PEPFAR

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

Asia Region Operational Plan

ROP 2020

Strategic Direction Summary

April 17, 2020

Table of Contents

Acronyms

1.0 Goal Statement

2.0 Epidemic, Response, and Updates to Program Context

- 2.1 Summary statistics, disease burden, and country profile
- 2.2 New Activities and Areas of Focus for ROP20, Including Focus on Client Retention
- 2.3 Investment profile
- 2.4 National sustainability profile update
- 2.5 Alignment of PEPFAR investments geographically to disease burden
- 2.6 Stakeholder engagement

3.0 Geographic and population prioritization

4.0 Client-centered Program Activities for Epidemic Control

- 4.1 Finding the missing, getting them on treatment
- 4.2 Retaining clients on treatment and ensuring viral suppression
- 4.3 Prevention, specifically detailing programs for priority programming
- 4.4 Additional country-specific priorities listed in the planning level letter
- 4.5 Commodities
- 4.6 Collaboration, Integration, and Monitoring
- 4.7 Targets for scale-up locations and populations
- 4.8 Viral Load Optimization

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.0 USG Management, Operations and Staffing Plan to Achieve Stated Goals

Annex 1 – Country Specific Context Figures and Tables

Annex 2 – Asia Regional KPIF Activities

Appendix A - Prioritization

Appendix B - Budget Profile and Resource Projections

Appendix C - Tables and Systems Investments for Section 6.0

Appendix D – Minimum Program Requirements

Abbreviations and Acronyms

AIDS	Acquired immunodeficiency syndrome
AEM	AIDS Epidemic Model
ALHIV	Adolescents living with HIV
AP	Andhra Pradesh
APL	Association of People Living with HIV/AIDS
ARP	Asia Regional Program
ART	Antiretroviral therapy
ARV	Antiretroviral drug
ASAP	Accelerate and Scale the Asia Program
CAA	Community action approach
CBART	Community-based ART
CBO	Community-based organizations
CBS	Case-based surveillance
CDC	Centers for Disease Control and Prevention
CHAS	Center for HIV and AIDS (Lao PDR)
CLHIV	Children living with HIV
COP	Country Operational Plan
CQI	Continuous quality improvement
CSO	Civil society organization
DBS	Dried/dry blood spot
DHIS	District health information software
DNO	Diagnosis network optimization
DOD	Department of Defense
DQA	Data quality assessment
DSD	Direct service delivery
DSDM	Differentiated service delivery models
DTG	Dolutegravir
EHCMS	Electronic HIV case management system
EMR	Electronic medical record
EPOA	Enhanced Peer Outreach Approach
EQA	External quality assurance
FSW	Female sex workers
FY	Fiscal year
GF	The Global Fund
GOK	Government of Kazakhstan
GOKR	Government of the Kyrgyz Republic
GOL	Government of Lao PDR
GOI	Government of India/Indonesia
GON	Government of Nepal
HFR	High-frequency reporting
HIV	Human immunodeficiency virus
HIVCAM	HIV Complementary and Alternative Medicine
HIVST	HIV Self-testing
HRH	Human Resources for Health
HSS	HIV sentinel surveillance
HTS	HIV testing services
IBBS	Integrated Bio-Behavioral Survey
IP	Implementing partner
IPV	Intimate partner violence
KP	Key populations
KPLHS	Key population-led health services
LAM	lipoarabinomannan assay
LAOPHA	Laos Positive Health Association

LTFU	Loss/lost to follow up
MAT	Medication-assisted therapy/methadone-assisted therapy
M&E	Monitoring and evaluation
MCH	Maternal and Child Health
MER	Monitoring, Evaluation, and Research
MH	Maharashtra
MMD	Multi-month dispensing
MMS	Multi-month scripting
MMT	Methadone Maintenance Therapy
MoH	Ministry of Health
MPR	Minimum Program Requirement
MRS	Medical record systems
MSM	Men who have sex with men
MSW	Male sex workers
N/A	Not available/not applicable
NAP	National AIDS Program
NASA	National AIDS Spending Assessment
NCLE	National Center of Laboratory and Epidemiology
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
NHSO	National Health Security Office
OGAC	Office of the Global AIDS Coordinator
OU	Operating unit
OVC	Orphans and vulnerable children
PARCU	PEPFAR Asia Region Coordination Unit
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHO	Provincial Health Office
PITC	Provider Initiated Testing and Counseling
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PNG	Papua New Guinea
PoART	PEPFAR Oversight Accountability Response Team
POC	Point of care
PP	Priority populations
PR	Principal recipient
PrEP	Pre-exposure prophylaxis
PSC	Personal Services Contractor
PSE	Population size estimate
PSF	Patient Satisfaction Feedback (Cambodia)
PSM	Procurement and supply management
PWID	People who inject drugs
QA/QI/QM	Quality assurance/improvement/management
QMS	Quality management system
RAC	Republican AIDS Center (Tajikistan)
RGC	Royal Government of Cambodia
ROP	Regional Operational Plan
sDART	Same day ART
SDS	Strategic Direction Summary
SI	Strategic information
SID	Sustainability Index Dashboard
SNS	Social Network Strategies
SNU	Sub-national unit

SOP	Standard operating procedure
SR	Sub recipient
SRE	Surveillance, Surveys, Research and Evaluation
STI	Sexually transmitted infection
TA	Technical assistance
TAT	Turnaround times
TB	Tuberculosis
TG	Transgender
TGM	Transgender women
TLD	tenofovir/lamivudine/dolutegravir
TLE	tenofovir/lamivudine/efavirenz
TPT	Tuberculosis preventive treatment
TRG	Technical resource group
TWG	Technical working group
U=U	Undetectable = untransmittable
UIC	Unique identifier code
UNAIDS	United Nations Agency for AIDS
UNICEF	United Nations Children's Fund
US	United States (of America)
USAID	United States Agency for International Development
USDH	US Direct Hire
USG	United States Government
VL	Viral load
VLC	Viral Load Coverage
VLS	Viral Load Suppression
VLSM	Viral Load Management System
WB	World Bank
WHO	World Health Organization

1.0 Goal Statement

The ROP20 **vision** for the 12 countries that form the PEPFAR Asia Region Program (ARP)—Burma, Cambodia, India, Indonesia, Kazakhstan, Kyrgyz Republic, Lao PDR, Nepal, Papua New Guinea, Philippines, Tajikistan, and Thailand—is to continue coalescing as a unified region to maximize impact and promote efficiencies to advance and sustain epidemic control, with special attention to key populations (KP), people living with HIV (PLHIV), and those at risk within their networks. The ARP will continue to advocate for the advancement of national progress toward epidemic control. Using data-driven approaches, country teams will continue to invest in the highest burden areas, and scale up differentiated service delivery models for KP with fidelity; work with governments to increase domestic financing for HIV services; strengthen policy frameworks, systems, and technical capacity for evidence-based programming; and improve the HIV clinical cascade.

The PEPFAR Asia Region Coordination Unit (PARCU), with guidance from the Advisory Council[1], will translate best practices quickly and efficiently into programmatic impact. Field teams will enhance regional connectivity efforts by sharing expertise across the region through the facilitation of technical exchanges among countries, sharing effective approaches and best practices to KP programming--such as pre-exposure prophylaxis (PrEP), index and self-testing, harm reduction programming, gender-affirming service delivery, differentiated service delivery models, reducing stigma and discrimination, improving data use, and initiating community-based monitoring.

By strengthening partnerships with host governments, multilateral organizations, and civil society organizations (CSOs), all countries will accelerate implementation of the World Health Organization's (WHO) policies and PEPFAR minimum program requirements (MPRs) to reach epidemic control. In addition, countries will focus on the specific Asia Region PEPFAR ROP20 technical directives as described below.

Tier 1: Sustain the Gains

Six countries--Burma, Cambodia, Kyrgyz Republic, Nepal, Tajikistan, and **Thailand--are at or near epidemic control and 90-90-90 or are expected to be by the end of ROP19. In ROP20, they will focus on closing the remaining gaps, sustaining epidemic control, distilling lessons learned, and taking on leadership roles in the region.** Three of the 6 countries--**Cambodia, Nepal,** and **Thailand**--will receive Ambition Funds to accelerate efforts even further to reach 95-95-95. Cambodia will expand the Chhouk Sar clinic model of delivering KP-friendly services. Nepal will focus on targeted testing strategies and increase its focus on PrEP, treatment initiation and retention, and viral load (VL) suppression. Thailand will sustain its investments in GeneXpert machines in 4 KPLHS sites in 3 high-burden provinces by maximizing the functionality for KP-centered VL coverage and suppression to achieve the third 95.

Burma, currently at **88-87-68**, will accelerate efforts by aggressively scaling up comprehensive HIV prevention and treatment strategies in 5 catchment areas and expanding VL access to achieve 100% coverage and 95% VL suppression nationally. In addition, Burma will scale up PrEP among men who have sex with men (MSM), transgender (TG), and people who inject drugs (PWID) in Yangon, Mandalay, and Kachin. Close coordination with the United Nations Agency for AIDS (UNAIDS), the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GF) principal recipients (PR)/sub recipients (SRs), and civil society, and leveraging the significant government HIV program investments will establish a comprehensive and sustainable HIV response.

[1] The Advisory Council represents the voice of the country teams to the PARCU, promoting regional cooperation, compliance with the annual ROP, and sharing of lessons; facilitates communication and activities across the 11 countries of the Asia Region; and provides input on key decisions that impact the region. The Philippines will be invited to name a representative to this structure in ROP20.

Cambodia, already at epidemic control at **85-99-82**, will work with the national HIV program, using a multifaceted approach to ensure program sustainability. Case-based surveillance (CBS) will be fully developed to track patients and detect outbreaks. Recency will be used in conjunction with CBS for public health response, and micro-targeted pre-exposure prophylaxis (PrEP) will be provided for selected high-risk populations.

Kyrgyz Republic, currently at **68-63-91**, will implement key client-centered policies and practices through aggressive roll-out of MPRs, including differentiated service delivery, tenofovir/lamivudine/dolutegravir (TLD) transition, 6-month multi-month dispensing (MMD) and PrEP, and antiretroviral (ARV) dispensing strategies--including community-based antiretroviral therapy (ART) in 4 oblasts. PEPFAR will strengthen supply chain management, focusing on the development of standard operating procedures and forecasting.

Nepal, at **86-77-64** as of the end of ROP19 Q1, will improve yields through KP-network testing modalities, expand PrEP access, continue to strengthen and monitor community-based ART, and expand VL coverage to 100%. PEPFAR-funded ROP20 activities support the Government of Nepal's efforts in 35 high-burden districts.

Tajikistan, at **62-78-84,** will work to identify undiagnosed people living with HIV (PLHIV), integrate community-based ART and HIV self-testing into the supply chain to meet 90% ART coverage goals in 3 PEPFAR-supported areas, and expand VL suppression approaches nationally. They will also introduce PrEP and continue expansion of recency testing. They will continue to collaborate with GF to strength supply chain systems to improve quantification and forecasting.

Thailand, which is very close to epidemic control, at **97-82-97**, will focus on expansion of index and recency testing, integration of HIV-self testing into current strategies, same-day ART (sDART), MMD, and TLD transition from site-level activities in 13 provinces to national scale. PrEP services will be accelerated, and KP-led health services institutionalized. Leveraging Thailand's experiences and success, the PEPFAR team and partners will provide technical expertise and support for a public health response through targeted technical assistance (TA) and technical exchange to increase regional impact.

Tier 2: Accelerate and Achieve

These 2 countries—**India** and **Lao PDR**--are not yet at epidemic control but will implement strategies in ROP20 to accelerate country progress.

India, currently at **79-82-81**, will leverage ROP19 incentive funds to focus on closing treatment gaps and VL suppression through aggressive implementation of HIV services, index testing, sDART, and 6-month MMD in 38 districts in 6 states. VL coverage will expand to achieve 80% coverage by ROP19 and 100% coverage in ROP20. PrEP and community ARV dispensation will be further scaled-up**.**

Lao PDR, currently at **75-75-79**, will advance self, index, and recency testing policy and implementation in 3 high-burden areas and address gaps in linkage and retention through enhanced case management, MMD, and TLD transition. PrEP will be implemented in Vientiane Capital among targeted high-risk MSM.

Tier 3: Maintenance/Protect the Investment

Despite substantial PEPFAR and other donor investments, these 3 countries--**Kazakhstan, Indonesia**, and **Papua New Guinea**--have experienced historical challenges in achieving UNAIDS 90-90-90 benchmarks.

Indonesia, at 59-34-N/A**,** will aggressively scale up to achieve 80% ART coverage in Jakarta by 2022, institutionalize MPRs, and expand VL coverage nationally. PEPFAR will continue to sustain and coordinate engagement with government, multilaterals, and USG agencies to address key barriers to HIV services.

Kazakhstan, at 82-68-78, will continue to provide site-level services in 2 geographic areas to maintain those PLHIV currently on ART, but will begin shifting its strategy from site-level service delivery to above-site activities to support sustainability of the HIV epidemic response. PEPFAR will work to address policy-related barriers that continue to hinder ART initiation and prioritize rapid test and start, ensure uninterrupted supply of ARVs, and prioritize social contracting for KP HIV services. Health facilities and community-based organizations (CBOs) will continue to focus on loss to follow up (LTFU) and self-testing, and PEPFAR will work with the MOH to develop self-testing and PrEP guidelines and standard operating procedures (SOPs).

