP is not yet widely available in the country, the PEPFAR program will advocate with other donors, such as the GFATM, to initiate targeted PrEP. With PEPFAR support, Laos' Ministry of Health has already approved PrEP in the national guidelines and is poised to implement PrEP if support is available.

5.3 Additional country-specific priorities listed in the planning level letter: Based on assessments of previous program performance and recommendations provided by OGAC, in ROP19 the Laos PEPFAR team will adopt and scale-up innovative, evidence-based solutions to reach epidemic control, as described below.

Optimized HIV index testing, including the use of self-testing: For KP PLHIV indexes, staff from CBOs will receive performance-based incentives. These incentives are associated with identifying HIV-positive individuals and reengaging or linking them to care and treatment services, while also expanding reach into highest risk networks to identify more HIV-positive MSM and TG individuals. These staff members have the competencies to use single oral-fluid

HIV tests for screening, assist referrals of clients with reactive results to confirmatory testing as per the national HIV testing algorithm, and linking and/or re-engaging to treatment. This intervention has addressed previous barriers to HIV testing uptake and early HIV diagnosis among KP. The success of the program from ROP17 and ROP18 will be leveraged in ROP19 as PEPFAR protects its investments made in Laos.

The Laos PEPFAR program will accelerate HIV index testing in facilities using the existing strengths of community-based peer navigators to offer HIV self-testing as part of the index case testing strategy. Pairing recency testing with index testing will help identify and intervene with those individuals most likely to transmit. The mix of HIV testing modalities will continue with a combination of HIV-positive identification in facilities, self-testing in communities, and an increasing proportion through index testing in ROP19.

Reduce loss to follow-up, increase retention rate to 95%, and address barriers to retention: PEPFAR Laos has successfully provided technical support to address the 2nd and 3rd 90 targets at sites, including setting standards and providing mentoring workshops and ART service quality improvement training workshops. PEPFAR has supported the updating of national guidelines, strategic information generating up-to-date dashboards for national, provincial, and hospital sites so that facility staff has the information needed to improve linkage to ART, increase viral load testing, and ensure viral load suppression. Better cascades have occurred over the last four-year period (2015-2018) for both PLHIV and MSM. While case-finding activities have focused on KP, treatment activities have supported both PLHIV in general and KP.

Despite quality improvement (QI) trainings and mentoring efforts geared towards ensuring staff have the skills and tools ensure adequate follow-up with patients, approximately 800 patients are lost to follow-up annually in the five PEPFAR-supported treatment sites. Existing staff at facilities may not have the resources to conduct intense follow-up visits in the communities to track these patients. Until now, PEPFAR has not supported case managers for these activities in Laos. Now that facility staff are properly trained and understand the importance of QI concepts, facilities have regularly updated line listings of patients with missed appointments.

In ROP19, the PEPFAR program in Laos will: (1) link PLHIV and HIV-positive key populations to ART services; (2) strengthen community-based peer navigators to intensively identify PLHIV LTFU and reengage them in care at facilities for ART and VL monitoring; (3) provide facility-level case management services; (4) strengthen adherence counseling; (5) screen for opportunistic infections; and (6) provide them with differentiated care services, including MMS. PLHIV and KP who are lost to follow-up will be tracked and linked to care, and counseling strategies will be used to improve adherence and promote case finding using index testing. PEPFAR support will be provided at the community level in Vientiane Capital and in five hospitals in the three provinces [three hospitals in Vientiane Capital City (Mahosod, Sethathirat, and Friendship)], Champasack Hospital, and Savannakhet Hospital).

PEPFAR support to one of the few CBOs providing HIV services in the country, Laos Positive Health Association (LaoPHA), ensures that peer navigation is an integral component of the

referral system to treatment in facilities in Vientiane, the highest burden province. In ROP19, LaoPHA will work closely with facilities to ensure that clients initiate ART rapidly after their HIV diagnosis; same-day initiation will continue to be advocated for by PEPFAR. Pending determination of TVPA restrictions, PEPFAR will support above-site activities including advocating to the GOL for ART decentralization by establishing point of care facilities for same day ART and MMS, final harmonization and integration of HIV data systems into DHIS2 (eCascade, HIVCAM, VCT data) to allow better reporting of morbidity and mortality, providing technical assistance on cascade quality and monitoring with weekly targets, and, finally, strengthening linkages using UIC within the national HIV system.

Ensure 100% access to viral load testing: Currently, all VL testing is centralized in Institut Merieux laboratory in Vientiane Capital. According to the national ART database, HIVCAM, approximately 400 patients who were on treatment for at least six months in the five treatment sites in the PEPFAR-focused provinces and eligible for a viral load test (4,832 patients) did not get a VL test. The Laos PEPFAR program will reinforce a viral load alert system for patients who missed appointments and with missing results and will investigate reasons for missing viral load results. Case managers will schedule follow-up contacts with these patients and reschedule appointments. To institutionalize this at the national level, PEPFAR will work with partners and the GOL to advocate for decentralized point of care viral load testing.

Increase access to recency testing in areas of new infrastructure development: Several major construction projects are ongoing in Laos. The high-speed train from Kunming, China, to Vientiane will be completed by 2021 and transverses the country. A recent report from the IOM raised concerns of possible increased HIV infections among construction workers and FSWs in areas within provinces with infrastructure development. To better quantify and monitor a potential increase in number of HIV infections in these sites, PEPFAR will set up a case-based surveillance system, including recency testing, in selected sentinel VCT sites along this railroad construction site in Luang Namtha, Luang Prabang, and Vientiane Capital.

5.4 Commodities: In the past year, there were sporadic stock outs of HIV rapid test kits, some ARV drugs, and isoniazid due to the rapid increase in number of people tested in some provinces. The supply chain management system is one of the areas that the GFATM and MOH are currently collaborating on to further strengthen, and the PEPFAR program projects no commodity concerns or stock outs in Laos in the near future. To support the transition to TLD and to further scale up the implementation of TPT, the Lao PEPFAR team will increase engagement in supply forecasting and review and procurement plans at the national level.

PEPFAR procures a limited supply of commodities to support site-level investments that are designed and implemented in close collaboration with partners. In FY2020, the Lao PEPFAR program will seek support for procurement of recency tests and OraQuick test kits.

5.5 Collaboration, Integration, and Monitoring: In ROP19, the Laos PEPFAR program is dedicated to building new and strengthening ongoing collaboration with partners and stakeholders and integrating sustainable systems to support progress toward 90-90-90 and

Ending AIDS. During FY2019-20, PEPFAR will continue to preserve partnerships with GFATM, multilaterals, and CSOs to enhance service delivery activities, improve and integrate systems, and monitor outcomes to address challenges across the clinical cascade, in particular linkage, retention, and viral suppression.

PEPFAR will continue to strengthen cross technical collaborations and implementation across agencies and with external stakeholders. In FY19-20, PEPFAR will work closely with GFATM, which supports test kits, case findings, ART drugs, VL test logistic supply chain, and health Information system; the World Bank, which supports health system financing; the WHO and UNAIDS, which support policy advocacy, strategic planning, and coordination; the Clinton Health Access Initiative, which supports supply chain management; and other development partners to ensure the synergy and complementary of the assistance given to the GOL and civil society organizations. PEPFAR has held multiple discussions with AHF, a growing stakeholder in Laos, regarding the possibility of continued HIV testing among KP in areas where PEPFAR is phasing out under the Tier 2 pivot.

PEPFAR, GFATM, and the GOL will plan in closer coordination during ROP19 to ensure synergistic coverage for maximum impact in the country. To do this, PEPFAR will support regular meetings with GOL, GFATM, WHO, and UNAIDS and other partners to develop a unified national strategy for sustainability, with focus on increased access to ART for all patients, especially stable patients (e.g. transport or decentralized ART points of care), VL testing points of care, and institutionalizing index testing.

A PEPFAR representative sits on the Global Fund CCM, through which issues related to GFATM priorities and coordination are addressed. PEPFAR implementation partners meet regularly with the prime recipient of the GFATM grants, the Laos MOH, to share innovation successes, guidelines, and training materials. The GFATM will support Laos until at least 2023.

PEPFAR will strengthen IP management, monitoring, and the implementation of innovative strategies across the cascade in ROP19. PEPFAR Laos currently holds routine meetings and data reviews with implementing partners and will immediately initiate biweekly data reviews and establish subsequent remediation plans with partners to ensure that programmatic adaptations and pivots are based on performance and achievements.

As a result of the findings of the TVPA report, PEPFAR will transition support from GOL to another partner to implement activities with fidelity and at scale, to improve impact within shorter time periods. These activities include improving data linkage methodologies and UIC for integration of national HIV monitoring systems under DHIS2 to better monitor activities across the cascade, improving quality and efficiencies of service delivery by institutionalizing index testing, introducing recency testing, and improving linkage to and retention in treatment in community and facility sites. In addition, PEPFAR will support a technical desk review of recent IBBS findings and methodologies.

PEPFAR works closely with the MOH to update guidelines and advocate for policy change so that optimized HIV cascade interventions can be nationally institutionalized, implemented, and financed.

5.6 Targets for scale-up locations and populations: The proposed targets that were submitted in the data pack, which were developed based on OGAC guidance, program data, and previous performance, are provided below. The focus is to maintain the PLHIV cohort, with the integration of index and self-testing.

Table 5.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts (Laos)

Table 5.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts			
Entry Streams for ART Enrollment	**Tested for HIV (APR FY20) *HTS_TST***	**Newly Identified Positive (APR FY20) *HTS_TST_POS***	**Newly Initiated on ART (APR FY 20) *TX_NEW***
Total Men	538	162	174
Total Women	439	132	143
Total Children (<15)	-	-	-
Total from Index Testing	977	294	317
Adults			
TB Patients	-	-	-
Pregnant Women	-	-	-
VMMC clients	-	-	-
Key populations	314	94	80
Priority Populations	-	-	-
Other Testing	-	-	-
Previously diagnosed and/or in care	-	-	-
Pediatrics (<15)			
HIV Exposed Infants			
Other pediatric testing			
Previously diagnosed and/or in care			

Table 5.6.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Attained Support Districts (Laos)

Table 5.6.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Attained Support Districts*			
Attained Support Volume by Group		**Expected result APR 19**	**Expected result APR 20**
HIV testing (all populations)	*HTS_TST*	4,263	977
HIV positives (all populations)	*HTS_TST_POS*	1,120	294
Treatment new	*TX_NEW*	742	317
Current on ART	*TX_CURR*	2,090	5,655
OVC	*OVC_SERV*	-	-

Key populations	*KP_PREV*	5,600	-

Tier 2: PAPUA NEW GUINEA

The PEPFAR program in PNG, in collaboration with key stakeholders under the leadership of the GoPNG, will focus on strengthening the key systems and policies that support people living with HIV (PLHIV) who are currently on ART, ensuring that they are retained and achieve viral suppression. The program will concurrently focus on institutionalization of its activities, advocate for, and support transition of the national HIV response to increased domestic financing, and will leverage resources from donors for a GoPNG-centered approach to interrupt transmission and control the epidemic. The PEPFAR PNG program will focus on above-site activities at the national and sub-national levels, increasing efficiencies and integrating GBV services into routine HIV care. The PEPFAR PNG team will work with NDoH and the NACS to improve monitoring of PLHIV on ART, strengthen quality VL testing, and support forecasting of HIV commodities to ensure adequate supplies are available at all levels. The PEPFAR PNG team will build on the successful implementation of Test and Start and move towards supporting the country to transition to TLD.

With its implementing partners, PEPFAR PNG will play a catalytic role to ensure current best practices at the PEPFAR-supported SNU are scaled up across high burden sites and nationally by the GoPNG with the support of other donor partners (GF, DFAT) and CSOs. PEPFAR PNG's role will be to support and strengthen implementation of policies, strengthen surveillance and monitoring capacity at the national and sub-national levels, improve KP data collection and collation at the central level, and strengthen quality VL testing. PEPFAR will work with the GoPNG and the PHAs to fully transition data systems to NDoH and NACS by building national capacity and transference of appropriate skills and knowledge required for systems management, data extraction, data analysis and use. Furthermore, PEPFAR will fully transition HIV quality of care for PLHIV to the GoPNG. At the national level PEPFAR will collaborate with NDoH, NACS and Family and Sexual Violence Action Committee (FSVAC) to support and strengthen HIV/GBV policies and guidelines and institutionalize them at the sub-national level. At the provincial level, PEPFAR will support integration and institutionalization of post GBV care, strengthen supply chain management to minimize stock-outs of HIV commodities, and institutionalize index–partner testing among PLHIV currently on treatment. It will also ensure systems to improve service delivery are strengthened, emphasizing quality health care, treatment adherence, and reduced LTFU. As a strategy to advocate and support transition to national financing, PEPFAR will provide support for improved planning and budgeting, particularly at the PHA level and, as needed, to the national level during the commodity planning process.

5.1 Finding the missing, getting them on treatment, and retaining them ensuring viral suppression: In ROP 19 PEPFAR PNG will shift focus from active case finding to improving retention, ensuring PLHIV on ART remain in care and reach and maintain viral suppression. PEPFAR PNG currently exhibits strong partnerships with the GF and will continue this in ROP19. The GF will continue to focus on active case finding among the high-risk, high-yield populations, using data that was generated through PEPFAR investments like the IBBS and experiences of

recent pilots using KP. PEPFAR PNG will strengthen the already comprehensive support to ART services to prioritize maintaining PLHIV on treatment, offering enhanced adherence counseling to those new positive cases found through index partner testing and those brought back into care through active LTFU tracing. All PLHIV will be screened for GBV on a regular basis and offered post-GBV care to support their ART adherence. PEPFAR PNG will support the integration of MMS practices into national treatment guidelines to ensure monthly ARV drug pickups do not continue to be a barrier to adherence. PEPFAR PNG will also play a pivotal role in working with key partners to ensure that these new guidelines are operationalized.

PEPFAR PNG will continue its TA to the national HIV program as it transitions to TLD as its first line ARV regimen. PEPFAR PNG will work towards reaching the second and third 90s in NCD in ROP19 by working with GoPNG to fully adopt best practices across program areas through coordinated and concerted efforts by partners and CSOs.

Barriers to adherence will also be addressed by implementing MMS for all stable patients and providing post-GBV care for those who are experiencing violence. TA support given to clinics will monitor stable patients, provide adherence counseling & support the implementation of MMD to keep clients in care. CSO and FBOs will be strengthened to support patient follow-up, detecting LTFU, counseling and returning patients back into care. The utilization of the HIV Patient Database (HPDB) at all PEPFAR supported treatment sites will see QI tracking activities developed to reduce LTFU by addressing specific barriers amongst key demographics. These collaborative track and trace initiatives will accelerate the process of closing the 90-90-90 gaps in NCD and field teams will place emphasis on the importance of early active case management, leveraging the revised MER LTFU indicator definition to support this early return to care. This will occur through improved retention monitoring activities and expanded use of unique identification codes (UIC) in PEPFAR-supported sites and through technical support to GoPNG will scale-up nationally.

PEPFAR PNG will ensure to work with clinics and CSO/FBO groups to strengthen LTFU tracking, reengagement into care and early treatment initiation PEPFAR PNG's plan to close the treatment gap in NCD will also see greater yield of new positives coming from index partner testing. Every effort will be made to improve and increase index testing and HIV positive yields among those on treatment; index testing on all currently on treatment, index testing on all LFTU cases successfully returned to care, and index testing on those referred to PEPFAR sites from satellite testing sites by CSOs/FBOs and GF. All index clients will be screened for intimate partner violence prior to partner notification, and offered GBV services in addition to supported partner notification. This strategy will accelerate the process of reaching the 90-90-90 targets in NCD. Including HIV recency testing for all new positives from index testing could provide greater insight into the transmission dynamics of the epidemic, particularly when paired with geospatial data to develop hotspots that could be used to further improve yield. The PEPFAR PNG team believes this could greatly assist the national program in its efforts to improve efficiencies in case- finding and would be an ideal activity as part of the PEPFAR incentive funding platform.

Additional attention will be placed on adherence to ensure all PLHIV on treatment are virally suppressed, so the transmission risks are fully minimized. Key to interrupting transmission in this process is returning FSW LFTU cases into the treatment pool by CSO/FBO engagement, and achieving VL suppression among this group. The recent IBBS in NCD showed that the population level VL suppression and condom use among FSWs were both low. This presents an unforeseen risk for the epidemic to expand, and requires stronger focus on KPs. The success of the recent pilot in NCD where CSOs and FBOs played a key role in bringing back into treatment KP LFTU cases back into care places PEPFAR in a strong position to utilize these strategies to mitigate these risks. With further COS/FBO engagement, index testing and MMS will be fully implemented in PEPFAR- supported sites to immediately close the treatment gap and control the epidemic.

VL testing is a priority for GoPNG and all partners and stakeholders with PEPFAR's contribution essential to the national VL roll-out strategy. PEPFAR has supported this activity from the initial pilots by Clinton Health Access Initiative (CHAI) in 2015-2017 to full scale up in NCD and other high-burden provinces (see Fig 4.1.2). VL testing is now available in areas where over 70% of PLHIV on ART reside. In NCD, VL suppression rates were over 80% among ART patients. In ROP19, PEPFAR will intensify its activities around MMS, and targeted enhanced adherence counselling so retention and VL suppression rates increase. Targeted adherence counselling to high VL patients has been the focus of PEPFAR's TA at the provincial and national levels and has resulted in the improvements in viral suppression rates.

Scaling up VL testing services using dry blood spot (DBS) sampling outside of NCD was critical in providing national VL testing services, given the huge logistical challenges in PNG. Currently, VL testing services using plasma are only available in NCD with the only testing platform (Roche Cobas Tagman 48) located in the capital. In 2018 access to VL testing became available beyond NCD after DBS was validated in 2017. Ten provinces now use DBS for VL testing. In ROP19, PEPFAR PNG will focus on catalyzing scale up of VL testing in all high-burden SNUs by leveraging partnerships and strengths across key partners.

5.2 Prevention, specifically detailing programs for priority programming: In ROP19, PEPFAR PNG plans to continue transitioning prevention activities to GoPNG and partners. Prevention efforts in COP18 focused on intensifying outreach activities and developing strategies to more effectively find high-risk populations and link them to testing and treatment. Through comprehensive PEPFAR TA, this activity has been transitioned to the GF in NCD in COP18. In other urban centers in PNG, CBOs are actively engaged in KP prevention, using models developed with PEPFAR support.

PEPFAR PNG prioritizes CSO engagement and through the recently established CSO consortium will work to ensure that prevention activities are successful. In the recent IBBS, engagement of CSOs yielded excellent results; LFTU were routinely traced back into treatment and greater positive cases were identified among hard-to-reach communities. This approach, combined with other PEPFAR-supported outreach models that are increasingly including GBV, are being

further developed by GF. Engaging CSOs will thus be key in ensuring PEPFAR PNG's retention strategies aimed at closing the treatment gaps in NCD and more broadly are effective.

5.3 Additional country-specific priorities listed in the planning level letter

GBV guidelines, policies, and systems: Two-thirds of women in the country experiencing GBV in their lifetime and two thirds of FSW experiencing violence in the past year. This situation increases the risks of acquiring HIV, of not seeking testing and treatment, of not adhering to treatment, and being lost to follow-up. With PEPFAR support, the national HIV guidelines will be modified to clearly articulate how the provision of clinical post-GBV care should be provided as a component of HIV treatment, and linkages to other sites that provide GBV services [for example, the Family Support Centers (FSCs)] will be strengthened to link HIV-positive GBV clients to HIV services in order to enroll them on ART. HIV and GBV policies, guidelines, and procedures will be fully adopted by the NCD and NDoH. PEPFAR PNG will further work NDoH to catalyze GBV services to other SNUs to improve treatment outcomes and prevent LTFU nationally. TA will continue to strengthen coordination of national entities, TWGs and stakeholders, such that HIV and GBV guidelines and policies can favor GBV-HIV integration. Support at the PHA level will focus on creating robust leadership and structures capable of furthering the GBV/HIV integration for improved service delivery. HIV service providers at PEPFAR-supported sites have been trained and mentored to offer KP-friendly comprehensive post-GBV clinical services, screening, GBV prevention, awareness, and referrals. Community outreach methodologies have been adapted and applied to have an increased focus on GBV. Community leaders have been trained to support prevention of GBV linked to HIV treatment.

For ROP19, the focus of GBV service provision will be to ensure that it is provided at every stage of the HIV clinical cascade. This will include screening for intimate partner violence (IPV) during index testing and partner notification, as well as for PLHIV enrolled in HIV treatment. A particular emphasis will be on linkage and retention of GBV survivors who are PLHIV. Information systems will be adjusted to report on the GBV cascade for GBV survivors enabling a more refined system for monitoring and decision making.

Of particular importance is the involvement of CSOs and FBOs to link GBV survivors to HIV services. Involvement is also needed to promote community support to ensure treatment adherence and reduction to loss to follow up.

TA is provided to strengthen and institutionalize post-GBV service uptake in HIV services such as treatment, retention, index testing and reducing LTFU. Indicators are being developed to measure the impact of activities. ROP19 activities will emphasize the provision of high-quality post-GBV care as an essential component of HIV treatment services, the identification of GBV survivors at ART sites, and the identification and linkage of HIV positive GBV survivors to ART sites. This will be accomplished through the systematic application of guidelines and SOPs with continuous mentoring, site level monitoring, and routine data collection and analysis to improve services. Support from other stakeholders will be leveraged for complementary GBV activities, such as community outreach and follow-up.

Commodities: Stockouts of ARVs, Roche VL test kits, HIV rapid diagnostic test kits, and blood collection supplies have negatively impacted progress to the 90-90-90 targets. The last imminent stockout of ARVs was averted by a three-month supply provided on credit by PEPFAR at the end of 2018. Stockouts of HIV test kits and reagents was recently solved by a purchase that arrived in February 2019. This situation is further complicated by inadequate distributions that leaves some centers with excess drugs and others with none. Condom stock-outs have also occurred repeatedly and there is currently a shortage of lubricants and female condoms. A 2017 analysis of medicines and medical supplies, supported by the US government and GF, recommended the need to improve efficiencies in forecasting, procurement, quality control and distribution of essential medicines and supplies. Stock-outs have pointed to needs of improving the supply chain management and is currently one of the top priorities of the Minister of Health. A working group was established involving the NDoH and major donors, this group however has not met for almost a year. The need for further coordination is essential, particularly as the Asian Development Bank (ADB) gets further involved in health system strengthening. Forecasting at the local and provincial level and adequate information systems to inform supply chain decisions are weak. CSOs, particularly those relying on HIV treatment, have no system to flag stockouts in a particular site or region.

In ROP19, TA to local facilities will support identification of patient loads and needs, tracking of inventories, forecasting and general supply chain procedures to ensure adequate supplies. At the provincial level, systems will be reviewed to see that there is adequate consolidation of systems, minimally using PEPFAR-supported sites as references to monitor system improvement. Following the system up the chain to the national level, a mobile supply system that was developed to inform decision makers on the current situation, gaps, and future needs will be strengthened. Going down the chain, national systems will verify the needs at the different levels and ensure a more accurate forecasting, planning, purchasing and distribution of HIV commodities. TA will also be given so the NDoH can adequately plan and budget for more effective and transparent procurement of HIV commodities. At the community level, CSOs, particularly those relying on ARVs, will be supported in the development of a communication platform to flag stockouts at the different levels of the health system.

5.4 Collaboration, Integration and Monitoring: As resources continue to diminish and donor funding landscapes become more volatile, PEPFAR PNG will advocate for development of mitigation strategies. PEPFAR will do this by supporting the GoPNG and partners to plan sustainable models of financing, sourcing financing locally from the private sector, while encouraging NDoH and NACS to continue the leadership role through implementation of the new HIV strategy.

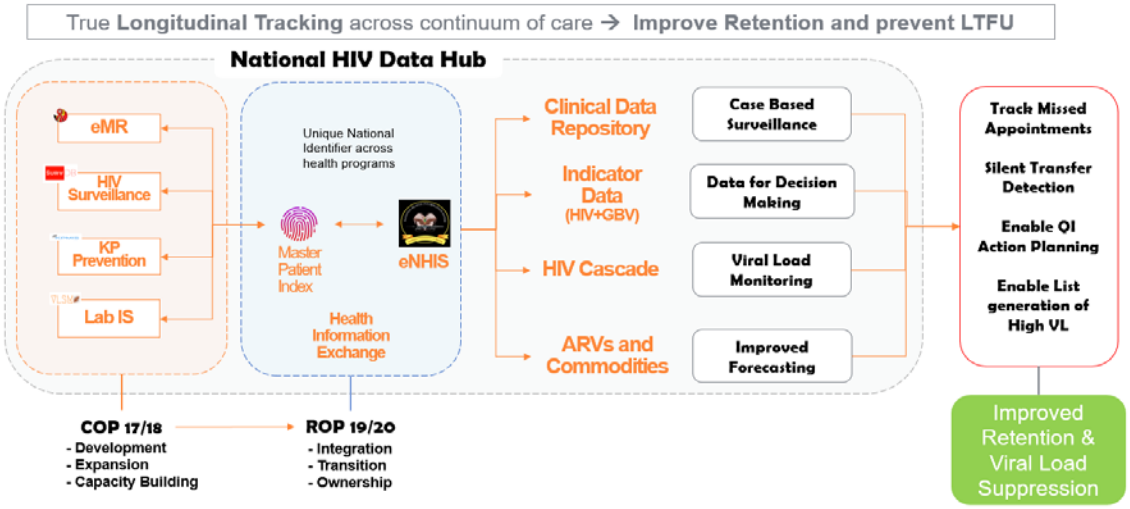
As NACS regains its role in coordinating efforts to reach sustainable HIV/GBV financing, and the decentralization process advances with the expectation of increased commitment of the PHAs to finance HIV activities, there is a need to support these offices to adequately budget and plan. PEPFAR PNG will support NDoH/NACS and NCD PHA in planning and budgeting of HIV activities, particularly as they refer to the acquisition of commodities and delivery of services. This may

include financing CSOs and FBOs for improved prevention and service delivery and community outreach. This will require coordination with other stakeholders such as GF, the ADB, and WHO.

In ROP19, PEPFAR PNG will reduce its spending in prevention significantly; most funding will be channeled to closing treatment gaps. These shifts in spending will require coordination and the PEPFAR team stands prepared to support the GoPNG to fully understand this process and charter the future accordingly. The PEPFAR PNG has and will continue to be a key player in all national coordination technical working groups (TWG): the national HIV-TWG, the HIV sub-SITWG, the HIV sub-VL TWG, and sub-Forecasting TWG. PEPFAR PNG will advocate and share best practices and emphasize on everyone's role in this challenging fiscal environment. UNAIDS, WHO, and other UN organizations have, as well, acknowledged PEPFAR's contributions, and they stand together to reinforce mutually benefiting processes for all players in the fight against the HIV epidemic. PEPFAR PNG has achieved a significant amount of its policy goals through these TWGs and will continue to capitalize on them for sharing future strategies and sustainable programming. Finally, to support overall coordination and to enable a more targeted HIV response, PEPFAR PNG will bring to bear its expertise in health information systems and data analytics by continuing to invest in vital information systems that support treatment, monitoring, and surveillance.

PEPFAR's investments in eHealth over the last two years, supporting the expansion of the HIV Patient Database (HPDB), development of the national HPDB data portal, creation of the first VL sample management system and decentralization of HIV surveillance has caused a shift to a more data-driven response by the national program. To capitalize on these developments, the national HIV data consensus group agreed to support PEPFAR's ROP19 initiative to develop an HIV datahub to help consolidate, analyze, and integrate all HIV data into the electronic national health information system (eNHIS) linked through a universal UIC that would allow for true longitudinal tracking of PLHIV across the continuum of care (see Fig 5.4.1).

Fig. 5.4.1 National HIV Datahub Proposed System Architecture and Outputs



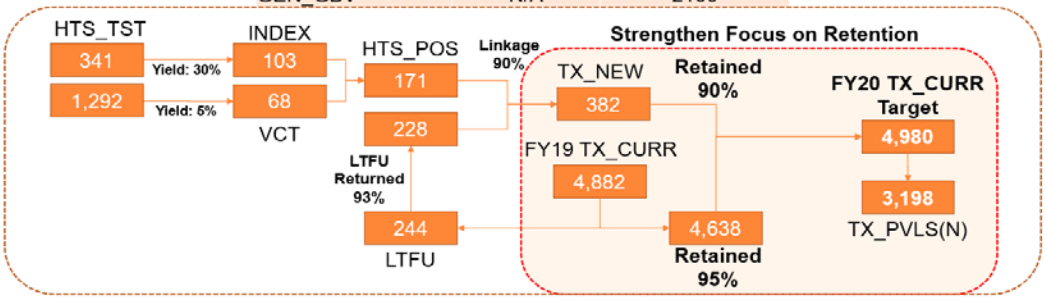
A priority of the HIV datahub will be to support the efforts to improve retention through the use of the UIC to improve tracking and tracing, appointment reminders and silent transfer detection. It will also support VL scale up through integration of the VLSM and the ability to generate high VL patient lists to maximize the effectiveness of adherence counseling.

The HIV Datahub is a vital step towards sustainable transition to GoPNG as appropriate technical capacity is developed within NDoH and the system is used to automate the generation of national, provincial, and site-level data analysis that, until now, have been extremely labor-intensive and required extensive technical expertise to produce.

5.5 Targets for scale-up locations and populations: ROP19 targets will be from NCD sites only, while national level TA will be captured through Table 6 benchmarks. Monitoring activities will cover the national program to ensure that the PEPFAR team adequately catalyzes best practices across the cascade and geographical hotspots. Figure 5.5.1 shows the ROP19 targets for NCD. ROP 19 will prioritize retention over case finding with an expected retention rate of 95% and 93% of LTFU being returned to care to achieve viral suppression.

Fig 5.5.1 ROP 19 Target summary for PEPFAR-supported SNU – NCD

ROP 2019 (FY 20 Targets)	Requirement per PLL	Data Pack Submission
HTS_TST	N/A	1,633
TX_NEW	N/A	382
TX_CURR	4,016	4,980
TX_PVLS(N)	N/A	3,198
GEN_GBV	N/A	2100



6.0 Program Activities for Epidemic Control in Sustain Countries

Tier 3, Sustain Epidemic Control
Cambodia

Tier 3: CAMBODIA

6.1. ROP19 Programmatic Priorities: Cambodia is the sole country in the "Sustain Epidemic Control" tier. The S/GAC FY19 Planned Allocation and Strategic Direction notification letter instructed Cambodia to focus on sustainable financing and strengthening national systems to identify and respond to new infections. In addition to this overall strategic direction, during the ROP19 Bangkok Review Meeting in April 2019, Cambodia received constructive and strategic comments on focus activities which are described further in Section 6.

6.2 Targets for Attained and Sustained Locations and Populations: Cambodia does not report MER indicators and therefore does not have targets.

6.3 Establishing service packages to meet targets in attained and sustained districts: In general, Cambodia PEPFAR will continue to focus targeted TA to the above-site level in Phnom Penh municipality, Battambang, Banteay Meanchey, and Siem Reap provinces, as these four locations include nearly 60% of PLHIV. Greater emphasis on national scale-up of key activities such as index case testing, MMS, same-day ART, TLD, and use of recency assay testing will occur during the remainder of COP18 and continue through ROP19. Cambodia PEPFAR will continue to support above-site programs to address three key system barriers: insufficient case finding efforts, inefficient quality management systems (including efficient means to track patients through the HIV cascade), and inadequate domestic financing.

7.0 Program Support Necessary to Achieve Sustained Epidemic Control—by country, by Tier

Tier 1, Accelerate and Achieve Epidemic Control
Burma, Kyrgyz Republic, Nepal, Tajikistan, and Thailand
Tier 2: Protect the Investment
India, Indonesia, Laos, Kazakhstan, and Papua New Guinea
Tier 3: Sustained Epidemic Control
Cambodia

Tier 1: BURMA

Burma has insufficient capacity to fully operationalize current policies, guidelines, and innovative cost effective interventions to achieve the vision of 90-90-90 by 2020, which has been committed in current NSP III (2016-2020). Key system barriers are inadequate numbers of human resource at public health sectors to perform outreach strategies to effectively reach KP for better yields and linkages to services, inability to provide KP-friendly HIV services at public health facilities to sufficiently address stigma and discrimination issues as well as poor coordination effort at SNU levels and service delivery points.

To address these barriers, Burma PEPFAR will expand above site TA to fully operationalize those strategies articulated in current NSP III (2016 – 2020). Burma PEPFAR strategies for COP 19 were developed in close consultation and collaboration with relevant in-country government and non-government stakeholders, the GF, other donors, service providers including implementing partners and civil society networks and organizations to close remaining gaps for achieving epidemic control. Specifically PEPFAR will have increased emphasis on providing above site TA by developing quality monitoring tools and operational SOPs for enhanced case finding and linkage to treatment, retention in care with high adherence by promoting differentiated service delivery approaches, and documented VL suppression to achieve UNAIDS 90/90/90 goals among selected KP groups. Burma PEPFAR site level activities will utilize all above tools and SOPs, developed by national program with the support of PEPFAR, when scaling up innovative interventions targeting specific KP groups. Experiences and lessons learnt from Burma PEPFAR Program will be shared concurrently with the GF partners and national program to achieve epidemic control at national level by 2020.

To achieve the goal for 90-90-90, PEPFAR will build the capacity of KP peer navigators who are working at public health facilities and in outreach settings in five high-burden regions. During COP17, PEPFAR successfully introduced the KP-friendly services model at public health facilities with the pilot project in one PEFPAR priority area–Yangon Region. PEPFAR TA will expand this success story to all PEFPAR priority regions, especially for clinicians and public health service providers working at public health facilities. Key innovative solutions supported by PEPFAR implementing partners will also include KP peer-led case management system for linkage to and retention in care, community based ART initiation, and ART pick-up models for hard to reach population, the expansion of existing and new social media and mHealth platforms to increase demand creation for ART and VL, and the development of community-based adherence and support groups for ART delivery and adherence.

To halt the trend of new HIV infection, Burma PEPFAR above-site investment will initiate implementation of PrEP in high burden areas, scale-up of index testing strategy and introduction of recency testing and self-testing in the country. Complementing PEPFAR above-site activities, PEFPAR's IPs will demonstrate the uptake of PrEP for MSM, TG and PWID, and adopt innovative case finding solutions such as index testing, partner initiated testing and counselling, social network testing, and self-testing targeted for KP groups.

Disaggregates for KP by HIV sero-status and enrollment on ART are not available in Burma's National AIDS Program report and SI remains a core activity for COP 2019 to produce valid cascade data for 90-90-90. PEPFAR will provide technical support for availability of HIV cascade data for each key population at national and subnational level, development of a unique identifier system for those key population who are reached and tested, and establishment of an HIV case-based surveillance system.

Burma has enough VL instruments, but their utilization is very low. Key issues are poor coordination among clinicians, VL facilities, and public health facilities to increase VL demand-creation, facilitate VL specimen transportation and improve result turnaround time. PEPFAR will provide monitoring and coordination TA by assigning laboratory advisors for five high-burden regions. In addition, quality performance of all VL platforms remains unaddressed till and therefore, PEPFAR will provide technical support to empower laboratory managers and staff from national reference laboratory to manage and supervise all VL platforms in order to provide reliable VL results for all clients. Similarly, PEPFAR will build the capacity of national reference laboratory to manage national proficiency testing program for external quality assurance to cover all point of care HIV testing sites and HIV laboratories facilities (about 1500 HIV confirmatory testing sites including those from public and INGOs). This will be achieved by PEPFAR TA on the introduction of electronic proficiency tool to manage proficiency data for all testing sites including VL testing laboratories.

Throughout the COP 19 implementation period, the USG team, PEPFAR-funded implementing partner agency staff, CSOs, and network representatives will be pro-actively involved in the development of next round of NSP for 2021-2025 as well as the GF concept note to contribute and help inform key decisions and priorities for country ownerships and accountability to sustain COP19 interventions.

Tier 1: KYRGYZ REPUBLIC

PEPFAR will increase above-site support to assist the Kyrgyz Republic to reach epidemic control and institutionalize sustainable systems. The ultimate goal of the systems investments is to ensure a stable and sufficient HIV response as external donor support decreases. This will require adequate and increasing government investment in the HIV response, including support of CSOs, national implementation of the Minimum Requirements, and strengthening of the ART supply chain.

The Republican AIDS Center has expressed its commitment to move towards sustained epidemic control. Currently the Global Fund procures ARVs and related commodities for the country, although the government has committed to gradually increase funding of procurement of ARVs. The GF is a powerful voice in policy decisions, so buy-in and support from the GF will be necessary to achieve epidemic control. The PEPFAR team will continue dialogue at the country level and relies on higher-level discussions between S/GAC and Global Fund Geneva to ensure this support and engagement in Kyrgyz Republic. PEPFAR also will provide national-level

TA to the government on procurement of ARVs and will initiate cooperation with the private sector to extend ARV accessibility.

In addition, PEPFAR will provide national-level TA on developing a social behavior change strategy (including messaging relating to stigma, self-stigma, confirmatory testing, treatment initiation, and adherence). PEPFAR also plans to provide TA to the Mandatory Health Insurance Fund (MHIF) for incentivized payments to health providers for adherence, as well as TA on self-testing, PrEP, and registration of drugs and commodities.