Papua New Guinea (PNG), at 71-88-85, will focus on ART patient retention to ensure saturation in the National Capital District (NCD) in ROP20. TLD transition and commodities will be closely monitored, and efforts will continue to expand VL coverage. PEPFAR will also continue to support government efforts for CBS and HIV data systems so PLHIV can be traced and tracked over the continuum of care. PEPFAR PNG will continue to support the National Department of Health (NDoH), Disease Control and Family Health Division, to ensure that PLHIV who experience gender-based violence (GBV) have access to appropriate services.

New Country Added

Philippines: During the ROP20 planning process, the PEPFAR interagency made the decision to include the Philippines in the PEPFAR Asia Region Program, as it is experiencing the fastest-growing HIV epidemic in Asia. Funding to address the epidemic was allocated as part of the ROP19 ASAP Incentive Fund. In ROP20, PEPFAR activities in the Philippines will focus on key HIV prevention and treatment service delivery gaps in public and community sites in Metro Manila, Cebu, and Davao, as well as above-site work on supply chain, data, and laboratory systems gaps, policies to further MPRs, and sustainability. Since the Philippines is a new addition to the Asia Region Program, it will be considered separately from the current tier structure.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden, and regional profile

With a combined population of almost 2 billion, there are an estimated 3.7 million people living with HIV (PLHIV) across the 11 countries--ranging from 8,500 in **Kyrgyz Republic** to 2,140,000 in **India**. Individual country host government results are presented in Table 2.1.1 in Appendix 1. ARP countries are characterized as mature epidemics with growing epidemics in KP, especially MSM, PWID, and female sex workers (FSW) and their clients. Countries demonstrate varied progress toward UNAIDS 95-95-95 goals. While some countries have reached or nearly reached epidemic control (**Cambodia, Thailand**), others are lagging. Treatment coverage among diagnosed PLHIV (second 95) in **Indonesia** at 34%, and **Kyrgyz Republic** at 63%, highlight ongoing weaknesses in the health systems and the lack of available access for key populations. *Country specific epidemic figures are available in Appendix 1.*

Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression

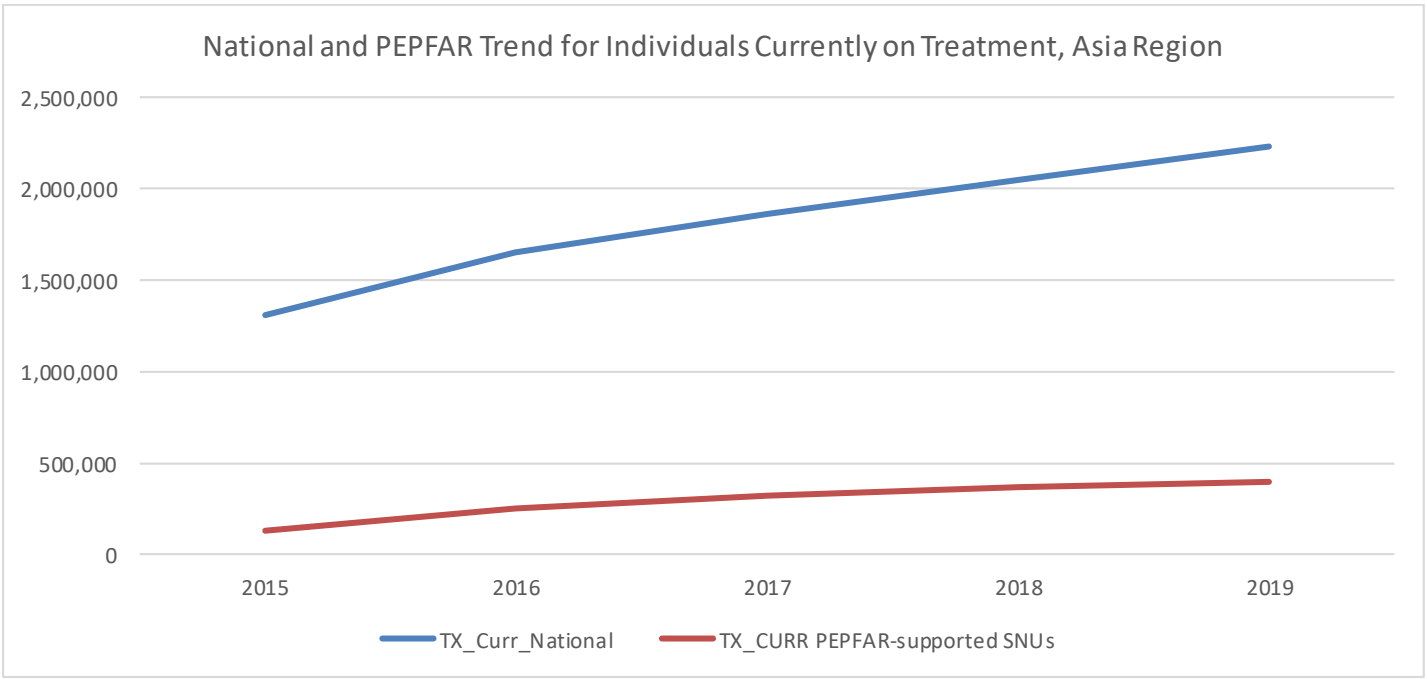
	Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Country	Total Pop. Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	Burma	54,340,000	0.57%	240,000	211,200	184,624	87%	68%	355,762	37,767	30,118
	Cambodia	15,288,489	0.6%	72,148	61,229	61,193	99.8%	82%	453,354	3,958	3,695
	India	1,300,000,000	0.22%	2,140,000	1,705,738	1,398,709	82%	81%	41,700,00	191,190	179,443
	Indonesia	271,066,400	0.33%	640,443	377,564	127,613	33.79%	N/A	4,199,992	52,638	40,062
	Kazakhstan (15+)	18,395,567	0.17%	30,887	25,506	17,107	68%	78%	3,069,199	3,644	2,877
	Kyrgyz Republic (15+)	6,389,500	0.13%	8,500	5,793	3,667	63%	91%	461,731	818	631
	Lao PDR	7,181,567	0.2%	12,810	9,766	7,299	75%	79%	84,876	1,387	1,199
	Nepal	29,097,158	0.14%	29944	23,137	18,628	77%	64%	237496	2298	2411
	PNG	8,889,786	0.84%	51,075	36,470	32,018	87.8%	84.8%	175,075	5,019	4,769
	Tajikistan (15+)	9,126,600	0.14%	12,000	7,737	6,272	78%	84%	1,062,508	1,136	1,021
	Thailand	68,541,727	0.68%	467,587	454,436	373,191	82%	97%	1,143,809	28,391	27,712
Population <15 years	Burma	14,825,000	-	9,800	-	-	83%	-	-	-	*1,131*
	Cambodia	-	-	2,999	2,553	2,548	99.8%	62%	-	-	101
	India	400,000,000	.015%	61,000	54900	54231	98.7%	-	-	-	-
	Indonesia	70,710,000	-	17,841	-	-	-	*N/A*	*60,358*	*1,423*	*1,083*
	Kazakhstan	-	-	-	-	-	-	-	-	-	-
	Kyrgyz Republic	-	-	-	-	-	-	-	-	-	-
	Lao PDR	2,336,164	0.02%	363	422	288	65%	70%	511	45	49
	Nepal	-	-	1,296	-	1,299	100	-	5,451	114	-
	PNG	3,155,732	-	3,104	1,544	1,247	81%	-	-	-	-
	Tajikistan	-	-	-	-	-	-	-	-	-	-
	Thailand	11,426,914	0.02%	2,442	3,249	2,195	90%	92%	18,834	151	175
Men 15-24 years	Burma	4,821,000	0.76%	140,000	-	-	-	-	-	-	*18,313 (>15)*
	Cambodia	-	-	1,534	2,270	2,266	99.8%	84%	-	-	497

	Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression										
	Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Country	Total Pop. Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
	India (>15)	450,000,000	0.27%	1,200,000	841,927	659,754	78%	-	-	-	-
	Indonesia	22,684,500	-	401,238^^	-	-	-	N/A	214,356	5,921	4,760
	Kazakhstan	1,202,398	0.01%	453	453	369	81%	80%	-	156	138
	Kyrgyz Republic	526,880	<0.01%	<200	172	125	73%	94%	-	48	36
	Lao PDR	739,336	0.03%	244	546	415	76%	67%	7,238	194	187
	Nepal	-	0.2%	630	-	-	-	-	-	-	-
	PNG	906,081	-	1,631	1,387	803	68%	-	-	-	-
	Tajikistan	870,700	<0.05%	<500	100	170	80%	80%	-	52	47
	Thailand	4,296,688	0.31%	13,515	19,961	14,297	72%	78%	161,556	5,017	4,327
Men 25+ years	Burma	13,702,000	-	-	-	-	-	-	-	-	-
	Cambodia	-	-	30,957	25,426	25,377	99.8%	81%	-	-	1,787
	India	*Combined with stats above*									
	Indonesia	77,327,500	-	-	-	-	-	N/A	663,417	27,256	21,161
	Kazakhstan	5,009,309	0.38%	19,129	14,922	9,408	63%	78%	-	2,252	1740
	Kyrgyz Republic	1,574,790	0.34%	5,400	3,253	1,833	56%	88%	-	425	318
	Lao PDR	1,675,138	0.39%	6,598	4,572	3,474	76%	80%	13,009	658	1,305
	Nepal	-	-	16,432	-	-	-	-	164738	1259	-
	PNG	2,003,984	-	18,886	13,750	11,452	83%	-	-	-	-
	Tajikistan	2,128,500	0.39%	8,400	4,289	3,235	75%	82%	-	609	527
	Thailand	29,391,557	0.84%	248,329	235,561	191,290	81%	97%	465,749	15,338	14,859
Women 15-24 years	Burma	4,825,000	0.39%	87,000	-	-	-	-	-	-	10,674 (>15)
	Cambodia	-	-	1,694	1,890	1,887	99.8%	88%	-	-	162
	India* (>15)	450,000,000	0.19 %	879,000	808,911	633,881	78%	-	-	-	-
	Indonesia	21,700,000	-	221,364##	-	-	-	N/A	988,665	3,631	2,260
	Kazakhstan	1,152,559	0.05%	590	372	294	79%	79%	-	112	96
	Kyrgyz Republic	506,386	<0.01%	<200	161	132	82%	87%	-	31	25
	Lao PDR	744,375	0.02%	177	452	288	64%	69%	30,062	138	100
	Nepal	-	0.2%	734	-	-	-	-	-	-	-
	PNG	852,879	-	2,751	2,003	1,295	65%	-	-	-	-
	Tajikistan	835,300	<0.060%	<500	228	208	91%	88%	-	60	57
	Thailand	4,265,500	0.21%	8,993	11,425	7,935	69%	79%	112,081	1,486	1,340
Women 25+ years	Burma	16,147,000	-	-	-	-	-	-	-	-	-
	Cambodia	-	-	24,064	20,160	20,115	99.8%	84%	-	-	1,148
	India	*Combined with stats above*									
	Indonesia	78,643,700	-	221,364##	-	-	-	N/A	2,273,196	14,407	10,797
	Kazakhstan	5,781,469	0.19%	10,715	9,759	7,036	72%	82%	-	1,124	903
	Kyrgyz Republic	1,696,028	0.16%	2,700	2,207	1,577	71%	94%	-	314	252
	Lao PDR	1,686,564	0.32%	5,483	3,754	2,824	75%	83%	24,056	868	757
	Nepal	-	-	10843	-	-	-	-	67307	925	-
	PNG	1,071,110	-	24,704	17,086	17222	96%	-	-	-	-
	Tajikistan	2,162,200	0.14%	3,000	3,030	2,659	88%	86%	-	415	390
	Thailand	30,587,982	0.64%	196,750	184,241	157,474	85%	100%	385,589	6,399	7,011

	Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression										
	Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Country	Total Pop. Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
MSM	Burma	252,000	11.6% (2015)	22,517	-	-	-	-	48,545	3,708	-
	Cambodia	72,000	4.0%	2851	-	-	-	-	21,276	484	470
	India	357,000	4.3%	15,351	9,947	8,274	83%	-	253,470	532	491
	Indonesia	754,210	25.8	110,566	40,801	15,723	31.51%	*N/A*	123,218	9,705	5,160
	Kazakhstan	62,000	6.20%	3,006	802	673	75%	92%	943	27	21
	Kyrgyz Republic	16,900	6.6%	1,064	207	139	67%	96%	37	22	19
	Lao PDR	-	3.33%	1,887	-	-	-	-	-	-	-
	Nepal	60333	-	2,647	-	286	-	-	70,658	142	-
	PNG	-	-	-	-	-	-	-	-	-	-
	Tajikistan	13,400	2.3%	361	116	88	76%	94%	6,070	28	23
	Thailand	603,600	11.0	62,206	25,470	16,060	63%	97%	66,777	6,714	6,053
FSW	Burma	66,000	14.6% (2015)	8,892	-	-	-	-	41,720	2,379	-
	Cambodia	41,600	3.2%	1322	-	-	-	-	35,650	77	76
	India	868,000	2.2%	19,096	13,100	9,233	70.5%	-	633,640	824	824
	Indonesia	226,791	8 (high risk) 2.2 (low risk)	3,993 (high risk) 3,466 (low risk)	27,601	2,268	8.22%	*N/A*	92,190	2,162	650
	Kazakhstan	18,400	1.9%	404	333	89	27%	74%	5,867	201	177
	Kyrgyz Republic	7,100	2.0%	156	82	32	39%	80%	25	6	4
	Lao PDR	-	0.80%	124	-	-	-	-	-	-	-
	Nepal	40018	-	533	-	320	-	-	27140	251	-
	PNG	-	-	-	-	-	-	-	-	-	-
	Tajikistan	17,500	2.0%	612	601	501	86%	84%	15,750	83	76
	Thailand	119,000	1.8	-	-	-	-	-	-	-	-
PWID	Burma	93,000	34.9% (2017)	21,212	-	-	-	-	47,955	13,114	-
	Cambodia	3,200	15.2%	487	-	-	-	-	416	3	3
	India	177,000	9.9%	17,523	11,846	9,033	76.2%	-	116,820	1308	1062
	Indonesia	33,402	28.8	7,023	13,185	2,451	10%	N/A	9,054	326	245
	Kazakhstan	120,500	7.9%	14,942	9,880	5,205	53%	77%	26,732	1,175	921
	Kyrgyz Republic	25,000	14.3%	3,300	1,071	840	27%	80%	706	92	56
	Lao PDR	-	7.32%	122	-	-	-	-	-	-	-
	Nepal	30867	-	930	-	1021	-	-	27862	46	-
	PNG	-	-	-	-	-	-	-	-	-	-
	Tajikistan	22,200	12.1%	2,997	1,889	1,180	62%	81%	30,774	132	107
	Thailand	25,800	-	-	-	-	-	-	-	-	-
Priority Pop	Cambodia	TG: 3,300	9.6%	298	-	-	-	-	4,250	196	196
	India	TG: 70,000	7.5%	5,250	2,604	3,244	124.6%*	-	49,000	289	214
	Indonesia	TG: 38,028	24.8%	3,633	9,106	731	8.03%	*N/A*	15,418	604	297
	Nepal	TG: 21,460	-	-	-	-	-	-	-	-	-
		MSW: 18,287	-	733	-	-	-	-	-	-	-

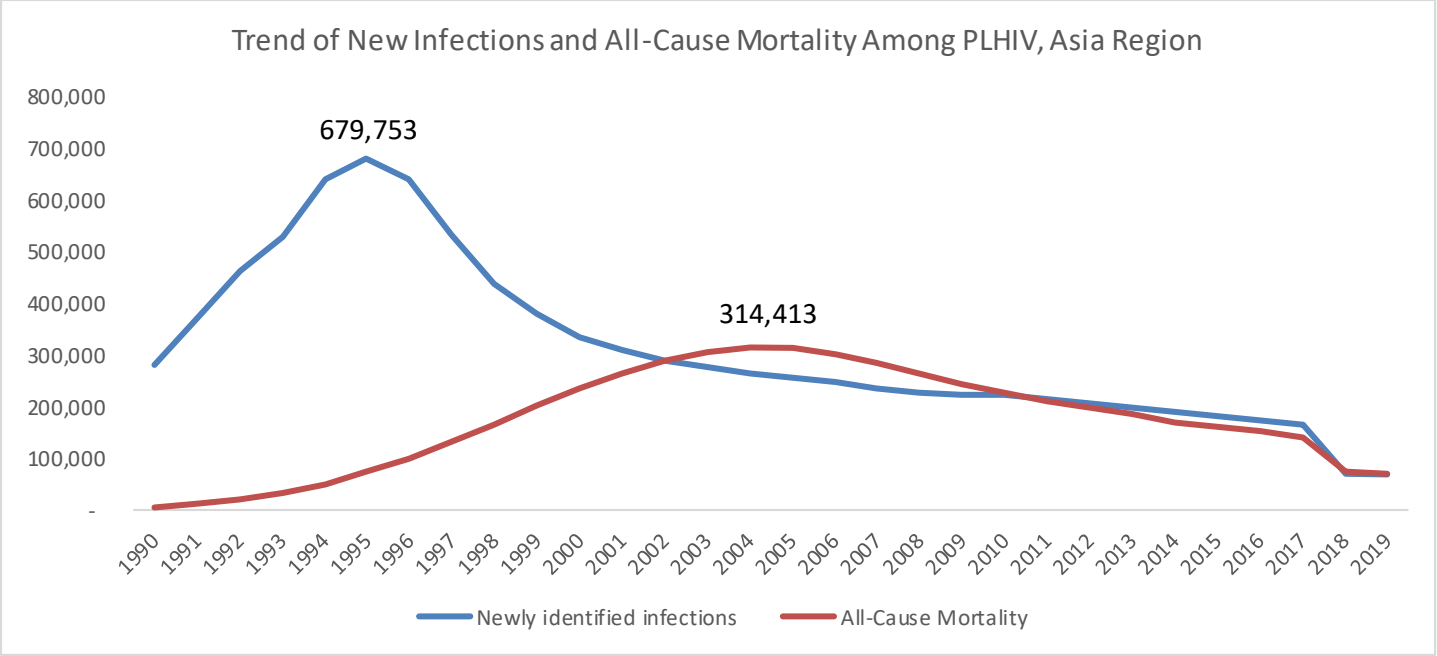
Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression											
	Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Country	Total Pop. Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
		Clients of FSW: NA	-	2528	-	-	-	-	28810	479	-
		Migrants: NA	-	6686	-	5645	-	-	11593	435	-
	Thailand	TGSW: 25,800	-	-	-	-	-	-	-	-	-
		MSW: 18,800	-	-	-	-	-	-	-	-	-
Sources & Notes	***Burma***: 2019 national estimates by AEM; National Strategic Plan on HIV and AIDS (2021-2025); 2019 preliminary national results. ***Cambodia***: Total newly initiated on ART derived from national NCHADS ART Report. Age/sex breakdown for <15, 15-24, and 15+ were obtained by calculating the fine age/sex distribution from the National ART database; Key population testing, positives identified and initiated on ART data based off prevention database. ***India***: UNAIDS Data Hub 2017; National AIDS Control Organization (2018-19). Annual Report; UNAIDS Data Hub 2017; National AIDS Control Organization (2017). Sankalak: Status of National AIDS Response; Integrated Bio Behavioural Survey (IBBS) 2014-15; HIV Estimates Report 2017 Note: ART coverage among TG shows more than 100% due to the methodology of estimating TG on ART and the TG PLHIV diagnosed. Triangulation with program data will be undertaken to reconcile this saturation. ***Indonesia***: Indonesia Bureau of Statistics, MOH, Quarterly Report December 2019; 2016 PSE; VL load data is not disaggregated by age/sex; ^^Total represents Men 15-24 years and Men 25+ years; ##Total represents Women 15-24 years and Women 25+ years; No national data for VL testing and suppression. ***Kazakhstan***: National Statistics Agency, As of Jan 01, 2019; EHCMS; UNAIDS for IBBS and PSE. ***Kyrgyz Republic:*** National Statistics Agency, As of Jan 01, 2019; EHCMS; IBBS RAC Report 2016. ***Lao PDR: No sources listed.*** ***Nepal:*** National HIV estimates 2018, National Routine Program Report, 2019. ***PNG:*** Spectrum Estimations, HIV Patient Database (HPDB), and HIV Surveillance Database. ***Tajikistan:*** National Statistics Agency, As of Jan 01, 2019; EHCMS; PSE 2018; IBBS, 2018. ***Thailand***: AIDS Epidemic Model (AEM, April 2019) and National AIDS Program Report (NAP, October 2019, HIV tested, HIV, positive and ART initiation in year 2019) and ARV dispensing from GPO; All newly initiated ART included prior diagnosed in past years and newly positive diagnosis in year 2019 who initiated ART in 2019.										

Figure 2.1.3 displays the combined national and PEPFAR trend for individuals currently on treatment throughout the Asia Region (please see country specific figure 2.1.3 in Appendix 1).



Note: Data for Cambodia and Nepal only represent national data (no PEPFAR site-level work in country in Cambodia, and Nepal just started reporting PEPFAR data in 2019); PEPFAR data for Indonesia only represents DKI Jakarta.

Figure 2.1.4 Trend of New Infections and All-Cause Mortality Among PLHIV, Asia Region
(please see country specific figures 2.1.4 in Appendix 1)



2.2 New Activities and Areas of Focus for ROP20, Including Focus on Client Retention

The following section describes **new** activities and focus on treatment program growth and retention of all clients over time (TX_CURR over time), and in relation to treatment initiation (TX_NEW), program loss (TX_ML), and program return to treatment (TX_RTT).

Tier 1: Sustain the Gains

Burma, Cambodia, Kyrgyz Republic, Nepal, Tajikistan, and **Thailand** PEPFAR teams will work aggressively to achieve and sustain UNAIDS 95-95-95 goals[2] among KP groups in priority locations, closing the remaining gaps towards epidemic control. Country teams will continue to support high-impact interventions targeting gaps in the prevention and treatment cascades, while also reaching into high-risk networks to ensure appropriate prevention, testing, and treatment measures are in place to achieve VL suppression. All countries will scale up best practices, including client-centered approaches implementing and expanding MMD, TLD transition, and TPT. Community involvement in HIV services will be strengthened using KP peer navigators in **Burma;** nurses and community-based workers in **Kyrgyz Republic** and **Tajikistan** to support adherence and improve retention; community volunteers and community ARV dispensing in **Cambodia**; and strengthening PLHIV peer navigators and community monitoring in **Nepal**. The **Kyrgyz Republic** will add social network testing strategies for PWID to expand achieved from index testing. Consolidating gains in continuous quality improvement (CQI) approaches with laboratory, services, and program data will continue, with creation and expansion of monitoring and evaluation (M&E) dashboards, and improved performance metrics and systems for better patient monitoring to reduce program loss and return patients to treatment in **Burma** and **Thailand**.

Tier 2: Accelerate and Achieve

In **Lao PDR and India**, the PEPFAR teams will accelerate country-level goals and effective programs. Activities will focus on the highest burden and prevalence geographies. Both countries will increase efforts for case finding of hard-to-reach KPs and improve client experience and treatment outcomes to increase retention rates and reduce loss to follow up (LTFU). Working in concert with host governments and stakeholders such as GF, WHO, UNAIDS, civil society, **India** and **Lao PDR** will scale up quality, client-centered treatment options to impact adherence and retention, which comprise facility and community-based strategies for service delivery, including MMD and TLD transition.

[2] In ROP19, accelerate countries aimed to achieve 90-90-90 by end of FY20. In ROP20 they will continue to saturate to reach 95-95-95.

Tier 3: Maintenance/Protect the Investment:

In **Indonesia, Kazakhstan, and Papua New Guinea,** PEPFAR teams will focus on activities that support PLHIV currently on ART while continuing to support policies and practices to ensure ART beneficiaries achieve and maintain VL suppression, with phased transition to a data-informed, sustainable government- and civil society-led response. TA will be provided to **Kazakhstan**, a government that finances the majority of its HIV health investments, to support social health contracting. Each country will focus on influencing the political climate to address policies and programming that ensure that the most at-risk populations are reached with the most effective prevention and treatment interventions. In **Indonesia and Papua New Guinea**, PEPFAR teams will focus on accelerating ART coverage in Jakarta and Port Moresby, respectively, and providing comprehensive, HIV/AIDS prevention, care, and treatment services at all PEPFAR sites--while assisting the MOH in its roll out of the PEPFAR MPRs, including a full transition to TLD. Central to this focus will be timely review of data at site level to effectively monitor the cascade to address patient LTFU and retention issues. In **Indonesia**, the team will work to improve data quality and use at service delivery sites and strengthen partnerships with civil society to improve client retention and monitor program performance. **Kazakhstan** will work to address policy-related barriers that continue to impede initiation on treatment and to prioritize rapid test and start. The team will also focus on the SUPPORT4HEALTH nurse-led activities to support adherence and retention, which will result in increased VL suppression. Kazakhstan will continue to address the shortage of ARVs through supply chain activities and TA to access TLD at a lower price.

In the **Philippines**, the interagency program will build on the existing USG global health platforms focused on key HIV prevention and treatment service delivery gaps in public and community sites as well as above-site work on supply chain systems gaps, policies, and sustainability. Implementing partners will work above site on laboratory, viral load, data systems, and analysis and support of service delivery in other high-burden regions outside of Luzon, including Regions 6 and 11, where Cebu and Davao are located. The program will support above-site activities focusing on treatment quality improvement/quality assurance and will expand military capacity to respond to HIV. Additional information on the current status of the MPRs for the Philippines is included in Appendix D.

2.3 Investment Profile

Investment data for the region has many gaps. The most complete data exist for clinical care, treatment, and support, with all countries reporting. Among the 11 ARP countries, host government contribution to the HIV response in this program area exceeds 70% in **India, Indonesia, Kazakhstan**, and **Thailand**. For **Burma, Cambodia, Kyrgyz Republic, Nepal** and **PNG**, GF was the largest funding source; "Other," followed by PEPFAR, was the largest for **Tajikistan**. Private sector resources make up the remaining source of funds for most countries, including the Elton John Foundation, AIDS Healthcare Foundation, and others. Of note, given that these are concentrated epidemics, PEPFAR and GF combined funds support many of the HIV testing services (HTS), priority prevention, and key population activities.

Table 2.3.1 Annual Investment Profile by Program Area

Table 2.3.1 Annual Investment Profile by Program Area						
Program Area	**Country**	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Clinical care, treatment and support	Burma	$36,091,324	3%	54%	40%	5%
	Cambodia	$12,379,018	1%	54%	40%	5%
	India	$500,000,000* (Not disaggregated by Program Area)	3%	10%	87%	-
	Indonesia	$26,817,292	4.3%	22.1%	73.6%	-
	Kazakhstan	$19,069,267	3.5%	0.6%	95.9%	-
	Kyrgyz Republic	$2,991,646	1.1%	61.3%	33.1%	5.0%
	Lao PDR	$260,642	47%	-	53%	-

	Nepal	$11,416,834	3%	89%	6%	2%
	PNG	$7,634,012	24.4%	44.2%	31.4%	-
	Tajikistan	$1,364,275	34.6%	25%	4.6%	35.8%
	Thailand	$175,509,453	0.75%	1.12%	98.13%	-
Community-based care, treatment, and support	Burma	$1,209,149	78%	22%	-	-
	Cambodia	$3,138,085	-	96%	-	4%
	Indonesia	$4,723,109	16.3%	83.7%	-	-
	Kazakhstan	$3,680,797	11.1%	1.2%	87.7%	-
	Kyrgyz Republic	$4,477,226	50.6%	49.4%	-	-
	Lao PDR	-	-	-	-	-
	Nepal	-	-	-	-	-
	PNG	-	-	-	-	-
	Tajikistan	$1,060,624	81.1%	17%	1.9%	-
	Thailand	-	-	-	-	-
PMTCT	Burma	$376,557	-	11%	-	89%
	Thailand	$3,218,723	0.11%	-	99.69%	0.19%
HTS	Burma	$2,086,565	55%	35%	-	10%
	Cambodia	$2,172,275	58%	27%	2%	12%
	Indonesia	$14,197,276	17.8%	16.3%	81.9%	-
	Kazakhstan	$3,118,872	18.9%	-	81.1%	-
	Kyrgyz Republic	$2,275,048.00	67.2%	8.9%	23.9%	-
	Lao PDR	-	-	-	-	-
	Nepal (incl. HIV prev. among KP & PP)	$17,802,301	12%	59%	11%	18%
	PNG					
	Tajikistan	$1,914,110	56.9%	43.1%	0%	0%
	Thailand					
Priority Populations	Burma	$486,361	-	100%	-	-
	Cambodia	-	-	-	-	-
	Indonesia	$18,250,987	-	44.1%	55.9%	-
	Kazakhstan	$12,373	-	-	100%	-
	Kyrgyz Republic	$308,745.00	-	49.7%	0.4%	49.9%
	Lao PDR	$869,076	25.4%	52.2%	22.4%	N/A
	Nepal	-	-	-	-	-
	PNG	-	-	-	-	-
	Tajikistan	$487,027		53.5%	46.5%	
	Thailand	$20,583,728	1.95%	4.18%	93.64%	0.24%
Key population prevention	Burma	22,872,394	12%	53%	4%	30%
	Cambodia	$1,490,936	27%	33%	3%	37%
	Indonesia	-	-	-	-	-
	Kazakhstan	$1,656,955	15.1%	55.1%	29.8%	-
	Kyrgyz Republic	$4,743,240.00	11.7%	70.1%	6.2%	12.0%
	Lao PDR	-	-	-	-	-
	Nepal	-	-	-	-	-
	PNG	$3,519,897	-	39.0%	60.2%	0.8%
	Tajikistan	$1,569,876	21.2%	77.4%	1.4%	0%
	Thailand	$13,004,616	24.35$	26.19%	49.13%	0.34%

OVC	Cambodia	$233,117	-	-	-	-
	Kazakhstan	$752,488	-	-	100%	-
	Nepal	288,078	-	100%	-	-
	Tajikistan	$8,680	-	100%	-	-
Laboratory	Burma	$1,303,700	17%	81%	-	2%
	Cambodia	$1,771,042	21%	77%	-	2%
	Indonesia	$1,940,872	14.1%	85.9%	-	-
	Kazakhstan	$1,269,331	3.4%	-	96.6%	-
	Kyrgyz Republic	$871,225.00	38.4%	60.5%	1.1%	-
	Lao PDR	-	-	-	-	-
	Nepal	-	-	-	-	-
	PNG	-	-	-	-	-
	Tajikistan	$354,924	100%	-	-	-
	Thailand	-	-	-	-	-
SI, Surveys and Surveillance	Burma	$2,092,496	17%	78%	-	4%
	Cambodia	$2,838,271	36%	16%	41%	6%
	Indonesia	$3,732,512	6.8%	22.6%	70.6%	-
	Kazakhstan	$2,408,768	5.8%	-	94.2%	-
	Kyrgyz Republic	$476,946	50.2%	13.1%	7.2%	29.6%
	Lao PDR	-	-	-	-	-
	Nepal	$508,423	3%	66%	31%	-
	PNG	$784,583	27.8%	72.2%	-	-
	Tajikistan	$473,778	16.3%	25.6%	58.1%	-
	Thailand	$4,623,835	19.24%	19.86%	59.97%	0.92%
HSS	Burma	$14,754,192	11%	89%	-	-
	Cambodia	$6,450,900	29%	1%	53%	17%
	Indonesia	1,065,933	100%	-	-	-
	Kazakhstan	$2,760,084	11.3%	5.2%	83.5%	-
	Kyrgyz Republic	$1,524,639	35.0%	-	38.2%	26.8%
	Lao PDR	$521,013	7%	41%	52%	-
	Nepal	$2,686,960	73%	24%	-	3%
	PNG	$5,370,403	20.7%	13.0%	18.9%	22.8%
	Tajikistan	$2,035,386	14.7%	68.2%	14.7%	2.4%
	Thailand	$15,351,107	54.76	25.97	18.98	0.29
Other	Thailand*	$16,572,829	4.28%	0.11%	95.29%	0.33%
Total	**All Countries**	**$1,044,667,206**	-	-	-	-

Sources: GRP, National AIDS Spending Assessment, 2012, all amounts in 2012 USD

NOTE: Percentages cannot be provided in total since not all countries have full breakout of program data.

Burma: PEPFAR FY2019 Expenditure Report and Funding landscape analysis for GF concept note.

Cambodia: 2019 expenditure report; GF: 2018 S/GAC resource alignment tool; Other: National AIDS Spending Assessment (NASA) 2017; Host Country: NASA 2017, adjustments for 2019 include ARVs increased from $831,209 to $1.5million and $743,000 to HIV sentinel surveillance (HSS) for additional HRH support.

India: India has no disaggregated program area data available; totals are included in the Regional Total. The GOI budget includes a loan from the WB.

Indonesia: 2016 NASA, in consultation with UNAIDS; GF confirmation from country team; PEPFAR 2019 Expenditure Reporting.

Kyrgyz Republic: National AIDS Center consolidated expenditure report 2018 with updated numbers for 2019.

Lao PDR: Consolidated expenditure report 2018.

Nepal: National AIDS Spending Assessment (NASA) 2016-2017, all amounts in USD. This is the latest NASA and next round of NASA is planned for 2020-2021.

PNG: *PEPFAR 2019 ER, DFAT HIV Spending Data and NDOH 2019 STI/HIV Financial Report.*

Thailand: Others include: Gender program, program for children & adolescents, social protection and community mobilization; Exchange rate: 33.9 THB/USD, World Bank 2017: http://wdi.worldbank.org/table/4.16; National AIDS Expenditure Report 2016-2017, updated by 18 July 2018.

Table 2.3.2 Annual Procurement Profile for Key Commodities in Asia Region

As above, annual procurement data for the region also has many gaps. ARVs continue to be a main cost driver for HIV spending in the region. GF supports procurement of many categories of commodities across the region, and several countries (**Burma, Cambodia, Kyrgyz Republic, Lao PDR, Nepal, PNG,** and **Tajikistan**) are heavily reliant upon their contribution. Host government contribution to ARV procurement exceeds 80% in **Indonesia, Kazakhstan**, and **Thailand**. For **Cambodia, Kyrgyz Republic, Lao PDR, Nepal, PNG**, and **Tajikistan**, GF procures over 50% of ARVs. PEPFAR contributes more than 25% of rapid test kits in **Thailand** and 100% of lab reagents in Kazakhstan. Full transition to TLD will reduce total expenditure in each country.

Table 2.3.2 Annual Procurement Profile for Key Commodities*						
Commodity Category	Country	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	Burma	$21,706,158	-	36%	64%	-
	Cambodia	$6,775,691	-	78%	22%	-
	India*	Unknown	-	50%	50%	-
	Indonesia	40,835,282	-	11%	89%	-
	Kazakhstan	$15,099,000	-	-	100%	-
	Kyrgyz Republic	$941,403.00	-	54.3%	46.0%	-
	Lao PDR	$919,074	0%	100%	0%	0%
	Nepal	$670,3490	-	100%	-	-
	PNG	$20,000,000	1.2%	58.8%	40%	-
	Tajikistan	$673,145	-	100%	-	-
	Thailand	$118,525,734	0.42%	0.86%	98.71%	-
Rapid test kits	Burma	$386,723	-	100%	-	
	Cambodia	$1,528,683	-	100%	-	-
	India	Unknown	-	100%	-	-
	Indonesia	9,154,130	-	-	100%	-
	Kazakhstan	$157,000	-	-	100%	-
	Kyrgyz Republic	$683,756	6.9%	29.8%	63.4%	-
	Lao PDR	$185,392	14%	86%	0%	0%
	Nepal	$2,011,377	-	100%	-	-
	Tajikistan	$270,765	-	100%	-	-
	Thailand	$6,011,778	26.9%	3.36%	69.63%	0.11%
Other drugs	Burma	$1,940,366	-	100%	-	-
	Cambodia	$100,757	-	100%	-	-
	Indonesia	Unknown	-	-	100%	-
	Kazakhstan	$242,000	-	-	100%	-
	Kyrgyz Republic	$4,979	100.0%	-	-	-
	Lao PDR	$93,831	0%	100%	0%	0%
	Nepal	$397,382	-	33%	-	66%
	Tajikistan	$165,595	-	49.7%	50.3%	-
	Thailand	$2,127,189	0.15%	-	99.85%	-
Lab reagents	Burma	$900,787	-	100%	-	-
	Cambodia	$210,991	-	100%	-	-
	Indonesia	Unknown	-	-	100%	-
	Kazakhstan	$4,678,000	1%	-	99%	-
	Kyrgyz Republic	-	-	-	-	-
	Lao PDR	-	-	-	-	-
	PNG	$2,2882	-	100%	-	-
	Tajikistan	$40,471	-	100%	-	-
	Thailand	$47,121,711	1.42%	-	98.58%	-
Condoms	Burma	$979,246	62%	38%	-	-
	Cambodia	$163,719	-	100%	-	-
	India	Unknown	-	100%	-	-
	Indonesia	Unknown	-	100%	-	-
	Kazakhstan	$631,000	-	-	100%	-
	Kyrgyz Republic	$490,633	-	95.9%	-	4.1%

	Lao PDR	-	-	-	-	-
	Thailand	$1,084,654	-	10.45%	89.55%	-
VL commodities	Burma	$759,787	-	100%	-	-
	Cambodia	$2,157,600	3%	97%	-	-
	Indonesia	$1,700,000	-	10%	90%	-
	Kazakhstan	$659,000	-	-	100%	-
	Kyrgyz Republic	$597,023.00	-	100.0%	-	-
	Lao PDR	-	-	-	-	-
	PNG	$7,900,000	15%	42%	43%	-
	Tajikistan	$428,413	19.7%	80.3%	-	-
MAT	Burma	$1,000,000	-	-	100%	-
	Indonesia	Unknown	-	-	100%	-
	Kazakhstan	$25,000	-	100%	-	-
	Kyrgyz Republic	$164,013	-	100.0%	-	-
	Lao PDR	-	-	-	-	-
	Thailand	$982,301	-	-	100%	-
Other commodities	Burma (Health Equip.)	$2,727,487	-	100%	-	-
	Cambodia	$26,864	100%	-	-	-
	India	Unknown	-	100%	-	-
	Indonesia	Unknown	-	-	100%	-
	Kazakhstan	$633,000	2%	-	98%	-
	Tajikistan	$33,815	0%	100%	0%	0%
	Thailand	$78,776	-	100%	-	-
Total	All Countries	$333,837,853	-	-	-	-

Sources & Notes:

Note: Percentage totals cannot be provided since data are incomplete for all commodities/countries.