Through a supply chain mechanism, PEPFAR will provide TA on community-based ART per the strategy endorsed by the RAC in the National Plan for ART Retention 2018-2021, and will procure rapid tests for confirmation and ART for same-day initiation in communities if necessary. It is important to note that increased PEPFAR engagement in case finding among new KP groups as described in Section 3.0 might also free up resources within the GF program to invest towards additional ART procurement as needed. In addition, PEPFAR will provide TA on LMIS for quantification of drugs and commodities, TA on TLD transition, and TA to the RAC on decentralized supply chain management.

The three key systems gaps identified for Kyrgyz Republic and related PEPFAR Table 6 activities are discussed below.

Key Systems Barrier #1: Quality of HIV treatment services not consistent with international/ PEPFAR/WHO standards: The government of the Kyrgyz Republic is committed to completing achievement of the Minimum Requirements, which will largely bring HIV services in line with international standards. PEPFAR will work with Kyrgyz Republic to implement all PEPFAR Minimum Program Requirements in ROP19, including: (1) expand and improve index testing, case finding and linkage to ART at facility and community levels; (2) fully implement Test & Start; (3) adopt and rollout multi-month scripting for stable patients; (4) complete transition to TLD; and (5) compete VL optimization and provide annual VL test for all patients on ART.

In order to accelerate this process, the PEPFAR-supported Leader project will hire additional staff in Kyrgyz Republic specifically to work with the RAC, the CCM, GF, the Government of the Kyrgyz Republic, and other partners at the policy level. All PEPFAR IPs will be heavily engaged in policy dialogue and advocate for the necessary policy changes to complete TLD transition, multi-month dosing and community access to ART for stable patients, scale up of index and self-testing as appropriate, direct and immediate linkage of all HIV-positive clients from testing to treatment, and VL optimization. In conjunction with site level training and mentoring support at the facility and community levels, as well as through collaboration with the Global Fund, PEPFAR will help to ensure that the remaining Minimum Requirements are fully implemented throughout the country.

Key Systems Barrier #2: National HIV response not fully monitored, managed and financed by the host country: Sustainable financing is required to ensure a sustained HIV response. While the Kyrgyz Republic is a lower-middle income country, it has decreasing GNI and many pressing

health concerns, so will likely continue to rely on external donors to support the HIV response for some time. On the other hand, the Kyrgyz Republic has a robust civil society, with PLHIV and KP actively engaged with the RAC and other partners, and has committed to increase domestic funding through the State Program 2017–2021 and UNAIDS 2020 Road Map. In order to ensure sustained financing along with continued community empowerment, PEPFAR will increase support to expand and strengthen existing mechanisms (Social Contracting) for funding local CSOs involved in the HIV response.

PEPFAR above-site support to implementing the Minimum Requirements and strengthening services throughout the cascade will lead to efficiencies in financing and human resources. Making the TLD transition will lead to more stable patients, with fewer lost-to-follow-up. Community case finding, adherence support and distribution of ART and PrEP will alleviate the burden on health care workers as more PLHIV initiate treatment.

Supply chain management is a key area of focus to ensure sufficient and optimal commodities are available to achieve and sustain epidemic control. PEPFAR will provide supply chain management technical assistance to assist in forecasting for rapid TLD transition, rapid attainment of the second 90, MMS, and PrEP for the highest risk individuals.

External Quality Assessment (EQA) is a multi-year endeavor, which requires substantial multilateral efforts. To sustain ongoing EQA efforts, PEPFAR will continue to build the capacity and support the Kyrgyz Center for the Quality Control of Laboratory Diagnosis of Infectious Diseases (the Kyrgyz Lab QC Center). This is the only independent HIV-related EQA/PT provider in Central Asia. Considering its unique functions and history of successful EQA/PT programs at the national and regional level, PEPFAR will continue involving the Kyrgyz QC Center and inviting international subject matter experts to provide above site technical assistance to Ministries of Health/AIDS centers in developing and implementing EQA/PT in PEPFAR supported countries in the region. PEPFAR will continue supporting participation of Kyrgyz Republic laboratories in international EQA/PT programs to help them become proficient and expand EQA/PT programs countrywide.

PEPFAR will support RAC in DQA, analysis and use of data from EHCMS for program quality improvement. Within cooperative agreement RAC will start to report some MER indicators (HTS_TST_TA, TX_NEW and TX_CURR). The MOH Order on HIV services decentralization contains check-lists for sites' performance monitoring and assessment. RAC will routinely conduct monitoring sites visits, aimed to conduct monitoring visits with use of check-lists (based on principles of PEPFAR SIMS visits), DQA in EHCMS and mentoring for site staff. Also, plans for continuous quality improvement of sites performance will be introduced into sites based on monitoring site visits. It will allow to improve performance and validity of data for each particular site and countrywide. PEPFAR will also support national interagency TWG, including representatives from the National Statistical Committee to solve the issue with data validation on PLHIV who have died. Different agencies have different statistical forms, which need to be harmonized and accepted by all stakeholders and amended to allow exclusion of PLHIV who have died from EHCMS.

PEPFAR will intensify VL optimization work through on-site mentorship support, on-the-job training, nurse case-management and assistance in technical maintenance of equipment. PEPFAR will support RAC staff engineers to participate in the certified course for the GeneXpert platform.

Key Systems Barrier #3: Lack of sound, current health and epidemiological data for decision-making: In ROP18, PEPFAR provided technical and financial support for a formative assessment to lay the groundwork for a Biological and Behavioral Surveillance (BBS) survey to be conducted in ROP19. The survey among PWID and MSM will provide a valuable snapshot of the HIV prevalence among these groups. A BBS conducted in Tajikistan in ROP17 with significant PEPFAR technical oversight revealed that the gaps between the estimated PLHIV PWID, those who know their status and those who are on treatment were much smaller than anticipated. This allowed PEPFAR to appropriately target resources towards the largest gap—VL suppression. With a similar epidemic in Kyrgyz Republic, accurate data from the BBS will allow all partners to take a more targeted approach with limited resources.

Tier 1: NEPAL

PEPFAR has identified three major barriers in Nepal: (1) policy implementation barriers for the expansion of community-based ART; (2) deficits in the capacity to conduct forecasting, quantification, procurement, and commodity logistics/supply chain activities, impacting multiple interventions; and (3) lack of a unified national information system with UIC. These are all further impacted by a funding gap in the national HIV/AIDS response, and the need to enhance domestic resource mobilization and sustainable financing.

In coordination with the GF and GON, TA, advocacy, and other above-site activities by the USG in ROP19 will help to resolve these gaps and result in the national expansion of community-based ART, resulting in improved ART coverage and retention; resolution of a number of commodity and stock-out issues, enhancing national results for testing, treatment (including TLD transition), and VL testing; and the existence of a single, integrated national HIV information system, based on DHIS2, and with UICs, which will improve national ability to monitor implementation, make prompt and targeted adjustments to improve performance, and track progress toward epidemic control.

PEPFAR will work with other stakeholders on all of these issues. For community-based ART, ART will be provided by the GON, and TA will be coordinated with the GF for non-USG-supported sites. For commodity issues, most TA is provided by GF; the USG will coordinate closely with the GF and the GON on additional TA. All procurement is done through GON systems, and partner efforts will strengthen these systems. For the national HIV information system with UIC, partial systems currently exist and are supported by the USG and GF/GON. PEPFAR will coordinate with the GF, GON, and other partners to integrate these systems to form one unified national system, which will be owned and managed by the GON. All interventions have clearly defined, objective indicators and benchmarks against which to measure progress and success.

Tier 1: TAJIKISTAN

PEPFAR will increase above-site support to assist Tajikistan to reach epidemic control and institutionalize sustainable systems. The ultimate goal of the systems investments is to ensure a stable and sufficient HIV response as external donor support decreases. This will require adequate and increasing government investment in the HIV response, including support of CSOs, national implementation of the Minimum Requirements, and strengthening of the ART supply chain.

The Republican AIDS Center (RAC) has expressed its commitment to move towards sustained epidemic control. The GF procures ART and related commodities for the country and is a powerful voice in policy decisions, so buy-in and support from the GF will be necessary. The PEPFAR team will continue dialogue at the country level and relies on higher-level discussions between S/GAC and GF Geneva to ensure this support and engagement in Tajikistan.
Table 6 includes two key systems barriers for Tajikistan. The quality of HIV treatment services is not consistent with international/PEPFAR/WHO standards. In addition, the national HIV response is not fully monitored, managed, and financed by the host country.

Key Systems Barrier #1: Quality of HIV treatment services not consistent with international/ PEPFAR/WHO standards: PEPFAR will work with Tajikistan to implement all PEPFAR Minimum Program Requirements in ROP19, including: (1) expand and improve index testing, case finding and linkage to ART at facility and community levels; (2) fully implement Test & Start; (3) adopt and rollout MMS for stable patients; (4) complete transition to TLD; and (5) complete VL optimization and provide annual VL test for all patients on ART.

PEPFAR will work with facility- and community-based IPs to evaluate and improve index and partner testing approaches and ensure all clients testing positive are immediately linked and initiated on ART. PEPFAR will also work with the RAC to adopt and implement continuous quality management systems and mentoring to ensure HIV care and treatment are client and key population-focused, and effective at achieving retention and adherence for all clients initiating on ART in Tajikistan.

Key Systems Barrier #2: National HIV response not fully monitored, managed and financed by host country: Tajikistan is one of the poorest countries in Central Asia, and will likely continue to rely on donor resources to fund the HIV response. PEPFAR will work with the GF and Tajikistan to collect and analyze data across the entire response (above-site and site level) to understand the activity-level costs of the HIV response. This information will be used to drive program priorities and promote efficiencies to help achieve an effective and sustainable response.

PEPFAR will also encourage and promote more effective engagement and leadership from PLHIV and civil society in the delivery of HIV services in Tajikistan. In ROP19, PEPFAR will work with Tajikistan to adopt and expand strategies such as social contracting mechanisms to support community-based testing, ART, PrEP and enhanced retention and adherence support

activities. PEPFAR will work with Tajikistan to reduce stigma and discrimination related barriers that KP face when accessing services, which undermine efforts towards effective and sustainable responses to HIV/AIDS.

Tier 1: THAILAND

In ROP19, the Thailand PEPFAR team will focus its above-site support on three main system gaps:

- Low coverage of KP case finding and linkage to care, ART initiation, and retention for PLHIV;
- Limited scope and quality of national HMIS systems for HIV cascade monitoring for KPs and PLHIV
- Lack of effective mobilization of central and local resources to support community KP services.

To address the first gap, the Thailand PEPFAR team and its implementing partners will increase capacity and knowledge of health care providers through above-site capacity building, advocacy, and policy support in key areas: index partner and recency testing, increasing uptake of MMS, VL testing and suppression, TLD transition, PrEP implementation and TB preventive therapy (TPT). The national treatment guidelines are being updated and an enhanced counseling package developed to improve adherence and retention, for KP and PLHIV. PEPFAR will continue to support differentiated care models for MSM and TG, using task sharing between facility and community-based services. KP Led Health Services remain a cornerstone of the response and will continue to network deeper into highest risk networks using various modalities described above. PEPFAR also will support capacity building for HIV case management coordinators and peer navigators who are expected to play pivotal roles in linking and re-engaging MSM/TG to testing, treatment, and PrEP. PEPFAR will continue to promote SDART at the policy level with further support to the adaptation of guidelines, and at the site level with TA and on-site training to facility and community-based care providers. Additionally, PEPFAR will continue to provide TA support to expand a VL alert system using an electronic data interchange, establish a viral load testing network and review site VL testing performance data. To address some of the barriers to PrEP uptake, a coordinated, targeted PrEP demand-creation campaign will be implemented in high-burden areas, building on previous promotional efforts supported by PEPFAR, to help reduce stigma and misconceptions associated with PrEP use. Similarly, PEPFAR support a focused media campaign on the U=U concept to enhance positive attitudes toward SDART among providers and PLHIV.

For the second gap, PEPFAR will address the HMIS challenges in several ways to better monitor performance. To ensure that the national program monitoring data base (NAP and RTCM) is used to its maximum capacity, PEPFAR will provide TA to perform regular data quality control to ensure improved tracking throughout the KP cascade. In Bangkok, with among the highest HIV burden, PEPFAR will work with the Bangkok Metropolitan Administration to establish a Health Data Center to improve its monitoring system for the KP cascade, as well as conducting mortality and morbidity surveillance. For PrEP, the reporting system will be strengthened to

provide more timely feedback to health care providers. Additionally, a national workshop will be held to review PrEP performance among government and CBO providers to inform strategies for partnership, facilitating PrEP scale-up among KP. In compliance with the national eHealth strategy 2017-2026, PEPFAR will continue to strengthen national data exchange and for subnational management, strengthen the use of eHealth for HIV-related surveillance and program monitoring. This will improve access and routine use of data for evidence-based program planning. Lastly, an innovative surveillance strategy using web-based respondent-driven sampling to recruit MSM and TG will be used to monitor program progress. In ROP19, UICs will be used by facilities and peer navigators to track testing, ART initiation, VL monitoring and suppression. These UICs and associated data are managed in eCascade, a system supported by PEFPAR, which allows the local organizations who serve clients to monitor performance.

PEPFAR will tackle the third gap by building on the catalytic successes of PIF (ROP17-18) and advocate for NHSO to further increase domestic funding through social contracting, and with the MoPH to establish a CSO/CBO certification system which will be the foundation of funding for community-led HIV services. Local resource mobilization for CBO services will also be integrated in provincial AIDS operational plans to ensure sustainable funding at community level. Additionally, support will be provided to CSOs to organize fora to advocate for increased funding for KP-led health services from the NHSO.

Tier 2: INDIA

Despite progress in generating more reliable and regular program data and trends across consistent sites for epidemic monitoring, India has seen slow progress in integrating its multiple data systems that cater to different program components. There is a crucial gap in the inability of the system to conduct patient-centered tracking with unique identifiers; this directly impacts the quality of the data, both aggregate and at site-level, and therefore our progress toward epidemic control in India.

Strengthening data systems will be a key activity at the above-site level. India PEPFAR partnerships with UNAIDS, WHO, and PATH facilitate high-quality data generation, data sharing, and data use to drive crucial programmatic decisions to analyze epidemic trends. PEPFAR will support the collection, analysis, and use of data for decision making. In this regard, India PEPFAR above-site support will strengthen systems and capacities to produce, analyze, and use data at the national level and in the clusters to characterize local epidemics and guide timely response and corrective actions to achieve 90-90-90. This includes support for the national HIV estimation exercise that ensures that India uses high quality population estimates to measure and track progress in controlling the HIV epidemic. With a more decentralized response, the need for district estimations of the PLHIV burden has been a focus of advocacy with NACO, directly and through multilateral partners. PEPFAR India will focus on strengthening methodologies for district burden estimation and ensure scale-up for facilitating district cascades analyses, including KP cascades, across the country. These cascades serve as benchmarks against which we can monitor our progress toward Table 6 goals. Support will be provided for national and sub-national epidemiological analysis in PEPFAR-supported districts

to identify KP, typologies, and geographies with consistently high positivity and high-risk behavior.

PEPFAR India, through above-site support, provides TA for national sentinel surveillance to ensure high quality standards, with adherence to surveillance methodology and continual improvements in surveillance protocols. PEPFAR India will provide TA for: (1) updating KP size estimates (a key input into the Spectrum-based modeling for HIV estimation and longitudinal prevention cascades); (2) improving the efficiency and frequency of behavioral data collection from KP, (3) facilitating epidemiological profiling of districts for prioritized resource mobilization and epidemiological analysis of drivers of the epidemic; (4) supporting cross-sectional/longitudinal cascades analysis linking findings to site-level issues to address the leaky clinical cascade; and (5) strengthening institutional and human capacity in data management and use through innovative approaches such as continuous quality improvement (CQI). PEPFAR India will recognize achievements in the use of data for decision making, through national dashboards, compilation of epi profiles of states and districts and documentation of the key innovations from the cluster districts that lead to above-site impact.

While India has adopted a number of WHO-recommended policies over the last two years, there are several more that need to be fully implemented to fast track the national HIV/AIDS response and meet its 2030 target of epidemic control. The delay in fully adopting key policies such as PrEP, same-day ART initiation, six-month MMD, routine VL, and TLD transition is a system barrier, and PEPFAR India will continue to prioritize policy adoption in ROP19 with increased advocacy.

Tier 2: INDONESIA

PEPFAR Indonesia's efforts to align with Tier 2 requirements by addressing key system, policy, and practice gaps related to the optimization of treatment outcomes by differentiating HIV treatment support, index and network testing, and case management based on viral burden and strengthening are reflected in the above-site activities outlined in Table 6 for ROP 2019.

To address these gaps, PEFPAR will expand, strengthen, and institutionalize the following: (1) Differentiated service delivery (DSD) models that optimize treatment outcomes and achieve viral suppression; (2) policy frameworks, M&E and supply chain systems, and technical capacity for treatment optimization and VLS; and (3) Indonesia's efforts to sustain financing for control of the HIV/AIDS epidemic and high-level engagement to influence political will.

The national HIV program lacks implementation of international standard best practices for retaining PLHIV in HIV services. There is currently 78% retention at the first 12 months in the 2017 ART cohort and 91% retention at six months in the 2018 ART cohort. In ROP19, efforts will focus on increasing retention to 85% at 12 months for the 2018 ART cohort and 95% retention at six months for the 2019 ART cohort that will be achieved by strengthening and operationalizing HIV data management systems to ensure optimal ART retention. In order to improve tracking and response to LTFU, PEPFAR Indonesia developed the ARK v.6 and Jak Trak

platforms which have been installed at 100% of PEPFAR-supported facilities. In ROP19, the Jak Trak applications will be systematically utilized by at least 75% of PEPFAR-supported facilities to track and respond to LTFU. In addition to these efforts, capacity building activities for district teams will support systematic application of Test & Start, index testing, differentiated care (MMS), LTFU response systems, VL monitoring and community-based service sustainability with the goal of reaching at least 90% VL testing coverage of TX_CURR clients at PEPFAR-supported facilities and at least 50% of PEPFAR-supported CSOs having direct access to Government of Indonesia funding. Lastly, PEPFAR Indonesia will provide TA to the MOH to improve data collection, analysis, and application of findings to national HIV program implementation, so the MOH will have the capacity to analyze testing and treatment data for 20% of high burden HIV districts in Indonesia and send feedback to District Health Offices for sub national HIV program implementation.

Inconsistent access to key HIV service commodities is another key barrier to improving PLHIV retention and VL suppression. PEPFAR Indonesia will work with the MOH and GF to develop an institutional multi-stakeholder platform to review supply chain data regularly and to use that data for decision-making, including forecasting, supply planning and monitoring functions to increase accountability and transparency and ensure commodity availability for expanding programs. These efforts will be focused on expansion of TLD, and other key ARV products, and to identify opportunities to optimize VL testing and reduce costs. In addition, focus will be placed on ensuring sufficient supplies are procured at the national level and are allocated to the Jakarta province to support national and Jakarta specific achievements. These efforts will result in 35,000 VL reagents being procured nationally (15,000 to Jakarta) to achieve TX_PVLS testing targets. There will also be close coordination with GF and PEPFAR partner LINKAGES to procure a first batch of recency tests for Jakarta Province PEPFAR DSD sites.

PEPFAR Indonesia also will coordinate with the MOH, GF, WHO, and CHAI to accelerate TLD transition at the national level and specifically for the Jakarta Province, and with a focus to support the provincial health office to ensure a reliable supply of TLD and other essential ARVs. These coordination efforts will leverage GF resources to purchase TLD for Q1 2020 for Jakarta Province to further catalyze the transition. In addition to these activities, PEPFAR Indonesia will use 90-day TLD kits for MMS for TLD eligible patients at four main PEPFAR DSD sites in Jakarta. PEPFAR Indonesia will support CSO engagement and advocacy with the MOH and Expert Panel around TLD and MMS to accelerate roll out, approvals, and endorsement for use at national levels and in Jakarta. These efforts will lead to the registration of TLD by at least two manufacturers in Indonesia, an increase in TLD access with a goal of 100% of all new patients initiated on TLD in Jakarta, and 25% of eligible TX_CURR patients in Jakarta transitioned to TLD. Another key activity to support access to key HIV service commodities is to leverage GF resources to support National Reference Laboratories in implementing EQA/PT for VL. In ROP 19, the MOU with Abbott, wherein Abbott will be contributing USD 1.2M, will be finalized to strengthen VL laboratory reporting and networks, including negotiations around VL reagent price reductions. These efforts will result in 15,000 tests being conducted in Jakarta and five Abbott labs in Jakarta functioning properly by maintaining a 0% stockout rate, all labs passing EQA/PT, and VL prices being reduced by 10%.

The Military SID 2016 identified the following gaps: (1) commodity security and supply chain; (2) resource mobilization; and (3) technical and allocative efficiencies. All logistics test reagents and ARVs for military health facilities is supported, managed and monitored by the MOH. The PEPFAR fund assisted the Indonesian military TNI to develop annual planning and a logic framework. In 2018, this project helped the Ministry of Defense to develop basic regulation (Permenhen) as the umbrella for HIV Prevention, Care and Treatment program. Since 2106, PEPFAR funds have assisted the Surgeon General's Office in reaching five additional military health facilities each year to start providing care, support and treatment services. In ROP19, the Office will continue to increase the number of health military facilities providing treatment services. This will include improving the quality of health services of military health facilities through a monitoring system on treated military client. In enabling the third 90 on virally suppress military population, coordination with MOH on VL machines is needed to increase number of VL machines for the military since the VL machines are located only in Jakarta and Central Java. Approximately 50% of all PLHIV in the military are located in Jakarta.

Tier 2: KAZAKHSTAN

As seen in Figure 2.1.4, new HIV cases and deaths are rising in Kazakhstan, and new cases outnumber deaths. The HIV epidemic in Kazakhstan is growing; and the country has not yet achieved sufficient prevention, treatment, and viral load suppression rates to achieve epidemic control. PEPFAR is ROP19 Tier 2 country focusing on maintaining its investments in two sub-national units, and on above-site support for attainment of the 90-90-90 targets nationally.

PEPFAR's above-site support in Kazakhstan focuses on two main objectives: (1) improving the quality of HIV treatment services to international (WHO and PEPFAR) standards nationwide; and (2) ensuring that the national HIV response is fully monitored, managed and financed by the government of Kazakhstan. Activities on the first objective included providing technical assistance to the RAC to develop and implement policies and guidelines consistent with the minimum guidelines expressed in the ROP Guidance. PEPFAR will support training and mentoring of HIV service providers and will support RAC to implement a routine Continuous Quality Improvement method for ensuring quality services nationwide as noted in section 4.5. For quality of VL monitoring, PEPFAR will work with RAC on quality assurance of viral load and HIV testing as well as training and maintenance of the VL equipment.

For the second objective for above-site support, PEPFAR will advocate and provide technical assistance to the government to increase efficiencies in HIV services and improve access to social contracting of NGOs/ CBOs to perform community level work. PEPFAR will continue to work with RAC and other partners on improvements to the system of quantification, procurement, and distribution of ARVs; including ways to access reduced price TLD.

In FY19, Kazakhstan plans to provide ART to 18,082 PLHIV (69% of estimated PLHIV), and 19,500 PLHIV (75%) in 2020. With a lower price of DTG-containing regimens and the same ARV budget from the government, Kazakhstan could reach 21,163 patients in 2020, which would be 81% of

current estimated PLHIV. If the number of PLHIV continues to grow, despite the recent ramp up of treatment, the 81% coverage goal would require a higher number of PLHIV on ART.

Tier 2: LAOS

The Laos team identified three main system gaps to be addressed in ROP19:

1) Limited staff capacity: There is a need to maintain a strong national HMIS for HIV cascade monitoring and HIV/AIDS data analysis and use for ART services improvement and national and subnational program planning.
2) High rate of LTFU and death among PLHIV in ART sites: There are a limited number of ART sites and, for many clients, long distances and costs associated with traveling to ART sites.
3) Lack of commitment of domestic financing mobilization to respond to the HIV epidemic.

To address the first gap, the Laos PEPFAR team will provide TA at national, provincial and site levels. The GOL uses a system-based UIC to monitor clients; using it to link data and track patients throughout the HIV cascade is still imperfect and will be strengthened in FY2020. In ROP19, UICs will be used by facilities and peer navigators as they track ART initiation, viral load monitoring and suppression, and index testing. These UICs and associated data are managed in eCascade, a system supported by PEPFAR, which allows local organizations who serve clients to monitor performance through user-friendly dashboards.

Health care providers at national and subnational levels will be trained to use an ART quality improvement dashboard to enhance adherence counseling. Data will inform the Laos National HIV Strategic Action Plan 2021-2025 and provincial and HIV/AIDS Plans in FY2020. Strengthening systems and improving data use are integral to monitor with site-level activities focusing on retention and viral load suppression among KP in PEPFAR-supported provinces.

For the second gap, PEPFAR will strengthen capacity of community- and facility-based health care workers on ART and VL suppression and monitoring. The Department of Health Care of the MOH has recently made progress in the area of quality assurance with its policy on health care service quality assurance of “five good, one satisfaction” at all levels of health facilities in Lao PDR, and its development of a new national HIV/AIDS quality management plan. In ROP19, PEPFAR will build on this success by providing TA on the implementation of QI/QM activities pertinent to ARV care and treatment services. To complement the work being done at the site level, the team will support National QI Workshops, to include coaching and an enhanced adherence-counseling package for implementation at ART facilities to address LTFU clients, VL suppression, and stigma and discrimination, and to improve retention in care and index testing. PEPFAR will establish and decentralize differentiated care and multi-month ARV drug prescription services in all ART sites and provide TA on community-based differentiated service delivery by FY2020. The team will also provide technical support to government and GFATM-supported sites on self-testing and index testing guidelines, transitioning from case-finding

activities to community support for treatment retention and index testing among KPLHIV (MSM and TG).

Finally, PEPFAR will tackle the third gap by ensuring key HIV-related policies and program directions are adopted and implemented by strengthening the coordination of the national ART committee and promoting activities that increase domestic resource mobilization. To do this, the Laos PEPFAR team will provide TA and try to ensure that ART service QI indicators are included in the MOH policy on Improving Quality of Health Services Five Good One Satisfaction's list of indicators. The team also will work to ensure that ARV drugs included in the MOH national essential drugs list, and that ARV and OI services and care adopted and covered in MOH's health financing scheme. Other priority policy-related activities include completing and sharing results from a PEPFAR-supported HIV service costing assessment with the GOL and stakeholders and investment and transition plans, and developing and implementing transition road maps. The PEPFAR's program goal in Laos is a 30% increase in investment in HIV-related activities by the GOL.

Tier 2: PAPUA NEW GUINEA

The PNG National HIV cascade clearly indicates retention of PLHIV on ART and VL testing as areas needing significant improvement. Despite 82.6% of the 47,412 estimated PLHIV knowing their status, only 65.5% are currently on ART. Although efforts have been made in case finding, retaining PLHIV on treatment remains a challenge. Among individuals currently on ART, only 9.4% had a VL test done, with a suppression rate of 83.1%.

For PNG to make progress towards epidemic control, PNG PEPFAR interventions will need to ensure that clients who test positive for HIV are linked to treatment, initiated on ART and, most importantly, maintained on ART to achieve viral suppression. PEPFAR recognizes these gaps and has framed the deliverables in ROP19 to support the GoPNG to make progress towards addressing these gaps. GoPNG is supportive of key policy changes that PEPFAR is focusing on such as Transition to TLD, MMD, index testing and GBV/HIV integration by revising the sexual and gender-based violence (SGBV) guidelines and the HIV treatment and care guidelines to ensure services provision and reporting at site level.

CSO engagement is critical across the treatment cascade for program success. Sustainable financing models for CSOs will ensure they are engaged across the continuum of care and in ROP19 PNG PEPFAR intends to support CSOs to achieve the capacity to play an active role in controlling the epidemic.

In ROP19, PEPFAR will support GoPNG's full transition to TLD as the first-line ART. PEPFAR is currently supporting GoPNG in updating the HIV care and treatment guidelines, and will support the dissemination and training of health care workers using TLD as the preferred first line ARV.

MMS of ART will be incorporated into HIV clinical care guidelines as a standard of care to reduce LTFU. For MMS to be possible at ART sites, supply chain issues need to be addressed to

ensure there is adequate stock of ART at the central level and in clinics. In ROP19 PEPFAR PNG will support the GoPNG to address supply chain issues both at the site level and nationally to ensure there are no ARV stockouts.

In ROP19 PNG PEPFAR will ensure that VL testing services are available to all patients on ART with a 90% VL suppression rate for all PLHIV who have a VL test done. PEPFAR will build the capacity of GoPNG to ensure VL testing services can be sustained.

The National HIV/STI Strategy 2018-2022 is committed to ending the HIV epidemic in the country, which coincides with PEPFAR's commitment to addressing key barriers that impede maintaining PLHIV on treatment. With GoPNG's direction of decentralized health care delivery through the establishment of PHAs in each province, PNG PEPFAR will align its ROP19 strategy to support decentralization.

PEPFAR PNG is strategically allocating resources to support maintaining PLHIV on treatment and ensuring VL testing scale up, while GF prioritizes prevention and case-finding activities.

Tier 3: CAMBODIA

As part of the ROP19 regionalization process, Cambodia has been included in the "Sustain Epidemic Control" tier. In ROP19 Cambodia PEPFAR will support above-site activities to address three key system barriers to sustaining epidemic control, as identified in the SID 3.0, the Transition Readiness Assessment, and through external stakeholder consultations.

Cambodia PEPFAR will continue to provide targeted TA to Phnom Penh municipality, as well as Battambang, Banteay Meanchey, and Siem Reap provinces. In addition, Cambodia PEPFAR will support national scale-up of key activities to sustain 90-90-90 achievements and accelerate progress towards 95-95-95. These activities include (1) implementing micro-targeted PrEP programs based on HIV testing yields through refined case-finding activities and POC recency testing; (2) ensuring full implementation of case-based surveillance; (3) supporting aggressive implementation of TLD, MMS, SDART and TPT; (4) maintaining retention above 95% and ensuring 100% access to viral load by focusing at the client level; and (5) increasing domestic investments.

A. Use of micro-targeted PrEP based on HIV testing yields through refined case-finding activities and point-of-care (POC) recency testing: In ROP19, Cambodia PEPFAR will accelerate new case detection among KP. This will be achieved through TA to KP community-based organizations and NCHADS to implement innovative approaches for targeted case finding and linkage to care and on treatment.

The latest AEM data show that the proportion of new PLHIV among MSM in Cambodia has increased from 13% in 2013 to 23% in 2018 (Figure 2.1.1). This may be related to some improvements in eliciting risk as well as an actual increase in HIV rates among MSM. In addition, B-IACM risk elicitation data showed that 67% of newly identified HIV positive MSM were between the ages of 20 and 29 (Figure 6.1.1). Given this growing risk population,

Cambodia PEPFAR will support innovative programming targeting MSM. In order to reach younger MSM, PEPFAR will use an online-to-offline approach for case finding using Grindr, Hornet, Facebook, and other popular dating apps to link MSM and TG to KP-competent HIV prevention and treatment services.

PEPFAR will support Cambodia to roll-out PrEP for MSM and TG women in micro-targeted areas (preliminary target 500 KP on PrEP in ROP19). Roll-out will focus on capacitated sites with existing prevention and ART services such as Chhouk Sar clinic which provides KP-friendly and comprehensive services. PrEP will be critical for high-risk HIV-negative Chhouk Sar clients, given an estimated HIV prevalence of 25.6% in 2018. PrEP will also be targeted to other high-yield hot spots for MSM and TGs, based on the results of HIV recency testing which will be implemented at all VCCT sites nationally in ROP19.

More broadly, Cambodia's PEPFAR program will support NCHADS to improve country-owned, targeted testing methods to identify hard-to-reach PLHIV through the rapid scale-up of cost-effective KP-led interventions such as social networking (PDI+), HIV self-testing, index case and recency testing.

A recent HIV self-testing project in Phnom Penh found that 76% of self-identified KP tested had never been tested before. Among 536 individuals tested, the positivity rate was 8%. PEPFAR will continue to support the scale up and implementation of HIV self-testing activities in high-burden hot spots. For key populations, self-testing will be combined with index testing.

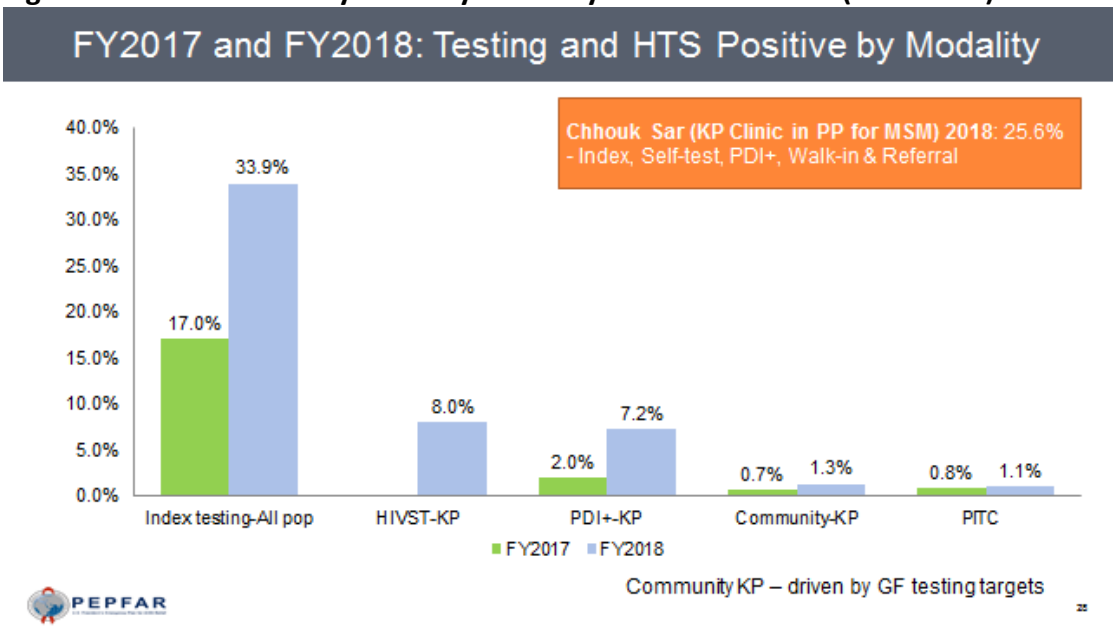
Index case testing has recently been scaled up nationally. Initial results indicate 33.9% of partners of index cases are newly identified as HIV infected (Figure 6.1.1). Despite this high positivity rate, risk elicitation in Cambodia's case management system remains inadequate and needs improvement. Improved risk elicitation will be critical to ensure optimal impact of index case testing. In ROP19, PEPFAR will support NCHADS to enhance counselors' skills to better elicit risk information and improve notification of partners, with a focus on better identifying KP for targeted follow-up. The benchmark for acceptance rate among index clients for partner notification and testing will increase from 70% to 80%, with at least 1.5 adult partners/clients on average, which will likely vary by sub-population.

As noted previously, in ROP19 PEPFAR will support NCHADS to incorporate POC recency testing into national testing guidelines, which currently include fourth generation rapid HIV tests. Recency testing will then be rolled-out at all VCCT sites nationwide. PEPFAR will support time-limited provision of the tests to mitigate potential GF procurement barriers and ensure this important tool for sustaining epidemic control is urgently implemented.

Key benchmarks for ROP19 case-finding efforts and recency testing roll-out include: (1) increased numbers of HIV-positive KP identified with at least 15% increase over COP18, (2) increased use of the recency assay with at least 80% of newly identified PLHIV with a recency assay result, and (3) increased number of partners of index cases tested with every newly identified index case having at least one partner tested. Progress toward these benchmarks will

be monitored through routine reviews of national site-level programmatic data from the Prevention, VCCT, BIACM, and ART databases, as well as in-depth quarterly monitoring meetings with PEPFAR priority provinces.