India*: Expectation is that GOI is procuring 50% of ARVs, and GF is procuring the remaining 50% per previous arrangements. GF is also expected to procure 100% of test kits, condoms, and other commodities, but proportion and total expenditures are unpublished; total expenditure for India is $500 million, inclusive of the program areas in Table 2.3.1.

Lao PDR: consolidated expenditure report 2018, it was reported that government of Lao PDR procures 10% of ARV drugs, condoms and test kits in 2019, but expenditure report is not yet available.

Nepal: National AIDS Spending Assessment (NASA) 2016-2017, all amounts in USD. This is the latest NASA and next round of NASA is planned for 2020-2021.

Other commodities ~~include:~~ Kazakhstan--self-testing kits and other RTKs; Tajikistan--recency assays, self-test kits, other RTKs; India--LA assays, recency, cryptococcal antigen.

Lao PDR, Thailand, PNG, Cambodia, and **Indonesia** had no commodities indicated in their FAST.

The annual U.S. Government (USG) non-PEPFAR-funded investments and integration is presented by country in Table 2.3.3, located in Appendix 1.

2.4 National Sustainability Profile Update

The following countries conducted Sustainability Index Dashboards (SIDs) in the Fall of 2019: **Burma, Cambodia, India, Indonesia, Kazakhstan, Lao PDR, PNG**, and **Thailand**.

Burma: In SID2019, 4 elements were found to be "sustained"; no SID elements were deemed "unsustainable.". In light of the 13 SID elements with "emerging sustainability," in ROP20, PEPFAR Burma will address critical gaps--finding missing cases, improving linkages and retention, and achieving the third 90--by leveraging KP-led outreach interventions, establishing community-led monitoring, strengthening supply chains for HIV commodities to deliver 6 months for MMD and TLD, and access VL testing services with scale and fidelity.

Cambodia continues to demonstrate the sustainability of its programs. Planning and coordination scores have been among the highest for all 3 SIDs because of strong partner coordination and sub-national unit accountability. The technical and allocative efficiencies element has been consistently high. Commodity security and supply chain, service delivery, resource mobilization, civil society, and private sector engagement scores were low. In ROP20, PEPFAR will continue to support domestic resource mobilization. GF

and PEPFAR will use funds that previously supported commodities to build the capacity of civil society organizations (CSOs) to provide services to KPs.

India continues to make progress toward greater sustainability, trending towards higher scores in each domain since 2017. Strengths included improvements in private sector engagement, human resources for health (HRH), quality management, and domestic resource mobilization. Areas of focus continue to be on commodity security, supply chain, and data for decision making.

Indonesia identified 3 main sustainability vulnerabilities–planning and coordination, service delivery, and HRH—while commodity security and supply chain experienced a decreased score. In ROP20, PEPFAR Indonesia will support national efforts to increase treatment coverage and to support GF and the MoH in the national roll out of TLD, supporting national planning, procurement and quantification efforts to ensure that TLD is available for all treatment naive patients in PEPFAR and GF sites.

In **Kazakhstan**, private sector engagement and human resources for health, which were vulnerabilities in 2017, improved in 2019. In ROP20, national health reform efforts will permit shifts to allow more space for the private sector to deliver HIV/AIDS services. There are noticeable reductions in the level of stigma and discrimination against KP by health care workers. The MoH made an investment case for increasing the HIV services diagnosis and treatment provided through the Mandatory Health Insurance Fund.

In **Lao PDR,** PEPFAR and UNAIDS co-convened the 2019 SID workshop with participation of the Center for HIV and AIDS and sexually-transmitted infections (STI) (CHAS), the National Center of Laboratory and Epidemiology (NCLE), World Health Organization (WHO), World Bank (WB), GF, PEPFAR, Laos Positive Health Association (LAOPHA), Association of People Living with HIV/AIDS (APL), and other key stakeholders. All elements were either "sustained" or "emerging." In ROP20, PEPFAR Lao PDR will continue to provide capacity building for scaling up VL testing and rolling out HIV external quality assurance (EQA), including the expansion of differentiated care (MMS, transition to TLD, Test and Start, and PrEP for KPs).

PNG continues to show progress in planning and coordination, market openness, policy and governance, public access to information, quality management, epidemiological and health data, and performance data. Civil society and private sector engagement and data for decision making ecosystem remain as vulnerabilities from previous SIDS. Unfortunately, severe government shortfalls in income have drastically reduced the National Department of Health (NDoH) budget, which has been compounded by expenses incurred during the hosting of the 2018 Asia Pacific Economic Cooperation event. In ROP20, PNG will partner with the GF to improve health systems in support of the cascade. With the GF, the team plans to address critical gaps in VL coverage barriers such as specimen transport and LTFU.

For **Thailand**, of 17 elements evaluated, 15 were "sustained," with private sector engagement and quality management scored as "emerging." Areas of further improvement include: effectiveness of planning and coordination, CSO participation, National Health Security Office (NHSO) timely support of local CSOs, institutionalized HRH, quality management at provincial level, accurate population size estimates, VL results, and HIV-related mortality data.

2.5 Alignment of PEPFAR investments geographically to disease burden

In all 11 ARP countries, PEPFAR investments are aligned to the disease burden geographically. Please refer to figures 2.5.1 in Appendix 1, which presents maps by country program.

In **Burma,** townships are categorized into high and low priority based on the population size estimates (PSE), HIV prevalence among KPs and other priority populations (PPs), and other quality factors influencing the size and risk behaviors. With this geographic township prioritization criteria, out of 330 townships, 167 are classified as high priority areas, and 90% of FSW, 80% of MSM, and 89% of PWID are located there. Among high priority townships, 113 (68%) are in the 5 high-burden states/regions (Yangon, Mandalay, Kachin, Shan [North] and Sagaing) where PEPFAR invests.

In **Cambodia**, PEPFAR-supported provinces (Phnom Penh, Battambang, Banteay Meanchey, and Siem Reap) account for more than 60% of PLHIV in the country. PEPFAR has provided technical and managerial support to the National HIV/AIDS, Dermatology, and STD Center (NCHADS), MOH, to implement high-quality HIV services for PLHIV. HIV prevalence among MSM is 6.1% in Phnom Penh and 6.9% in Siem Reap. The prevalence among TG is 14% in Phnom Penh and 16.4% in Siem Reap (IBBS, 2019). PEPFAR has worked with NCHADS and partners to implement PrEP in the 4 high-burden provinces. The lessons learned from PEPFAR-supported provinces have been used to roll out GF-supported activities in other provinces; for example, micro-targeted PrEP, which started among the PEPFAR-supported provinces, will be expanded to 7 more PrEP sites in 2020 with financial support from GF.

In **India,** HIV prevalence is concentrated among key and vulnerable populations, and PEPFAR will develop and implement life-saving interventions in the 38 most populous districts of 5 states with the highest HIV burden, prevalence, or HIV incidence, focused on prevention among KPs and treatment, retention and viral load suppression (VLS) among all PLHIV. The current districts are in Maharashtra (MH), Andhra Pradesh (AP), and the North East (NE) states of Mizoram, Manipur, and Nagaland. In the latter half of ROP2019, with incentive funds, PEPFAR India was able to expand to Telangana state and an additional 10 districts in AP.

In **Indonesia**, HIV prevalence is concentrated among key affected populations. PEPFAR prioritizes in DKI Jakarta an estimated 16.6% (106,194/640,443) of the national estimated number of PLHIV. For ROP20, Indonesia, as a "protecting the investment country," will focus on index testing and strengthening retention. With incentive funds (ASAP), Indonesia aims to have 39,030 PLHIV on ART for DKI Jakarta.

In **Kazakhstan**, the 2 sub-national units (SNUs) PEPFAR supports account for 20% of PLHIV PSE in Kazakhstan. These SNUs also include a significant number of PWID. The current PEPFAR-supported program implements targeted KP-focused activities in these 2 SNUs (Pavlodar and East Kazakhstan). Key areas of focus for ROP20 in these SNUs is a continued push for improved case finding, rapid ART initiation, and intensive support for ART adherence amount KP populations.

In the **Kyrgyz Republic,** the HIV burden is concentrated in 4 SNUs where PEPFAR works, which account for 81% of all PLHIV. The current PEPFAR-supported program implements targeted KP-focused activities in these 4 SNUs (Bishkek, Chui oblast, Osh city, and Osh oblast). PEPFAR case finding contributed to half of the new HIV cases found in FY19. Due to robust PEPFAR advocacy, the country acknowledges successful PEPFAR models that resulted in including the entire HIV cascade and results-based financing in the new GF application to replicate nationally. Chui oblast will require the greatest assistance across the HIV cascade.

Lao PDR will provide support to 7 sites in 5 provinces, including 5 sites in the 3 highest burden provinces, accounting for 68% of all PLHIV and 61% of HIV+ MSM/TG. In addition, PEPFAR will also support 2 sites in the North, along the China-Laos high speed train project; data from the International Migration Organization indicate that these sites may experience an increase in HIV infections.

In ROP20, PEPFAR **Nepal** will support 19 existing districts with a full package of HIV prevention, care, treatment, and VL testing services. In addition, the program will provide TA to an additional 16 districts, or 35 districts total, through direct service delivery (DSD) or TA-SDI. Additionally, the program will focus on reducing LTFU and increasing retention across the cascade as part of efforts to accelerate the number of PLHIV in treatment.

In **PNG**, PEPFAR supports 1 SNU (NCD), which accounts for 13% of PLHIV in PNG and over 16% of PLHIV on ART in country. This is the highest burden province in PNG and has the highest HIV prevalence amongst KP groups of all 3 cities included in the 2017 IBBS. Key activities in this SNU will focus on operationalizing safe index testing, improving retention through enhanced outreach approaches, MMD and differentiated service delivery models (DSDMs), and expanding VL testing on/near point of care (POC) platforms. PEPFAR anticipates achieving saturation in the NCD in ROP20, allowing for successful strategies to be adopted by the GF and the national program for similar success in other high-burden SNUs around the country.

In **Tajikistan**, the HIV burden is concentrated in 4 out of 5 SNUs. PEPFAR works in Dushanbe, Districts of Republican Subordination, and Sughd SNUs that account for 69% of the total estimated number of PLHIV

and for 63% of the total estimated number of KPs in the country, including PWID, SWs, and MSM. The current PEPFAR-supported program implements targeted KP-focused activities in these 3 oblasts. In ROP19, with PEPFAR support, the number of PLHIV receiving treatment increased by 28% in PEPFAR-supported SNUs and further closed the gaps towards the 90-90-90. Dushanbe SNU will require the greatest amount of work, as this SNU has the highest estimated number of PLHIV and highest number of LTFU as well as those who had been diagnosed with HIV but never were linked to care.

Thailand has a concentrated HIV epidemic among MSM, comprising approximately 47.8% of total new HIV infections (SPECTRUM AEM 2019). In coordination with RTG and GF, PEPFAR continues to focus its investment in 13 (of a total 77) highest-burden provinces, in which 54.7% of all new HIV-infections occur, and where 55.3% of new MSM and TG infections will occur. Projected ART coverage in FY2020 indicates the following PEPFAR categorizations: 2 of the 13 provinces are attained, 5 are sustained, and 6 are scale up. Targeted interventions include PrEP expansion among most-at-risk MSM and TG in 12 provinces, increased focus on Online2Offline case finding, linkage to sDART, ensuring access to VL testing and suppression, and improved retention and data quality.

2.6 Stakeholder Engagement

Country Level: Across the 11 countries in the ARP, the development of ROP20 was a participatory process which included consultation with all the key stakeholders of the HIV national response. Collaboration with community groups, CSOs, and clients/service users helped stakeholders diagnose and pinpoint persistent problems, challenges, and barriers with service uptake and client outcomes at the site level. Between January and February 2020, each country held events attended by a range of key stakeholders, including MOH, CSOs, GF, UNAIDS, WHO, WB, and the private sector. The teams reviewed progress, activities, and complementarity across all development partners. PEPFAR teams discussed in detail the development of ROP20 plans, to ensure alignment and inclusive planning, and to obtain preliminary commitments of others to ambitious PEPFAR targets and goals. Across the region, each country's strong engagement continued, and team received broad-based support and input on key factors affecting the long-term sustainability of the national program.

Regional Level: In January 2020, PEPFAR ARP also hosted a separate stakeholder meeting that brought together CSOs, UNAIDS, and GF to discuss the unique needs across the region. Areas discussed included: (1) the ongoing challenges in delivering dynamic programs with limited funding and staffing footprint; (2) the different stage each country is at in addressing the epidemic and sharing lessons learned across the region; and (3) how the USG could partner more deliberately with civil society, government structures, and multilateral agencies to address needs. The event was co-hosted by UNAIDS, and a significant amount of time was given to strengthening partnerships with regional civil society networks. In addition, CSO representatives from each country actively participated at the meeting, and these representatives will continue to play a key role, including scaling up CSO-led community-based monitoring of the HIV response.