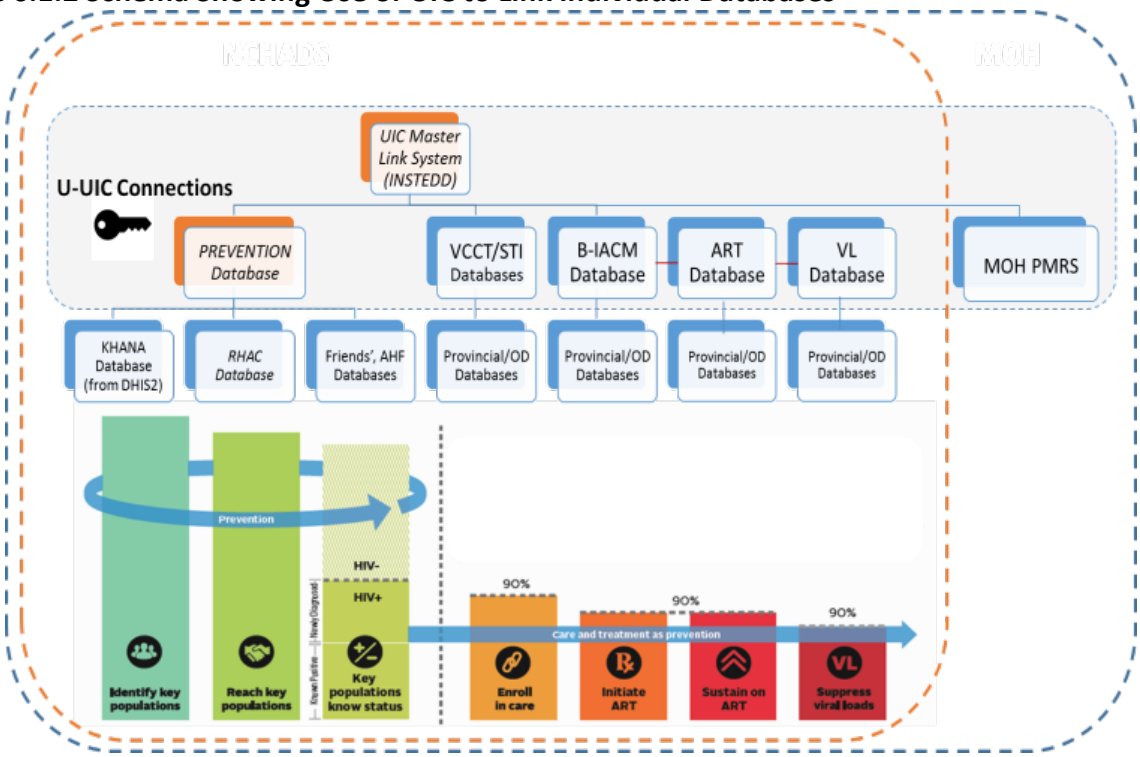
Figure 6.1.1. HIV Positivity Rates by Modality in 2017 and 2018 (Cambodia)



B. Ensure full implementation of case-based surveillance: In ROP19, PEPFAR will support full implementation of case-based surveillance across Cambodia. The B-IACM system, which tracks individuals across the cascade, serves as the primary platform for case-based surveillance. To date, B-IACM has been implemented in 14 provinces. B-IACM will be scaled-up to the remaining 11 provinces in ROP19, and implementation of the system dashboard will be completed. Of note, POC recency testing will be a core component of case-based surveillance.

PEPFAR will also support implementation of a UIC, such as the universal unique identifier code, and patient management and registration system (PMRS) number to fully link existing NCHADS databases (including prevention, VCCT/STI, ART, B-IACM, and VL databases). PEPFAR funding will support development of a Master Patient Index (MPI), a single repository of UIC-linked patient records which can be used by NCHADS to more efficiently track individuals, including KP, across the HIV cascade. Figure 6.1.2 shows how the UIC is a key to unlock linkage of individual level data across existing databases.

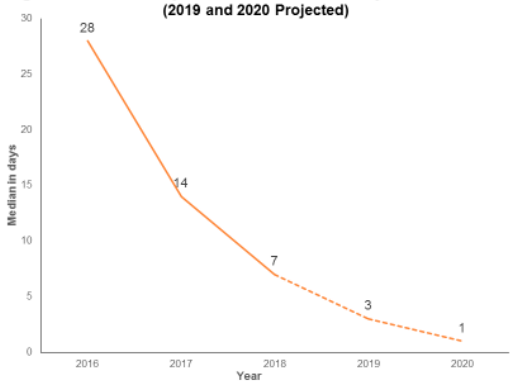
Figure 6.1.2 Schema Showing Use of UIC to Link Individual Databases



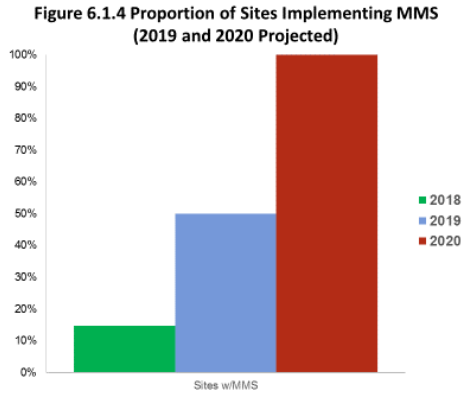
Key benchmarks for implementation of case-based surveillance include improved availability of disaggregated data for monitoring prevention efforts, testing yields, case identification, linkage to care and on treatment rates and viral suppression outcomes; and full utilization of national dashboards for KP prevention and treatment at the national and sub-national level. These dashboards will be monitored by the national SI technical working group (TWG), which includes the MOH, GF, CSOs, UNAIDS, PEPFAR, and other key stakeholders. In addition, PEPFAR will continue to strengthen the SI TWG by improving its governance structure and technical capacity to strategically monitor the national response and ensure sustained epidemic control in Cambodia.

C. Aggressive implementation of TLD, MMS, SDART and TPT: With a focus on accelerated implementation of critical policies, Cambodia began using TLD in March 2019 for new patients and those with side effects on efavirenz, including women. The MOH has a current stock of TLE400 that will run out by the end of 2020. More than 90% of patients will transition to TLD by ROP20.

Figure 6.1.3 Median Days to ART Initiation for Newly Identified PLHIV (2019 and 2020 Projected)



Before the end of COP18, NCHADS will update current treatment guidelines to implement a more aggressive policy for MMS and SDART use. NCHADS has a goal of half of sites across Cambodia implementing MMS and SDART by the end of 2019 and 100% of sites in 2020. Figure 6.1.3 shows progress thus far and the anticipated trajectory to full implementation of SDART in 2020. Figure 6.1.4 shows the anticipated percentage of sites implementing MMS within 2020.



In ROP19, Cambodia PEPFAR will assist the MOH to optimize and scale up TPT nationally. Although TPT has been provided in Cambodia since 2010, only 14% of PLHIV have received a course of TPT. For a subset of PLHIV, pulmonary TB cases cause significant morbidity, with nearly 19% of patients referred for TB screening in 2018 being diagnosed with pulmonary TB. After updating national guidelines and disseminating these nationally, scale-up will be accomplished by strengthening staff at ART clinics to review their own data to improve screening rates and initiation of TPT.

Key relevant benchmarks include incorporation of TLD, MMS, and SDART into revised HIV treatment guidelines, an increase in the percentage of eligible patients receiving script of more than six months, and an increased percentage of PLHIV having received TPT.

These benchmarks will be monitored through routine review of national site-level programmatic data from the BIACM and ART databases as well as in-depth quarterly monitoring meetings with PEPFAR priority provinces.

D. Maintaining retention above 95% and ensuring 100% access to viral load by focusing at the client level: Recent analysis of RGC data suggests approximately 49,335 PLHIV on ART receive a VL test in 2018. This represents 83% of the total number of PLHIV on ART testing, leaving a gap of approximately 10,191 PLHIV who did not have a VL test. Given that VL testing is available at 100% of ART clinics, the reason for this gap are unclear and may represent PLHIV lost to follow-up (LTFU) or operational challenges at the site level.

Cambodia PEPFAR, in collaboration with NCHADS, will use several approaches to investigate and address LTFU and re-engage patients in care and treatment. As 23% of PLHIV who miss VL testing are from Phnom Penh, Cambodia PEPFAR and NCHADS will conduct a 100$ chart review at the 12 ART clinics in Phnom Penh, where nearly 20,000 PLHIV are on ART. In addition to collecting individual level data on retention and VL testing, charts will be assessed to identify PLHIV eligible for MMS, TPT, and transition to TLD. Subsequent chart reviews will be conducted

in Banteay Meanchy, Battambang, and other provinces with a large gap missing VL testing. In addition to facilitating LTFU patients to re-engage into care and on treatment, information collected during this clinic "blitz" will aid the revision of SOPs for better tracking and retention to ensure that PLHIV are able to stay on life-long treatment. PEPFAR will also support sub-national health officials to identify high- and low-performing sites through granular review of site-level data, thorough review of operating procedures for each type of site, and institutionalize a system for sharing of best practices within provinces.

Cambodia PEPFAR will also use results from the Patient Satisfaction Feedback (PSF) system in eight ART sites to improve patient-level care at ART sites with high LTFU. Results from the PSF will provide information to ART sites on how to improve their KP-competent and inclusive services and reduce stigma and discrimination. ROP 19 will provide additional training on how to deliver KP-competent and inclusive services at those ART sites with high KP populations and low retention.

Furthermore, the CAA activity focuses on identifying PLHIV in key and other priority populations linking newly diagnosed individuals to HIV treatment, and supporting ART adherence and retention. PEPFAR will also provide TA to NCHADS to improve the quality and efficiency of the CAA to optimize ART linkage and retention outcomes. This will include a focus on strengthening case profiling for all new positives, adherence counseling, and tracking LTFU.

E. Increase domestic investments and funding for CSO-run clinics: The RGC has growing demands on its emerging economy and must plan for the transition of donor programs, including donor-funded health systems strengthening and vertical health programs. Current national health finance-related priorities include universal health coverage through social health protection schemes; modernizing government systems; decentralizing funding flows and program oversight; more efficient health spending; and sustaining critical health services, including vertical programs which are currently donor dependent, such as HIV. As mentioned in Section 2.2, Investment Profile, Cambodia's fragile HIV/AIDS progress depends on increasing its domestic financial contribution and leveraging existing funding platforms, like the HEF, and performance-based financing mechanisms, such as Service Delivery Grants.
In 2019, the RGC showed tremendous political will towards funding its HIV/AIDS response. The senior-level HIV Policy Advisory Board Meeting in December 2018 adopted six policy resolutions focused on sustainable domestic financing for HIV/AIDS. These six policy measures were endorsed by the Prime Minister, in the SorChorNor#213 dated February 2019. Below are the circular's six priority areas:

1) Increases in domestic resources for HIV/AIDS and integration of HIV/AIDS into the commune plans will be promoted.
2) All PLHIV are vulnerable and will be eligible for ID poor and HEF card.
3) Health centers and referral hospitals need to have their own funds for responding to HIV/AIDS.
4) CSOs are recognized as important to the HIV/AIDS response in Cambodia and will continue their participation through funding from the government.

5) The Supreme National Economic Council of Cambodia should study the fiscal space to ensure the implementation of RGC commitments to eliminate HIV and AIDS by 2025.
6) The MOH will continue to strengthen human resources for health, the procurement system, supply chain management, and the health information system that allow a mainstreaming of HIV/AIDS response to be more effective and sustainable.

Cambodia's PEPFAR program will support the government to increase domestic investments for the HIV response through implementation of the Prime Minister's HIV/AIDS circular. This will include a focus on increasing HIV/AIDS funding from the government's budget for CSOs in the near-term and institutionalizing a process for CSOs to receive funding from the government in the long-term. PEPFAR will also support the implementation and monitoring of access to social protection schemes for all PLHIV. With support from the US Department of Treasury, PEPFAR will work with the Supreme National Economic Council to study the fiscal space for virtual elimination of HIV and AIDS by 2025. PEPFAR will also work with the RGC to increase technical efficiencies by harmonizing and leveraging existing health financing structures. Lastly, PEPFAR will advocate for increased domestic resources for ARVs during negotiations for the upcoming 2021-2023 GF grant.

Benchmarks for ROP19 sustainable financing activities include ARV facilities receiving reimbursement from social health protection schemes for services provided, CSOs receiving HIV/AIDS funding from the RGC, increased financial contribution from the RGC for ARVs in the next GF grant, and increased domestic resources for HIV/AIDS from existing health financing structures. These benchmarks will be rigorously monitored through the Sustainability TWG and the National AIDS Authority's (NAA) coordination of the six policy measures.

In ROP19, Cambodia's PEPFAR program will provide stopgap support for two CSO-run clinics, Chhouk Sar and Center of Hope, which are receiving GF support through the end of 2019. PEPFAR support will ensure that critical services for PLHIV and KP will continue while PEPFAR works with the RGC to operationalize their political commitment to fund CSOs working in HIV.

8.0 USG Management, Operations, and Staffing Plan to Achieve Stated Goals—by country, by Tier

Tier 1: Accelerate and Achieve Epidemic Control
Burma, Kyrgyz Republic, Nepal, Tajikistan, and Thailand
Tier 2: Protect the Investment
India, Indonesia, Kazakhstan, Laos, and Papua New Guinea
Tier 3: Sustained Epidemic Control
Cambodia

Headquarters Operational Plan (HOP)
U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA)

Tier 1: BURMA

Burma PEPFAR conducted a staffing analysis to align staffing, management and operations with goals. To ensure efficiency, PEPFAR will reduce its staffing footprint from 9.45 FTEs to 7.5 FTEs, a 1.95 decrease overall. LES will be reduced from 6.2 to 5.5 FTEs and direct hires will be reduced from 3.25 to 2.0 FTEs. This 1.95 total FTE decrease represents the reduction of 1.0 direct hire CDC Deputy Director position and a 0.95 FTE reduction for USAID across multiple positions.

To fill the gap from the CDC Deputy Director position, CDC's Public Health Administrative Management Assistant will work with USAID's Health Program Assistant to provide interagency support on budget and finance monitoring and reporting issues. Both of these positions will receive additional training to fulfill this role.

Additionally, in order to reduce the staffing footprint, Burma PEPFAR team will identify and request additional support from regional and HQ support when possible. No new positions are proposed for ROP 19.

Tier 1: KYRGYZ REPUBLIC

OGAC provided Kyrgyz Republic with its PEPFAR management and staffing plan during the Asia Region Operational Unit regionalization meeting in November 2019. The approved management and staffing plan from this meeting are reflected in the ROP19 submission.

One vacant USPSC (local hire) position will go unfilled per OGAC guidance. Otherwise the PEPFAR Kyrgyz Republic staffing is unchanged from ROP18. Projected ROP19 CODB for Kyrgyz Republic cannot be directly compared to ROP18, because in the past CODB was combined for the Central Asia Region. It is expected that CODB will be similar to ROP18.

Tier 1: NEPAL

USG staffing in Nepal for PEPFAR includes one FSN (filled) and one USPSC (vacant), both at USAID, which is the only USG Agency implementing HIV activities in Nepal. The USPSC is a new position for ROP19, and was added after Nepal became a PEPFAR country, reflecting the added workload of complying with PEPFAR management systems such as the ROP process, SIMS, etc. It also reflects the fact that Nepal was designated an "accelerate and achieve" country. The USPSC will provide the high-level technical advice, intensive program and partner management, and other services required to support rapid acceleration and intensification of USG programming to reach 90-90-90 by 2020, the goal of accelerate and achieve programs.

Tier 1: TAJIKISTAN

OGAC provided Tajikistan with its PEPFAR management and staffing plan during the Asia Region Operational Unit regionalization meeting that took place in November 2019. The approved management and staffing plan from this meeting are reflected the ROP19 submission and in the CODB tab in PEPFAR FACTS Info NextGen.

Tier 1: THAILAND

The PEPFAR program in Thailand recognizes that ROP19 is a pivotal year and has aligned its staffing footprint in accordance with the outcome from the Asia Regionalization meeting held in November 2018. It was agreed that in ROP19 Thailand PEPFAR would support a total of six US direct-hire positions; three at CDC and three at USAID.

For CDC, the staffing agreement resulted in CDC USDH positions being reduced from four to three positions. The following three positions will comprise the CDC USDH staffing footprint for ROP19: (1) the CDC DGHT Program Director: responsible for direct oversight of Thailand, Laos, and Papua New Guinea (PNG) programs; (2) the Deputy Director: responsible for managing and coordinating all management and operations (M&O) for Thailand, Laos, and PNG and may also provide M&O support for other countries in the region as needed; and (3) the Medical Epidemiologist: serves as the CDC Agency Regional Representative and provides senior technical and strategic leadership across CDC for the 11 countries within the new consolidated Asia Region. Organizationally this position is one of three positions that form the PEPFAR Asia Regional Coordination Unit (PARCU).

CDC Thailand will eliminate one USDH position, the Epidemiologist/Strategic Information Advisor. The Locally Employed Staff (LES) footprint has been reduced by one position from ROP18. The Communications/Translator Specialist position will not be backfilled. CDC Thailand has one vacancy that will be recruited and filled as a Medical Officer and support Treatment and Care activities. CDC Thailand is not requesting new positions. The CODB decreased to $4,939,260 in 2019. The decrease is attributed to reduction of retirement compensation for LES during ROP19. Approximately $300,000 was paid out for retirement of LES during ROP18. USDH salary and benefits were reduced due to the elimination of one USDH position.

For USAID, the three positions are as follows: (1) as a result of the November 2018 interagency review held in Washington, DC, the interagency team identified the need for a USAID SI Advisor, which will be recruited by July 1, 2019, to provide direct in-country TA. The SI Advisor will ensure program effectiveness and monitor USAID's overall contributions to 90-90-90 in countries throughout the Region. In addition, USAID's Regional SI Advisor will devote 50 percent LOE to OGAC planning and reporting requirements, in partnership with the Regional PEPFAR Coordinator and the 50 percent SI Advisor detailed from CDC. (2) The Senior HIV Regional Technical Advisor provides senior technical and strategic leadership for the 11 countries within USAID for the new consolidated Asia Region. (3) The PEPFAR Coordinator will serve in an interagency function facilitating efforts to ensure a cohesive interagency program (PARCU). USAID follows its requirements set forth in the ADS regarding the management of implementing partners, including the design, implementation, financial and administrative oversight, and monitoring and evaluation. USAID relies heavily on non-funded PEPFAR staff to complete these activities.

The team would like to begin the recruitment process for key positions immediately given the length of time onboarding new staff requires.

Regarding vacant positions, the HIV Deputy Team Leader (LE) resigned, and new recruitment is currently underway. The selection process is scheduled be completed by the end of May 2019. In addition, due to the classified grade of the position, the HIV Clinical Specialist position (LE) remains vacant despite three rounds of solicitation. As a result, the position will be repurposed to focus specifically on strengthening the clinical cascade, with special attention given to retention into care and index case testing. The HIV KP Specialist (LE) position is under recruitment and is responsible for biomedical and behavioral interventions, including test and start, PrEP expansion, and innovative online case finding. In November 2018, two new positions and associated costs were approved during the inter-agency meeting. The two requested positions are a newly-solicited PEPFAR Coordinator (USPSC) and an SI Adviser (USPSC). Adjustments will be made after the hiring process concludes.

PEPFAR staff will continue to conduct SIMS on a routine schedule working closely with in-country staff and regional Bangkok-based support.

ROP19 will continue the formalization of the PARCU, created following the November Regionalization Meeting. The PARCU will consist of two Agency Representatives (one non-PEPFAR-funded USAID USDH and one PEPFAR-funded CDC USDH), the regional PEPFAR coordinator, and one administrative staff detailed from CDC. This unit will serve as the primary point of communication between OGAC and the region and assist in the consolidation of documents and tools for ROP submission, routine quarterly reporting, and regional TA needs. Terms of reference for its functioning are being developed as well as the structure of a Regional Secretariat to serve in an advisory capacity.

Thailand PEPFAR has made the necessary staffing adjustments to further strengthen and align staffing to meet the program needs in ROP19. Thailand PEPFAR has prioritized to align staffing with technical and administrative priorities while recognizing the limited fiscal environment. Thailand is a TA country, and in the TA model, the PEPFAR team recognizes that it is important to have the right mix of technical, financial, and administrative staff. For all agencies, technical staff has expertise in the areas of HIV prevention, treatment and care, strategic information, and laboratory strengthening. Technical staff members will use their expertise in specific technical areas to work with ministries of health and other partners to implement priority activities along the HIV continuum of care 90-90-90 and to adapt successful strategies and activities from the other PEPFAR country programs that form the new Asia Region. Financial and management staff will ensure proper management of PEPFAR funds for strong accountability and transparency. Staffing will continue to be assessed according to the needs of Thailand within the context of the new SE Asia Region and the PEPFAR program goal.

Tier 2: INDIA

With the shift to a regional platform in ROP19, India PEPFAR reviewed the program's current staffing footprint with a lens on regional support. The team is comprised of a strong cadre of technical public health specialists in prevention, care and treatment, laboratory support, and strategic information. The India team is positioned to provide technical support across the larger Asia region.

As a result of regionalization and as part of ROP19 planning, the India PEPFAR team conducted a detailed analysis of the programmatic alignment of staff and its ability to successfully implement the PEPFAR program. Reductions to the India PEPFAR USDH staffing footprint were made with efficiencies in mind.

CDC will decrease from four USDH positions to two USDH positions by September 2019, which will result in reduced clinical expertise in the office. CDC also plans to move one key technical staff from the Hyderabad office to the Delhi office by September 2019 to provide locally-employed staff (LES) leadership in the main office, more effective technical assistance to all the PEPFAR-supported districts, as well as for regional support. All SIMS visits will be covered by staff traveling to PEPFAR-supported sites for conducting routine review and technical assistance. CDC has not identified any further skill deficiencies in the program.

USAID will discontinue all seven USDH/USPSC positions fully or partially funded by PEPFAR. The USAID Health Office will retain its two U.S. Foreign Services Officers, who will no longer be funded by PEPFAR but who will oversee USAID's PEPFAR investments. The four local-hire USPSC positions that were partially funded by PEPFAR under USAID will be retained using other health funding. Currently, USAID has three full-time LES technical positions dedicated to the PEPFAR portfolio; the remaining 11 LES positions provide various fractional programmatic and administrative support to PEPFAR.

Under the regional model, there will no longer be a PEPFAR Coordinating Unit in India. The SI liaison position seconded to the PEFPAR office is included in the CDC footprint plan and will become part of the CDC technical team; the direct-hire coordinator position in the USAID footprint will be discontinued.

Because a majority of programming occurs at the subnational level in India, frequent engagement at the state and district level is necessary by the PEPFAR team based in Delhi; PEPFAR staff spend 25-30% of their time each month in the field. CDC and USAID each have a LES position in Mumbai to provide additional coordination for PEPFAR activities in Maharashtra.

A significant number of CDC staff members in India provide ongoing TA at the district, state, and national levels in the areas of prevention (one staff with a second position currently filled by a PSC); care and treatment (three staff, including one vacancy approved to fill in 2019); laboratory support (three staff); and strategic information (three staff). This level of effort is calculated at 66.7% of total staff time and excludes management staff, who also spend a

significant amount of time representing the program and influencing policy in meetings and events with the GOI. The remaining two LES staff positions are in finance and human resources/administration.

In India, USAID does not maintain additional staff at the district and state levels, expect for the partially PEPFAR-funded LE staff in Mumbai coordinating PEPFAR activities in the State of Maharashtra and Andhra Pradesh, as needed. USAID implementing partners' scope includes providing TA at the subnational level across the continuum of care, with regular oversight provided by the New Delhi based team, which also regularly liaises with central-level technical teams and leadership.

Given the budgetary constraints of ROP19, the team looked for ways to reduce the cost of doing business across agencies, finding efficiencies in several areas, including cost savings due to exchange rate fluctuations and a reduction of administrative costs. The cost of doing business is expected to show some marginal increases over time including Capital Security Cost Sharing and ICASS costs. It is expected that LE Staff salaries will increase later in FY 2020 to keep up with inflation, which could range from 15–25%.

Tier 2: INDONESIA

In Indonesia, the USG maintains a core team of highly skilled and dedicated national and expatriate staff to effectively manage PEPFAR planning, implementation, and monitoring in Indonesia. The USG's investment serves to strengthen Indonesia's capacity to develop evidence-based HIV/AIDS programming that responds appropriately to the Indonesian epidemic. This support remains a critical contribution to the national HIV response, which the GOI values greatly. The PEPFAR team in Indonesia consists of a PEPFAR Point of Contact who also serves as the USAID Health Office Director and Embassy Health Attaché; a USAID Point of Contact; a DOD Point of Contact; and a Program Management Specialist. Additionally, a Fellow who is partially funded by PEPFAR serves as the Quality Assurance and Logistics Advisor for both HIV and TB programs.

There are still vacancies within the USAID/Indonesia team. USAID is in the process of recruiting an infectious disease team lead and intends to fill this position as quickly as possible.

Tier 2: KAZAKHSTAN

OGAC, in agreement with CDC and USAID headquarters, provided Kazakhstan with its PEPFAR management and staffing plan during the Asia Region Operational Unit regionalization meeting that took place in November 2019. The approved management and staffing plan from this meeting are reflected in the ROP19 submission.

Two USDH positions will end in FY19, leaving one PEPFAR-funded USDH in ROP19. The interagency SI Advisor position has been vacant since July 2018 and will not be re-filled. The current USAID Strategic Information Advisor will largely fill this role along with the CDC Associate Director. HHS/CDC will reduce to one USDH position that will remain in Kazakhstan

until the end of his two-year tour in summer 2020. In 2020, the new CDC DGHT Director will be hired in Bishkek, Kyrgyz Republic, assuming that the Kyrgyz Republic US Ambassador approves and NSDD38 is approved. The CDC LE Prevention Advisor left in 2018 and will not be replaced per OGAC guidance to reduce LE staffing through attrition. The CDC Prevention Advisor used to oversee and provide technical assistance to the Republican Mental Health Center's activities for MAT. Given lack of funding and technical oversight to this cooperative agreement, the RMHC cooperative agreement will phase out in ROP19 and will not be renewed. The USAID HIV Team Lead position (locally employed) will be vacated by the current staff member; however, since it is such a critical position, USAID Kazakhstan intends to re-fill it. The PEPFAR team does not currently possess a staff member with a skill set for ARV logistics and supply chain management; however, the existing HIV treatment team leader will take on this task, and the PEPFAR team will seek external TA in this critical area. There are no new positions. Reductions in the ROP19 CODB are due to reduced US staffing costs.

Tier 2: LAOS

The Laos PEPFAR Program recognizes that ROP 2019 is a pivotal year and has aligned its inter-agency staffing in accordance with the outcome from the Asia regionalization meeting held in November 2018. CDC Laos will maintain its staffing footprint with one LES Public Health Specialist. Although the staffing level will remain the same as ROP18, the responsibilities of the position will shift to support the goals and objective of a Tier Two Country. Currently USAID does not have an FTE for PEPFAR in Laos; it leverages the FTEs in RDMA located in Bangkok and technical staff based at Embassy Laos. There are no vacant positions and no new positions are being requested.

USAID has managed support to Laos through regular TDYs from Bangkok-based staff on the HIV team. CDC is represented by a full-time public health specialist assigned to Laos and receives supervision, support, and guidance from CDC staff based in the South East Asia Regional Office in Thailand. USAID and CDC jointly participate in required SIMS visits, and in quarterly meetings where all implementing partners, CBOs and government officials meet to review progress. Inter-agency meetings are held on a regular basis.

Given Laos' categorization in Tier 2, it is expected that the USAID Regional Technical Advisor and Strategic Information Specialist will provide support to USAID-supported programming through routine phone calls to the Deputy Chief of Mission and TDYs to ensure a well-monitored and sustained program pivot. As previously mentioned, CDC's full-time Laos LE staff member's responsibilities have been reviewed and aligned to support activities that support the Tier 2 strategy.

USAID Laos currently has no staff dedicated to PEPFAR, and the HIV Team at RDMA provides support virtually and through TDY visits. There are no new positions. Reductions in the ROP19 CODB are due to reduced US staffing costs.

Tier 2: PAPUA NEW GUINEA

PNG PEPFAR continues its management strategy of building strong in-country capacity to support core activities within the national HIV response. The US Ambassador leads the small but dynamic interagency team with staff from the Department of State (DOS), USAID, and CDC.

In PNG, each agency uses its unique expertise to provide focused TA in support of core activities. USAID's TA focuses on building capacity of the GoPNG and CSOs to efficiently and effectively maintain PLHIV on treatment, and to focus on addressing GBV issues. TA at the site level generates lessons learned and best practices, which informs TA provided to policy makers to improve national guidelines and procedures. With core strengths in quality improvement in HIV care and treatment, HIV laboratory strengthening, and HIV strategic information, CDC's cost-effective TA continually uses CDC country staff to help build above-site capacity of national and provincial health staff.

The USAID Health Advisor USPSC position will not be recruited when the position is vacated in 2019. This gap will require the remaining USAID LES staff based in PNG to take on more leadership roles and may require the sourcing of needed expertise from regional resources. Two CDC positions were removed during Q1 of FY19--one USDH country director position and one LES laboratory advisor position. The functions of the Country Director now fall under the CDC regional office in Thailand with continued oversight from CDC headquarters.

The CDC HIV Senior Health Specialist, the team lead for the country team, has also assumed all tasks and activities previously undertaken by the laboratory advisor. The HIV senior health specialist will report to the CDC Thailand Regional Director. There are no plans for expansion.

With the removal of the CDC US direct-hire position and the USAID Health Advisor USPC position, there are expected savings in ROP19 CODB. The savings due to these salary costs will be used for future programs for the engagement of an indigenous FBO or CSO.

Tier 3: CAMBODIA

PEPFAR in Cambodia is now part of the Asia Regional Platform, and staffing shifts are planned to align with the regional approach and to increase operational efficiencies. As part of this process, 7.6 FTE US direct hire and personal service contractor positions will be reduced to 1.5 FTEs, and key locally employed staff positions will be repurposed to include leadership and supervisory responsibilities. This will eventually result in a significant decrease in the cost of doing business.

In Cambodia, PEPFAR ROP19 staffing will optimally align with the goal of sustained epidemic control, including achievement of specific benchmarks in Table 6. Staff will continue to actively participate on national TWGs, donor coordination groups and the CCM in order to encourage innovation, the adoption of best practices and policies, and sustainability. Staff will also assist with the development and revision of national HIV guidelines and SOPs, the provision of technical guidance and direction through active involvement in program decisions, including

encouraging the use of novel and evidence-based approaches to accelerate and sustain progress and transition activities to the national government.

For CDC, funding to RGC partners is coupled with technical support by CDC staff. In ROP19, CDC will continue its "cascade of TA" approach whereby CDC staff strengthen the national level and provincial levels to not only implement quality services, but to become mentors and TA providers to their subordinate levels (national to provincial, provincial to operating district, etc.). CDC CODB contribution to program implementation can be found in Table 6.

In addition to the TA and participation in HIV national fora mentioned above, engaging and building critical relationships with the MoEF and leading donor working groups related to HIV financing and mainstreaming into the health system is a key area for USAID staff. USAID staff time dedicated to HIV financing and domestic resource mobilization has increased significantly as the RGC formulates its social protection framework and policies that include HIV and health.

Headquarters Operational Plan (HOP): U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

SAMHSA/Southeast Asia is staffed by two positions and serves the following eight countries: Burma, Cambodia, India, Indonesia, Laos, Nepal, Papua New Guinea, and Thailand. SAMHSA has conducted an initial assessment of the countries' needs in the area of policy and capacity building in the nexus between HIV and substance use disorders. The regional substance abuse office assists missions and the governments of the SEA countries to develop and implement evidence-based, client-centered, and rights-based policies, programming, and services to address the issue of HIV with a focus on addiction, give that all of the target countries have concentrated HIV epidemics within IDU and Non-IDU, MSM, TG, and commercial sex workers. While the main focus is on those individuals with a substance use disorder (IDU/Non-IDU), the other three key populations often have issues with addictive substances, and programming should also address their respective situations.

Policy: The policies that are currently being enforced often are more punitive rather than public health-focused; as a result, they have a direct relationship to KPs seeking treatment for Substance Use Disorders (SUD) and HIV. This is particularly true for members of the three main key populations: (1) People who Use Drugs (both injectors and non-injectors); MSM; and sex workers. To achieve epidemic control, these policies must be addressed to enable access to quality care and treatment. Therefore, policy as well as capacity building activities are included in the SAMHSA Regional Office scope of work.

Table 6.1. Policies related to SUD and HIV

Country	Compulsory drug treatment	Criminalize same sex sexual activity	Criminalize sex work	Criminalize HIV transmission or exposure	HIV+ restrictions on entry, stay, and residence

Burma	Yes	Yes	Yes	No	No
Cambodia	Yes	Yes	Yes	No	No
India	No	No	Yes	No	No
Indonesia	Yes	Yes	Yes	No	No
Laos	Yes	No	Yes	Yes	No
Nepal	No	No	Yes	NA	No
PNG	No	Yes	Yes	Yes	Yes
Thailand	Yes	No	Yes	NA	No

Source: UNAID Country Cards/Profiles-UNAIDS Data Hub-2018

SEA regional country drug use patterns: According to the ASEAN Drug Use Report of 2018 and a paper by Dargan and Wood (2012), alcohol is the most used drug; Methamphetamine tablets and crystal are increasing; and heroin use remains unchanged. While the lack of data does not allow determination of a clear route of administration, the literature clearly associates the use of these drugs with increased risk for HIV; in addition, those on ART and actively using are less likely to be compliant with and retained in treatment.

Table 6.2. Drug Use in Southeast Asia

Country	Alcohol	Opium	Heroin	Methamphetamine	Crystal Meth (da/shabu)	Cannabis
Burma	Yes	Yes	Yes	Yes	Yes	Yes
Cambodia	Yes	No	Yes	Yes	Yes	Yes
India	Yes	Yes	Yes	Yes	Yes	Yes
Indonesia	Yes	No	Yes	Yes	Yes	Yes
Laos	Yes	Yes	Yes	Yes	Yes	Yes
Nepal	Yes	No	Yes	Yes	Yes	Yes
PNG	Yes	No	No	Yes	Yes	Yes
Thailand	Yes	Yes	Yes	Yes	Yes	Yes

Treatment Systems: According to the ASEAN Drug Report-2015 and the WHO World Atlas on Drug Use 2010, the following represents information about the treatment systems in the eight countries; however, the information should be viewed carefully as the existence of even one clinic or outpatient program gives the country a “yes” in the treatment category. It does not speak to the issue of coverage, quality, or linkages between the MOH HIV treatment services and the SUD services that often are operated by different ministries, which are frequently nonexistent.

Table 6.3. Drug treatment services

Country	Treatment and rehabilitation for people with SUD	Syringe exchange program	Community-based services	Medication-assisted treatment	Implement SBIRT in primary care
Burma	Yes	Yes	No	Yes	Yes
Cambodia	Yes	Yes	No	Yes—poor coverage	No
India	Yes—but no implementation	Yes	Yes	Yes	No
Indonesia	Yes	Yes	Yes	Yes	No
Laos	Yes	No	No	No	No
Nepal	No	Yes	Yes	Yes	No
PNG	No	Yes	Yes	Yes	No
Thailand	Yes	Yes	Yes	Yes	No

Sources: WHO World Atlas on Drug Use-2010 AND ASEAN Drug Report -2015.

The review of the SUD treatment system revealed a potential missed opportunity to improve care and services for PWID and PWUD as well as an area where case finding and the 90-90-90 goals may be also be missed. More closely connecting these two systems (MOH-MOI) that almost certainly serve the same person would improve the quality of life of these patients and improve the 90-90-90, potentially assisting greatly with controlling the epidemic. SAMHSA SEA Regional will address four barriers in the region, as follows:

- Persistent policy issues restrict access to HIV care and treatment along with restricting SUD treatment through the use of treatment protocols that are not best practices, client-centered, or human rights-based.
- Persistent gaps in the national infrastructure impede the implementation of patient-centered drug abuse treatment approaches, stability of the commodity supply chain, integration of services, and quality assurance of test and start services, which in combination negatively impact HIV diagnosis (first 90) and ART treatment initiation (second 90).
- Capacity of fragile health systems to respond to SUD results in poorly coordinated care, inadequate access to community care, and an insufficient number of credentialed professionals to meet demand. More SUD treatment professionals will be needed in the next few years. While there is limited data to track the projected growth, retraction, and composition of the SUD workforce able to care for individuals with SUDs in a variety of managed health care settings, the SUD treatment workforce needs to be better qualified with continuous knowledge and skills development.
- Mandatory detoxification results in interrupted access to drug abuse and/or HIV services, impacting the first 90 by impeding case finding and the second 90 by interrupting ART treatment.

Appendix A Prioritization

Tier 1: Accelerate and Achieve Epidemic Control
Burma, Kyrgyz Republic, Nepal, Tajikistan, and Thailand
Tier 2: Protect the Investment
India, Indonesia, Laos, Kazakhstan, and Papua New Guinea
Tier 3: Sustained Epidemic Control
Cambodia

Tier 1: BURMA

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

SNU	COP	Prioritization	Results Reported	Attained: 90-90-90 by Each Age and Sex Band to Reach 95-95-95 Overall																								Overall TX Coverage
				Treatment Coverage at APR by Age and Sex																								
				<0		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Burma	COP 15	Scale-up aggressive	APR 16	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	57%
Burma	COP 16	Scale-up aggressive	APR 17	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	66%
Burma	COP 17	Scale-up aggressive	APR 18	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	73%
Burma	COP 18	Scale-up aggressive	APR 19	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	77%
Burma	COP 19	Scale-up aggressive	APR 20	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	81%

Note: NAP calculated this trend based on 90-90-90 and FY20 Overall TX coverage 81% is 90% of All HIV test positive.

Table A.2 ART Targets by Prioritization for Epidemic Control (PEPFAR sites)

Table A.2 ART Targets by Prioritization for Epidemic Control (PEPFAR sites)						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY19)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY20) *TX_CURR***	**Newly initiated (APR FY20) *TX_NEW***	**ART Coverage (APR 20)**
Attained						
Scale-Up Saturation						
Scale-Up Aggressive	**NA**	**7,617**	**NA**	**10,405**	**3,483**	**NA**
Sustained						
Central Support						
Commodities (if not included in previous categories)						
Total	**NA**	**7,617**	**NA**	**10,405**	**3,483**	**NA**

Tier 1: KYRGYZ REPUBLIC

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

SNU	COP	Results reported	Attained 90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) Overall																Overall TX Coverage
			15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
			F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Bishkek city	COP 15	APR 16	33%	67%	23%	32%	28%	21%	25%	22%	27%	23%	29%	18%	32%	16%	36%	22%	24%
	COP 16	APR 17	33%	75%	43%	28%	35%	29%	28%	29%	33%	23%	33%	24%	36%	26%	44%	23%	29%
	COP 17	APR 18	0%	50%	37%	38%	36%	34%	34%	36%	36%	26%	34%	29%	44%	24%	40%	25%	32%
	COP 18	APR 19	50%	71%	45%	48%	47%	46%	46%	47%	48%	47%	43%	49%	58%	50%	50%	44%	48%
	COP 19	APR 20	83%	86%	82%	81%	81%	81%	81%	81%	81%	81%	81%	81%	82%	81%	81%	81%	81%
Chui oblast	COP 15	APR 16	17%	0%	33%	17%	41%	26%	34%	29%	36%	30%	36%	32%	34%	32%	37%	28%	32%
	COP 16	APR 17	33%	0%	35%	46%	47%	37%	41%	35%	46%	34%	44%	36%	36%	37%	46%	34%	38%
	COP 17	APR 18	57%	0%	51%	48%	52%	44%	48%	43%	46%	41%	49%	43%	42%	42%	49%	40%	44%
	COP 18	APR 19	71%	100%	65%	59%	64%	63%	63%	60%	62%	62%	61%	66%	60%	59%	58%	57%	61%
	COP 19	APR 20	86%	100%	80%	83%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%
Osh city	COP 15	APR 16	0%	50%	53%	53%	44%	27%	50%	29%	41%	29%	44%	26%	39%	21%	44%	25%	34%
	COP 16	APR 17	33%	33%	57%	50%	54%	35%	49%	39%	52%	27%	52%	34%	44%	26%	43%	29%	39%
	COP 17	APR 18	50%	75%	56%	67%	66%	57%	54%	45%	60%	38%	59%	43%	51%	39%	58%	39%	49%
	COP 18	APR 19	71%	83%	77%	86%	83%	81%	83%	82%	80%	82%	82%	80%	76%	82%	82%	80%	81%
	COP 19	APR 20	86%	83%	81%	86%	80%	82%	82%	80%	81%	80%	80%	82%	81%	81%	82%	82%	81%
Osh oblast	COP 15	APR 16	40%	67%	54%	50%	43%	53%	49%	29%	51%	23%	34%	27%	36%	32%	44%	27%	39%
	COP 16	APR 17	25%	60%	59%	60%	51%	48%	57%	33%	55%	41%	55%	42%	50%	32%	56%	35%	49%
	COP 17	APR 18	38%	68%	71%	57%	52%	43%	60%	43%	60%	33%	56%	44%	56%	36%	59%	34%	51%
	COP 18	APR 19	70%	69%	69%	67%	69%	68%	71%	77%	78%	74%	75%	71%	69%	70%	70%	69%	72%
	COP 19	APR 20	81%	81%	81%	83%	81%	82%	81%	81%	81%	81%	82%	81%	81%	82%	81%	82%	81%
Talas oblast	COP 15	APR 16	0%		0%		22%	20%	11%	0%	29%	29%	0%	44%	0%	33%	50%		20%
	COP 16	APR 17	0%	0%	67%	0%	29%	29%	8%	0%	0%	27%	40%	43%	33%	33%	100%	100%	26%

	COP 17	APR 18	0%	0%	33%	0%	67%	67%	20%	27%	17%	24%	30%	17%	100%	43%	33%	67%	33%
	COP 18	APR 19	0%	0%	100%	0%	75%	67%	64%	62%	67%	59%	60%	67%	100%	57%	67%	67%	63%
	COP 19	APR 20	0%	0%	100%	0%	100%	100%	87%	85%	83%	82%	80%	83%	100%	86%	100%	100%	86%
Batken oblast	COP 15	APR 16	50%	50%	60%	33%	29%	0%	30%	38%	33%	44%	50%	12%	38%	13%	27%	44%	33%
	COP 16	APR 17	33%	100%	50%	0%	31%	43%	42%	33%	39%	43%	57%	33%	67%	13%	40%	46%	37%
	COP 17	APR 18	100%	100%	63%	33%	62%	57%	33%	35%	44%	75%	63%	44%	57%	6%	44%	56%	45%
	COP 18	APR 19	100%	100%	67%	0%	71%	67%	68%	70%	70%	71%	71%	70%	67%	69%	71%	69%	70%
	COP 19	APR 20	100%	100%	89%	0%	80%	78%	82%	81%	81%	86%	86%	81%	78%	81%	83%	81%	82%
Naryn oblast	COP 15	APR 16	0%	0%	0%	0%	36%	17%	50%	14%	50%	46%	40%	20%	0%	27%		44%	29%
	COP 16	APR 17	100%	0%	33%	0%	33%	57%	43%	0%	44%	42%	50%	29%	33%	32%	100%	23%	32%
	COP 17	APR 18	100%	0%	67%	0%	20%	67%	43%	25%	67%	30%	45%	33%	50%	33%	67%	38%	39%
	COP 18	APR 19	0%	0%	67%	100%	67%	67%	67%	67%	75%	70%	69%	71%	67%	70%	75%	69%	69%
	COP 19	APR 20	0%	0%	83%	100%	78%	83%	78%	78%	75%	80%	85%	83%	100%	81%	75%	81%	81%
Jalalabad oblast	COP 15	APR 16	25%	20%	41%	23%	34%	18%	35%	18%	35%	20%	31%	21%	32%	22%	35%	27%	27%
	COP 16	APR 17	33%	33%	58%	25%	41%	21%	43%	22%	31%	25%	45%	24%	33%	22%	40%	29%	32%
	COP 17	APR 18	29%	50%	60%	43%	56%	28%	48%	33%	43%	33%	50%	27%	43%	31%	46%	39%	41%
	COP 18	APR 19	67%	67%	68%	71%	69%	69%	70%	70%	69%	69%	69%	69%	69%	69%	70%	70%	69%
	COP 19	APR 20	78%	83%	82%	83%	81%	79%	81%	81%	81%	81%	82%	81%	82%	81%	82%	82%	81%
Issykkul oblast	COP 15	APR 16			45%	17%	42%	23%	29%	29%	55%	21%	40%	15%	20%	50%	67%	44%	33%
	COP 16	APR 17	0%	0%	56%	14%	48%	27%	38%	37%	50%	24%	67%	14%	33%	44%	50%	33%	35%
	COP 17	APR 18	0%	0%	57%	30%	55%	36%	40%	39%	45%	22%	67%	33%	29%	39%	60%	31%	40%
	COP 18	APR 19	0%	0%	67%	70%	71%	69%	68%	69%	70%	70%	71%	68%	71%	70%	70%	69%	69%
	COP 19	APR 20	0%	0%	78%	80%	83%	81%	82%	83%	81%	79%	86%	80%	86%	81%	80%	85%	81%

Table A.2 ART Targets by Prioritization for Epidemic Control (PEPFAR sites)

Table A.2 ART Targets by Prioritization for Epidemic Control (PEPFAR sites)						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY19)**	**Additional patients required for 81% ART coverage**	**Target current on ART (APR FY20) *TX_CURR***	**Newly initiated (APR FY20) *TX_NEW***	**ART Coverage (APR 20)**
Attained						
Scale-Up Saturation	6,445	4,038	1,181	5,219	1,385	81%
Scale-Up Aggressive						
Sustained						
Central Support						
Commodities (if not included in previous categories)						
Total	6,445	4,038	1,181	5,219	1,385	81%

Tier 1: NEPAL

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

SNU	COP	Results reported	Attained 90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) Overall																Overall TX Coverage
			15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
			F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Banke	COP 19	APR 20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	78%
Bhaktpur	COP 19	APR 20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	11%
Chitawan	COP 19	APR 20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	148%
Dang	COP 19	APR 20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	36%
Dhanusha	COP 19	APR 20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	89%
Jhapa	COP 19	APR 20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	53%
Kailali	COP 19	APR 20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	121%
Kanchanpur	COP 19	APR 20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	56%
Kapilbastu	COP 19	APR 20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	99%
Kaski	COP 19	APR 20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	135%
Kathmandu	COP 19	APR 20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	91%
Lalitpur	COP 19	APR 20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	87%
Makawanpur	COP 19	APR 20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	47%
Morang	COP 19	APR 20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	35%
Nawalparasi East	COP 19	APR 20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

SNU	COP	Results reported	Attained 90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) Overall																Overall TX Coverage
			15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
			F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Nawalparasi West	COP 19	APR 20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	33%
Parsa	COP 19	APR 20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	187%
Rupandehi	COP 19	APR 20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	124%
Sunsari	COP 19	APR 20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	80%

Table A.2: Targets by Prioritization for Epidemic Control

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY19)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY20) *TX_CURR***	**Newly initiated (APR FY20) *TX_NEW***	**ART Coverage (APR 20)**
Attained						
Scale-Up Saturation						
Scale-Up Aggressive	29,944 (16,002 in PEPFAR program districts)	16,914 (11,887 in PEPFAR program districts)	7,041 (1, 914 in PEPFAR program districts)	3,440	1,925	73% (current coverage 56%)
Sustained						
Central Support						
Commodities (if not included in previous categories)						
Total						

Tier 1: TAJIKISTAN

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

SNU	COP	Results reported	Attained 90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) Overall																Overall TX Coverage
			15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
			F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Dushanbe city	COP 15	APR 16	17%	21%	24%	8%	25%	13%	24%	13%	21%	15%	19%	13%	23%	12%	20%	12%	16%
	COP 16	APR 17	25%	21%	24%	25%	27%	17%	26%	18%	25%	17%	25%	14%	25%	16%	26%	15%	19%
	COP 17	APR 18	38%	38%	28%	24%	29%	25%	29%	18%	26%	22%	26%	19%	32%	20%	31%	18%	23%
	COP 18	APR 19	34%	36%	38%	39%	40%	40%	37%	37%	37%	37%	37%	37%	37%	37%	37%	37%	37%
	COP 19	APR 20	83%	82%	80%	80%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%
RRS	COP 15	APR 16	33%	33%	29%	24%	26%	18%	28%	20%	29%	21%	32%	20%	29%	23%	25%	25%	26%
	COP 16	APR 17	43%	42%	40%	33%	34%	27%	35%	28%	34%	31%	38%	29%	40%	28%	31%	34%	32%
	COP 17	APR 18	45%	43%	43%	38%	38%	35%	39%	32%	39%	34%	42%	32%	41%	33%	39%	40%	36%
	COP 18	APR 19	40%	41%	43%	44%	44%	44%	43%	43%	43%	43%	42%	44%	44%	43%	41%	43%	43%
	COP 19	APR 20	80%	82%	80%	81%	81%	80%	81%	81%	81%	81%	80%	81%	80%	81%	81%	80%	81%
Sogd oblast	COP 15	APR 16	30%	33%	29%	30%	28%	26%	28%	24%	30%	24%	27%	29%	25%	28%	26%	25%	27%
	COP 16	APR 17	40%	38%	40%	38%	32%	37%	37%	33%	35%	33%	37%	34%	36%	33%	30%	33%	35%
	COP 17	APR 18	40%	42%	43%	38%	39%	41%	41%	40%	39%	40%	38%	39%	41%	38%	37%	39%	39%
	COP 18	APR 19	50%	50%	46%	44%	44%	46%	47%	45%	44%	44%	45%	45%	55%	48%	39%	42%	45%
	COP 19	APR 20	80%	83%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%
Khatlon oblast	COP 15	APR 16	24%	33%	24%	28%	25%	25%	23%	21%	27%	22%	27%	21%	28%	25%	25%	21%	24%
	COP 16	APR 17	44%	36%	32%	33%	33%	34%	31%	28%	32%	31%	32%	26%	33%	32%	31%	26%	31%
	COP 17	APR 18	43%	38%	38%	31%	35%	37%	34%	31%	37%	33%	33%	33%	37%	35%	38%	30%	34%
	COP 18	APR 19	44%	44%	44%	43%	44%	44%	44%	44%	44%	44%	44%	44%	44%	44%	44%	44%	44%
	COP 19	APR 20	78%	80%	81%	80%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%
GBAO	COP 15	APR 16		33%	33%	33%	20%	25%	18%	26%	27%	19%	23%	20%	29%	16%	30%	24%	22%

SNU	COP	Results reported	Attained 90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) Overall																Overall TX Coverage
			15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
			F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
	COP 16	APR 17			40%	33%	40%	28%	22%	30%	32%	28%	29%	26%	40%	23%	31%	28%	28%
	COP 17	APR 18	50%		29%	50%	38%	44%	32%	36%	41%	33%	35%	30%	39%	32%	37%	28%	33%
	COP 18	APR 19	50%	0%	43%	50%	41%	40%	42%	41%	41%	42%	41%	43%	41%	42%	41%	43%	42%
	COP 19	APR 20	50%	0%	71%	100%	82%	80%	81%	83%	81%	81%	82%	81%	81%	81%	81%	82%	81%

Table A.2 ART Targets by Prioritization for Epidemic Control (PEPFAR sites)

Table A.2 ART Targets by Prioritization for Epidemic Control (PEPFAR sites)						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY19)**	**Additional patients required for 81% ART coverage**	**Target current on ART (APR FY20) *TX_CURR***	**Newly initiated (APR FY20) *TX_NEW***	**ART Coverage (APR 20)**
Attained						
Scale-Up Saturation	**8,696**	**4,365**	**2,676**	**7,041**	**2,899**	**81%**
Scale-Up Aggressive						
Sustained						
Central Support						
Commodities (if not included in previous categories)						
Total	**8,696**	**4,365**	**2,676**	**7,041**	**2,899**	**81%**

Tier 1: THAILAND

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

SNU	COP	Prioritization	Results reported	Attained 90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) Overall																Overall TX Coverage
				15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Bangkok	COP 19	Scale Up Aggressive	APR 20	46%	56%	80%	155%	51%	74%	38%	57%	45%	59%	52%	55%	54%	47%	99%	73%	65%
Chiang Mai	COP 19	Scale Up Aggressive	APR 20	72%	107%	92%	195%	43%	80%	45%	90%	39%	51%	51%	51%	66%	45%	145%	104%	80%
Chiang Rai	COP 19	Scale Up Aggressive	APR 20	64%	114%	114%	128%	62%	63%	36%	61%	40%	57%	76%	68%	93%	77%	139%	121%	82%
Chon Buri	COP 19	Scale Up Aggressive	APR 20	45%	58%	102%	162%	86%	116%	77%	92%	78%	94%	81%	79%	80%	69%	142%	124%	93%
Khon Kaen	COP 19	Scale Up Aggressive	APR 20	115%	154%	155%	249%	83%	124%	55%	105%	67%	93%	83%	79%	88%	73%	112%	89%	108%
Nakhon Ratchasima	COP 19	Scale Up Aggressive	APR 20	81%	115%	124%	197%	86%	113%	63%	92%	63%	91%	73%	79%	74%	70%	125%	111%	97%
Nonthaburi	COP 19	Scale Up Aggressive	APR 20	52%	70%	110%	212%	93%	97%	62%	88%	72%	99%	85%	95%	85%	81%	172%	149%	101%
Pathum Thani	COP 19	Scale Up Aggressive	APR 20	28%	48%	62%	188%	49%	85%	36%	54%	34%	58%	36%	52%	33%	41%	78%	80%	60%
Phuket	COP 19	Scale Up Aggressive	APR 20	42%	64%	74%	171%	76%	157%	78%	115%	77%	112%	84%	96%	81%	80%	120%	120%	97%
Samut Prakan	COP 19	Scale Up Aggressive	APR 20	53%	49%	158%	184%	101%	106%	73%	79%	76%	91%	75%	92%	70%	66%	118%	96%	93%
Songkhla	COP 19	Scale Up Aggressive	APR 20	54%	145%	103%	158%	166%	149%	108%	166%	81%	100%	88%	108%	85%	90%	131%	120%	116%
Ubon Ratchathani	COP 19	Scale Up Aggressive	APR 20	103%	140%	139%	218%	85%	114%	62%	93%	80%	97%	94%	98%	105%	92%	138%	115%	111%
Udon Thani	COP 19	Scale Up Aggressive	APR 20	103%	140%	139%	218%	85%	114%	62%	93%	80%	97%	94%	98%	105%	92%	138%	115%	106%

Table A.2 Thailand ART Targets by Prioritization for Epidemic Control (Thailand)

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY19)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY20) TX_CURR***	**Newly initiated (APR FY20) TX_NEW**	**ART Coverage (APR 20)***
Scale-Up Saturation	15,176	12,174		12,370	238	82%
Scale-Up Aggressive	101,702	57,534	23,828	65,813 *(44,246)*	3,523	65%
Sustained	87,858	79,221		82,420	1,447	94%
Central Support						
Commodities (if not included in previous categories)						
Total	204,736	148,929	23,828	160,603 *(44,246)*	5,208	78%

To estimate the percent ART coverage in PEPFAR supported provinces, the Tx_curr numbers and percent coverage used numerators and denominators of the whole province where PEPFAR supported sites locate. The number in parenthesis is the targeted Tx_curr in direct PEPFAR supported sites.

Tier 2:

INDIA

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1

SNU	COP	Prioritization	Results Reported	Attained: 90-90-90 by Each Age and Sex Band to Reach 95-95-95 Overall																						
				Treatment Coverage at APR by Age and Sex																						
				<0		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		Overall TX Coverage
				F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Aizwal	COP 19	Scale-up: Aggressive	APR 20			56%	62%	63%	57%	61%	73%	80%	62%	103%	63%	65%	72%	73%	62%	62%	74%	63%	64%	65%	64%	62%	65%	64%
Bishunupur	COP 19	Scale-up: Aggressive	APR 20			37%	37%	45%	49%	482%	81%	47%	39%	47%	52%	46%	44%	47%	45%	47%	46%	47%	48%	46%	46%	23%	27%	65%

Champai	COP 19	Scale-up: Aggressive	APR 20	66%		75%	76%	66%	90%	88%	66%	78%	75%	75%	75%	74%	75%	74%	75%	76%	74%	75%	75%	74%	76%	40%	40%	72%
Chandel	COP 19	Scale-up: Aggressive	APR 20			6%	5%	6%	6%	6%	7%	11%	9%	10%	9%	10%	10%	11%	10%	10%	10%	10%	10%	11%	8%	2%	2%	8%
Churachandpur	COP 19	Scale-up: Aggressive	APR 20		32%	72%	74%	67%	71%	34%	33%	58%	61%	58%	57%	58%	58%	58%	59%	58%	58%	59%	58%	71%	57%	21%	21%	54%
Imphal East	COP 19	Scale-up: Aggressive	APR 20			137%	125%	120%	133%	121%	93%	106%	119%	108%	123%	107%	107%	109%	109%	108%	108%	109%	109%	111%	110%	42%	44%	107%
Imphal West	COP 19	Scale-up: Aggressive	APR 20			17%	22%	22%	24%	4%	3%	87%	93%	90%	89%	89%	90%	89%	90%	89%	89%	102%	89%	89%	90%	48%	52%	66%
Kiphiri	COP 19	Scale-up: Aggressive	APR 20			40%	61%	40%				50%		50%	59%	51%	50%	51%	50%	39%	52%	39%	39%	39%	39%	13%	21%	44%
Kohima	COP 19	Scale-up: Aggressive	APR 20			55%	55%	47%	50%	55%	40%	47%	48%	49%	50%	49%	49%	49%	49%	49%	49%	48%	48%	50%	49%	30%	37%	48%
Kolasib	COP 19	Scale-up: Aggressive	APR 20	127%	127%	56%	73%	59%	48%			69%	65%	67%	65%	66%	63%	64%	65%	64%	63%	69%	63%	68%	67%	30%	29%	67%
Krishna	COP 19	Scale-up: Aggressive	APR 20			55%	52%	66%	62%	65%	67%	105%	108%	104%	103%	105%	105%	105%	105%	104%	104%	104%	105%	104%	104%	145%	147%	97%
Lunglei	COP 19	Scale-up: Aggressive	APR 20			71%	80%	71%	53%	53%	53%	79%	79%	77%	76%	76%	81%	74%	75%	76%	76%	76%	79%	72%	76%	75%	77%	73%
Mamit	COP 19	Scale-up: Aggressive	APR 20				9%	9%	17%	9%		24%	20%	17%	16%	15%	15%	16%	15%	15%	18%	17%	16%		24%	14%	12%	16%
Mokchung	COP 19	Scale-up: Aggressive	APR 20			67%	83%	83%	83%	63%		94%	76%	98%	102%	99%	98%	98%	97%	96%	96%	96%	101%	102%	97%	72%	77%	89%
Mumbai	COP 19	Scale-up: Aggressive	APR 20			35%	40%	37%	40%	42%	40%	82%	80%	80%	80%	80%	79%	78%	79%	79%	79%	79%	79%	80%	79%	125%	129%	73%
Pune	COP 19	Scale-up: Aggressive	APR 20			34%	36%	38%	36%	40%	37%	56%	57%	58%	59%	57%	58%	57%	57%	57%	57%	57%	57%	54%	56%	80%	82%	54%
Tamenglong	COP 19	Scale-up: Aggressive	APR 20				13%	13%	13%	14%		12%		12%	12%	14%	15%	15%	16%	12%	12%	12%	16%	12%		5%	12%	13%
Thane	COP 19	Scale-up: Aggressive	APR 20			43%	42%	40%	39%	49%	48%	93%	98%	96%	95%	95%	95%	95%	95%	95%	95%	94%	95%	91%	95%	126%	134%	84%

Thoubal	COP 19	Scale-up: Aggressive	APR 20			12%	13%	15%	14%	13 9%	99%	24%	19%	22%	24%	22%	21%	22%	22%	22%	22%	22%	22%	22%	22%	22%	6%	8%	28%
Tuensang	COP 19	Scale-up: Aggressive	APR 20			59%	59%	48%	89%	85%	11 9%	64%	60%	63%	62%	63%	64%	64%	63%	64%	63%	63%	64%	69%	62%	31%	21%	64%	

Table A.2 ART Targets by Prioritization for Epidemic Control

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY19)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY20) *TX_CURR***	**Newly initiated (APR FY20) *TX_NEW***	**ART Coverage (APR 20)**
Attained	86,004	**76,814**	**0**	**82,963**	**9,700**	**96%**
Scale-Up Saturation	29,469	**23,462**	**113**	**25,337**	**2,958**	**86%**
Scale-Up Aggressive	163,985	**89,443**	**41,745**	**96,589**	**11,276**	**59%**
Sustained						
Central Support						
Commodities (if not included in previous categories)						
Total						

Tier 2: INDONESIA

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

PLHIV age/sex distribution in Jakarta				PLHIV on ART in Jakarta end of Dec 2018			ART Coverage			Remaining PLHIV currently not on ART		
2018	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
0 – 14	2,587	1,313	1,280	640	328	312	25%	25%	24%	1,947	985	968
15 – 19	2,511	1,580	931	326	214	112	13%	14%	12%	2,185	1,366	819
20 – 24	14,849	8,568	6,297	2,474	1,819	655	17%	21%	10%	12,375	6,749	5,642
25 – 49	87,947	56,227	31,703	16,778	12,594	4,184	19%	22%	13%	71,169	43,633	27,519
>50	1,782	1,407	369	1,238	952	286	69%	68%	78%	544	455	83
Total	109,676	69,096	40,580	21,456	15,907	5,549	20%	23%	14%	88,220	53,189	35,031

Table A.2 ART Targets by Prioritization for Epidemic Control

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY19)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY20) TX_CURR**	**Newly initiated (APR FY20) TX_NEW**	**ART Coverage (APR 20)**
Attained						
Scale-Up Saturation						
Scale-Up Aggressive						
Sustained	**109,676**	**14,751**	**72,990**	**14,751**	**821**	**13.40%**
Central Support						
Commodities (if not included in previous categories)						
Total						

Tier 2: KAZAKHSTAN

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

Kazakhstan																				
SNU	COP	Prioriti-zation	Results reported	Attained 90-90-90 (81%) by each age and sex band to reach 95-95-95 (90%) Overall																
				15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		Overall TX Coverage
				F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
East Kazakhstan	COP 15		APR 16	60%		21%	21%	32%	23%	33%	32%	34%	37%	34%	37%	48%	41%	42%	38%	34%
	COP 16		APR 17	50%		48%	30%	49%	36%	50%	38%	43%	44%	44%	45%	56%	45%	49%	46%	44%
	COP 17		APR 18	60%	100%	68%	52%	56%	47%	60%	44%	48%	47%	49%	50%	60%	49%	59%	47%	50%
	COP 18		APR 19	75%	100%	62%	48%	61%	52%	63%	46%	48%	47%	39%	36%	78%	79%	58%	47%	51%
	COP 19		APR 20	75%	100%	73%	65%	61%	54%	64%	46%	47%	46%	39%	35%	76%	73%	58%	45%	50%
Pavlodar	COP 15		APR 16	38%		9%	10%	16%	11%	26%	17%	30%	20%	26%	20%	36%	25%	38%	24%	22%
	COP 16		APR 17	67%	100%	19%	25%	35%	17%	38%	23%	41%	30%	38%	30%	45%	31%	53%	32%	33%
	COP 17		APR 18	50%		45%	82%	55%	39%	47%	36%	52%	41%	53%	41%	53%	44%	57%	42%	46%
	COP 18		APR 19	50%	0%	48%	69%	59%	43%	55%	39%	56%	45%	43%	35%	71%	65%	59%	45%	49%
	COP 19		APR 20	67%	0%	52%	50%	62%	49%	55%	41%	58%	45%	44%	34%	71%	62%	59%	43%	49%
Akmola	COP 15		APR 16	100%		0%	29%	39%	20%	42%	28%	34%	30%	32%	44%	52%	32%	50%	38%	35%
	COP 16		APR 17			100%	71%	55%	54%	50%	44%	48%	22%	53%	28%	67%	39%	50%	19%	41%
	COP 17		APR 18	100%		60%	50%	57%	48%	65%	44%	61%	61%	50%	52%	56%	57%	60%	52%	55%
	COP 18		APR 19	50%		63%	58%	61%	60%	62%	61%	62%	61%	62%	61%	62%	60%	61%	62%	61%
	COP 19		APR 20	75%		71%	69%	71%	72%	72%	73%	72%	72%	72%	73%	71%	72%	72%	72%	72%
Aktobe	COP 15		APR 16	0%	0%	0%	33%	50%	9%	31%	30%	30%	25%	54%	24%	29%	25%	33%	22%	28%
	COP 16		APR 17			100%	71%	55%	54%	50%	44%	48%	22%	53%	28%	67%	39%	50%	19%	41%
	COP 17		APR 18		100%	50%	67%	70%	59%	63%	52%	51%	31%	74%	33%	63%	38%	53%	14%	47%
	COP 18		APR 19		100%	33%	46%	48%	46%	47%	46%	48%	47%	44%	47%	44%	48%	47%	47%	47%
	COP 19		APR 20		100%	33%	50%	50%	49%	50%	50%	50%	49%	50%	49%	50%	48%	50%	50%	49%
Almaty obl	COP 15		APR 16	43%	67%	18%	35%	26%	21%	31%	22%	31%	31%	41%	26%	28%	32%	24%	32%	29%

	COP 16		APR 17	67%	100%	45%	18%	37%	31%	43%	32%	42%	36%	42%	36%	44%	40%	38%	39%	38%
	COP 17		APR 18	50%	80%	43%	38%	48%	48%	53%	44%	59%	48%	52%	48%	56%	49%	54%	51%	50%
	COP 18		APR 19	56%	50%	50%	48%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%
	COP 19		APR 20	50%	63%	54%	54%	54%	54%	54%	54%	54%	54%	54%	54%	54%	54%	54%	54%	54%
Atyrau	COP 15		APR 16			0%	0%	58%	60%	57%	29%	32%	45%	38%	22%	43%	40%	80%	13%	41%
	COP 16		APR 17			67%	29%	60%	40%	62%	45%	50%	33%	62%	43%	67%	67%	69%	25%	50%
	COP 17		APR 18			75%	33%	57%	64%	68%	45%	60%	32%	45%	37%	64%	79%	73%	47%	53%
	COP 18		APR 19			33%	50%	53%	50%	50%	52%	50%	50%	50%	52%	50%	47%	47%	53%	50%
	COP 19		APR 20			33%	54%	50%	52%	52%	54%	52%	52%	53%	51%	54%	53%	53%	50%	52%
Zhambyl	COP 15		APR 16	0%		44%	17%	33%	37%	44%	37%	47%	43%	53%	43%	60%	48%	50%	40%	43%
	COP 16		APR 17	50%	50%	57%	67%	63%	54%	52%	44%	55%	44%	66%	48%	63%	52%	58%	57%	52%
	COP 17		APR 18		100%	75%	50%	70%	65%	54%	60%	61%	55%	69%	56%	72%	55%	71%	60%	60%
	COP 18		APR 19		100%	59%	57%	58%	60%	59%	59%	59%	59%	58%	58%	61%	58%	59%	58%	59%
	COP 19		APR 20		100%	61%	57%	62%	62%	62%	63%	63%	62%	63%	62%	63%	62%	63%	62%	62%
West-Kazakhstan	COP 15		APR 16	100%		45%	83%	48%	33%	31%	43%	38%	39%	68%	38%	55%	27%	38%	36%	41%
	COP 16		APR 17	100%	100%	43%	71%	47%	48%	38%	39%	57%	51%	63%	38%	50%	42%	65%	33%	47%
	COP 17		APR 18		100%	57%	75%	55%	52%	49%	48%	64%	55%	63%	44%	63%	39%	59%	41%	52%
	COP 18		APR 19		100%	43%	50%	50%	52%	51%	51%	51%	51%	50%	51%	47%	51%	52%	51%	50%
	COP 19		APR 20		100%	57%	50%	55%	52%	53%	52%	53%	53%	53%	53%	53%	53%	52%	53%	53%
Karaganda	COP 15		APR 16	56%	50%	20%	14%	21%	20%	28%	25%	34%	28%	41%	34%	40%	43%	50%	34%	32%
	COP 16		APR 17	57%	83%	33%	32%	41%	29%	46%	37%	43%	38%	47%	41%	50%	49%	56%	43%	43%
	COP 17		APR 18	61%	86%	55%	57%	48%	39%	55%	42%	51%	46%	52%	45%	56%	52%	62%	47%	50%
	COP 18		APR 19	47%	56%	48%	49%	49%	49%	49%	49%	49%	49%	49%	49%	49%	49%	49%	49%	49%
	COP 19		APR 20	53%	50%	52%	52%	52%	52%	52%	52%	52%	52%	52%	52%	52%	52%	52%	52%	52%
Kostanay	COP 15		APR 16	0%		23%	21%	27%	14%	27%	17%	24%	20%	38%	27%	21%	37%	23%	21%	23%
	COP 16		APR 17	100%		44%	35%	42%	18%	35%	31%	43%	32%	48%	38%	50%	41%	53%	38%	37%
	COP 17		APR 18	100%	100%	52%	60%	61%	51%	54%	45%	59%	49%	55%	47%	65%	56%	62%	52%	53%
	COP 18		APR 19	33%	100%	52%	53%	52%	51%	52%	52%	52%	52%	52%	52%	53%	53%	52%	52%	52%

	COP 19		APR 20	67%	100%	57%	56%	56%	56%	56%	56%	56%	56%	56%	56%	56%	56%	55%	56%	56%
Kyzylorda	COP 15		APR 16			0%	33%	27%	9%	20%	13%	33%	25%	0%	27%	17%	40%	40%	30%	24%
	COP 16		APR 17	0%		40%	0%	70%	33%	67%	43%	50%	35%	20%	38%	60%	38%	40%	30%	40%
	COP 17		APR 18	100%		50%	25%	82%	60%	73%	53%	100%	50%	67%	67%	80%	31%	71%	18%	57%
	COP 18		APR 19	100%	100%	50%	57%	62%	57%	62%	59%	100%	59%	57%	59%	57%	56%	56%	58%	58%
	COP 19		APR 20	100%	100%	75%	71%	64%	71%	64%	67%	100%	63%	71%	63%	71%	65%	60%	67%	65%
Mangystau	COP 15		APR 16			0%	33%	27%	9%	20%	13%	33%	25%	0%	27%	17%	40%	40%	30%	24%
	COP 16		APR 17			0%	13%	46%	38%	38%	22%	35%	38%	57%	50%	40%	44%	43%	25%	37%
	COP 17		APR 18			0%	56%	38%	48%	67%	52%	58%	36%	58%	59%	33%	56%	56%	55%	52%
	COP 18		APR 19			50%	55%	50%	55%	54%	56%	57%	57%	54%	55%	57%	57%	55%	56%	56%
	COP 19		APR 20			75%	64%	63%	65%	64%	63%	63%	65%	64%	66%	71%	63%	64%	65%	65%
North-Kazakhstan	COP 15		APR 16	0%	0%	20%	10%	22%	12%	35%	23%	40%	34%	50%	37%	47%	38%	39%	24%	30%
	COP 16		APR 17	100%		40%	38%	33%	32%	51%	36%	54%	43%	51%	48%	67%	48%	62%	54%	44%
	COP 17		APR 18	50%		67%	50%	50%	50%	62%	56%	68%	54%	66%	59%	65%	53%	66%	52%	57%
	COP 18		APR 19	33%		57%	55%	56%	55%	56%	56%	55%	56%	56%	56%	55%	56%	58%	56%	56%
	COP 19		APR 20	67%		58%	62%	60%	60%	60%	60%	59%	60%	60%	60%	59%	59%	60%	61%	60%
South Kazakhstan	COP 15		APR 16	64%	60%	26%	41%	31%	14%	45%	23%	44%	33%	43%	35%	42%	30%	48%	34%	36%
	COP 16		APR 17	80%	71%	48%	42%	43%	42%	56%	36%	53%	42%	54%	41%	59%	39%	55%	39%	47%
	COP 17		APR 18	70%	84%	60%	63%	58%	45%	58%	41%	61%	44%	55%	44%	58%	47%	60%	41%	52%
	COP 18		APR 19	48%	50%	49%	50%	49%	49%	49%	49%	49%	49%	50%	49%	50%	49%	49%	50%	49%
	COP 19		APR 20	50%	51%	51%	52%	52%	52%	52%	51%	52%	52%	52%	52%	51%	52%	52%	52%	52%
Almaty city	COP 15		APR 16	60%	100%	51%	31%	45%	35%	49%	36%	48%	37%	46%	37%	42%	38%	52%	41%	41%
	COP 16		APR 17	67%	57%	53%	41%	49%	38%	49%	41%	53%	38%	45%	39%	47%	39%	54%	46%	44%
	COP 17		APR 18	100%	78%	52%	57%	56%	46%	58%	43%	56%	44%	49%	39%	46%	41%	57%	47%	48%
	COP 18		APR 19	33%	56%	49%	49%	49%	49%	49%	49%	49%	49%	49%	49%	49%	49%	49%	49%	49%
	COP 19		APR 20	67%	50%	54%	55%	54%	54%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%
Astana city	COP 15		APR 16		0%	13%	7%	19%	12%	33%	21%	25%	22%	25%	26%	24%	27%	26%	17%	22%
	COP 16		APR 17	100%	0%	13%	29%	33%	23%	37%	27%	32%	28%	32%	31%	39%	28%	31%	37%	30%

	COP 17		APR 18	50%	0%	36%	55%	42%	33%	43%	35%	48%	38%	42%	39%	54%	35%	44%	43%	40%
	COP 18		APR 19	50%	50%	43%	43%	43%	43%	43%	42%	43%	43%	43%	42%	43%	43%	42%	43%	43%
	COP 19		APR 20	50%	50%	50%	48%	49%	48%	49%	48%	49%	49%	48%	49%	48%	48%	49%	48%	48%

Table A.2 ART Targets by Prioritization for Epidemic Control (PEPFAR sites)

Table A.2 ART Targets by Prioritization for Epidemic Control (PEPFAR sites)						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY19)**	**Additional patients required for 81% ART coverage**	**Target current on ART (APR FY20) *TX_CURR***	**Newly initiated (APR FY20) *TX_NEW***	**ART Coverage (APR 20)**
Attained						
Scale-Up Saturation						
Scale-Up Aggressive						
Sustained	6,479	3,067	2,181	3,223	346	50%
Central Support						
Commodities (if not included in previous categories)						
Total	6,479	3,067	2,181	3,223	346	50%

Tier 2: LAOS

Tier 2: LAOS

Table A.2 ART Targets by Prioritization for Epidemic Control

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY19)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY20) *TX_CURR***	**Newly initiated (APR FY20) *TX_NEW***	**ART Coverage (APR 20)**
Sustained	8,467	5,655	1,119	5,655	317	67%
Not PEPFAR Supported						
Total	8,467	5,655	1,119	**5,655**	317	67%

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

SNU	COP	Prioritization	Results Reported	Atttained: 90-90-90 by Each Age and Sex Band to Reach 95-95-95 Overall																
				Treatment Coverage at APR by Age and Sex																
				15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		Overall TX Coverage
				F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Champasak	COP 19	Sustained	APR 20	67%	83%	79%	76%	104%	83%	91%	83%	70%	68%	70%	67%	65%	80%	67%	65%	79%
Savannakhet	COP 19	Sustained	APR 20	75%	73%	63%	68%	74%	65%	65%	71%	65%	66%	65%	65%	72%	65%	68%	65%	68%
Vientiane Capital	COP 19	Sustained	APR 20	84%	72%	78%	70%	83%	66%	75%	70%	70%	74%	69%	68%	69%	65%	69%	65%	72%
Langnamtha	COP 19	Sustained	APR 20	0%	0%	0%	100%	100%	67%	100%	100%	100%	0%	71%	67%	69%	71%	69%	75%	67%
Luangprabang	COP 19	Sustained	APR 20	0%	0%	67%	69%	75%	67%	67%	100%	67%	100%	65%	68%	65%	65%	65%	66%	65%

The wide variation observed in some cells in the table for Luang Prabang and Luang Namtha are likely a reflection of imprecise size estimates for PLHIV and small numbers of people on ART for some age/sex groups in those provinces.