Global Fund and UNAIDS: PEPFAR country teams are fully engaged in completing the next round of GF applications. Additional coordination is occurring with UNAIDS at the country level, as well as regionally, including joint planning between GF and PEPFAR to ensure complementarity and avoid duplication of activities. PEPFAR, GF, and UNAIDS have united around the data and a common understanding of key population epidemics and the interventions to control them. Together, the 3 entities have a shared assessment of the current regional HIV situation and trends and are prioritizing recommendations for action. Also, they are partnering to monitor progress, leveraging their comparative advantage, and when needed, expressing joint concerns for course correction. Equally important, PEPFAR, UNAIDS, and the GF have agreed to convey similar messaging to government policy- and decision-makers.

3.0 Geographic and Population Prioritization

Across the 10 countries with site-level activities, PEPFAR will support 142 SNUs, of which 6 are "attained"; 5 are "scale up to saturation"; 119 are "aggressive scale up"; and 12 are "sustained." **Cambodia** provides central support only to 25 SNUs. With Telangana and the 10 new districts in AP under ROP19 ASAP, **India** will support 38 districts; of these, 4 are "attained"; 2 are "scale up to saturation"; and 32 are "aggressive scale up."

Table 3.1 Current Status of ART saturation by Country

	Table 3.1.1 Current Status of ART saturation				
Prioritization Area	**Country**	**Total PLHIV/% of all PLHIV for ROP20**	**# Current on ART (FY19)**	**# of SNU ROP19 (FY20)**	**# of SNU ROP20 (FY21)**
Attained	India	114,929	77,114	4	4
	Thailand	16,881	16,009**	0	2
Scale-up Saturation	India	27,575	23,938	2	2
	PNG	6412	4280	0	1
	Thailand	28,354	22,855**	0	2
Scale-up Aggressive	Burma	N/A*	8376	38	36++
	India	411,657	91,149	17	32
	Kyrgyz Republic	6686	2671	4	4
	Lao PDR	8,467	6,677	0	5
	Nepal	29,944	14,938**	19	35
	Tajikistan	8,254	3,579	3	3
	Thailand	117,498	74,450**	4	4
Sustained	Indonesia	106,194	24,686**	5	5
	Kazakhstan	6213	3419	2	2
	Thailand	55,540	54,375**	0	5
Central Support	Cambodia	72,148	61,193	25	25
Total		1,010,666	282,396	123	167

**No Township (prioritized SNU) level data are available.*
***Includes national contribution.*
++2 SNUs that only provide HTS services are excluded.

The current status of ART saturation, by country and SNU (Figure B.1.1) is presented in Appendix B.

4.0 Client-Centered Program Activities for Epidemic Control

4.1 Finding the missing and getting them on treatment

All 11 countries will focus on differentiated case finding strategies for KPs, primarily through the scale up of index partner testing and their partners, accompanied by social network strategies (SNS) with immediate ART initiation facilitated by peer navigators, community workers, case managers, nurses, and others--depending on country and local context. With a focus on provider training in intimate partner violence (IPV) screening, the 5 Cs (consent, confidentiality, counseling, correct test results, and connections to care, treatment and prevention services), adverse event monitoring, and ethics (respect for client rights, informed consent, and do no harm), PEPFAR programs are working to establish monitoring approaches to ensure consent procedures and confidentiality are protected, and assessment of IPV is incorporated into the testing modalities. Monitoring systems will be strengthened through improvements and integration of M&E systems, including developing One national HIV information system with unique identifier codes (UIC) (**Nepal),** tracking linkage to care (**Burma**), integrating index testing performance indicators into the updated version of the national HIV information system, and promoting the systematic use of unique identification codes for continuous quality improvement and responsive course correction throughout the program period (**Indonesia**). The military program in **Indonesia** will continue to increase the number of military health facilities providing treatment and predominantly focus on scaling up VL coverage. Where client elicitation has been challenging among KP (MSM, FSW, and TG women), PEPFAR **India** will increase training for social network models/enhanced peer outreach approach (EPOA)-focused strategies. PEPFAR will scale up assisted self-testing and virtual outreach for clients seeking anonymity.

All countries are meeting with partners regularly and taking advantage of newly-implemented mechanisms such as high-frequency reporting (HFR). For example, **Kyrgyz Republic** established weekly/monthly targets with implementing partners (IPs) to accelerate activities. PEPFAR **Indonesia** will meet with IPs on a weekly basis to ensure alignment with PEPFAR program strategy and to promote a continual quality improvement focus. USAID IPs will report on key clinical cascade indicators on a weekly basis. In **Kazakhstan**, this has helped facilitate ongoing, open dialogue between PEPFAR and partners on site level performance, allowing for any issues that arise to be easily identified and addressed in a timely manner. In **Lao PDR**, sites were trained in the use of the standard reports for self-monitoring in real time, as well as use of HIV Complementary and Alternative Medicine/District health information software (HIVCAM/DHIS) data and output for program improvement. A standard coaching form will be developed, and coaching will be conducted at sites with poor performance; in addition, regular technical meeting with IPs and MoH will be conducted. In **Nepal**, the partner self-monitors performance daily. The partner has a real time, online DHIS2-based data recording and reporting system that allows them to closely track performance.

Innovative, evidence-based solutions are at the forefront of PEPFAR Asia Region programming. **Thailand** is expanding innovative, web-based, respondent-driven sampling for HIV prevalence and incidence surveillance among MSM, transgender women (TGW), and non-venue sex workers (SW). PEPFAR **Indonesia** is using a micro-epidemic control approach for case finding and treatment support efforts in networks with the highest viral burden to optimize the impact of all available resources. **Cambodia** is working to respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them and prevent transmission. Cutting-edge HIV prevention technologies and strategies will allow NCHADS to help local public health officials identify where HIV prevention and treatment services are most urgently needed. Real-time response systems are key to ending the HIV epidemic in **Cambodia**. Not all areas have the resources to identify, investigate, and respond to potential HIV outbreaks. PEPFAR will increase the capacity of the national program to track, monitor, and respond locally. Finally, PEPFAR Cambodia will support the national program to assess and address gaps in staffing, expertise, and data management systems that prevent provinces and local areas from being able to fully investigate and respond to increases in HIV transmission and outbreaks--and to take HIV prevention and treatment resources to where they are needed quickly.

Countries at or close to epidemic control (**Burma, Nepal**) will continue or shift in ROP20 to targeted case finding using index and SNS for the remaining concentrated HIV-positive people in close social network

groups. **Thailand** and **Cambodia** will enhance index and SNS activities with recency testing. **Thailand** and **Nepal** will use online reach to offline testing at convenient and client-friendly service facilities. PEPFAR **Thailand** will move forward with a client-focused transition plan with a shift to above-site support for sites with high performance. PEPFAR **Thailand** will incorporate recency testing into the national public response system and will continue to build capacity of public sector and community-based workers in monitoring and evaluation (M&E) and quality improvement (QI) using site-level data. Starting in July 2019, **Kazakhstan** introduced self-testing through an Elton John Foundation grant to MSM in all regions that will continue in 2020. In October 2019, PEPFAR started self-testing in its SNUs and will continue this activity in 2021.

Countries initiating self-testing in ROP19 (**Cambodia, Kazakhstan, Kyrgyz Republic, Nepal, Tajikistan, Thailand**) will scale up implementation and examine distribution of HIV self-testing (HIVST) through more convenient channels, e.g., online and in pharmacies. **Cambodia** conducted a pilot project on HIVST from December 2018 to September 2019. PEPFAR is working with the national program to update their national guidelines to include HIVST and advocate for GF to procure test kits in ROP19 and support national implementation in ROP20. Linkage strategies for self-testing will be especially important for implementation in ROP20, and 7 countries have proposed ROP20 targets ranging from 116 in **India** to 6,000 in **Nepal**. In **Burma**, national HIV testing service (HTS) guidelines will be amended to incorporate self-testing, and PEPFAR will lead a demonstration of HIV self-testing. **Thailand** plans to start self-testing through pharmacy distribution in May 2020, immediately after receipt of final country ethical committee approval. In ROP20, PEPFAR will continue participant recruitment, conduct data analysis, and provide results to the MOPH for implementation of HIVST through the pharmacy model.

In **Indonesia**, PEPFAR supports the host country government to improve the quality of TB screening and diagnostic evaluation for HIV patients through improved TB Preventive Treatment (TPT) commodity forecasting and drug procurement. PEPFAR and USAID TB resources will promote collaborative TPT forecasting between HIV and TB programs. PEPFAR will work to ensure all PLHIV have access to TPT in Jakarta. TPT for PLHIV is a national policy in **India** since 2017 and is implemented by the National HIV and TB program with 64% coverage across the country. PEPFAR supports improved implementation of TPT.

For case finding among PWID, specifically, **Kyrgyz Republic** and **Tajikistan** will strengthen coordination between AIDS Centers and MAT centers for improved PWID retention; accelerate implementation of co-located MAT-ART; and implement a social network testing strategy among PWID to complement case-finding gains from index testing. **Kyrgyz Republic** will also enhance work in prisons (e.g., Chui) with high numbers of PWID.

Gaps in testing coverage and linkage to care will continue to be addressed through policy changes. In ROP19, in **Kazakhstan**, policy shifts resulted in reducing the wait time for ART initiation from 204 days (2017) to 19 days (2019). MOH standards were introduced to support earlier ART initiation, mandating that this occur within 14 days of diagnosis. In **Lao PDR**, PEPFAR has supported the development of an index testing manual and SOPs, with national-level training, and policy shifts have allowed for the transition of HIVCAM to DHIS2 to improve tracking of PLHIV across the cascade. In ROP20, in **Tajikistan**, PEPFAR will work with the host government, Republican AIDS Center, and key stakeholders to update the national HIV testing algorithm to implement a more rapid confirmation testing process to get PLHIV on ART. In **Burma**, national HTS guidelines will be amended to incorporate self-testing, and PEPFAR will lead a demonstration of HIV self-testing.

All countries plan to meet MPR to increase linkage to treatment to > 95% and sDART. New strategies for linkage include community sensitization on undetectable=untransmittable (U=U) to help find undiagnosed individuals and link them to treatment (**Tajikistan**), and facility performance-based incentives strategically utilized to systematize optimal linkages (**Indonesia**). For immediate ART, **Kyrgyz Republic** will ensure rapid ART initiation, including sDART, via on/off-site clinical mentoring, and QI activities. ART distribution through NGOs/CSOs will be initiated to improve treatment initiation and retention. **Nepal** will implement community-based ART (CBART) services.

4.2 Retaining clients on treatment and ensuring viral suppression

All ARP countries are moving toward full access to VL coverage as well as ensuring 90% VL suppression and 95% retention.

In FY 2019-20, PEPFAR **Burma, Kyrgyz Republic**, **Nepal, Tajikistan, and Thailand** conducted data quality assessments (DQA) to validate the documentation practices of health facilities and their management of patients receiving ART. The PEPFAR teams worked with their counterparts and adjusted programs as a result of the findings, especially to improve retention and LTFU, and are currently in the process of improving data quality as part of CQI and related program activities (e.g., efforts to improve retention) at PEPFAR and at national sites.

Gaps identified in Q1-Q3 PEPFAR Oversight Accountability Response Team (PoART) calls and agency self-assessments were used to improve program performance in ROP19. **Indonesia** took the feedback from the Q3 PoART and is continuing to work on ART acceleration. PEPFAR **Kazakhstan** is providing supply chain management TA to the government to ensure an uninterrupted ARV supply and assist in increasing access to lower-cost TLD/DTG, DTG transition, and 6-MMD transition for KP. **Thailand** is working on improve case-profiling of individuals who are unsuppressed and intensify index testing and referrals of network members to treatment.

ART retention is a key issue in the region. **Nepal** has identified men as failing to enroll in treatment, and overall LTFU is 12% nationally. In PEPFAR districts the majority of LTFU were men and women below 35 years, and the majority of deaths were men and women above 35 years. In **Lao PDR**, the cumulative LTFU from 2003-2019 is 21%: 53% were male, including MSM/TG. MSM/TG were responsible for 11.6% of the total LTFU, and 65% of those 20-29 years old were LTFU. **Burma** has identified PWID and FSW as more likely to be LTFU. In **India**, LTFU occurs among age groups 20-44 years, both men and women, and in the Northeast, **India** is losing young IDU and adolescents. Virtual outreach has helped follow and reduce LTFU for MSM and TG women. The **Kyrgyz Republic, Kazakhstan,** and **Tajikistan** have identified the majority (67%, 62%, and 60%) of LTFU were ≥30 years males, and IDU was one of the main factors of LTFU in **Kazakhstan** and **Kyrgyz Republic**. After an intensive chart review of 20,882 PLHIV at 12 ART clinics in Phnom Penh, **Cambodia** determined that 9.6% were LTFU, and 12.7% of eligible patients did not have a VL test. Of those LTFU, 92% were non-KP; 4% were MSM, 3% were FSW, and 1% were TG. To date, Cambodia has placed 559 back on treatment and 2,652 have been given a VL test. In **Thailand**, the percentage of LTFU among PLHIV was 3.8% and 2.5% after 12 and 24 months of ART, respectively, and the LTFU among MSM was 3.0% and 1.9% after 12 and 24 months of ART, respectively. LTFU did not differ significantly across all ages and genders.