Tier 2: PAPUA NEW GUINEA

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

SNU	COP	Prioritization	Treatment Coverage																		Overall Coverage
			<15		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
			F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
National Capital District	ROP19	Sustained	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
	ROP20	Sustained	66%	57%	92%	93%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	91%	92%	89%

Table A.2 ART Targets by Prioritization for Epidemic Control

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY19)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY20) *TX_CURR***	**Newly initiated (APR FY20) *TX_NEW***	**ART Coverage (APR 20)**
Attained						
Scale-Up Saturation						
Scale-Up Aggressive						
Sustained	5260	4882	0	4980	154	95%
Central Support						
Commodities (if not included in previous categories)						
Total	5260	4882	0	4980	154	95%

Tier 3: CAMBODIA

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

Treatment Coverage by Each Age and Sex Band to Reach 95-95-95 (90%) Overall[59]						
Treatment Coverage at December 2018 by Age and Sex						
SNU	Results	<15		>15		Overall TX Coverage
		Female	Male	Female	Male	
Banteay Meanchey	CY 18	35%	47%	79%	74%	75%
Battambang	CY 18	82%	118%	78%	80%	80%
Kampong Cham	CY 18	71%	62%	70%	67%	68%
Kampong Chhnang	CY 18	96%	113%	63%	59%	63%
Kampong Speu	CY 18	133%	244%	52%	61%	61%
Kampong Thom	CY 18	31%	41%	46%	51%	47%
Kampot	CY 18	129%	115%	134%	116%	125%
Kandal	CY 18	61%	56%	65%	54%	59%
Kep	CY 18	288%	0%	165%	146%	157%
Koh Kong	CY 18	49%	42%	75%	63%	68%
Kratie	CY 18	41%	58%	75%	65%	69%
Mondulkiri	CY 18	68%	0%	42%	22%	32%
Oddor Meanchey	CY 18	43%	54%	49%	43%	47%
Pailin	CY 18	126%	86%	93%	89%	92%
Phnom Penh	CY 18	115%	116%	134%	114%	123%
Preah vihear	CY 18	134%	165%	89%	102%	98%
Prey Veng	CY 18	63%	106%	72%	66%	70%
Pursat	CY 18	54%	64%	61%	55%	58%
Rattanakiri	CY 18	104%	39%	60%	50%	56%
Siem Reap	CY 18	88%	93%	64%	63%	65%
Sihanouk Ville	CY 18	51%	79%	85%	77%	81%
Stung Treng	CY 18	98%	92%	75%	62%	70%
Svay Rieng	CY 18	67%	80%	63%	61%	63%
Takeo	CY 18	71%	93%	79%	70%	75%
Tbong Khum	CY 18	36%	38%	59%	55%	56%

[59] SNU proportions for estimated PLHIV is from the 2016 AEM SNU proportions.

Appendix B- Budget Profile and Resource Projections

Tier 1: Accelerate and Achieve Epidemic Control
Burma, Kyrgyz Republic, Nepal, Tajikistan, and Thailand
Tier 2: Protect the Investment
India, Indonesia, Kazakhstan, Laos, and Papua New Guinea
Tier 3: Sustained Epidemic Control
Cambodia

Tier 1: BURMA

B.1 COP19 Planned Spending

Table B.1.1 COP19 Budget by Program Area

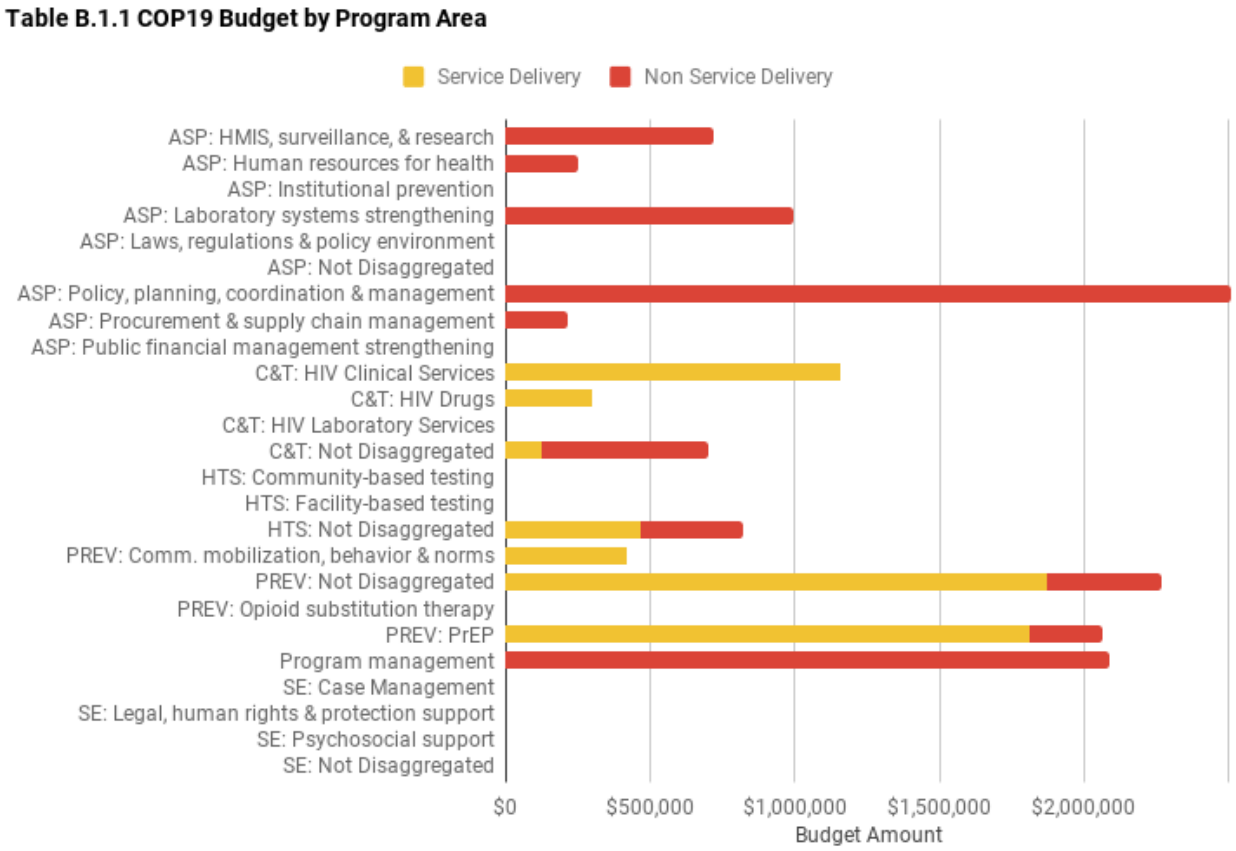


Table B.1.2 COP19 Total Planning Level

Table B.1.2 COP19 Total Planning Level

Applied Pipeline	New Funding	Total Spend
$US 3,037,249	$US 13,449,697	$US 16,486,946

Table B.1.3

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	0
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	0
HVOP	Other Sexual Prevention	2,930,584
IDUP	Injecting and Non-Injecting Drug Use	2,374,694
HMBL	Blood Safety	0
HMIN	Injection Safety	0
CIRC	Male Circumcision	0
HVCT	Counseling and Testing	1,547,880
HBHC	Adult Care and Support	978,639
PDCS	Pediatric Care and Support	0
HKID	Orphans and Vulnerable Children	0
HTXS	Adult Treatment	2,882,574
HTXD	ARV Drugs	0
PDTX	Pediatric Treatment	0
HVTB	TB/HIV Care	174,031
HLAB	Lab	1,263,150
HVSI	Strategic Information	440,255
OHSS	Health Systems Strengthening	525,854
HVMS	Management and Operations	332,035
TOTAL		**13,449,697**

B.2 Resource projections: Burma PEPFAR's resource projections for ROP19 are based on the following: a review of Expenditure Reporting (ER) data, national surveillance and survey data, national and partner program results, projected activities and outcomes, and projected external donor and government resource projections.

ER was used to determine budget projections for both continuing and new implementing mechanisms. For the continuing implementing mechanisms, PEPFAR used ER data to assess spending and burn rates and projected changes in program activities to determine funding levels for each mechanism. Similarly, ER was used for new mechanisms where program activities were expected to be similar to old or expiring mechanisms.

EA data were used to provide target-based budgeting to ensure budget codes accurately reflect Burma PEPFAR activities. Implementing mechanisms were also analyzed by budget code to ensure mandatory earmarks and budgetary requirements were met (e.g., care and treatment) and to maximize the impact of the funds.

Increased resources are projected for activities related to fulfilling the PEPFAR Minimum Requirements as well as other PEPFAR priorities including PrEP implementation and Recency testing. Resources are targeted towards the highest risk KP in the highest burden geographical areas to ensure 90-90-90 is achieved.

Tier 1: KYRGYZ REPUBLIC

B1. COP 19 Planned Spending

Table B.1.1 COP19 Budget by Program Area

Table B.1.1 COP19 Budget by Program Area

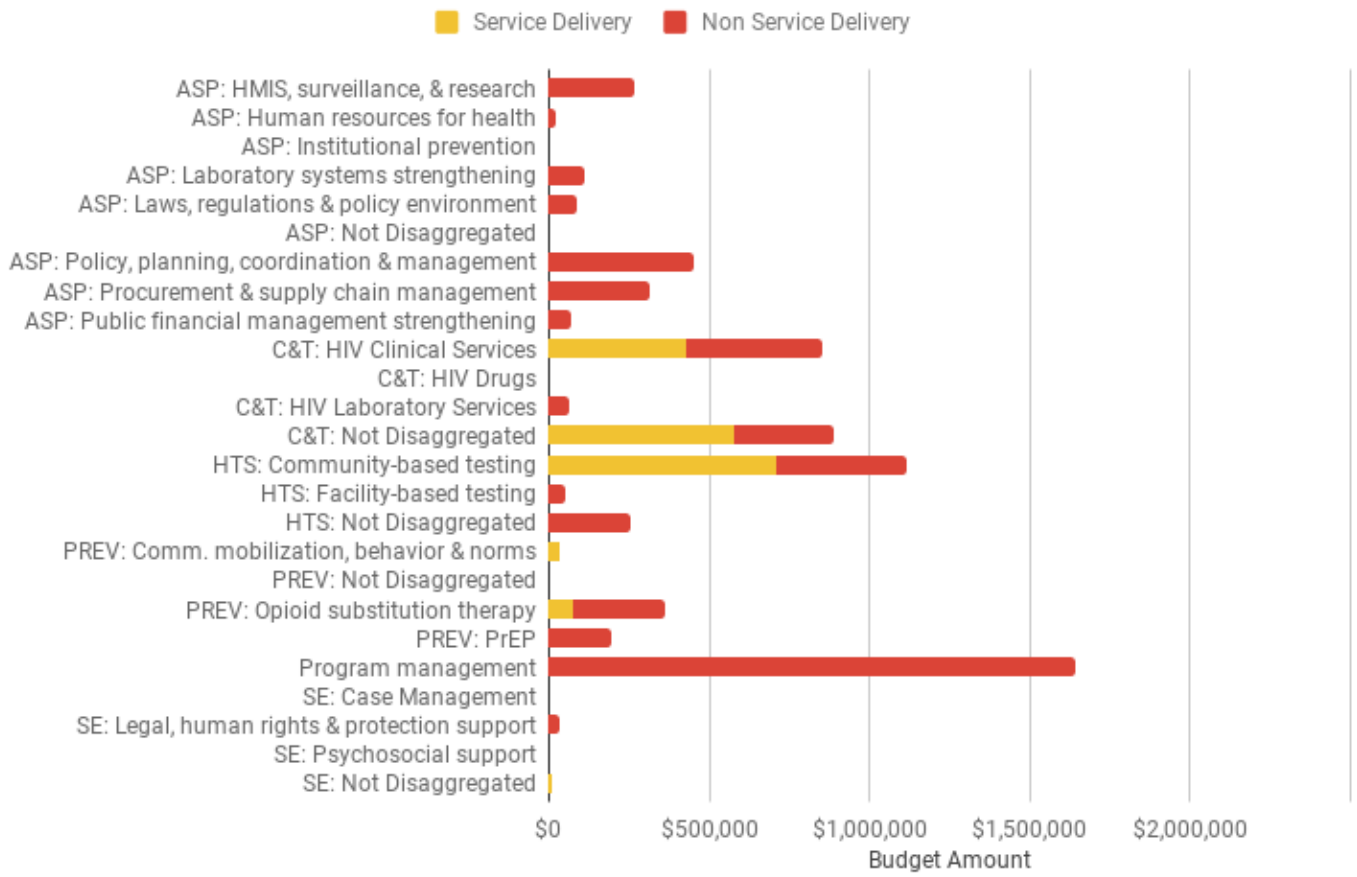


Table B.1.2 COP19 Total Planning Level

Table B.1.2 COP19 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$US 1,383,699	**$US 6,278,679**	**$US 7,662,378**

Table B.1.3

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	
HVOP	Other Sexual Prevention	387,108
IDUP	Injecting and Non-Injecting Drug Use	74,787
HMBL	Blood Safety	
HMIN	Injection Safety	
CIRC	Male Circumcision	
HVCT	Counseling and Testing	1,569,778
HBHC	Adult Care and Support	1,209,586
PDCS	Pediatric Care and Support	
HKID	Orphans and Vulnerable Children	
HTXS	Adult Treatment	1,137,381
HTXD	ARV Drugs	
PDTX	Pediatric Treatment	
HVTB	TB/HIV Care	
HLAB	Lab	89,710
HVSI	Strategic Information	92,442
OHSS	Health Systems Strengthening	1,355,156
HVMS	Management and Operations	362,729
TOTAL		**6,278,679**

Tier 1: NEPAL

Table B.1.1 COP19 Budget by Program Area

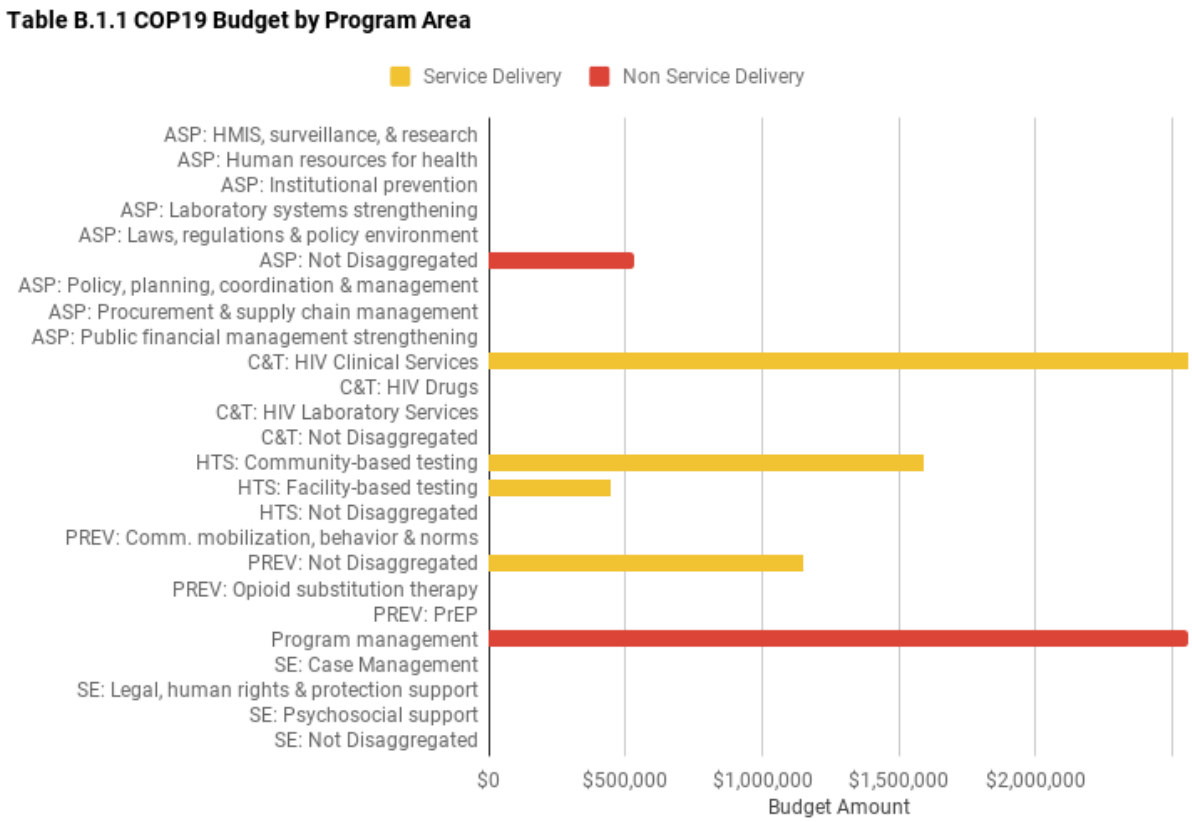


Table B.1.2 COP19 Total Planning Level

Table B.1.2 COP19 Total Planning Level

Applied Pipeline	New Funding	Total Spend
$US	$US 9,676,764	$US 9,676,764

Table B.1.3

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	84,385
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	
HVOP	Other Sexual Prevention	1,618,111
IDUP	Injecting and Non-Injecting Drug Use	
HMBL	Blood Safety	
HMIN	Injection Safety	
CIRC	Male Circumcision	
HVCT	Counseling and Testing	2,862,814
HBHC	Adult Care and Support	2,150,982
PDCS	Pediatric Care and Support	
HKID	Orphans and Vulnerable Children	
HTXS	Adult Treatment	1,458,293
HTXD	ARV Drugs	
PDTX	Pediatric Treatment	
HVTB	TB/HIV Care	$36,456
HLAB	Lab	279,682
HVSI	Strategic Information	204,145
OHSS	Health Systems Strengthening	142,512
HVMS	Management and Operations	839,381
TOTAL		**$9,676,764**

B.2 Resource projections: Required resources were calculated based on epidemiologic and program data, including the number of people to reach in each step of the cascade, as well as historic costs to the program for similar work. Above-site estimates are based on previous similar work in PEPFAR and non-PEPFAR programs.

Tier 1: TAJIKISTAN

B1. COP 19 Planned Spending

Table B.1.1 COP19 Budget by Program Area

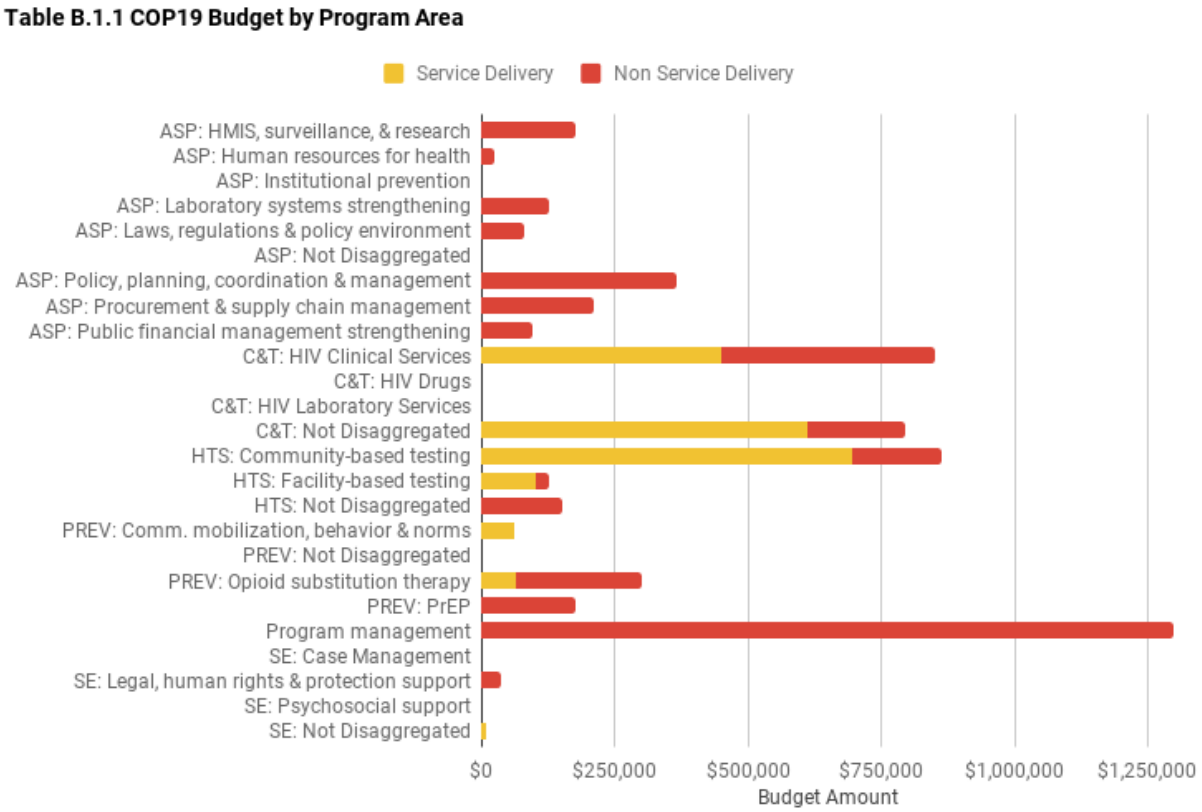


Table B.1.2 COP19 Total Planning Level

Table B.1.2 COP19 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$US 807,875	**$US 5,730,988**	**$US 6,538,863**

Table B.1.3

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	
IDUP	Injecting and Non-Injecting Drug Use	32,944
HMBL	Blood Safety	
HMIN	Injection Safety	
CIRC	Male Circumcision	
HVCT	Counseling and Testing	1,298,695
HBHC	Adult Care and Support	1,258,133
PDCS	Pediatric Care and Support	
HKID	Orphans and Vulnerable Children	
HTXS	Adult Treatment	1,002,247
HTXD	ARV Drugs	
PDTX	Pediatric Treatment	
HVTB	TB/HIV Care	8,810
HLAB	Lab	130,731
HVSI	Strategic Information	124,700
OHSS	Health Systems Strengthening	1,150,864
HVMS	Management and Operations	398,960
HVOP	Other Sexual Prevention	324,902
TOTAL		**$5,730,988**

Tier 1: THAILAND

B1. COP 19 Planned Spending

Table B.1.1 COP19 Budget by Program Area

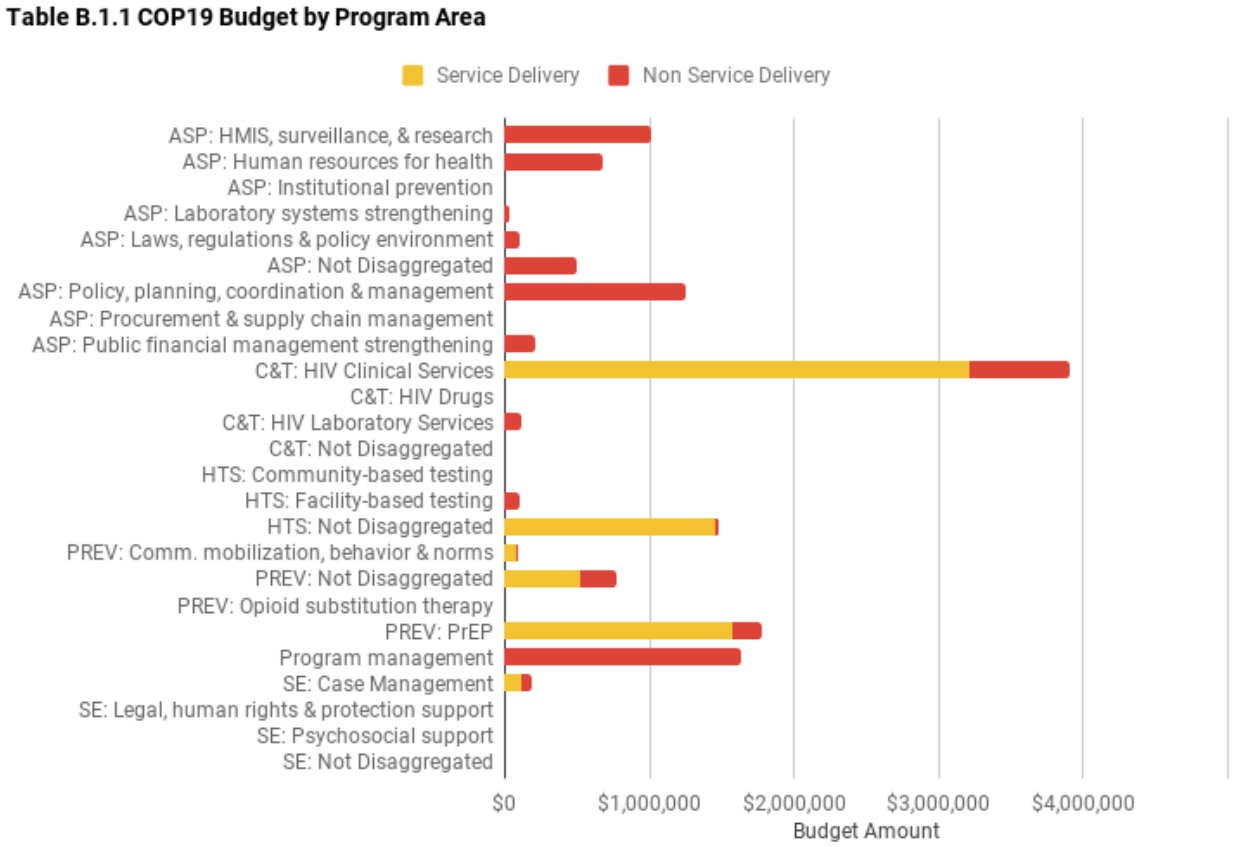


Table B.1.2 COP19 Total Planning Level

Table B.1.2 COP19 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$US 1,944,233	**$US 19,197,218**	**$US 21,141,451**

Table B.1.3

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	$3,149
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	$114,000
HVOP	Other Sexual Prevention	$3,341,216
IDUP	Injecting and Non-Injecting Drug Use	-
HMBL	Blood Safety	-
HMIN	Injection Safety	-
CIRC	Male Circumcision	-
HVCT	Counseling and Testing	$2,562,160
HBHC	Adult Care and Support	$2,244,928
PDCS	Pediatric Care and Support	$18,898
HKID	Orphans and Vulnerable Children	-
HTXS	Adult Treatment	30,942
HTXD	ARV Drugs	-
PDTX	Pediatric Treatment	-
HVTB	TB/HIV Care	$40,392
HLAB	Lab	$638,409
HVSI	Strategic Information	$1,773879
HVMS	Management	3,806,171
OHSS	Health Systems Strengthening	1,673,792
Total		19,197,218

B.2

Resource projections: Projected resources were based on multiple data sources and methods for estimating resource needs as described below. Some methods were utilized by all Asia Region countries while other methods were applied by some country offices. Lump sum budgeting approaches were employed and pipeline was applied as required. Minimum percentage at 21% of care and treatment earmark is also considered.

To generate lump sum costs for Thailand, costs were estimated from partner activities and proposed budgets. The FY2018 PEFAR Expenditure Report and performance were reviewed to understand expenditures and partner performance in each area. Additionally, proposed costs are based on previously completed program costs that are similar to the current requirement. The team also considered leveraging funds from associated activities and other sources. For example, PEPFAR resources and targets will be combined with those of the Global Fund to support the country ownership strategy, intervention programs, promotion of CSO engagement, and harmonization of host government health information systems will be leveraged. In addition, there is an opportunity to leverage additional resources from the

National Health Security Office (NHSO) of the MoPH to support CSOs, national, and sub-national level for HIV/AIDS activities.

The lump sum budget calculation is split into two parts. For USG M&O, resources required for FY2020 were based on historical expenditures, plus future plans, including additional travel costs for SIMS visits and for the PEPFAR Coordination Unit. Resource projections were calculated for each activity and for each IM based on previous and current project budgets and work plans (as appropriate), program descriptions, expected activities, outcomes, outputs, and results, considering the remaining funds after subtracting M&O. The investment in each program area is allocated based on PEPFAR's strategy to support impactful interventions to achieve epidemic control in Thailand. The estimates for each budget-code category were based on the percentage of specific work required by each IM's activity under that budget code multiplied by the total estimated budget of each mechanism. The cost categories of M&O are based on historical data, travel costs, personnel costs including estimated cost of living increases, and time allocated to budget code based on projected activities.

Pipeline was applied for Thailand budgets. The applied pipeline was derived from historical and projected expenditures, planned activities, and the current pipeline to determine the applied pipeline from ROP18. There was an issue for one implementing partner in ROP18. As a result, funding for that partner will be reprogrammed to another mechanism next year.

Tier 2: INDIA

B1. COP 19 Planned Spending

Table B.1.1 COP19 Budget by Program Area

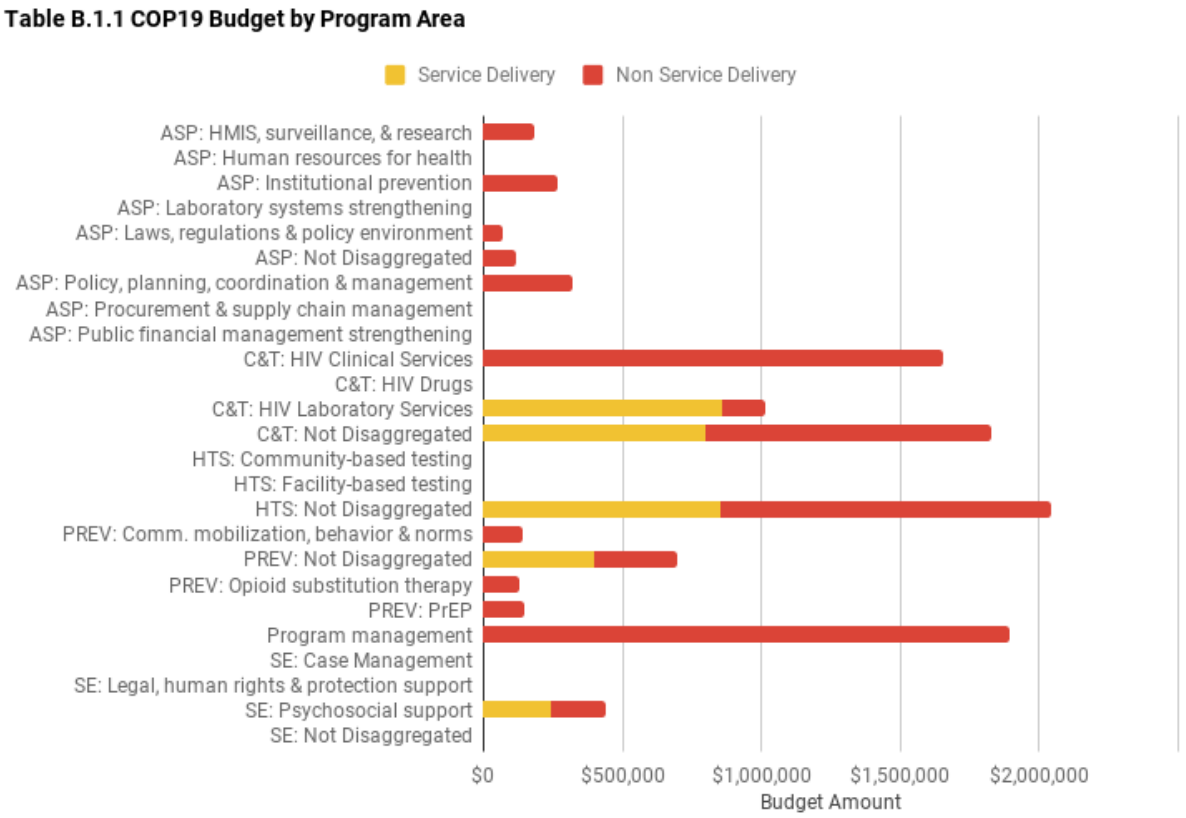


Table B.1.2 COP19 Total Planning Level

Table B.1.2 COP19 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$US 10,008,850	**$US 4,991,150**	**$US 15,000,000**

Table B.1.3

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	
HVOP	Other Sexual Prevention	41,334
IDUP	Injecting and Non-Injecting Drug Use	49,607
HMBL	Blood Safety	
HMIN	Injection Safety	
CIRC	Male Circumcision	
HVCT	Counseling and Testing	392,353
HBHC	Adult Care and Support	220,322
PDCS	Pediatric Care and Support	
HKID	Orphans and Vulnerable Children	249,143
HTXS	Adult Treatment	1,177,281
HTXD	ARV Drugs	
PDTX	Pediatric Treatment	11,710
HVTB	TB/HIV Care	29,450
HLAB	Lab	392,952
HVSI	Strategic Information	529,634
OHSS	Health Systems Strengthening	39,442
HVMS	Management and Operations	1,857,917
TOTAL		**4,991,150**

B.2 Resource projections: In ROP19, PEPFAR India shifted to program-based budgeting using historical costs and targets. The program applied an incremental, activity-based budgeting approach to ascertain the appropriate budget per implementing mechanism. This entailed a review of the implementing mechanism's expected scope of work and, if applicable, targets. This included an assessment of each partner's capacity based on previous achievement to determine the required resources to protect prioritized program activities within the 40% reduced budget level for ROP19.

Tier 2: INDONESIA

B1. COP 19 Planned Spending

Table B.1.1 COP19 Budget by Program Area

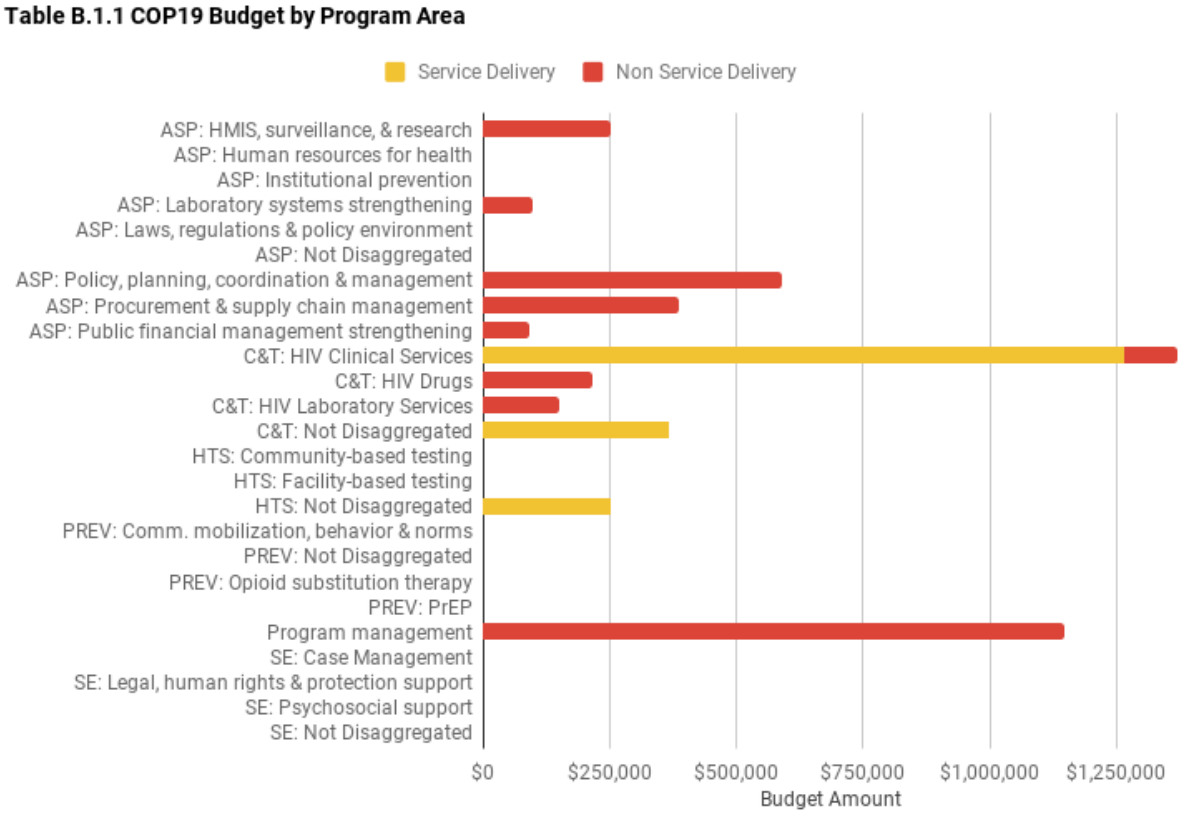


Table B.1.2 COP19 Total Planning Level

Table B.1.2 ROP 19 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$US 3,026,534	**$US $2,595,969**	**$US $5,622,503**

Table B.1.3

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	
HVOP	Other Sexual Prevention	
IDUP	Injecting and Non-Injecting Drug Use	
HMBL	Blood Safety	
HMIN	Injection Safety	
CIRC	Male Circumcision	
HVCT	Counseling and Testing	$ 175,536
HBHC	Adult Care and Support	$ 368,554
PDCS	Pediatric Care and Support	
HKID	Orphans and Vulnerable Children	
HTXS	Adult Treatment	$ 866,997
HTXD	ARV Drugs	
PDTX	Pediatric Treatment	
HVTB	TB/HIV Care	
HLAB	Lab	$ 45,696
HVSI	Strategic Information	$ 374,746
OHSS	Health Systems Strengthening	$ 650,574
HVMS	Management and Operations	$ 113,864
TOTAL		**$ 2,595,969**

B.2 Resource projections: Based on historical data and, 2018 Expenditure Reporting and new guidance provided by PEPFAR, as a Tier 2 country the budget has been allocated to support protecting the investment.