Across the ARP, at PEPFAR-supported sites, countries will: (1) implement same-day ART initiation; (2) utilize peer educators, navigators, health care workers, and case managers to assist and track PLHIV through the clinical cascade; (3) scale up DSD, MMD, TLD, and TPT; (4) set up appointment reminders to clients (via SMS messages and phone calls); and (5) track defaulters through phone calls, home visits, and social networks to increase retention and ensure viral suppression. Burma is implementing several interventions to improve retention, including scaling 6MMD and DSD through mobile services and co-locating ART with MMT. **Burma** is also working to reform the legal environment and advocate to the government for more patient-centered care, including U=U and for community adherence groups. PEPFAR **Thailand** will expand peer navigator support for KP clients for treatment and promote retention and viral suppression through case management, enhanced counseling, MMD, and flexible scheduling for ART follow up, immediate missed appointment tracing community and PLHIV networks, and U=U message promotion. Index testing will also be used to re-engage patients back to treatment. In **Indonesia**, monthly LTFU and missed appointment lists are shared with members of facilities and community "rapid response" teams that meet regularly to provide navigation support. To enhance ART retention PEPFAR **Indonesia** will implement robust tracking of missed appointment and LTFU ART clients; intensified site-level clinical mentoring; and re-engagement of LTFU and missed appointment ART clients through formal partnerships of facility- and community-based implementers at site level.

Site-level activities are supported by recent policy changes. Policy change in **Burma** is helping to achieve the roll-out of 6-MMD and 100% VL coverage nationally with 95% VL suppression rates. **Cambodia** has adopted

all MPR, and a new decentralization policy (adopted in December 2019) assigns the management function of the provincial health departments, health operational districts, hospitals, and health centers to the provincial administration--allowing for a more rapid response to HIV services. **Kyrgyz Republic** and **Tajikistan** adopted the MPRs and implementation of the Test and Treat strategy, TPT scale up, DSD models, and the MMD roll-out for stable patients. In Nepal, the public procurement policy is currently focused on enacting a multi-year procurement plan for HIV commodities. In **India,** the Transgender Persons Bill passed in 2019, increasing the number of PLHIV linked to and retained on ART, and improving VL testing among the TG community. In **Indonesia**, the July 2019 MOH circular (Surat Edaran No. HK. PR.01.05/I/ 1822/2019 31 July 2019 - Acceleration of ART in 2019–2020) establishes aggressive district-level ART targets and provides clear guidance for rapid ART implementation; reemphasizes the critical role that CSOs, patient advocacy groups, and PLHIV/KP associations play in ART retention efforts; highlights the systematic practice of MMD for stable PLHIV; and establishes parameters for VL testing scale up. In December 2019, the Jakarta provincial health office issued a provincial circular letter for ART acceleration to reinforce the MOH national directive. The Government of **Kazakhstan** (GoK) has made significant improvements in timely ARV procurement. In FY19, all ARVs, with the exception of dolutegravir, arrived in the country in February, earlier than in prior years. In 2019, **PNG** updated the national guidelines to adopt TLD and DSD, including MMD. TLD rollout is progressing rapidly in NCD and the program is expected to transition all clients before FY 2021. Point of Care VL testing was adopted in the national strategy and GF-supported procurement of VL machines.

Peer educators, navigators, client patients, and health care workers will continue to play critical roles in regular follow up, making sure that clients are supported and are retained in care through pre-visit appointment reminders through calls, SMS messages, and home visits to ensure ART adherence, retention in care, and timely VL testing. Countries will re-engage PLHIV who are currently LTFU through treatment strategies such as the **Cambodian** Community Action Approach (CAA), and improve health information systems to enable tracking of individual-level data by age band across the testing and treatment cascade (**Indonesia, Nepal**).

To provide continued access ARVs, facilities will work closely with the governments to innovate and scale quality, client-centered treatment options, including assisted navigation for never-registered PLHIV identified in community-based case finding efforts (**Indonesia**); decentralized ART initiation (**India, Lao PDR, Nepal, PNG**); ARV delivery at primary and community health care centers and integrated counseling and testing sites (**India, Kazakhstan**); flexible-hour clinics for testing and ART services (**Kazakhstan, PNG**); and fast-track pharmacy lanes (**Burma**). For enhanced ART retention among PWID, specifically, **Kyrgyz Republic** will accelerate implementation of co-located MAT-ART for improved PWID ART retention and expand the co-located integrated care delivery system (HIV, TB, and MAT through "one window"). Community-led solutions in **India** include community ART refill groups in remote locations to increase adherence, family-centered models for ART pick up, ART at police hospitals, urban health clinics, tribal hospitals, and prisons, with key linkages between facility and community.

Access to VL testing and subsequent viral suppression will be improved through diagnostic network optimization activities, demand creation with U=U messaging, and enhanced adherence counseling. PEPFAR-supported sites will conduct community-led monitoring and assisted navigation aided by CSOs, and timely receipt of results will be emphasized through U=U messaging and VL alerts (**Burma, India, Lao PDR, PNG, Thailand**). For those who are not virally suppressed, robust adherence counseling and enhanced support strategies will be provided according to the WHO and national guidelines (**Burma**). PEPFAR will track VL results to ensure timely delivery and recording of results for all PLHIV on ART in all PEPFAR-supported sites. In **Burma**, PEPFAR will continue support for sample transportation for clients at PEPFAR sites. In **India**, VL testing coverage is being increased through dried blood spot (DBS) and a hub-spoke model, as well as update of tests through lab-clinical interface.

4.3 Prevention, specifically detailing programs for priority programming:

a. HIV prevention and risk avoidance for OVC (India)
b. Key populations
c. Addressing gender-based violence (GBV) among key populations (PNG)

HIV prevention and risk avoidance for OVC. Only PEPFAR **India** (USAID) receives OVC funding within the ARP. The OVC program shifted its focus to children of KP in 2017. In ROP20, the work will continue to support OVCs across the continuum of care, and implementation will occur in all SNUs, including the existing 3 districts in AP with the targets for OVC included in the Datapack, as well as the 10 new districts under ASAP. However, targets have not been set for the new districts as the direct situational assessments need to be completed first. ART sites have partnered with OVC IP to facilitate bi-directional referrals; provide complementary service delivery for children/adolescents living with HIV (C/ALHIV); and routinely address the psycho-social, economic, and protection needs of children. India will continue to work with children of KPs and focus on linking all children living with HIV (CLHIV) and adolescents living with HIV (ALHIV) in the 38 PEPFAR SNUs to OVC support services. The goal of the OVC intervention is to improve the health and well-being of children of KP, CLHIV, and ALHIV through comprehensive age-appropriate, tailored interventions and linkages to critical health and non-health services and support. This program component will also focus on building capacity of caregivers.

A comprehensive family case profiling exercise will be undertaken to understand needs of each family that informed the delivery of services most necessary for the child(ren) as well as the caregiver(s). Based on the specific needs of children, the IP will link the children with health services, psychosocial support, nutrition, education and protection support. A special emphasis will be given to CLHIV and ALHIV to ensure ARV adherence is more than 95%, along with 95% viral suppression. The risk assessment of adolescent children of KPs will be continued to identify and manage the significant vulnerabilities and risks related to drug use, sexual violence, abuse, and neglect. Adolescent children between the ages of 10-18 will be reached and provided services through Life Skills Education sessions using evidence-based curricula.

Key Populations: The 11 countries in Asia Region will continue to tailor and scale-up programs for KPs, specifically targeting MSM, TG, FSW, and PWID, depending on the country-specific epidemiology. This includes investments that expand differentiated models of care, further enhancing peer outreach and case finding. In some countries (**India, Kazakhstan, Kyrgyz Republic, Thailand**), governments are directly financing CSO- and KP-led organizations to provide HIV services as they are close to or within KP communities and networks. For countries with large PWID populations, this will result in strengthened linkages with MAT and ART services (**Burma, India, Kazakhstan, Kyrgyz Republic**, and **Tajikistan**). In ROP19, PEPFAR **Burma** and **Tajikistan** supported the drafting of national buprenorphine guidelines.

In COP18, index partner testing in ARP was not a focus; consequently, countries lagged behind other PEPFAR country programs. After 2 PEPFAR-supported regional index partner trainings in 2019, PEPFAR country staff, MOH, and IPs initiated activities. In ROP19-20, country teams will work to reach deeper into KP networks through proven social network strategies, which include traditional outreach and online approaches (**India, Nepal**) and self-testing. Many countries have adopted index client family and partner testing in the national guidelines (**India, PNG 2019**), and scale-up of partner notification and index testing (using the 5Cs) will also be central to work in Asia with aggressive scale-up and saturation of PEPFAR-supported SNUs (**India**). Self-testing will be used in conjunction with targeted index testing and will be scaled up in **Lao PDR** and **Nepal**. Ongoing community case management support across the cascade will also be a focus. All countries will work to reduce the barriers to treatment initiation to ensure that 95% of KP who test positive are linked to ART.

Recency activities to support identification of recent infections and areas and populations with ongoing transmission are in progress and will be scaled up across the region. In **Cambodia**, the national program and Centers for Disease Control and Prevention (CDC) ethical review have approved the recency testing protocol and workplan; as a result, rapid implementation has begun, with expansion planned in ROP20. **Lao PDR** will introduce use of the recency assay in FY2020 and implement at ART sites in ROP20. **Thailand** will also scale up recency activities to cover high-volume hospitals within 13 PEPFAR-supported SNUs in ROP20. **Kyrgyz Republic** and **Tajikistan** will support the scale up of self-testing and initiate recency testing in ROP19/20. In ROP2019, 30% of newly-diagnosed patients in **Tajikistan** had advanced diseased (stage 3 or 4). PEPFAR Tajikistan expects to see a decline in this number with the combination of the implementation of recency testing and rapid initiation of treatment in the newly diagnosed in ROP20.

PrEP scale up continues to progress across the region. **Cambodia** ambition funds will support the Chhouk Sar clinic model to become a true social enterprise to deliver KP-friendly services, including PrEP. The model

will be expanded to other major urban areas. **Nepal** plans to scale up PrEP nationally through ambition funds, and **Burma** will focus on introducing PrEP for the highest risk populations at PEPFAR-supported sites in Yangon and Kachin and expand into Mandalay. In addition, utilizing KPIF, PEPFAR **Burma** will work closely with KP-led and CSO groups to increase PrEP demand, scale up PrEP, and establish Burma's first TG clinic and a base for national advocacy and policy generation. National PrEP SOPs and DHIS-2 tracker for PrEP cohorts are in place in **Burma** to monitor progress. **Thailand** will continue PrEP implementation at 78 sites in 30 provinces (as of 2019, the national health insurance includes PrEP services as a reimbursable expense) and monitor PrEP coverage nationally. In **Lao PDR**, PrEP will be implemented as a demonstration model in Vientiane Capital among MSM at highest risk for HIV. In **India**, the launch of PrEP is planned for the summer of 2020, and national guidelines have been prepared.

Gender-based Violence (GBV): GBV remains a major barrier to health services in **PNG**. Approximately two-thirds of women reported having experienced GBV in their lifetime, and 41%-45% of FSW and MSM/TG, respectively, reported sexual violence in the past 12 months (Kelly-Hanku et al, 2017). Exposure to GBV, particularly IPV, fuels lower ART use, decreases ART adherence, and significantly lowers the rates of viral suppression. In response, the PEPFAR **PNG** team will continue to support the National Department of Health (NDoH), Disease Control and Family Health Division to ensure that PLHIV who experience GBV have access to appropriate services as it expands to even more sites in ROP20. This includes ensuring that HIV/STI clinical data collection tools for screening for GBV are in place and being used at health facilities. The team will also ensure, as it scales up index testing efforts, that services are being implemented safely, meeting all the 5Cs. The team will partner with UN Women to advocate for the availability of post/non-clinical care services in communities.

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

The planning level letter provided a number of specific directives for the region for ROP2020, based on performance in ROP2019 and gaps to meet the minimum program requirements. In addition to the activities described in this narrative, Table 4.4.1 in Appendix 1 highlights additional country-specific priorities.

4.5 Commodities

The availability of commodities and the strength of the supply chain differs by country. Stockouts of HIV commodities at site level in the various countries do occur on a periodic basis, and a number of countries depend entirely on GF procurement of ARVs and VL reagents. **Kazakhstan**, and **Thailand** procure their own ARVs entirely through host government resources, although Kazakhstan continues to struggle with full implementation of Test and Start because of an inability to procure sufficient quantities of ARVs within the government budget. In ROP19, ASAP funding was allocated to **PNG** to collaborate with GF in an emergency procurement of ARVs, and **Nepal** was approved for an emergency procurement of ARVs to address an impending stock-out due to COVID-19. In ROP20, **Kazakhstan Tajikistan**, and **Kyrgyz Republic** will use PEPFAR funds to procure rapid test kits and recency assays; India will procure recency assays. **Cambodia** will work with GF to ensure availability of recency assay test kits in ROP20, supporting the host government's institutionalization. In addition, PEPFAR **Nepal** will procure ARVs for PrEP, RTKs, syphilis tests and drugs, and VL reagents and supplies. PEPFAR **India** also will procure cryptococcal antigen tests and urine lipoarabinomannan assay (LAM) kits for early detection of TB in HIV-coinfected patients in PEPFAR districts for national uptake and scale. **Burma, Indonesia, Lao PDR, PNG,** and **Thailand** will not purchase any commodities in ROP20.