Tier 2: KAZAKHSTAN

B1. COP 19 Planned Spending

Table B.1.1 COP19 Budget by Program Area

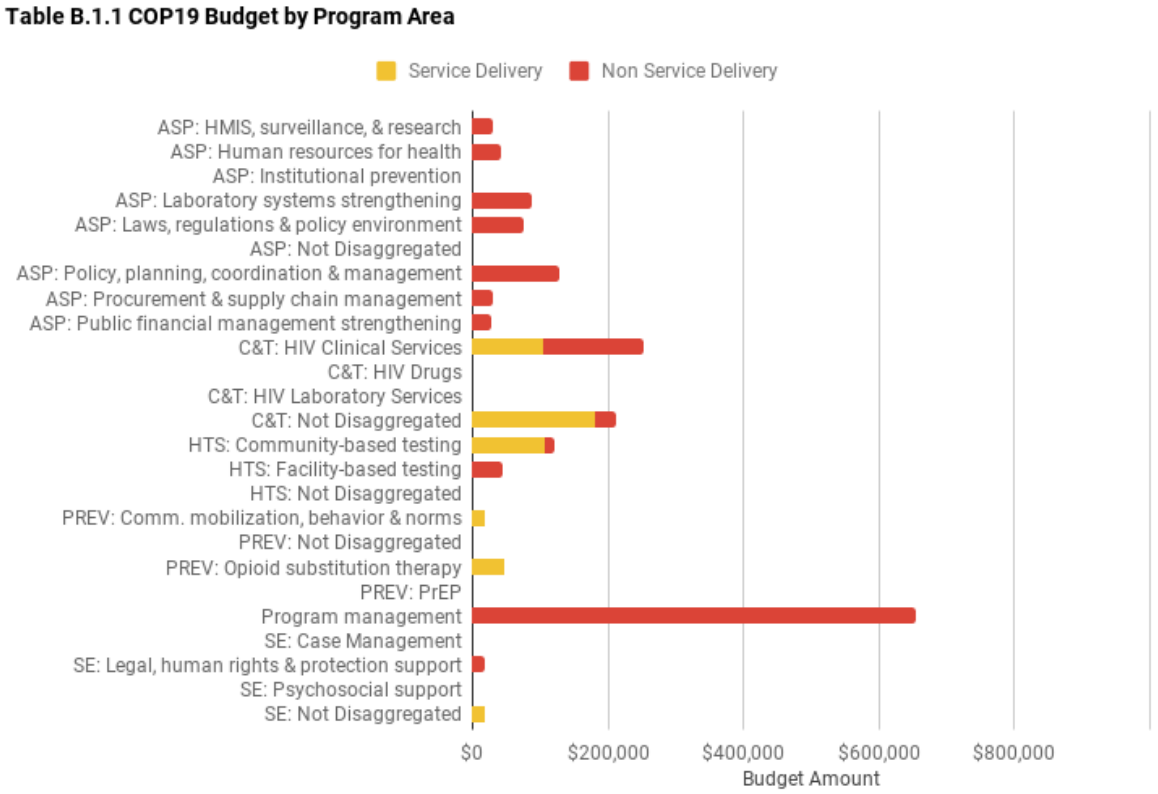


Table B.1.2 COP19 Total Planning Level

Table B.1.2 COP19 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$US 926,957	**$US 3,232,430**	**$US 4,159,387**

Table B.1.3

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	
HVOP	Other Sexual Prevention	17,115
IDUP	Injecting and Non-Injecting Drug Use	68,967
HMBL	Blood Safety	
HMIN	Injection Safety	
CIRC	Male Circumcision	
HVCT	Counseling and Testing	211,565
HBHC	Adult Care and Support	550,828
PDCS	Pediatric Care and Support	
HKID	Orphans and Vulnerable Children	
HTXS	Adult Treatment	255,844
HTXD	ARV Drugs	67,305
PDTX	Pediatric Treatment	
HVTB	TB/HIV Care	8,275
HLAB	Lab	82,754
HVSI	Strategic Information	55,183
OHSS	Health Systems Strengthening	481,009
HVMS	Management and Operations	1,433,581
TOTAL		**$3,232,430**

Tier 2: LAOS

B1. COP 19 Planned Spending

Table B.1.1 COP19 Budget by Program Area

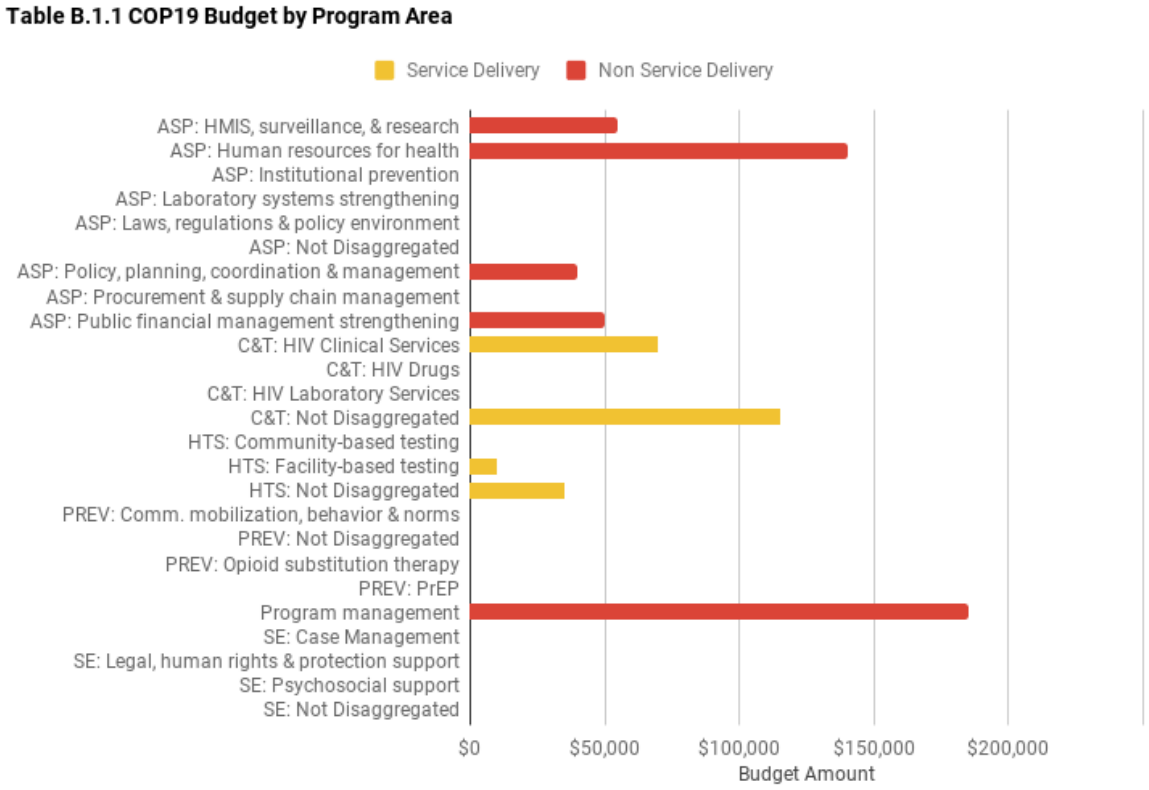


Table B.1.2 COP19 Total Planning Level

Table B.1.2 COP19 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$US 0	**$US 840,000**	**$US 840,000**

Table B.1.3 Laos Resource Allocation by PEPFAR Budget Code

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	-
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	-
HVOP	Other Sexual Prevention	$10,000
IDUP	Injecting and Non-Injecting Drug Use	-
HMBL	Blood Safety	-
HMIN	Injection Safety	-
CIRC	Male Circumcision	-
HVCT	Counseling and Testing	$113,200
HBHC	Adult Care and Support	$119,000
PDCS	Pediatric Care and Support	-
HKID	Orphans and Vulnerable Children	-
HTXS	Adult Treatment	$191,700
HTXD	ARV Drugs	-
PDTX	Pediatric Treatment	-
HVTB	TB/HIV Care	-
HLAB	Lab	-
HVSI	Strategic Information	$79,100
OHSS	Health Systems Strengthening	$245,000
HVMS	Management and Operations	$82,000
TOTAL		**$840,000**

B.2 Resource projections: Projected resources were based on multiple data sources and methods for estimating resource needs, as described below. Lump sum budgeting approaches were employed for resource allocation in Laos. The minimum percentage at 21% of care and treatment earmark is also considered.

Several methods were used to generate lump sum costs for Laos PEPFAR's activities. Costs were estimated from partner activities and their proposed budgets. The FY2018 PEPFAR Expenditure Report and performance reports were reviewed to understand expenditures and partner performance in each area. Additionally, the proposed costs were based on previously completed program costs that are similar to current requirements. The team collaborates with other donors in the country to maximize impact with limited resources. For example, PEPFAR resources and targets will be combined with those of other key stakeholders in the country such as the GF to support the country ownership strategy, intervention programs, promotion of CSO engagement, and harmonization of host government health information systems.
The lump sum budget calculation is split into two parts. For USG M&O, resources required for FY2020 were based on historical expenditures, plus future plans, including additional travel

costs for SIMS visits. Resource projections were calculated for each activity and for each Implementing Mechanism (IM) based on previous and current project budgets and work plans (as appropriate), program descriptions, expected activities, outcomes, outputs, and results, considering the remaining funds after subtracting M&O. The investments in each program area also are allocated based on PEPFAR's strategy that supports PLHIV currently on treatment. The estimates of each budget-code category were based on the percentage of specific work required by each IM's activity under that budget code multiplied by the total estimated budget of each mechanism. The cost categories of M&O are based on historical data, travel costs, personnel costs including estimated cost of living increases, and time allocated to budget code based on projected activities.

Tier 2: PAPUA NEW GUINEA

B1. COP 19 Planned Spending

Table B.1.1 COP19 Budget by Program Area

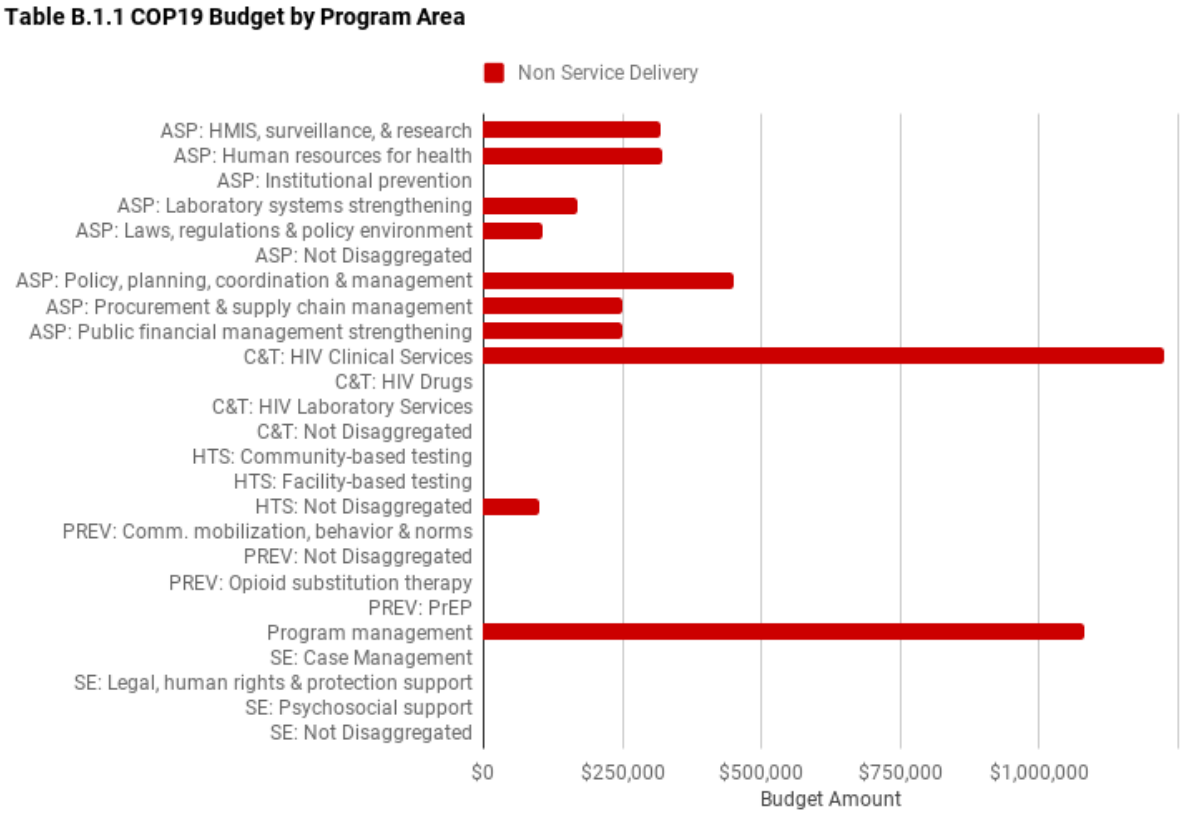


Table B.1.2 ROP19 Total Planning Level

Table B.1.2 COP19 Total Planning Level

Applied Pipeline	New Funding	Total Spend
$US 598,812	$US 5,300,723	$US 5,899,535

Table B.1.3

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
HVCT	Counseling and Testing	$159,850
HTXS	Adult Treatment	$2,227,238
HTXD	ARV Drugs	$10,070
HVTB	TB/HIV Care	$45,557
HLAB	Lab	$270,139
HVSI	Strategic Information	$748,749
OHSS	Health Systems Strengthening	$846,266
HVMS	Management and Operations	$992,854
TOTAL		**$5,300,723**

B.2 Resource projections: PNG PEPFAR used activity-based budgeting for ROP 2019. USAID also referenced the Expenditure Reporting 2018 allocations per program area to estimate the amounts needed to support some of the USAID activities for ROP 2019.

Implementing mechanism activities were evaluated based on FY18 Expenditure Analysis as well as budget codes to ensure activities and budgets aligned with mandatory earmarks.

Tier 3: CAMBODIA

B1. COP 19 Planned Spending

Table B.1.1 COP19 Budget by Program Area

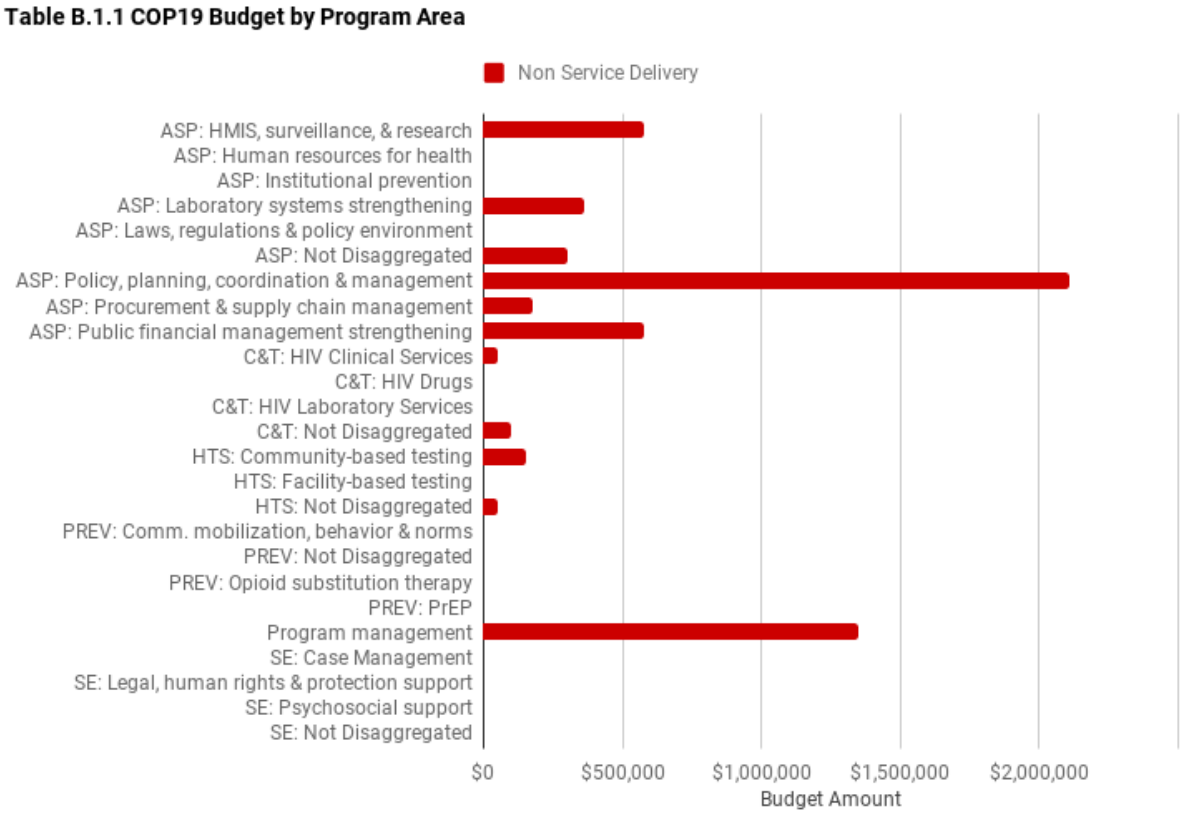


Table B.1.2 COP19 Total Planning Level

Table B.1.2 COP19 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$6,812,383	**$1,882,323**	**$8,694,706**

Table B.1.3 Resource Allocation by PEPFAR Budget Code

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	
HVOP	Other Sexual Prevention	
IDUP	Injecting and Non-Injecting Drug Use	
HMBL	Blood Safety	
HMIN	Injection Safety	
CIRC	Male Circumcision	
HVCT	Counseling and Testing	216,488
HBHC	Adult Care and Support	250,000
PDCS	Pediatric Care and Support	
HKID	Orphans and Vulnerable Children	
HTXS	Adult Treatment	308,135
HTXD	ARV Drugs	
PDTX	Pediatric Treatment	11,883
HVTB	TB/HIV Care	5,944
HLAB	Lab	356,823
HVSI	Strategic Information	340,472
OHSS	Health Systems Strengthening	92,944
HVMS	Management and Operations	299,634
TOTAL		**1,882,323**

B.2 Resource Projections: The ROP19 budget for Cambodia was developed based on consideration of intended program outputs and outcomes. Given that Cambodia's program focuses almost exclusively above-site, activities and required funding to reach Table 6 benchmarks were a key factor. In addition, COP17/18 expenditure reporting data were reviewed to inform the projected costs of interventions. A significant proportion of Cambodia's ROP19 budget is applied pipeline. Over 50% of new funds are allocated to adult and pediatric treatment, strategic information, and laboratory costs, reflecting Cambodia PEPFAR's support to priority activities including scale up of TLD, MMS, and SDART; implementation of case-based surveillance; and use of the recency assay.

APPENDIX C – Tables and Systems Investments for Section 6.0

Tier 1: Accelerate and Achieve Epidemic Control
Burma, Kyrgyz Republic, Nepal, Tajikistan, and Thailand
Tier 2: Protect the Investment
India, Indonesia, Kazakhstan, Laos, and Papua New Guinea
Tier 3: Sustained Epidemic Control
Cambodia

Tier 1: BURMA

The Table 6-E tab and for Burma. The Burma PEPFAR program does not have any planned SRE for ROP19

Burma Table 6 E.pdf

Tier 1: KYRGYZ REPUBLIC

Appendix C Table 6 - E Kyrgyz Republic 6 M

Appendix C SRE Tool-E Kyrgyz Republi

Tier 1: NEPAL

Table 6-E is attached. The Nepal PEPFAR program does not have any planned SRE for ROP19.

Nepal Table 6 E.pdf

Tier 1: TAJIKISTAN

Appendix C SRE Tool - E Tajikistan May 201

Appendix C Table 6 - E Tajikistan May 2019

Tier 1: THAILAND

The Table 6-E tab and SRE Tool-E tab for Thailand are attached here.

Thaialnd Table 6 E.pdf

Thailand SRE.pdf

Tier 2: INDIA

The Table 6-E tab is attached. The India PEPFAR program does not have any planned SRE for ROP19.

India Table 6.pdf

Tier 2: INDONESIA

Table 6-E is attached. The Indonesia PEPFAR program does not have any planned SRE for ROP19.

Indonesia Table 6

Tier 2: KAZAKHSTAN

Table 6-E and SRE tabs for Kazakhstan are attached.

Appendix C Table 6 - E Kazakhstan 6 May 2(

Appendix C SRE Tool - E Kazakhstan 6 May

Tier 2: LAOS

Table 6-E is attached. The Laos PEPFAR program does not have any planned SRE for ROP19.

Laos Table 6

Tier 2: PAPUA NEW GUINEA

Table 6-E for PNG is attached. The PNG PEPFAR program does not have any planned SRE for ROP19.

PNG Table 6.pdf

Tier 3: CAMBODIA

Table 6-E for Cambodia is attached. The Cambodia PEPFAR program does not have any planned SRE for ROP19.

Cambodia Table 6.pdf

APPENDIX D– Minimum Program Requirements

Tier 1: Accelerate and Achieve Epidemic Control
Burma, Kyrgyz Republic, Nepal, Tajikistan, and Thailand
Tier 2: Protect the Investment
India, Indonesia, Kazakhstan, Laos, and Papua New Guinea
Tier 3: Sustained Epidemic Control
Cambodia

Tier 1: BURMA

The Minimum Requirements for continued PEPFAR support in Burma include:

Minimum Requirement	Status
1. Adoption and implementation of Test and Start	Important policy and strategy changes in Burma included the transition to Test and Start for all PLHIV which had happened in 2017 and ART coverage among total estimated PLHIV had increased from 57% in 2016 to 73% at the end of 2018.
2. Differentiated service delivery models, including six-month MMS	National policy and standard operating procedures for MMS (up to six months) had been rolled out in 2018 and six-month MMS was identified as a priority intervention in the Sub-National Plans of Kachin, Shan (North) and Yangon. Further support from PEPFAR is required to operationalization of MMS in Burma.
3.TLD transition	TLD regimen was added as first-line preferred regimen with TLE per 2018 update to national clinical management guidelines. Clinician education, and demand creation are critical to successful TLD transition and PEPFAR program plans to provide TA on informed choice and disseminating global safety evidence on TLD transition.
4.Scale-up of index testing and self-testing; monitoring intimate partner violence (IPV) established	Index testing has been carried out across PEPFAR-supported service delivery sites since 2018 and PEPFAR program would ensure Index testing and partner notification provided for all new diagnoses. Above-site TA will be provided for SOPs development and monitoring & evaluation support to promote scale-up of a mix of testing modalities including KP-specific SOPs for index testing and facilitated partner notification for newly diagnosed MSM, FSW and PWID, set-up of training cascade for KP index testers and strengthening laboratory capacity for self-testing roll out.
5.TB preventive treatment (TPT) for all PLHIV	NSP III aimed to achieve 50% of persons with newly diagnosed HIV infection starting TPT by 2020 and the current achievement for 2018 from national TB/HIV reports showed that TPT among new ART patients was only around 18%. TPT guidelines were updated in COP 17/18 and stakeholder consultations were ongoing to improve patient monitoring and identify gaps for provision of TPT for all eligible PLHIV. ROP19 Burma will provide TA to address barriers and evidence for TPT scale-up.
6.Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups	Maximize HIV testing and linkage to treatment was a priority intervention of NSP III. Retention on ART at 12 months for 2017 ART initiated cohort was reported as 86%.
7.Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity	Morbidity and mortality outcomes of patients including infectious and non-infectious morbidity were not systematically and routinely monitored and reported. PEPFAR program will promote monitoring and reporting of morbidity and mortality outcomes including treatment retention and VL suppression in ROP19 through strategic information TA.
8. Evidence of resource commitments by host governments with year after year increases	The investment by Burma's government had increased year after year from $9 million in 2016, to $15 million in 2017 to $17.5 million in 2018.
9. Clear evidence of agency progress toward local, indigenous partner prime funding	Currently, there was no current local, indigenous partner prime funding happening in Burma but there were local organizations funded by PEPFAR as sub-partners since COP17. In ROP19, PEPFAR program will expand its partnership with KP community networks,

Minimum Requirement	Status
	CSOs, and other and local partners to enhance case finding, and optimize direct and immediate linkage, retention, and viral suppression among KP.
10. Scale-up of unique identifiers for patients across all sites	Public HIV facilities used manual recording and reporting system for years and the national program had introduced OpenMRS, an electronic open source medical record system, in ART centers and decentralized sites. By end of 2018, OpenMRS had been expanded to 93 facilities capturing the records of around 50,000 people on ART. NSP III (2016-2020) recommended development of UIC to track, monitor and retain patients on ART and the Strategic Action Plan for Strengthening Health Information (2017-2021) defined a timeline to develop and implement Client Registry and Master Patient Index (MPI) as a unique identifier across all sites in TB and HIV programs. Operationalization of MPI had carried out by phase approach and Phase II of MPI demonstration project in 2019 focused on high priority areas including HIV, eMTCT, TB and Laboratory services.

Tier 1: KYRGYZ REPUBLIC

The Minimum Requirements for continued PEPFAR support the Kyrgyz Republic include:

Minimum Requirement	Status
1. Test and Start	Approved and implemented
2. Differentiated Service Delivery Models, including six-month MMS	Three-month MMS approved; will change policy to six months before the end of the year.
3. TLD Transition	RAC has a plan to transition within the next 18 months. The first shipment of TLD procured by the GF will arrive in May 2019. GF buy-in is needed, as GF procures ART. Current policy does not allow dolutegravir for women of reproductive potential. This will be updated to allow for informed consent by the end of the year.
4. Scale up of index testing and self-testing	Partner elicitation and index testing is done at facility for all new cases, and will be strengthened. Community index testing and assisted partner notification done for newly found KP. Will be strengthened and expanded. Supportive policies for self-testing are being developed and the Kyrgyz Republic is currently introducing self-testing for MSM and TG individuals on a small scale in Bishkek and Osh, with PEPFAR support.
5. TB Preventive Treatment	Completed, included in routine package of services.
6. Direct and immediate (95%) linkage of clients from testing to treatment	In progress. The government and PEPFAR will continue to train HCWs to provide ART immediately following confirmation. Peer navigators will strengthen counseling for newly diagnosed PLHIV and those lost to follow up to initiate/re-initiate ART.
7. Elimination of user fees in public sector	Completed. Government does not charge for HIV or TB services.
8. Completion of VL/EID optimization	In progress.
9. Monitoring and reporting of morbidity and mortality	Completed. The current HIV/AIDS case report system is capable of routinely monitoring morbidity and mortality.
10. OVC services	N/A
11. Year after year increase in resource commitments by host government	GF requires year on year increases to receive GF grant, including some procurement of ART. Government of Kyrgyz Republic has committed to this.
12. Agency progress towards local partners	Met. Three local partners and three international partners. (Four international partners were recently dropped.)
13. Scale up of unique identifiers	Completed. Unique identifiers are used throughout the country.

Tier 1: NEPAL

The Minimum Requirements for continued PEPFAR support in Nepal include:

Minimum Requirement	Status
1. Adoption and implementation of Test and Start	Completed. Test and Start was rolled out in March 2017. There are some persistent medical barriers to some providers initiating the treatment before they have a full CD4 count. Some PLHIV are also reluctant to initiate treatment at the time of diagnosis due to limited time to absorb the information, need for more counseling, and more explanation of the health benefits to the patient.
2. Differentiated service delivery models, including six-month multi-month scripting (MMS)	Not completed yet but will be completed during ROP19. The GON agreed in April, following the Bangkok meeting, to move towards a 6-month MMS for all eligible PLHIV. They have also approved in principle the 12-month supply of drugs for migrants. This is predicated upon supply chain considerations to ensure there are sufficient drugs to avoid a stock-out. PEPFAR support to ensure roll-out of this policy is to incorporate this approach into the HIV technical guidance which is being drafted in mid-May 2019.
3. Completion of TLD transition	The GON agreed this year but has not yet met the requirements. Will be completed by end of 2022. The GON already has a plan to complete the full transition. They are using these drugs now. PEPFAR's assistance will consist of procurement and supply change management to ensure a smooth transition to the new TLD treatment regimen.
4. Scale up of index testing and self-testing, and monitoring of intimate partner violence (IPV) established	Not completed. Index testing will be intensified in USG districts and scaled up in non-USG districts, and self-testing will be made available nationally after product registration, during ROP19.
5. TB preventive treatment (TPT) for all PLHIV must be scaled-up as an integral and routine part of the HIV clinical care package (required in COP18).	Completed. This is underway. The GON approved the TPT policy was approved in December 2012. The importance of TPT will be reemphasized within the minimum HIV clinical care package currently under revision in mid-May. Minimum package is expected to be approved by July 2019.
6. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	Not completed. Overall linkage to treatment is 70%. USG technical assistance emphasizes direct linkage to treatment and is a continuing priority of the USG/Linkages activity. Presently Nepal does not have age, sex, and risk group-specific data at the national level. This will be completed by the end of 2021. The need to gather this kind of disaggregated data on immediate linkage to treatment will be supported and replicated in non-USG areas. This issue will be addressed in the current realignment and joint work planning with the government and the GF.
7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC, TB, and routine clinical services, affecting access to HIV testing and treatment and prevention (required in COP17 and COP18).	N/A
8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity	N/A

Minimum Requirement	Status
and mortality across age, sex, and risk groups, including >80% access to annual viral load testing and reporting.	
9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity (required in COP18).	Not completed. Monitoring and reporting will be initiated by the GON during ROP19, with expected completion in 2020. This issue is part of the realignment discussions that will take place in mid-May with the GF and the GON. The actual MMR data may be included during future DQAs.
10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management (required in COP17 and COP18).	N/A
11. Evidence of resource commitments by host governments with year after year increases (required in COP14).	Completed. GON contributions for HIV response have gone from 52% of expenditures in 2010 to just under $10 million in 2018, i.e., ARVs were 80% financed by GON in 2018 and will be 100% financed by GON in 2019.
12. Clear evidence of agency progress toward local, indigenous partner prime funding (required in COP18).	Partially completed. Nineteen indigenous NGOs work with FHI 360 across the USAID regions. Capacity assessments are presently underway for all of these partners that have the potential to be direct recipients of external funding. Two are likely to have the capacity for direct USG funding within a year. More LP capacity strengthening required to advance this objective.
13. Scale up of unique identifiers for patients across all sites.	Not completed. Planned for ROP19. All USG regions with Linkages support have adopted unique identifiers. National-level scale-up is planned and will be incorporated into the minimum HIV package. Linkages is providing TA.

Tier 1: TAJIKISTAN

The Minimum Requirements for continued PEPFAR support in Tajikistan include:

Minimum Requirement	Status
1. Adoption and implementation of Test & Start with demonstrable access across all age, sex, and risk groups (required in COP16).	Approved and implemented. Challenges with actual implementation at some sites documented. PEPFAR is supporting site-level implementation in 2 SNUs.
2. Adoption and implementation of differentiated service delivery models, including six-month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents (required in COP16).	Six-month MMS approved for stable patients. For the stable patients who plan to be in labor migration for more than six months, ARVs will be dispenses for the period longer than six months.
3. Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine-based regimens (required in COP18).	TLD is included in the National HIV treatment guidelines as the preferred first line regimen for people living with HIV, including those with TB coinfection receiving rifampicin-containing regimen for TB treatment and pregnant women after the first trimester of pregnancy. Women of childbearing potential will be offered DTG-containing regimes with counseling. The National HIV treatment guidelines recommend using DTG in combination with an optimized NRTI backbone as the preferred second-line regimen for PLHIV for whom non-DTG based regimens failed. Transition to TLD will begin in October 2019 after the first shipment of this regimen and DTG 50 mg (as a single drug) procured by the GF will arrive in September 2019. Starting from October 2019, RAC plans to initiate 95% of new patients on TLD and transition to TLD more than 90% of those receiving other regimes within the next 12 months. GF buy-in is needed, as GF procures ART.
4. Scale up of index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established (required in COP18).	Partner solicitation and index testing is done at facility for all new cases. To improve positivity yield in index partners, HIV recency testing will be performed with all newly diagnosed PLHIV as a part of an epidemiological investigation. Community index testing and assisted partner notification done for newly found KP's will be strengthened and expanded.
5. TB preventive treatment (TPT) for all PLHIV must be scaled-up as an integral and routine part of the HIV clinical care package (required in COP18).	Completed, included in routine package of services.
6. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	According to the National HIV treatment guidelines, ART should be offered to all PLHIV right after their diagnosis is confirmed. To reduce the time between the first HIV reactive test and confirmed diagnosis, the National HIV testing algorithm was simplified and Western blot was excluded as the confirmatory HIV test. The current ART coverage rate of those who are aware of their HIV positive status is 77% (15+).
7. Elimination of all formal and informal user fees in the public sector	Completed. Government does not charge for HIV or TB services.

Minimum Requirement	Status
8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including >80% access to annual viral load testing and reporting.	In progress.
9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity (required in COP18).	Completed.
10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17	N/A.
11. Evidence of resource commitments by host governments with year after year increases (required in COP14).	GF requires year on year increases to receive GF grant, including some procurement of ART. Government of Tajikistan has committed to this. From 2018 to 2019, the government contribution increased 17%. The Government of Tajikistan has indicated that they plan to transition all HIV and TB funding to government by 2026. PEPFAR will continue high level dialogue with the Ministry of Health and other partners to ensure that government funding continues to increase.
12. Clear evidence of agency progress toward local, indigenous partner prime funding (required in COP18).	3 Local Partners; 3 International (dropped 4 in ROP19).
13. Scale up of unique identifiers for patients across all sites.	Completed.

Tier 1: THAILAND

The Minimum Requirements for continued PEPFAR support in Thailand include:

Minimum Requirements	Status
1. Adoption and implementation of Test and Start	Adopted and fully implemented. ROP18-10: Same Day ART is widely implemented in community-led health services and being integrated in the national HIV management guidelines, which are expected to be launched in July 2019, to promote same-day ART in public health facilities.
2. Adoption and implementation of differentiated service delivery models, including six-month multi-month scripting (MMS)	Adopted but implementation varied. Higher rate pf practice in PEPFAR-supported sites. ROP19: Six-month MMS training will be targeted to large health facilities to increase the practice of MMS.
3. Completion of TLD transition	TLD national working group committee established. Transition plan developed. Continue to accelerate through Thailand FDA and essential drug list registration.
4. Scale up of index testing and self-testing	Policy and guidelines on index testing including national monitoring system for this strategy are being reviewed by the MoPH to ensure focus on KP. The PEPFAR team will develop protocol, tools, and a monitoring system for KP index testing. HIV self-test will be implemented through pharmacy, online distribution, and community-led health services. As of Apr 9, 2019, Thailand's FDA approved the public sale of home HIV test kits via pharmacies.
5. TB preventive treatment (TPT) for all scale-up as an integral and routine part of the HIV clinical care package	TPT policy and guidelines were launched; TPT is a key MOPH policy. The PEPFAR team will promote the implementation of TPT in PEPFAR-supported sites and support the national program training to update knowledge and practice for public health care providers.
6. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	Same-day ART will be promoted to accelerate 95% linkage of client (see #1). Peer navigator/HIV case management coordinators will be used to facilitate linkage to treatment in communities and facilities.
7. Elimination of all formal and informal user fees in the public sector	N/A
8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality	In PEPFAR-priority provinces, USG will introduce and implement VL electronic data exchange tools to facilitate specimen request and results reporting processes.
9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity (required in COP18)	To address the limited scope and quality of national HMIS for KP and PLHIV cascade monitoring, PEPFAR will continue to strengthen the national HMIS and develop tools to monitor the KP cascade, including mortality and morbidity surveillance.
10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17	N/A
11. Evidence of resource commitments by host governments with year after year increases (required in COP14).	The RTG has increased support to the national HIV program over time as reported in NASA report 2018. In 2017, 89% of national AIDS expenditures came from domestic financing.
12. Clear evidence of agency progress toward local, indigenous partner prime funding (required in COP18).	Thailand PEPFAR invests more than 80% of its budget in indigenous partners, including the MoPH and Thai Red Cross AIDS Research Centre and CBOs. CBOs are funded through a prime partner INGO. PEPFAR

Minimum Requirements	Status
	provides capacity building and TA in implementation science, exchange of international practices, fiduciary management, and routine program monitoring. As a result of increased capacity of CBOs though PEPFAR investments, the Thai Government has directly funded CBOs for approximately $1.4 million in FY18.
13. Scale up of unique identifiers for patients across all sites	The MoPH supported by PEPFAR, has initiated an informatics system to harmonize data across systems, giving it access to comprehensive service delivery data along the community-to-facility cascade. An on-line dashboard has been established to summarize key indicators, ensuring timeliness and accurate monitoring results for program planning. In ROP19, UICs will be used by facilities and peer navigators to track ART initiation, VL monitoring and suppression, and index testing. These UICs and associated data are managed in eCascade, a system supported by PEFPAR, which allows the local organizations who serve clients to monitor performance.

Tier 2: INDIA

The Minimum Requirements for continued PEPFAR support in India include:

Minimum Requirements	Status
1. Adoption and implementation of Test and Start	Policy of Test and Start adopted by GOI and fully implemented across all geographic areas and all age, sex, and risk groups.
2. Adoption and implementation of differentiated service delivery models, including six-month multi-month scripting (MMS)	Policy of various differentiated service delivery models have been adopted and implemented across all geographic areas and all age, sex, and risk groups. Support for uniform implementation is still required.
3. Completion of TLD transition	The technical resource group (TRG) recommended the adoption of TLD in October 2018. TLD is moving forward in all new patients initiating ART and those with HIV/TB co-infection, and women and adolescent girls of childbearing potential who want to become pregnant will be given an informed choice. Forecasting is currently underway. An estimated 19,267 new PLHIV and women of childbearing age would be started on TLD by December of 2019, with this number increasing to 459,379 by December 2022. All PLHIV on TLN would be transitioned to TLD in the first phase. The decision for transitioning all other existing patients (on TLE for example) to TLD will be taken after all PLHIV have a documented VL test result.
4. Scale up of index testing and self-testing, and monitoring of intimate partner violence (IPV) established (required in COP18).	Index Testing of KP is being implemented in PEPFAR priority states and districts, in collaboration with the State AIDS Control Societies in AP, MH, Mizoram, Manipur and Nagaland. Based on the learnings of the PEPFAR implementation, index testing has been recently taken-up as national policy in the revamped TI guidelines.
5. TB preventive treatment (TPT) for all PLHIV must be scaled-up as an integral and routine part of the HIV clinical care package (required in COP18).	TPT is a national policy and implemented across all geographic areas and all age, sex, and risk group but coverage is low. PEPFAR is coordinating with NACO to strengthen roll-out and coverage.
6. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups	The policy of NACO is to ensure linkage of all clients to treatment; gaps exist and therefore achievement of 95% linkage is in process.
7. Elimination of all formal and informal user fees in the public sector	N/A
8. Completion of VL/EID optimization activities and ongoing monitoring	N/A
9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity (required in COP18)	NACO has a monthly practice of reporting this data in the site level monthly Progress Report.
10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17	India PEPFAR's OVC program shifted its focus to children of KP in 2017. Efforts will focus on building a comprehensive package of services to KP addressing the critical needs of children of KP as a key target group. OVC interventions will improve the health and well-being of all enrolled children of KP through age-appropriate, tailored interventions, and linkages to critical health and social services and support based on individual needs.

Minimum Requirements	Status
11. Evidence of resource commitments by host governments with year after year increases (required in COP14)	In March 2019, the GOI formally approved the three-year continuation of the NACP, Phase IV over a three-year period ending on March 31, 2020, with a total approved three-year budget of approximately $950 million. For the current Indian financial year beginning on April 1, 2019, the allocated budget for NACP is approximately $368 million. In the 2019–2020 GOI national budget, the estimate for the NACP represents a 29% increase from the previous year
12. Clear evidence of agency progress toward local, indigenous partner prime funding (required in COP18)	Yes, indigenous prime partners receive 46% of funding for one U.S. implementing agency.
13. Scale up of unique identifiers for patients across all sites	Through the support of the GF, India is developing an integrated monitoring and evaluation system with a national unique identifier for improved linage and LTFU tracking (Project SOCH).

Tier 2: INDONESIA

The Minimum Requirements for continued PEPFAR support in Indonesia include:

Minimum Requirements	Status
1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups (required in COP16).	Adopted and fully implemented. MOH circular letter (Surat Edaran No. HK. 02.02/I/1564/2018 included provisions for Test and Start (same day - up to seven days) and regular VL reporting due to advocacy efforts from PEPFAR.
2. Adoption and implementation of differentiated service delivery models, including six-month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents (required in COP16).	Adopted, but implementation varies. The Provincial Health Office in Jakarta endorsed offer of MMS to at least 10% of stable PLHIV. Need to continue to advocacy for MMS.
3. Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine-based regimens (required in COP18).	The final implementation plan for TLD transition is pending a WHO-led expert panel meeting scheduled for mid-May 2019.
4. Scale up of index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established (required in COP18).	The MOH is currently rolling out a national index testing framework, with technical support from WHO, UNFPA, UN Women and PEPFAR. PEPFAR has developed the national SOPs, job aides, and recording tools that are in alignment with WHO Five Cs of HTS.
5. TB Prevention Treatment for all PLHIV must be scaled-up as an integral and routine part of the HIV clinical care package (required in COP18).	The updated policy has been enacted with a focus on PLHIV and under 5 children.
6. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	PEPFAR will intensify TA to the Government of Indonesia on utilization of cohort data (from the national cohort application, SIHA NIK, and/or the PEPFAR Test and Treat All tracker) will foster more granular site and partner monitoring for continual quality improvement and responsive course correction throughout the programmatic period.
7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC, TB, and routine clinical services, affecting access to HIV testing and treatment and prevention (required in COP17 and COP18).	For members of Universal Health Coverage, the user fee to access the public and private services is free as long as they pay the monthly premium. The Government of Indonesia pays the premium for the bottom 40% of the population, as well as civil servants and members of the military.
8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and	In progress in Jakarta. Nationally, this will take time.

mortality across age, sex, and risk groups, including >80% access to annual VL testing and reporting.	
9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity (required in COP18)	To address the limited scope and quality of national HMIS for KP and PLHIV cascade monitoring, PEPFAR will continue to strengthen the national HMIS and develop tools to monitor the KP cascade, including mortality and morbidity surveillance.
10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management (required in COP17 and COP18).	In Indonesia, the government provides financial support for treatment for OVC; however, the social and care support for the children is still provided by international resources.
11. Evidence of resource commitments by host governments with year after year increases (required in COP14).	Evidence of resource commitments by host governments with year after year increases (required in COP14). Indonesia's most recent NASA (2018) shows expenditures from domestic (75%) and external (35-25%) sources, totaling USD 177 million in 2016.
12. Clear evidence of agency progress toward local, indigenous partner prime funding (required in COP18).	USAID/Indonesia has provided direct grants to local CSOs directly for TB programs since 2012. As for HIV, currently USAID is working with international CSOs. The DOD provides direct funding to provide grants to local organization.
13. Scale up of unique identifiers for patients across all sites	In progress using national ID to access HIV treatment.

Tier 2: KAZAKHSTAN

The Minimum Requirements for continued PEPFAR support in Kazakhstan include:

Minimum Requirement	Status
1. Test and Start	Approved and implemented to the extent possible given the available ARV supply. In FY19, ARV supply should be sufficient to allow full implementation.
2. Differentiated Service Delivery Models, including six-month MMS	Three-month MMS approved. Will change policy to six months before the end of the year.
3. TLD Transition	As an upper-middle income country, Kazakhstan has been unable to negotiate reduced prices for DTG containing regiments, making progress on the TLD transition difficult. PEPFAR will continue to work with RAC and other partners on this issue. Viiv and GSK are opposed to Kazakhstan purchasing generic TLD.
4. Scale up of index testing and self-testing	Partner elicitation and index testing is done at facility for all new cases, and will be strengthened. Community index testing and assisted partner notification done for newly found KP. Community index testing will be strengthened and expanded. Self-testing not yet available.
5. TB Preventive Treatment	Completed, included in routine package of services.
6. Direct and immediate (95%) linkage of clients from testing to treatment	Clients are linked from testing to treatment services, although not yet at the 95% target. As a PI country, PEPFAR will no longer work in HTS except for community index partner testing.
7. Elimination of user fees in public sector	Complete. Government does not charge for HIV or TB services.
8. Completion of VL/EID optimization	In progress. Kazakhstan has a network of VL testing labs, though not all of them use WHO prequalified tests and reagents.
9. Monitoring and reporting of morbidity and mortality	Completed.
10. OVC services	N/A
11. Year after year increase in resource commitments by host government	In FY15/16, the Government of Kazakhstan funded 78% of the HIV response and in FY17/18, GOK is funding 85% of the total response.
12. Agency progress towards local partners	3 Local partners 3 International (dropped 4)
13. Scale up of unique identifiers	Completed.

Tier 2: LAOS

The Minimum Requirements for continued PEPFAR support in Laos include:

Minimum Requirements	Status
1. Adoption and implementation of Test & Start	The Test & Start policy has been in the National ART guidelines since 2016 and implemented in all 11 ART facilities in the country.
2. Adoption and implementation of differentiated service delivery models, including six-month MMS and delivery models	The MMS policy has been in the National ART guidelines since 2016 and implemented in all 11 ART facilities in the country. Currently, three months of scripting of ARV drugs are given to stable patients.
3. Completion of TLD transition.	The transition to TLD was initiated in all 11 ART facilities beginning in October 2018. PEPFAR will work with partners to transition from LNZ and Nevirapine-based regimen by 80% in 12 months.
4. Scale up of index testing and self-testing, and monitoring of intimate partner violence (IPV) established.	Index testing and self-testing are included in the national guidelines as the policies. PEPFAR will build capacity and leverage the resources for full implementation of HIV self-testing and index testing among PLHIV.
5. TB preventive treatment (TPT) for all PLHIV scaled-up as an integral and routine part of the HIV clinical care package (required in COP18)	TPT has been adopted in the National ART guidelines since 2016 and implemented in all 11 ART facilities in the country. TPT is one of the national core ART services quality improvement indicators. PEPFAR will further work with partners to monitor and support the implementation of TPT.
6. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups	N/A
7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC, TB, and routine clinical services, affecting access to HIV testing and treatment and prevention (required in COP17 and COP18)	HIV Testing and ART services and TB screening and treatment services are provided free-of-charge in Laos
8. Completion of VL/EID optimization activities and ongoing monitoring	N/A
9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity	The current HIV/AIDS case report system is capable of routinely monitoring morbidity and mortality. Further efforts will be made to improve the completeness and quality of data and utilization of data for course correction.
10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17	N/A

Minimum Requirements	Status
11. Evidence of resource commitments by host governments with year after year increases (required in COP14)	The GOL is genuinely committed to progressive HIV policies and resources. It has doubled its co-financing of commodities with the GF, such as test kits, ARV, and OI drugs. There is ongoing multi-ministerial consultation to consider for inclusion of HIV services in the National Universal Health Care package.
12. Clear evidence of agency progress toward local, indigenous partner prime funding (required in COP18)	N/A
13. Scale up of unique identifiers for patients across all sites	The demographic UIC has been applied to track linkage from HIV testing to ART care and initiation. It requires further strengthening and integration of UIC as part of national system.

Tier 2: PAPUA NEW GUINEA

The Minimum Requirements for continued PEPFAR support in PNG include:

Minimum Requirements	Status
1. Adoption and Implementation of Test and Start	Fully implemented
2. Differentiated Service Delivery Models, including six-month MMS	Integration into National Treatment guidelines underway. three-month MMS practiced informally. MMS and DSDM to be formally made policy.
3. Completion of TLD Transition	Transition expected to commence December 2019. Guideline change and procurement in progress.
4. Scale up of index testing and self-testing	GoPNG committed to formalize policy. Planned Integration into National Testing Guidelines underway.
5. TB preventive treatment (TPT) for all PLHIV scaled-up as an integral and routine part of the HIV clinical care package	Fully Implemented across PEPFAR sites as well as nationally
6. Direct and immediate (95%) linkage of clients from testing to treatment	Implementation in progress. 87% in PEPFAR SNU.
7. Elimination of user fees in public sector	Currently, there are no user fees in all government clinics.
8. Completion of VL/EID optimization	Fully implemented in PEPFAR supported SNU, implementation in progress nationally
9. Monitoring and reporting of morbidity and mortality	Planning for implementation in progress in line with improving Health Information systems and HIV data hub.
10. Year after year increase in resource commitments by host government	There is commitment, but the resources have not increased substantially over the past few years due to fluctuations in commodity prices.
11. Agency progress towards local partners	Initial discussions done within PEPFAR team. Possibilities would be to look at FBOs.
12. Scale up of unique identifiers	Implemented with good uptake in PEPFAR supported SNU, but limited uptake nationally
13. GBV Integration	Fully implemented in >50% of the sites in the PEPFAR supported SNU

Tier 3: CAMBODIA

The Minimum Requirements for continued PEPFAR support in Cambodia include:

Minimum Requirements	Status
1. Adoption and implementation of Test and Start	Test and Start has been a policy in Cambodia since late 2016. However, current policy allows PLHIV to be started on ART up to 14 days after their diagnosis. Currently it takes a median of 7 days between HIV diagnosis and ART initiation. PEPFAR Cambodia is working with the Cambodian Ministry of Health (MOH) to expand training on same-day ART initiation.
2. Adoption and implementation of differentiated service delivery models, including six-month multi-month scripting (MMS)	PEPFAR Cambodia has been supporting MMS training and implementation in the PEPFAR priority provinces since ART spacing started in late 2017. Currently ten ART sites implement MMS of 67 sites. Additional ART sites are scheduled to start MMS in ROP19.
3. Completion of TLD transition	TLD has started being used in March 2019 and will complete transition from nevirapine-based regimens in early 2020. PEPFAR Cambodia is also supporting the MOH to expedite use of TLD in lieu of efavirenz-based regimens which will be completed by early ROP20.
4. Scale up of index testing and self-testing	Index testing is being implemented in 27 ART clinics (out of 67); training was completed nationally in mid-2018 with scale-up to finish in remaining ART clinics by early ROP19. Self-testing has been introduced in Phnom Penh and will be scaled in ROP 19.
5. TB preventive treatment (TPT) for all PLHIV scaled-up as an integral and routine part of the HIV clinical care package (required in COP18)	TPT has been a policy in Cambodia since 2010. Since 2017 Cambodia has provided TPT to all newly identified PLHIV with a coverage rate of 12% in 2017 and 28% in 2018. In ROP19, PEPFAR Cambodia will strengthen existing systems to monitor TPT use and ensure all PLHIV have received at least one course of TPT.
6. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups	Currently the Cambodia national HIV program has a linkage rate of 90% of new positives.
7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC, TB, and routine clinical services, affecting access to HIV testing and treatment and prevention (required in COP17 and COP18).	Cambodia does not require user fees and all HIV treatment is free to the patient. Under the Prime Minister's recent circular from February 2019, all HIV services are covered under the Health Equity Fund ensuring health care facilities are also fully reimbursed for providing HIV services.
8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality	100% of ART clinics have capability of collecting and shipping samples for VL testing at VL test sites. In ROP19, PEPFAR Cambodia will support the MOH to make turnaround of VL results timelier.
9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity (required in COP18)	Continuous quality improvement (CQI) systems for monitoring and reporting mortality and morbidity data were introduced in July 2018 (COP17). PEPFAR Cambodia is supporting development of dashboards for improved visualization and understanding of CQI data at the site-level in COP18 and full implementation should be completed in ROP19.
10. Alignment of OVC packages of services and enrollment to provide	N/A

Minimum Requirements	Status
comprehensive prevention and treatment services to OVC ages 0-17	
11. Evidence of resource commitments by host governments with year after year increases (required in COP14)	Host government increased ARV contribution to $1.5million in 2017 from $800,000 in 2015. The Prime Minister signed a circular in February 2019 to increase RGC financial contribution to HIV. ROP 19 will focus on implementing Prime Minister's health financing circular.
12. Clear evidence of agency progress toward local, indigenous partner prime funding (required in COP18)	PEPFAR supports increasing funding for local partners from the host government. PEPFAR partners provides capacity building support to local partners providing direct service delivery through the Global Fund grant.
13. Scale up of unique identifiers for patients across all sites	UICs were introduced in COP18 and are being scaled up across multiple databases nationally. Currently U-UIC and PMRS IDs are available in 55 of 67 ART clinic sites.

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	Country	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
HHS/CDC	World Health Organization	Burma	17112	ASP: Policy, planning, coordination & management	$ 288,000	TA through WHO: Development of next National Strategic Plan on HIV (2021-2025); Development of evidence-based policies, guidelines, and SOPs for HIV; coordination of complex initiatives such as DQA/Epi review, national prevention/ treatment program reviews; TA for operationalizing innovative strategies like index testing , PrEP, self-testing and social network testing	National strategic plans, operational plans and budgets	Insufficient capacity to operationalize current policies and guidelines to optimize KP-friendly HIV services ; And poor availability of and ability to use reliable program data.	COP18	Operational guidance revised and updated to maximize effectiveness and efficiency; Implementation of the guidance on sub-national planning and response assessed for revision
HHS/CDC	CODB	Burma	HHS/CDC 1	ASP: Policy, planning, coordination & management	$ 50,000	TA on development and implementation of national strategies and policies such as HIV National Strategic Plan (2021-2025), the Global Fund program review and concept note for next round, PrEP, index testing and Self-testing, TLD transition, and other minimum program requirements	National strategic plans, operational plans and budgets	Insufficient capacity to operationalize current policies and guidelines to optimize KP-friendly HIV services ; And poor availability of and ability to use reliable program data.	COP18	N/A
HHS/CDC	CODB	Burma	HHS/CDC 1	ASP: Policy, planning, coordination & management	$ 100,000	TA on development and revision of clinical guidelines, guidelines on TB/HIV integrated activities including IPT, and MAT/ART guidelines	Clinical guidelines, policies for service delivery	Insufficient capacity to operationalize current policies and guidelines to optimize KP-friendly HIV services ; And poor availability of and ability to use reliable program data.	COP18	N/A
HHS/CDC	CODB	Burma	HHS/CDC 1	ASP: Laboratory systems strengthening	$ 50,000	TA on laboratory continuous quality improvement, quality HIV testing services and viral load scale up	Lab quality improvement and assurance	Inadequate coverage, quality and coordination of HIV laboratory services, including viral load testing, which negatively affect efficient case-finding and HIV care outcomes	COP18	N/A
HHS/CDC	CODB	Burma	HHS/CDC 1	ASP: HMIS, surveillance, & research	$ 50,000	TA on development of protocols, reports and utilization of surveillance and cascade data	Program and data quality management	Insufficient capacity to operationalize current policies and guidelines to optimize KP-friendly HIV services ; And poor availability of and ability to use reliable program data.	COP17	N/A
USAID	UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS	Burma	17111	ASP: HMIS, surveillance, & research	$ 239,838	Provide technical and staff support to UNAIDS to strengthen strategic information data collection and products for use by government and stakeholders;	HMIS systems	Insufficient capacity to operationalize current policies and guidelines to optimize KP-friendly HIV services ; And poor availability of and ability to use reliable program data.	COP16	1) A strategy and a work plan for the data hub by November 2017; 2) Advisory committee meets quarterly including membership from National Aids Program, the Department of Medical Research and National Statistics Institute; 3) HR capacity building plan completed by Q2 FY18; 4) M&E training curriculum developed, including one in-service training; 5) Establishment of an in-country M&E Core Team

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	Country	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
USAID	UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS	Burma	17111	ASP: Policy, planning, coordination & management	$ 252,209	Funding to UNAIDS to support the Civil Society Strengthening (CSS) project, which includes national level CSO networks, including, but not limited to, organizations working with FSW, MSM, TG, PWID and PLHIV. Building local implementation capacity.	Service organization and management systems	Insufficient capacity to operationalize current policies and guidelines to optimize KP-friendly HIV services ; And poor availability of and ability to use reliable program data.	COP17	1) At least two CSO groups are qualified to apply as sub-recipients for Global Fund support; 2) At least one case of stigma and discrimination brought to court by a CSO member of the CSS project.
USAID	Chemonics International, Inc.	Burma	18193	ASP: Procurement & supply chain management	$ 213,000	Improve supply chain data visibility for HIV and integration with national LMIS systems, and support for HIV forecasting, quantification and supply planning	Forecasting, supply chain plan, budget, and implementation	Lack of availability and use of supply chain data for decision-making to ensure commodity security across the HIV cascade.	COP17	Progress on integrated and functional LMIS and eLMIS will be providing reports on stock data availability
USAID	Chemonics International, Inc.	Burma	18193	ASP: Laboratory systems strengthening	$ 142,000	Lab network optimization including analysis of network capacity to meet patient demand from a supply chain and logistics perspective, in order to generate evidence to inform broader lab system strengthening, complementing CDC TA.	Lab policy, budgets, and strategic plans	Lack of availability and use of supply chain data for decision-making to ensure commodity security across the HIV cascade.	COP19	Development of an integrated national lab logistics system.
USAID	Chemonics International, Inc.	Cambodia	17570	ASP: Procurement & supply chain management	$ 50,000	Support NCHADS to implement multi-month scripting	Forecasting, supply chain plan, budget, and implementation	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP19	N/A
USAID	Chemonics International, Inc.	Cambodia	17570	ASP: Procurement & supply chain management	$ 125,000	TA to evaluate and scale up an enhanced, integrated MOH LMIS, including ARVS, to reduce wastage and increase efficiencies in support of increased DRM	Supply chain infrastructure	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP19	LMIS pilot assessed, refinements made to LMIS, and MOH approval for national scale up (Reprogram funds if RGC doesn't want to scale in FY'19)

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	Country	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
USAID	Palladium International, LLC	Cambodia	18584	ASP: Policy, planning, coordination & management	$ 175,000	In close alignment with the Sustainability Roadmap and National Strategic Plan (NSP), support NAA to implement the Prime Minister's SorChorNor on HIV financing. Provide technical guidance and input to rolling out strategic documents, facilitating stakeholder meetings and workshops. Support NAA to confirm the vision and mission of a sustainable HIV program including its structural components and implementation mechanisms. Support Prime Minister's SorChorNor on HIV financing policy issue number three : Support MoH and MoEF to amend and develop rules and procedures for allowing health centers and referral hospitals to have their own funds for response to HIV/AIDS.	National strategic plans, operational plans and budgets	Insufficient domestic resources for HIV/AIDS response.	COP19	N/A
USAID	Palladium International, LLC	Cambodia	18584	ASP: Public financial management strengthening	$ 225,000	Support Prime Minister's SorChorNor on HIV financing policy issue number two: ensure all PLHIV have access to health and social protection schemes. Roll-out HIV treatment, care and selected prevention and outreach services into social health insurance scheme benefit packages to leverage additional contributions to the HIV program and secure more robust funding. 1) Support MoEF and MoH to implement and monitor HIV services under social health insurance schemes. 2) Support subnational level awareness about the HEF and HIV-related benefits, due to those clients classified as ID-poor or vulnerable.	Administrative and financial systems	Insufficient domestic resources for HIV/AIDS response.	COP17	100% of facilities with ART centers being reimbursed for HIV services through HEF and other social health insurance schemes.

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	Country	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
USAID	Palladium International, LLC	Cambodia	18584	ASP: Policy, planning, coordination & management	$ 150,000	Support Prime Minister's SorChorNor on HIV financing policy issue number four: provide fund from the Royal Government of Cambida for CSOs according to the availability of the National Budget. Local partner sustainability strengthened through social contracting for prevention, care and support services for CSOs. 1) MOH projects workforce needs for prevention, care and support in its annual plan and budgeting 2) Based on the social contracting framework, identify which posts at OD/Facility level could be contracted for prevention, care and support 3) Request approval from the relevant Ministries to hire CSOs or contract staff. 4) Assist lower levels to include funding for these CSOs or contracted staff in their routine budget requests.	National strategic plans, operational plans and budgets	Insufficient domestic resources for HIV/AIDS response.	COP18	Government agreement to fund HIV CSOs and community health workers

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	Country	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
USAID	FHI Development 360 LLC	Cambodia	18633	ASP: Policy, planning, coordination & management	$ 275,000	Enhancing stigma and discrimination (S&D) free services with client-focus, including GBV and KP -competent services. Supporting the national and sub-national KP policy and standard operating procedures. Support national and sub-national KP monitoring tools and quality assurance through: (a) Training for competent and inclusive services including microtargeting PrEP for key and priority populations, as well as monitoring tools to document change and performance results. (b) Scale up the implementation of Patient Satisfaction Feedback (PSF) system. (c) Collaborate with EQHA, NAA and NCHADS to set up GBV referral network to provide legal, social and medical support for KP experiencing GBV (includes intimate partner violence) including prompt referral and access to PEP.	Oversight, technical assistance, and supervision to subnational levels	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP17	Skill building curriculum adjusted based on initial training experience and training scaled up in 4 additional provinces, ensuring coverage of the 4 PEPFAR-supported provinces. Competency of participants from year 1 and client satisfaction assessed.
USAID	FHI Development 360 LLC	Cambodia	18633	ASP: HMIS, surveillance, & research	$ 250,000	Case-base surveillance: enable the linkages through introducing the KP U-UIC into the existing NCHADS databases (VCCT, ART, B-IACM, PMTCT and STI.) Build a consolidated dashboard to track KPs across the HIV cascade using common U-UIC. Strengthen SI TWG governance structure and technical direction to optimize new case detection and tracking KP cohorts across the cascade.	Program and data quality management	Lack of efficient data systems to track PLHIV across the cascade and respond to new infections.	COP19	N/A

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	Country	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
USAID	FHI Development 360 LLC	Cambodia	18633	ASP: Policy, planning, coordination & management	$ 100,000	TA support to NCHADS to implement public-private sector strategies, like linking with Reproductive Health Association of Cambodia (RHAC) clinics, Chouksar and other private settings. Include private sector HIV data in	Service organization and management systems	Insufficient domestic resources for HIV/AIDS response.	COP19	N/A
USAID	FHI Development 360 LLC	Cambodia	18633	ASP: Policy, planning, coordination & management	$ 250,000	TA support to NCHADS to improve high-quality and efficient Community Action Approach (CAA) to maintain retention at 95% and aggressive implementation of MMS, TLD transition and SDART.	Oversight, technical assistance, and supervision to subnational levels	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP17	NCHADS and PEPFAR Provinces analyze community-based HTC data and identify challenges. Findings used to refine CAA SOP to increase index case testing and yield and improve ART retention. Nationwide scale up of revised CAA SOP.
USAID	FHI Development 360 LLC	Cambodia	18633	ASP: Policy, planning, coordination & management	$ 300,000	TA support to NCHADS to roll-out PrEP for MSM/TG in micro-tageted area and to improve country-owned, targeted testing for KP to optimize new case finding through the rapid scaling up of cost-effective interventions such as social networking (PDI+), HIV self testing, index case and recency testing and use of social media	Oversight, technical assistance, and supervision to subnational levels	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP17	Operational challenges from initial scale up of case detection identified and used to refine models and inform policy SOPs for nationwide implementation.
HHS/CDC	NATIONAL CENTER FOR HIV/AIDS DERMATOLOGY AND STDS (NCHADS)	Cambodia	18571	ASP: Policy, planning, coordination & management	$ 100,000	Refine and optimize case finding strategies (e.g. index case testing/PNTT) and improve counseling of index patients to identify and test partners	Oversight, technical assistance, and supervision to subnational levels	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP17	80% of newly identified PLHIV for whom index testing is conducted in 4 PEPFAR provinces
HHS/CDC	NATIONAL CENTER FOR HIV/AIDS DERMATOLOGY AND STDS (NCHADS)	Cambodia	18571	ASP: HMIS, surveillance, & research	$ 280,000	Operationalize integrated HIV information system through linking existing data systems (using unique identifying code) for active case reporting, outbreak identification and investigation, and interoperability with other health information systems	HMIS systems	Lack of efficient data systems to track PLHIV across the cascade and respond to new infections.	COP19	N/A
HHS/CDC	NATIONAL CENTER FOR HIV/AIDS DERMATOLOGY AND STDS (NCHADS)	Cambodia	18571	ASP: Policy, planning, coordination & management	$ 110,000	Optimize linkage, adherence and retention by strengthening active case management (B-IACM)	Oversight, technical assistance, and supervision to subnational levels	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP19	Risk of infection identified in 75% of newly identified PLHIV

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	Country	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
HHS/CDC	NATIONAL CENTER FOR HIV/AIDS DERMATOLOGY AND STDS (NCHADS)	Cambodia	18571	ASP: Policy, planning, coordination & management	$ 55,000	Optimize continuous quality improvement (CQI) including real time data to reduce mortality	Oversight, technical assistance, and supervision to subnational levels	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP19	N/A
HHS/CDC	NATIONAL CENTER FOR HIV/AIDS DERMATOLOGY AND STDS (NCHADS)	Cambodia	18571	ASP: Policy, planning, coordination & management	$ 90,000	Find patients lost to follow-up (not returning within 30 days of missed appointment) and reengage them in care/treatment	Oversight, technical assistance, and supervision to subnational levels	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP19	N/A
HHS/CDC	NATIONAL CENTER FOR HIV/AIDS DERMATOLOGY AND STDS (NCHADS)	Cambodia	18571	ASP: Laboratory systems strengthening	$ 75,000	Ensure high quality HIV testing services at VCCT sites	Lab quality improvement and assurance	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP17	All HTC sites in all 4 PEPFAR-supported provinces are participating in HIV related diagnostics quality assurance programs
HHS/CDC	NATIONAL CENTER FOR HIV/AIDS DERMATOLOGY AND STDS (NCHADS)	Cambodia	18571	ASP: HMIS, surveillance, & research	$ 50,000	Improve capacity for real-time use and visualization of granular data for improved case management and decision-making through dashboards	Program and data quality management	Lack of efficient data systems to track PLHIV across the cascade and respond to new infections.	COP17	B-IACM dashboard implemented in all 4 PEPFAR-supported provinces
HHS/CDC	NATIONAL CENTER FOR HIV/AIDS DERMATOLOGY AND STDS (NCHADS)	Cambodia	18571	ASP: Policy, planning, coordination & management	$ 95,000	Incorporate same-day ART initiation, multi-month scripting, and dolutegravir implementation into updated treatment guidelines and ensure adoption nationally	Clinical guidelines, policies for service delivery	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP19	N/A
HHS/CDC	NATIONAL CENTER FOR HIV/AIDS DERMATOLOGY AND STDS (NCHADS)	Cambodia	18571	ASP: Laboratory systems strengthening	$ 75,000	Ensure high quality viral load testing and rapid turnaround time (for better clinical decision making and improved adherence counseling)	Lab quality improvement and assurance	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP19	N/A
HHS/CDC	NATIONAL INSTITUTE OF PUBLIC HEALTH	Cambodia	18573	ASP: Laboratory systems strengthening	$ 110,000	Optimize laboratory quality management systems, external quality assurance, and maintain ISO accreditation.	Lab quality improvement and assurance	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP19	N/A
HHS/CDC	NATIONAL INSTITUTE OF PUBLIC HEALTH	Cambodia	18573	ASP: Laboratory systems strengthening	$ 100,000	Support National Institute of Public Health's plans to export their ISO expertise (that was built through PEPFAR support) for ISO accreditation of NCHADS laboratory	Lab accreditation	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP19	N/A

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	Country	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
HHS/CDC	NATIONAL CENTER FOR HIV/AIDS DERMATOLOGY AND STDS (NCHADS)	Cambodia	18571	ASP: Policy, planning, coordination & management	$ 60,000	Incorporate the HIV recency assay into routine clinical practice at POC VCCT sites	Clinical guidelines, policies for service delivery	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP18	Rapid recency testing of newly identified PLHIV being used routinely in 4 PEPFAR-supported provinces
HHS/CDC	NATIONAL CENTER FOR HIV/AIDS DERMATOLOGY AND STDS (NCHADS)	Cambodia	18571	ASP: Policy, planning, coordination & management	$ 75,000	Implement TPT for all PLHIV, including policy and guideline updates for use of TPT, training, and data collection systems.	Clinical guidelines, policies for service delivery	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP19	N/A
USAID	Chemonics International, Inc.	Indonesia	18225	ASP: Procurement & supply chain management	$ 136,367	Work with MoH and GF to develop institutional multistakeholder platform to review supply chain data regularly and use that data for decision making. Forecasting, supply planning and monitoring functions will conducted under the platform to increase accountability and tranparency and ensure commodity availability for expanding programs. Focus will be placed on ensuring sufficient supplies are procured at the national level and are allocated to the Jakarta province to support national and jakarta specific acheivments. Pricing, competition and registration issues will also be addressed. Stakeholders under this platform will also support a registration workshop to increase competition and number of distributors for TLD and other key ARV products. Conduct analyses to Identify opportunities to optimize VL and reduce costs. Support increase in VL testing and TLD coverage. to support TX_PVLS and TX_Curr targets/patients.	Forecasting, supply chain plan, budget, and implementation	Inconsistent access to key HIV service commodities limits PLHIV retention and VL suppression	COP18	24,000 VL tests procured with domestic resources at the end of 2018 as a result of PEPFAR TA and negotiation. Jakarta Allocation for VL to support TX_PVLS at PEPFAR sites - 8,600.
USAID	FHI Development 360 LLC	Cambodia	18633	ASP: Not Disaggregated	$ 300,000	Ensure funding to two CSO-run HIV care and treatment clinics for KP in Phnom Penh		Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP19	N/A
USAID	FHI Development 360 LLC	Indonesia	17600	ASP: HMIS, surveillance, & research	$ 252,366	Strengthen and operationalize HIV data management systems to ensure optimal ART retention at 56 PEPFAR sites in Jakarta	Program and data quality management	National HIV program lacks implementation of international standard best practices for retaining PLHIV in HIV services	COP18	ARK v.6 and Jak Trak platforms developed; MOH circular issued to reinforce systematic cohort and VL reporting

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	Country	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
USAID	FHI Development 360 LLC	Indonesia	17600	ASP: Policy, planning, coordination & management	$ 411,754	Strengthen the capacity of district team to support systematic application of test and start, index testing, differentiated care (multi-month scripting), loss-to-follow up response systems, VL monitoring, and community-based service sustainability	Oversight, technical assistance, and supervision to subnational levels	National HIV program lacks implementation of international standard best practices for retaining PLHIV in HIV services	COP18	MOH circular issued to reinforce systematic cohort and VL reporting; guidelines adapted to reinforce VL monitoring; CSO organizational development parameters tracked with demonstrated capacity improvement; PEPFAR CSOs assessed on readiness to access direct Government of Indonesia financing, with all assessed as partially ready
USAID	Chemonics International, Inc.	Indonesia	18225	ASP: Laboratory systems strengthening	$ 45,696	Leverage GF resources to support National Reference Laboratories in implementing EQA/PT for VL. Develop and finalize MOU (PPP) with Abbott (Abbott contributes 1.2m USD) to strengthen VL laboratory reporting and network. Negotiate VL reagent price reductions with Abbott and local distributors.	Lab quality improvement and assurance	Inconsistent access to key HIV service commodities limits PLHIV retention and VL suppression	COP18	8,000 VL Tests in Jakarta TX_PVLS
USAID	Palladium International, LLC	Indonesia	17598	ASP: Policy, planning, coordination & management	$ 267,812	Provide TA to national-level MOH to improve data collection, analysis, and application of findings to national HIV program implementation	Training in coordination and management of health systems	National HIV program lacks implementation of international standard best practices for retaining PLHIV in HIV services	COP18	Improved data quality system and improved capacity of MOH in using and analyzing the data. Reduction of number of HIV indicators required at the national level.
HHS/CDC	World Health Organization	Papua New Guinea	17091	ASP: Laws, regulations & policy environment	$ 105,000	Improved retention of PLIHIV on ART using HIVQUAL and Multimonth month ART script and tracking policy activities to return those LFTU	Clinical guidelines, policies for service delivery	Maintaining PLHIV on Treatment	COP16	HIVQUAL adopted as national framework. HIVQUAL Framwork disseminated in 5 High Burden Provinces
HHS/CDC	World Health Organization	Papua New Guinea	17091	ASP: HMIS, surveillance, & research	$ 100,000	HIV Data Hub: Integration of HIV Data Systems and Capacity Building for national ownership	HMIS systems	Weak health systems and limited health worker capacity to deliver HIV treatment services	COP18	HPDB Data Portal developed, SurvDB Decentralized in NCD, improved surveillance reporting rates, eHealth technical capacity built through GEEKS Trainees (2)
HHS/CDC	World Health Organization	Papua New Guinea	17091	ASP: Laboratory systems strengthening	$ 50,000	Viral Load Sample Management System - Integration and Improved Data use for Patient Care	Laboratory infrastructure	Weak health systems and limited health worker capacity to deliver HIV treatment services	COP18	Lab Information system (VLSM) modified, adapted and deployed at CPHL. Actively used for VL Scale Up
HHS/CDC	World Health Organization	Papua New Guinea	17091	ASP: HMIS, surveillance, & research	$ 40,000	Strengthen Surveillance for Key Populations and Surveillance for HIV Drug Resistance	Program and data quality management	Weak health systems and limited health worker capacity to deliver HIV treatment services	COP18	KP Surveillance Tools Developed but no active surveillacne taking place
HHS/CDC	World Health Organization	Papua New Guinea	17091	ASP: HMIS, surveillance, & research	$ 30,000	Strengthening Human Resource Capacity for Data Analysis and Data Use for Epidemic Control	Program and data quality management	Weak health systems and limited health worker capacity to deliver HIV treatment services	COP17	3 Key HIV staff mentored and trained in one PEPFAR supported SNU, with one taking on leadership responsibility

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	Country	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
HHS/CDC	World Health Organization	Papua New Guinea	17091	ASP: Policy, planning, coordination & management	$ 100,000	TLD Transition: PNG moving to TLD	Clinical guidelines, policies for service delivery	Maintaining PLHIV on Treatment	COP17	NODH adpots Policy for TLD as first line ART.
HHS/CDC	World Health Organization	Papua New Guinea	17091	ASP: Laboratory systems strengthening	$ 119,469	VL Testing for PLHIV on Treatment	Lab policy, budgets, and strategic plans	Maintaining PLHIV on Treatment	COP16	VL testing using DBS available in two provinces outside of NCD with VL testing available to 50% of PLHIV on ART.
USAID	UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS	India	18168	ASP: Laws, regulations & policy environment	$ 70,000	1. Improved uptake and implementation of the Transgender Bill.	Assessing impact of policies and regulations on HIV	Slow progress in policy adoption and/or implementation of globally recommended new strategies and approaches including PrEP, HIV self-testing, TPT, differentiated care models, and TLD transition	COP19	N/A
USAID	UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS	India	18168	ASP: Policy, planning, coordination & management	$ 30,000	1. Advocacy initiatives for improved uptake and implementation of targeted community-based testing policy.	Training in coordination and management of health systems	Slow progress in policy adoption and/or implementation of globally recommended new strategies and approaches including PrEP, HIV self-testing, TPT, differentiated care models, and TLD transition	COP19	N/A
HHS/CDC	World Health Organization	India	17353	ASP: HMIS, surveillance, & research	$ 94,536	Strengthen systems and capacities to produce, analyze, and use data at the national level and in the clusters to characterize local epidemics and guide timely response and corrective actions to achieve 90-90-90	HMIS systems	Slow progress in strengthening institutional capacity for integrated data systems and epidemic monitoring as well as challenges in optimal utilization and leveraging of resources.	COP18	1. Technical guidelines and supervision platforms for conducting HSS Plus, including KP-focused BBS Lite, and population size estimations (PSE) of KPs developed 2. Mobile-ART (m-ART) for paperless ART and advancement in clinical decision-making, improved patient experience demonstrated to Maharashtra SACS and Mumbai district AIDS control society. 3. Increased evidence of district burden, and gaps in 90-90-90 cascade, to inform site-level action for improving program response

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	Country	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
HHS/HRSA	UNIVERSITY OF WASHINGTON	India	18167	ASP: Policy, planning, coordination & management	$ 91,000	1. Support National AIDS Control Organization (NACO), Maharastra (MH) and 3 Northeast State AIDS Control Societies (SACS) and 15 Centers of Excellence (COE) to implement treat all, data utilization, and tools to improve the care cascade 2. TA to NACO, SACS in MH and NE and 15 Centers of Excellence (COE) to Implement and scale differentiated service delivery models (DSDM) including key population (KP)-specific DSDM. 3.Support the implementation of TLD transition nationally through phase in approach, which includes national rollout for treatment naïve patients, 2nd and 3rd line line patients, and informed choice for women of childbearing age. 4. Support the National government in above site activities for the development of a Policy on PrEP through participation in the Technical Expert Group	Clinical guidelines, policies for service delivery	Slow progress in policy adoption and/or implementation of globally recommended new strategies and approaches including PrEP, HIV self-testing, TPT, differentiated care models, and TLD transition	COP19	1a. Treat All policy adoption and implementation through pre-ART mop up in MH and NE 1b. Decentralized ART initations at 1 site in NE and 0 MH 1c. No policy framework for community starter packs 2a. MMD implemented at 14/52 PEPFAR-supported sites in MH and NE with systems developed for M&E 2b. Community ART dispensation for KP at 12 sites (10 sites for PWID in NE and 2 for FSW and MSMs in Maharashtra) 2c. Community ART dispensation at 3 sites in prisons 2d. Differentiated care package for advanced disease management developed 3a. Support adoption of policy for TLD transition through advocacy in National Technical Resource Group and forecasting on TLD requirement 4a TA for a national level technical group meeting on PrEP
HHS/CDC	PATH	India	18543	ASP: Not Disaggregated	$ 119,167	Strengthen institutional and human capacity in data management and use through innovative approaches such as continuous quality improvement (CQI) techniques	HMIS systems	Slow progress in strengthening institutional capacity for integrated data systems and epidemic monitoring as well as challenges in optimal utilization and leveraging of resources.	COP19	1. Situation assessment of existing data management practices completed at the sampled CQI site 2. Strengthen data management and decision making capacity of the staff at the selected facility units (e.g. TI NGO, FICTC, ARTC etc.) through focused CQI techniques
HHS/CDC	MINISTRY OF PUBLIC HEALTH	Thailand	100199	ASP: HMIS, surveillance, & research	$ 180,000	Develop and establish data quality system into the national program monitoring (NAP and RTCM) to monitor community-to-facility service delivery cascade among KP	Program and data quality management	Limited scope and quality of national HMIS systems for HIV cascade monitoring (prevention and curative services) for KPs and PLHIV	COP18	1. The prototype of web-service developed focusing of linkage of KP community-based data and health facility-based data (NAP and MoPH HIV Case Reporting Surveillance) using UIC in 2 priority provinces. 2. Data quality assurance guidelines are developed to improve KP reporting and monitoring.
HHS/CDC	MINISTRY OF PUBLIC HEALTH	Thailand	100199	ASP: HMIS, surveillance, & research	$ 60,500	Implement the first IBBS-web RDS to increase sampling coverage among MSM, MSW and TG, and to better monitor progress toward ending AIDS	Surveillance	Limited scope and quality of national HMIS systems for HIV cascade monitoring (prevention and curative services) for KPs and PLHIV	COP18	The first IBBS-web RDS implemented

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	Country	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
HHS/CDC	MINISTRY OF PUBLIC HEALTH	Thailand	100199	ASP: HMIS, surveillance, & research	$ 35,000	Strengthening national PrEP M&E system	Program and data quality management	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP17	N/A
HHS/CDC	MINISTRY OF PUBLIC HEALTH	Thailand	100199	ASP: Human resources for health	$ 10,000	Establish certification system for CBO services. Assessment of CBO performance and domestic funding following PIF.	Institutionalization of in-service training	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP18	1. National CBO services standard officially approved by MOPH 2. CBO certification body and system initiated 3. Consultant/evaluator identified to work on protocol development 4. Draft protocol shared with stakeholder and initiate non-research determination
HHS/CDC	MINISTRY OF PUBLIC HEALTH	Thailand	100199	ASP: HMIS, surveillance, & research	$ 120,000	Develop and scale up an integrated HMIS (EIIS) to enhance monitoring HIV related morbidity and mortality among KP and PLHIV	HMIS systems	Limited scope and quality of national HMIS systems for HIV cascade monitoring (prevention and curative services) for KPs and PLHIV	COP16	1. The EIIS integrated into the MOPH Health Data Center 2. Four of 17 hospitals reported HIV related morbidity and mortality among KP and PLHIV
HHS/CDC	MINISTRY OF PUBLIC HEALTH	Thailand	100199	ASP: Human resources for health	$ 25,000	Evaluation of Thailand's stigma & discrimination intervention program (2018-2019) in health care settings	Institutionalization of in-service training	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP18	S&D evaluation protocol developed and approved by ethical reviews.
HHS/CDC	MINISTRY OF PUBLIC HEALTH	Thailand	100199	ASP: Human resources for health	$ 35,000	National workshop to review PrEP performance among government and CBO providers to inform stratgies for partnership leading to scale-up among KP.	Institutionalization of in-service training	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP18	Draft concept for workshop shared with stakeholders
HHS/CDC	MINISTRY OF PUBLIC HEALTH	Thailand	100199	ASP: Human resources for health	$ 50,000	Update of national treatment literacy, national treatment guidelines, and adherence package to incorporate modules addressing TPT, TLD transition, MMS, KP and stigma and discrimination	Institutionalization of in-service training	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP19	N/A
HHS/CDC	MINISTRY OF PUBLIC HEALTH	Thailand	100199	ASP: Human resources for health	128,000	Establishment of provincial and national QI coaching team to provide coaching to improve second and third 90 (MOPH) including increase uptake of MMS, TLD transition and TPT	Institutionalization of in-service training	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP18	1. 4 provinces and Bangkok have trained coaching teams.
HHS/CDC	MINISTRY OF PUBLIC HEALTH	Thailand	100199	ASP: Laboratory systems strengthening	$ 30,000	National viral load network workshop to review VL performance and develop strategies to improve VL coverage, implement VL alerts and VL electronic data interchange to reduce turnaround time	Lab quality improvement and assurance	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP19	N/A

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	Country	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
HHS/CDC	MINISTRY OF PUBLIC HEALTH	Thailand	100199	ASP: Policy, planning, coordination & management	50,000	Developing and implementing index testing curriculum and tools	Clinical guidelines, policies for service delivery	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP19	N/A
HHS/CDC	MINISTRY OF PUBLIC HEALTH	Thailand	100199	ASP: Policy, planning, coordination & management	$ 20,000	Engaging provincial stakeholders to mobilize local/domestic funding support to community-based organizations for KP service delivery and capacity building	National strategic plans, operational plans and budgets	Lack of effective mobilization of central and local resources to support community KP services.	COP17	1. At least 4 of 13 priority provinces finalized provincial operation plan for ending AIDS including resource mobilization plan for CBO HIV services 2. CBOs standards finalized. 3. at least 2/4 CBOs were trained on standardized R&R training program for CBO services 3. 40% increased in local/domestic funding allocated to CBO in 4 provinces
HHS/CDC	MINISTRY OF PUBLIC HEALTH	Thailand	100199	ASP: Policy, planning, coordination & management	$ 20,000	Establish the differentiated care for KP (MSM/TG) and young men strategies utilizing task sharing between facility and community-based services	Oversight, technical assistance, and supervision to subnational levels	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP19	N/A
HHS/CDC	MINISTRY OF PUBLIC HEALTH	Thailand	100199	ASP: Policy, planning, coordination & management	$ 20,000	Development of national HIV Clinical management tools to address same day ART initiation, MMS, LTFU	Clinical guidelines, policies for service delivery	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP19	N/A
HHS/CDC	MINISTRY OF PUBLIC HEALTH	Thailand	100199	ASP: HMIS, surveillance, & research	$ 33,500	Evaluation of HIV self test delivery channels targeting MSM/TG	Program and data quality management	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP18	Protocol approved and recruitment activities started
HHS/CDC	BANGKOK METROPOLITAN ADMINISTRATION	Thailand	100200	ASP: HMIS, surveillance, & research	$ 33,000	Implementation and assessment of feasibility of rapid recency assay and index testing among MSM and TG to identify area of transmission	Program and data quality management	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP18	Design intervention implementation and protocol submitted to ERC

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	Country	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
HHS/CDC	BANGKOK METROPOLITAN ADMINISTRATION	Thailand	100200	ASP: HMIS, surveillance, & research	$ 280,000	Establish the BMA Health Data Center and tools to improve the quality of HIV monitoring data for KP cascade, and mortality and morbidity surveillance in Bangkok	Program and data quality management	Limited scope and quality of national HMIS systems for HIV cascade monitoring (prevention and curative services) for KPs and PLHIV	COP18	1. The BMA Health Data Center platform set up . 2.The data quality improvement system was developed 3. Coverage and utilization of UIC for community-facility KP data linkage reviewed. 4. Implementing DQI in 3 BMA hospitals 5. ART coverage in Bangkok in 2018 was 61%; coverage of VL testing in Bangkok in 2018 was 78%.
HHS/CDC	BANGKOK METROPOLITAN ADMINISTRATION	Thailand	100200	ASP: Human resources for health	$ 20,000	Implementing enhanced adherence counseling package for KP and PLHIV to improve retention and viral load suppression	Institutionalization of in-service training	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP19	N/A
HHS/CDC	BANGKOK METROPOLITAN ADMINISTRATION	Thailand	100200	ASP: Policy, planning, coordination & management	$ 20,000	Lead MSM, TG, and FSW size estimation and target setting, and develop policy document to accelerate the Ending AIDS Strategy in Bangkok.	National strategic plans, operational plans and budgets	Limited scope and quality of national HMIS systems for HIV cascade monitoring (prevention and curative services) for KPs and PLHIV	COP19	N/A
HHS/CDC	BANGKOK METROPOLITAN ADMINISTRATION	Thailand	100200	ASP: Policy, planning, coordination & management	$ 30,000	Decentralization and strengthening referral network of ART services including PrEP for KP and PLHIV in Bangkok	Oversight, technical assistance, and supervision to subnational levels	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP19	N/A
USAID	FHI Development 360 LLC	Thailand	100195							
USAID	FHI Development 360 LLC	Thailand	100195	ASP: Policy, planning, coordination & management	$ 104,731	Increased integrated TG competent care in health and HIV services	Clinical guidelines, policies for service delivery	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP19	30% uptake of the HIV cascade among TG
USAID	FHI Development 360 LLC	Thailand	100195	ASP: Public financial management strengthening	$ 209,461	Support community based organizations to organize advocacy forum and activities to increase alternative funding from the Thai National Health Security Office (NHSO), for key population-led health services	Training in public financial management strengthening	Lack of effective mobilization of central and local resources to support community KP services.	COP17	1. Increase amount invested in community-based organizations proving HIV services 2. Certification systems are being developed 3. Social contracting implementation guide is being developed in collaboration with NHSO
USAID	FHI Development 360 LLC	Thailand	100195	ASP: Laws, regulations & policy environment	$ 94,731	Provide TA for development of self-testing and index testing policies	Assessing impact of policies and regulations on HIV	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP17	1. Oral fluid screening activities under research are completed 2. Findings of this research are disseminated

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	Country	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
USAID	FHI Development 360 LLC	Thailand	100195	ASP: Human resources for health	$ 154,730	Expansion of Same-Day ART in facility- and community-based care providers and TA provision to GF programs and other stakeholders involved with HIV treatment initiation and retention in care and treatment services.	Institutionalization of in-service training	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP17	60-70% uptake of the HIV cascade
USAID	FHI Development 360 LLC	Thailand	100195	ASP: Human resources for health	$ 104,731	Provide technical support to GF-supported sites on case findings, self testing, index testing, PrEP and SDART	Institutionalization of in-service training	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP19	N/A
USAID	FHI Development 360 LLC	Thailand	100195	ASP: HMIS, surveillance, & research	$ 104,731	Continue to support Ecascade to document, track and minimize loss to follow up of the HIV activities across the cascade	HMIS systems	Limited scope and quality of national HMIS systems for HIV cascade monitoring (prevention and curative services) for KPs and PLHIV	COP18	1. Completed integration of eCascade at the national level 2. Continue as a program performance monitoring tool
USAID	FHI Development 360 LLC	Thailand	100195	ASP: HMIS, surveillance, & research	$ 35,000	Implementation study to determine the effect of HIV self-testing on the uptake of and retention in pre-exposure prophylaxis service among older adolescent men who have sex with men and transgender women	Research	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP18	1. training on the use of POC completed 2. Data collection forms developed and used by all sites

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	Country	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
USAID	FHI Development 360 LLC	Thailand	100195	ASP: Not Disaggregated	$ 500,000	Regional technical assistance and capacity building, based on best practice models in Thailand and elsewhere, to promote efficient and effective epidemic control among key populations in Asia: 1) Convening of Asia regional technical meeting on PrEP implementation in collaboration with UNAIDS, WHO and IAS 2) Regional consultation on SDART among the tier 1 countries 3) Regional forum on TG competent 4) HIVST and index testing forum In-country TA support 1) Support for high-level regional ministerial meeting on PrEP, TLD transition 2) Regional TA on TG services to priority countries (India, Nepal, Vietnam, Cambodia,	Institutionalization of in-service training	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP19	N/A
USAID	FHI Development 360 LLC	Thailand	100195	ASP: Policy, planning, coordination & management	$ 230,913	Support integration of community based HIV VL testing, STI screening services	Oversight, technical assistance, and supervision to subnational levels	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP19	N/A
USAID	FHI Development 360 LLC	Thailand	100195	ASP: HMIS, surveillance, & research	$ 36,217	Implementation study to evaluate the feasibility of the point-of-care (POC) testing for chlamydia and gonorrhea (CT/NG) in community-based clinics using the Cepheid Xpert system	Research	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP18	1. training on the use of POC completed 2. Data collection forms developed and used by all sites

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	Country	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
USAID	FHI Development 360 LLC	Thailand	100195	ASP: Laws, regulations & policy environment	$ 10,000	Support policy advocacy activities for TLD transition ART initiation strategy for facility- and community-based care providers and other stakeholders involved with HIV treatment initiation and retention in care and treatment services.	Information and sensitization for public and government officials	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP19	1. TLD is not yet available in Thailand 2. On-going discussion on TLD use
USAID	FHI Development 360 LLC	Thailand	100195	ASP: HMIS, surveillance, & research	$ 96,352	Test and Treat HIV and Viral Hepatitis for People who Inject Drugs in Thailand: The C-Free Study	Research	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP18	1. Government support for integration of HCV PWID 2. FDA approves use of HCV drugs for PWID 3. Community and health care providers capacity for HCV provision
USAID	EFYU KAZAKHSTAN, OF	Kazakhstan	100173	ASP: Laws, regulations & policy environment	$ 21,000	Compile lessons learned, share with government, advocate for scale-up of prisoner support program	Information and sensitization for public and government officials	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP18	Data, lessons learned from HIV REACT prison project compiled, shared with government, partners
USAID	Population Services International	Kazakhstan	100176	ASP: Policy, planning, coordination & management	$ 108,000	TA and advocacy to government to develop and implement guidelines and policy around relevant minimum requirements	Clinical guidelines, policies for service delivery	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP16	Test and Start implementation begun; 3 month MMS implemented; DSD guidelines approved
USAID	Central Asian Association of People Living with HIV	Kazakhstan	100190	ASP: Human resources for health	$ 12,000	Integrate stigma and discrimination module into pre-service training curriculum for HCWs	Pre-service training	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP19	N/A
USAID	Central Asian Association of People Living with HIV	Kazakhstan	100190	ASP: Laws, regulations & policy environment	$ 36,000	Advocacy to government and community to develop guidelines and policy around relevant minimum requirements	Information and sensitization for public and government officials	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP19	N/A
USAID	Central Asian Association of People Living with HIV	Kazakhstan	100190	ASP: Public financial management strengthening	$ 18,000	Advocacy and TA to government to increase efficiencies in HIV services and improve access to social contracting mechanisms	Administrative and financial systems	National HIV response not fully monitored, managed and financed by host country	COP19	N/A
USAID	EFYU KAZAKHSTAN, OF	Kyrgyzstan	100174	ASP: Laws, regulations & policy environment	$ 12,180	Compile lessons learned, share with government, advocate for scale-up of prisoner support program	Information and sensitization for public and government officials	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP18	Data, lessons learned from HIV REACT prison project compiled, shared with government, partners
USAID	Population Services International	Kyrgyzstan	100177	ASP: Policy, planning, coordination & management	$ 234,000	TA and advocacy to government to develop and implement guidelines and policy around relevant minimum requirements	Clinical guidelines, policies for service delivery	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP18	Test and Start implementation begun; 3 month MMS implemented; DSD guidelines approved

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	Country	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
USAID	Central Asian Association of People Living with HIV	Kyrgyzstan	100191	ASP: Human resources for health	$ 24,000	Integrate stigma and discrimination module into pre-service training curriculum for HCWs	Pre-service training	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP19	N/A
USAID	Central Asian Association of People Living with HIV	Kyrgyzstan	100191	ASP: Laws, regulations & policy environment	$ 72,000	Advocacy to government and community to develop guidelines and policy around relevant minimum requirements	Information and sensitization for public and government officials	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP19	N/A
USAID	Central Asian Association of People Living with HIV	Kyrgyzstan	100191	ASP: Public financial management strengthening	$ 36,000	Advocacy and TA to government to increase efficiencies in HIV services and improve access to social contracting mechanisms	Administrative and financial systems	National HIV response not fully monitored, managed and financed by host country	COP19	N/A
USAID	EFYU KAZAKHSTAN, OF	Tajikistan	100175	ASP: Laws, regulations & policy environment	$ 8,820	Compile lessons learned, share with government, advocate for scale-up of prisoner support program	Information and sensitization for public and government officials	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP18	Data, lessons learned from HIV REACT prison project compiled, shared with government, partners
USAID	Population Services International	Tajikistan	100178	ASP: Policy, planning, coordination & management	$ 252,000	TA and advocacy to government to develop and implement guidelines and policy around relevant minimum requirements	Clinical guidelines, policies for service delivery	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP18	Test and Start and MMS implemented; approval of TLD treatment protocol; self-testing initiated
USAID	Central Asian Association of People Living with HIV	Tajikistan	100192	ASP: Human resources for health	$ 24,000	Integrate stigma and discrimination module into pre-service training curriculum for HCWs	Pre-service training	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP19	N/A
USAID	Central Asian Association of People Living with HIV	Tajikistan	100192	ASP: Laws, regulations & policy environment	$ 72,000	Advocacy to government and community to develop guidelines and policy around relevant minimum requirements	Information and sensitization for public and government officials	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP19	N/A
USAID	Central Asian Association of People Living with HIV	Tajikistan	100192	ASP: Public financial management strengthening	$ 36,000	Advocacy and TA to government to increase efficiencies in HIV services and improve access to social contracting mechanisms	Administrative and financial systems	National HIV response not fully monitored, managed and financed by host country	COP19	N/A
HHS/CDC	AIDS CENTER OF THE REPUBLIC OF KAZAKHSTAN	Kazakhstan	100166	ASP: HMIS, surveillance, & research	$ 29,000	Development, analysis and use of MOH owned HMIS information for HIV program quality improvement	HMIS systems	National HIV response not fully monitored, managed and financed by host country	COP18	HMIS system produces relevant HIV indicators; RAC staff manage HMIS with minimal TA
HHS/CDC	AIDS CENTER OF THE REPUBLIC OF KAZAKHSTAN	Kazakhstan	100166	ASP: Laboratory systems strengthening	$ 43,500	Quality Assurance of Viral Load and HIV testing	Lab quality improvement and assurance	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP18	National policies for EQAS approved by the MOH, and implementation started

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	Country	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
HHS/CDC	AIDS CENTER OF THE REPUBLIC OF KAZAKHSTAN	Kazakhstan	100166	ASP: Procurement & supply chain management	$ 29,000	Improvements to system for quantification, procurement and distribution of ARVs; including working with UNICEF to purchase TLD	Forecasting, supply chain plan, budget, and implementation	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP17	Test and START Protocols implemented and monitored
HHS/CDC	Kyrgyzstan AIDS Center	Kyrgyzstan	100193	ASP: HMIS, surveillance, & research	$ 150,000	Bio-behavioral Survey among People who Inject Drugs and Men who have Sex with Men in the Kyrgyz Republic	Surveillance	Lack of sound, current health and epidemiologic data for decision making	COP19	Formative assessment completed
HHS/CDC	Kyrgyzstan AIDS Center	Kyrgyzstan	100193	ASP: Laboratory systems strengthening	$ 25,000	Implementation of national EQA system for VL testing and HTS from national and international quality assurance lab	Lab quality improvement and assurance	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP17	National policies for EQAS approved by the MOH, and implementation started
HHS/CDC	TAJIKISTAN AIDS CENTER	Tajikistan	100164	ASP: HMIS, surveillance, & research	$ 75,000	DQA, analysis, and use of MOH owned HMIS information for HIV program quality improvement	HMIS systems	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP18	HMIS system produces relevant HIV indicators; RAC staff manage HMIS with minimal TA
HHS/CDC	TAJIKISTAN AIDS CENTER	Tajikistan	100164	ASP: Laboratory systems strengthening	$ 50,000	Implementation of national EQA system for VL testing and HTS from national and international quality assurance lab	Lab quality improvement and assurance	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP18	National policies for EQAS approved by the MOH, and implementation started
HHS/CDC	RESPUBLIKANSKI NAUCHNO-PRAKTICHESKI TSENTR PSIKHICHESKOGO ZDOROVYA, GP	Kazakhstan	100183	ASP: Laws, regulations & policy environment	$ 19,239	With Global Fund, support development of additional investment cases and evidence base for MAT. Writing and MOH approval of policies for Medication Assisted Treatment of Opiod addiction and Depression treatment for PLHIV	Information and sensitization for public and government officials	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP18	Revised MOH clinical protocols for MAT revised, approved by MOH, and implemented in PEPFAR sites
HHS/CDC	Republican Narcology Center of the Republic of Kyrgystan	Kyrgyzstan	100165	ASP: HMIS, surveillance, & research	$ 30,000	DQA, analysis, and use of MOH owned HMIS for program quality improvement	HMIS systems	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP17	HMIS system produces relevant HIV indicators; RNC staff manage HMIS with minimal TA
HHS/CDC	Republican Clinical Centre of Narcology	Tajikistan	100182	ASP: HMIS, surveillance, & research	$ 25,000	DQA, analysis, and use of MOH owned HMIS for program quality improvement	HMIS systems	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP17	HMIS system produces relevant HIV indicators; RNC staff manage HMIS with minimal TA
USAID	FHI Development 360 LLC	Laos	100194	ASP: Human resources for health	$ 125,000	1. Strengthen capacity of community health care workers on ART and viral load suppression and monitoring, 2. Provide technical support on community-based differentiated service delivery , and 3. Support case finding through index testing among KPLHIV (MSM and TG)	Institutionalization of in-service training	High rate of lost to follow up and death among PLHIV in ART sites, Limited number of ART sites and long distance for ART sites, can't afford transportation to visit ART sites	COP19	70-80% treatment and care cascade

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	Country	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
USAID	FHI Development 360 LLC	Laos	100194	ASP: Policy, planning, coordination & management	$ 25,000	Provide technical support to GOL and GFATM-supported sites on self-testing and index testing guidelines, transitioning from case-finding activities to community support for treatment retention and index testing	Oversight, technical assistance, and supervision to subnational levels	High rate of lost to follow up and death among PLHIV in ART sites, Limited number of ART sites and long distance for ART sites, can't afford transportation to visit ART sites	COP19	1. Provide TA to GFATM sites for GOL implementation of self testing guidelines 2. Training activities implemented 3. SOP on self testing and index testing developed and implemented
USAID	FHI Development 360 LLC	Laos	100194	ASP: HMIS, surveillance, & research	$ 25,000	Transition E-Cascade to the GOL DHS2 database	HMIS systems	Limited staff capacity to maintain national HMIS for HIV cascade monitoring and high need for capacity surge in HIV/AIDS data analysis and use for ART sevices improvement and national and subnational program planning	COP18	1. Provide TA to support integration of eCascade and DHS2 systems
USAID	FHI Development 360 LLC	Laos	100194	ASP: Public financial management strengthening	$ 50,000	Promote activities that increase Domestic Resource Mobilization and ensures HIV services are included in the essential service package	Resource tracking and costing	Lack Domestic Financing mobilization to respond to the HIV epidemic	COP18	1. HIV service costing assessment with GOL and stakeholders completed 2. Findings from the assessment discussed
HHS/CDC	UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS	India	14088	ASP: HMIS, surveillance, & research	$ 89,051	Strengthen use of strategic information to accelerate progress and fast track responses; analysis of data to strengthen India's ability to measure progress towards 90-90-90 goals	HMIS systems	Slow progress in strengthening institutional capacity for integrated data systems and epidemic monitoring as well as challenges in optimal utilization and leveraging of resources.	COP18	1. National HIV Estimates process initiated with national government, conducted with high quality standards and adherence to surveillance methodology. Technical Support for population size estimates of KPs, including support for virtual mapping of KPs provided. 2. District PLHIV Estimates National Working Group decides methodology for carrying out district estimations for country, based on lessons from cluster pilots 3. National monitoring dashboards with key priority indicators developed, with focus on data analysis on prevention to care continuum. Capacity building for analysis and use of routine quality data at the national level carried out, including support for National Data Analysis Plan.
HHS/CDC	CODB	Cambodia	HHS/CDC 2	ASP: Laboratory systems strengthening	$ 34,000	Support National Institute of Public Health's plans to export their ISO expertise (that was built through PEPFAR support) for ISO accreditation of NCHADS laboratory	Lab accreditation	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP19	N/A
HHS/CDC	CODB	Cambodia	HHS/CDC 2	ASP: Laboratory systems strengthening	$ 37,000	Ensure high quality viral load testing and rapid turnaround time (for better clinical decision making and improved adherence counseling)	Lab quality improvement and assurance	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP19	N/A

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	Country	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
HHS/CDC	CODB	Cambodia	HHS/CDC 2	ASP: Policy, planning, coordination & management	$ 66,000	Incorporate same-day ART initiation, multi-month scripting, and dolutegravir implementation into updated treatment guidelines and ensure adoption nationally	Clinical guidelines, policies for service delivery	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP19	N/A
HHS/CDC	CODB	Papua New Guinea	HHS/CDC 9	ASP: Policy, planning, coordination & management	$ 91,199	TA for TLD transition.	Clinical guidelines, policies for service delivery	Maintaining PLHIV on Treatment	COP18	NDoH adpots Policy for TLD as first line ART.
HHS/CDC	CODB	Papua New Guinea	HHS/CDC 9	ASP: Laboratory systems strengthening	$ 65,142	TA for roll out of VL road map	Training in laboratory systems strengthening	Maintaining PLHIV on Treatment	COP16	VL testing using DBS available in two provinces outside of NCD with VL testing available to 50% of PLHIV on ART.
HHS/CDC	CODB	Papua New Guinea	HHS/CDC 9	ASP: HMIS, surveillance, & research	$ 78,170	TA for HIV Information system development, planning and capacity building	Training in HMIS systems or processes	Weak health systems and limited health worker capacity to deliver HIV treatment services	COP17	2 eHealth Fellows trained, HPDB Informatics Project completed
HHS/CDC	CODB	Papua New Guinea	HHS/CDC 9	ASP: HMIS, surveillance, & research	$ 26,057	TA for HIV Surveillance and HR Capacity Building for Efficient transition of PEPFAR suported activities	Program and data quality management	Weak health systems and limited health worker capacity to deliver HIV treatment services	COP17	KP Surveillance Tools Developed; DR study results shared and made available; Capacity building for three key HIV program staff in one PEPFAR supported SNU
HHS/CDC	CODB	Kazakhstan	HHS/CDC 5	ASP: Policy, planning, coordination & management	$ 88,500	TA for TLD transition and optimization of ARV formulary including TA for supply chain mangement; TA for ART maintenance and quality improvement; TA for HIV clinical guidelines and SOPs	Clinical guidelines, policies for service delivery	Insuffcient and/ or interrupted ARV drug supply	COP16	TLD transition and ARV regimen optimization started; Results of PEPFAR-supported VLS improvement shared with government
HHS/CDC	CODB	Kazakhstan	HHS/CDC 5	ASP: Laboratory systems strengthening	$ 88,500	Ensure high quality viral load testing and rapid turnaround time (for better clinical decision making and improved adherence). TA for External Quality Assurance of HIV VL testing.	Lab quality improvement and assurance	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP16	National policies for EQAS approved by the MOH, and implementation started;
HHS/CDC	CODB	Kyrgyzstan	HHS/CDC 6	ASP: Policy, planning, coordination & management	$ 76,000	TA for TLD transition; TA for ART maintenance and quality improvement. TA for HIV surveillance. TA for HIV clinical guidelines, SOPs, and decentralization.	Clinical guidelines, policies for service delivery	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP16	ART optimization including TLD transistion started; PEPFAR activities for improving VLS (mentoring, nurse case management) evaluated and dessiminated to GOK Standards developed for integration of ART to primary care

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Funding Agency	PrimePartner	Country	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
HHS/CDC	CODB	Kyrgyzstan	HHS/CDC 6	ASP: Laboratory systems strengthening	$ 55,000	Ensure high quality viral load testing and rapid turnaround time (for better clinical decision making and improved adherence). TA for External Quality Assurance of HIV VL testing including ISO accreditation of national HIV reference lab.	Lab quality improvement and assurance	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP16	National policies for EQAS approved by the MOH, and implementation started ISO accreditation of the national HIV reference lab started
HHS/CDC	CODB	Tajikistan	HHS/CDC 10	ASP: Policy, planning, coordination & management	$ 52,620	TA for ARV regimen optimization including TLD transition; TA for ART maintenance and quality improvement. TA for HIV clinical guidelines and SOPs.	Clinical guidelines, policies for service delivery	Maintaining PLHIV on Treatment	COP16	ARV regimen optimization (including TLD transition) started PEPFAR-supported activities (mentoring, CQI, nurse case management) for improved VLS evaluated and shared with GOT
HHS/CDC	CODB	Tajikistan	HHS/CDC 10	ASP: Laboratory systems strengthening	$ 69,746	Ensure high quality viral load testing and rapid turnaround time (for better clinical decision making and improved adherence). TA for External Quality Assurance of HIV testing.	Lab quality improvement and assurance	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP16	5 VL testing labs perform at least one round of international PT testing
HHS/CDC	CODB	Kyrgyzstan	HHS/CDC 6	ASP: Policy, planning, coordination & management	$ 76,000	TA for MAT policy, guidelines and SOP; TA for continuous quality improvement of MAT and HIV treatment; TA for increased government financing of HIV prevention and treatment; TA for integration of HIV services into primary care; liaise with Global Fund	National strategic plans, operational plans and budgets	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP16	"One window" integrated ART MAT and TB approach evaluated and disseminated
HHS/CDC	CODB	Tajikistan	HHS/CDC 10	ASP: Policy, planning, coordination & management	$ 52,000	TA for MAT policy, guidelines and SOP; TA for continuous quality improvement of MAT and HIV treatment; TA for increased government financing of HIV prevention and treatment; TA for integration of HIV services into primary care	Clinical guidelines, policies for service delivery	Quality of HIV treatment services not consistent with international/ PEPFAR/ WHO standards	COP16	"One window" integrated ART MAT and TB approach evaluated and disseminated Bupreorphrine added to national guidelines
HHS/CDC	MINISTRY OF PUBLIC HEALTH	Thailand	100199	ASP: Human resources for health	$ 60,000	Above site training and coaching for MOPH hospitals provinces with low uptake of MMS and for new HIV treatment and care guidelines(TLD/MMS) and improve VL testing	Institutionalization of in-service training	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP19	N/A
HHS/CDC	MINISTRY OF PUBLIC HEALTH	Thailand	100199	ASP: Human resources for health	$ 50,000	Supporting international partnerships and innovation for strengthening health care workforce capacity	Institutionalization of in-service training	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP18	Pilot draft S&D training curriculum and conduct one regional workshop

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Funding Agency	PrimePartner	Country	Mech ID	COP19 Program Area	Activity Budget	COP19 Activity Description	COP19 Activity Category	Key Systems Barrier	Intervention Start	COP18 Benchmark
HHS/CDC	BANGKOK METROPOLITAN ADMINISTRATION	Thailand	100200	ASP: Human resources for health	$ 40,000	Above site training and coaching for hospitals in Bangkok with low uptake of MMS and for new HIV treatment and care guidelines (TLD/MMS) and improve VL testing	Institutionalization of in-service training	Low coverage of KP case finding and, linkage to care, ART initiation, and retention for PLHIV	COP19	N/A
USAID	Chemonics International, Inc.	Indonesia	18225	ASP: Procurement & supply chain management	$ 250,000	Coordinate with MoH, GF, WHO and CHAI to accelerate TLD transition at the National Level and specifically for the Jakarta Province. Coordinate First TLD Purchase for Q1 2020 for Jakarta Province using Global Fund resources to accelerate transition- First purchase will be used to accelerate transition in Jakarta. Support Provincial Health Office in transition to TLD and ensuring a reliable supply of TLD and other essential ARVs at all sites in Jakarta. Support PHO in stock monitoring and action in transition phase to minimize stock shortages and stock outs. Use 90-day TLD kit for Multi Month Scripts for TLD eligible patients at 3 main PEPFAR DSD sites in Jakarta. Support Civil Society Engagement and advocacy with the MoH and Expert Panel around TLD and Multi-Month Scripts with kits- to accelerate roll out and approvals and endorsement for use at national levels and in Jakarta. Coordinate with GF to procure first batch of recency tests for Jakarta	Forecasting, supply chain plan, budget, and implementation	Inconsistent access to key HIV service commodities limits PLHIV retention and VL suppression	COP18	TLD Not registered or procured; not available in Indonesia nor Jakarta. No recency Testing/recency tests in Indonesia.
USAID	Chemonics International, Inc.	Indonesia	18225	ASP: Laboratory systems strengthening	$ 96,029	50% of Fast Track sites in Jakarta don't have access to GeneXpert machines for VL Testing. These sites are and will be required to rely heavily on specimin referral to high throughput laboratories. Support will be provided to the PHO and all applicable PEPFAR Sites to utilize specimin trasnport for same-day referal and transport of specimins to high throuput VL testing Laboratories. There will be site level support for sites which is included in the FAST.	Lab quality improvement and assurance	Inconsistent access to key HIV service commodities limits PLHIV retention and VL suppression	COP18	No existing Specimin Trasnport Mechanism for routine and reliable transport to high throughput VL testing laboratories.

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