4.6 Collaboration, Integration and Monitoring

a. Strengthening cross-technical collaborations and implementation across agencies and with external stakeholders, including the GF and MOH

ARP countries closely collaborate with the MOH as well as GF, WHO, World Bank, and UNAIDS on HIV programming to scale PEPFAR minimum program requirements, address sustainability risks, and provide technical input to ensure countries are accelerating and sustaining the gains towards 95-95-95. Programs strengthen coordination with these entities through routine engagement at the national and sub-national levels through HIV working groups and key country meetings with implementing partners, civil society, and

other stakeholders. In 2019, GF contributed to and provided input to PEPFAR Acceleration country proposals for **India, Indonesia,** and **PNG**, and currently all PEPFAR country programs have been providing input on the new 2021-2023 GF funding requests. PEPFAR and GF work closely on the implementation and coordination of various strategic activities (i.e., PrEP in **Burma**, patient retention in **India**, alignment of MER indicators in **Indonesia**; scale up of comprehensive prevention programs for KP including PrEP, recency testing and index testing in the **Kyrgyz Republic**, and PrEP, HIV self-testing, index testing, standard service package for HIV response, and One national HIV information system in **Nepal**). In **Thailand**, DQA and DQI to improve the national database were implemented in collaboration with IPs (government and CSO), and UNAIDS and UNICEF supported the expansion of DQI activities to non-PEPFAR supported sites. PEPFAR is also ensuring coordination between NHSO, GF, and PEPFAR in accelerating support to CSOs. In **Lao PDR and Nepal**, PEPFAR--with GF and other donors--is coordinating to improve case finding and strengthen health information systems. Additionally, GF and PEPFAR jointly work with the MoH for a greater definition regarding country contribution to the HIV response.

At the regional level, UNAIDS, GF, and ARP co-hosted 2 multilateral meetings during 2019 to strengthen cross-technical collaboration: an Indo-Pacific meeting in Bangkok (September 2019) and a EuroAsia meeting in Istanbul (November 2019). As part of pre-ROP planning in January 2020, UNAIDS, GF, and PEPFAR co-hosted a regional civil society stakeholders meeting to incorporate CSO input into ROP20 country plans. In ROP20, PEPFAR ARP plans to continue engagement with GF and UNAIDS around country sustainability roadmaps, community monitoring, and ongoing coordination efforts to benefit country-level programs.

b. 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

Through regular (weekly, biweekly, monthly) consultations and site visits with IPs, ARP will ensure granular management and monitoring of program interventions across the cascade and will facilitate course correction within shorter time periods. PEPFAR and partners will use dashboards, apps, and other electronic health information systems to monitor the HIV clinical cascade at national and subnational levels and strengthen systems, data utilization, and feedback to providers to improve case finding, track PLHIV, and provide linkage to facility and community services.

c. Improving integration of key health system interventions, including HRH and laboratory (VL) activities across the cascade

ARP supports improving the integration of the following key health system interventions:

1. Improvement of health information systems (EMRs, CBS) to integrate programmatic and supply chain data/interventions for patient-centered care
2. Strengthening of HIV and VL diagnostic network laboratory capacity to improve coverage and the quality of HIV and VL testing.
3. Supply chain strengthening for HIV commodities
4. Technical assistance to host governments to identify and continue financing of key population-led health service (KPLHS) delivery
5. HIV service integration into DHIS-2 and interoperability with community-based systems, HRH capacity building that advance efforts in epidemic control (index testing training, DQI/DQA).

d. Improving quality and efficiencies of service delivery through improved models of care delivery across community and facility sites

Improved and innovative models of care at community and facility sites have improved the quality and efficiencies of service delivery to KP across the region.

Community models of care include the Community Action Approach in **Cambodia** to enhance counseling techniques and review data to improve retention. **Burma** is implementing a community health support model in Kachin where trained community prevention workers (such as shop owners) and peer educators are supported and connect PEPFAR mobile and outreach teams with communities, peers, and clients served. Community-based services (testing, naloxone, syringes, condoms) and community support play a critical role

in referral of clients and enrollment in care. In **India**, PEPFAR is supporting community dispensation of ART by FSW in AP: community ART refill groups in Mizoram Manipur and Nagaland; utilization of sub-district urban health centers to deliver ART in remote locations; and community ART for migrant workers in MH.

Facility models of care include the Jakarta SeHATI initiative in **Indonesia,** which establishes community-facility Lost and Link response teams for enhanced ART retention at targeted facilities. Over ROP20, data from this initiative will be used to strengthen and systematize improved models of care delivery across all community and facility sites. **Lao PDR** uses peer supporters at government ART facilities to strengthen adherence and retention. **Nepal** will support online booking of appointments and referrals and SMS reminders for drug pickups. In the **Kyrgyz Republic** the facility models of care--such as SUPPORT4HEALTH and HERE4YOU--in close collaboration with community-level case management, have improved linkage to care and ART adherence. In **Kazakhstan, Kyrgyz Republic**, and **Tajikistan**, the SUPPORT4HEALTH project focuses on patients newly initiated or restarted on ART and those with an unsuppressed VL. Nurses provide structured and systematized home and community visits and phone calls. In **Thailand**, HIV treatment and care services will be strengthened through CQI for optimizing voluntary counseling and testing (VCT)/provider-initiated testing and counseling (PITC), linkage to sDART, DSD, and coaching. PEPFAR and its partners will provide training and SOP/guidelines/job aides to update knowledge and support of key MPRs. Thailand will improve the quality of services by strengthening the delivery of KP-led and gender-affirming services.

Across the region, peer case managers at facilities will assist health care workers (HCWs) in initiation, retention, and contact tracing. VCT and ART clinics also are an entry point for KP clients referred from targeted outreach, SNS, and online to offline reach to test and link to ART. Index testing will be reintroduced to VCT and ARV clinics after certification. Lastly, recent infections will be used for developing targeted reach to index partners and high-risk networks.

e. Supporting community-led monitoring of treatment services with minimum quarterly meetings to review reported observations and recommendations with representatives and follow up as needed

Community monitoring by NGOs and CSOs will add value, increase transparency and accountability, and encourage co-responsibility by communities and facilities over issues discovered and workable solutions generated. PEPFAR countries vary in both the stage of community-monitoring as well as the type of community-led monitoring approach. **PNG** is at the beginning stages of establishing a consumer network consultation forum. In **Kazakhstan**, use of a community score is helping support the provision of client-centered service delivery at all levels. In **Lao PDR**, PEPFAR will identify ongoing/existing CQI processes and community bodies to establish a formalized CBO/community-led monitoring process. In **Cambodia**, community monitoring is being scaled up through the implementation of the "Patient Satisfaction Feedback" (PSF) system. which will be used as an S&D monitoring platform for KP and PLHIV. The PSF will be integrated into the national CQI and existing service delivery dashboards that are used by quality improvement teams (Group of Champion) in health care facilities for improving service delivery. **Nepal** will strengthen use of online feedback tool and joint monitoring from government, HIV partners, and CSOs. Through KPIF, regional KP-led networks supporting community monitoring will start in select countries.

f. Ensuring above service delivery activities are mapped to key barriers and measurable outcomes related to reaching epidemic control

Across the ARP countries, above-site service delivery activities are mapped to country key barriers and measurable outcomes related to reaching epidemic control are described (see Section 5.0 for common barriers across the region and Table 6 for country-specific barriers [Appendix C]).

Specifically for **Cambodia**, which is focusing on sustaining epidemic control, to address their first barrier (inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control), PEPFAR Cambodia worked with NCHADS to conduct an intensive chart review (CamBlitz) of all PLHIV in Phnom Penh and incorporate the findings into the national quality improvement program (CQI). Cambodia is also implementing sDART, MMD, and TLD. To address the second system barrier (lack of efficient data systems to track PLHIV across the cascade and respond to new infections), PEPFAR Cambodia is helping

NCHADS develop and implement a CBS system. To address the third barrier (insufficient market approaches for sustainable epidemic control), PEPFAR Cambodia is using a business model from a local reproductive health clinic previously supported by PEPFAR to help Chhouk Sar, a KP clinic, generate its own income.

g. Use of unique identifiers across sites and programs in clinical settings

A number of ARP countries--**Kazakhstan, Kyrgyz Republic**, **Tajikistan**, and **Thailand**--have highly functioning CBS systems and use unique identifiers. The AIDS and Narcology services in **Kazakhstan**, **Kyrgyz Republic,** and **Tajikistan** utilize a national integrated electronic HIV case management system (EHCMS) and electronic methadone register (EMR) to generate the country's national HIV strategic information and monitor and evaluate the National HIV Program. Other programs are advancing use of identifiers. **Nepal**'s PEPFAR-supported new "One national HIV information system" with UICs, based on biometric data, will be online beginning in April 2020. In **Cambodia**, PEPFAR is supporting the government to align and harmonize databases through optimizing the use of existing unique key identifiers for PLHIV and key populations. The alignment of unique identifiers is part of the CBS roadmap for scale up. PEPFAR **Indonesia** is currently supporting systematic utilization of ARK 6.0, which records individual clients through patient ID codes across Jakarta facilities. In ROP20, PEPFAR will assist the MOH to roll out the SIHA NIK patient records system which will utilize the National ID number as a unique identifier and ensure that PLHIV can be supported and tracked across facilities and geographic areas for more personalized, client-centered care. In **Burma**, using innovative technology that includes iris scanning, UIC was tested at 3 PEPFAR sites and scaled to 11 GF sites—now including a cohort of 61,000 people with a 13.9% HIV+ yield. PEPFAR is working with national government to develop national-level UIC.

4.7 Targets by population

Table 4.7.1 ART Targets by Prioritization for Epidemic Control

Prioritization Area	Country	Total PLHIV	Expected current on ART (APR FY20)	Additional patients required for 80% ART coverage	Target current on ART (APR FY21) *TX_CURR*	Newly initiated (APR FY21) *TX_NEW*	ART Coverage (APR 21)
Attained	India	114,929	82,596	-	91,560	10,474	80%
	Thailand	16,881	16,009**	-	-	-	100%
Scale-Up Saturation	India	27,575	25,362	-	27,262	2,455	99%
	PNG	6,412	4,980	150	5,977	300	93%
	Thailand	28,354	22,855**	464	7,168	709	85%**
Scale-Up Aggressive	Burma*	-	8,548	-	11,078	2,713	
	India	411,657	96,931	9,935	103,100	8,626	25%
	Kyrgyz Republic	6,686	4,436	913	5,219	889	78%
	Lao PDR	8,467	5,655	1,118	6,433	905	76%
	Nepal	23,864	14,771	4,320	18,094	3,300	76%
	Tajikistan	8,254	5,986	617	7,041	1,200	85%
	Thailand	117,498	74,450**	21,316	24,441	3,090	67%**
Sustained	Indonesia	106,194	33,096	51,859	33,281	855	29%
	Kazakhstan	6,213	3,965	1,005	4,362	487	70%
	Thailand	55,540	54,375**	-	12,739	1,600	100%**
Total		938,524	286,326	91,697	357,755	37,603	38%

*: No Township (prioritized SNU) level data are available.
**Includes national contribution.

Standard Table 4.7.2 is not required as the region has no VMMC investments or targets.

Table 4.7.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Table 4.7.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control				
Country	**Target Populations**	**Population Size Estimate (SNUs) and disease burden**	**Coverage Goal (in FY21)**	**FY21 Target**
Burma	FSW MSM/TG PWID	23,939 51,311 60,796	37.2% 21.3% 11.6%	8,900 10,970 7,010
India	FSW (KP Prev) MSM (KP Prev) TG (KP Prev) PWID (KP Prev)	153,725 50,402 9,373 44,264	6% 13.4% 25.9% 21.5%	9,278 6,751 2,433 9,512
Indonesia*	MSM, FSW, PWID, TG	83,797	-	-
Kazakhstan*	PWID	20,500 Est Size; 12% Prev	-	-
Kyrgyz Republic	PWID	25,000 Est. Size, 14.3% Prev	-	350
Lao PDR	FSW MSM/TG (high risk) PWID	15,900 19,300 1,700	NA	3,316
Nepal	FSW (KP Prev) MSM/TG (KP Prev) Clients of FSWs, high risk male and female, migrants and prisoners (PP_Prev)	41,562 80,733 N/A	25% 19% N/A	6,671 10,011 11,121
PNG*	MSM FSW	-	-	-
Tajikistan	PWID	22,200 Est Size; 12.1% Prev	-	170
Thailand	MSM	119,791	30%	36,941
Total	**FSW MSM/TG PWID Clients of FSWs, prisoners, migrants**			**123,434**

Sources & Notes:
Kazakhstan: UNAIDS 2018.
Indonesia, Kazakhstan, and PNG, as Tier 3 countries, do not have KP-Prev or PP_Prev targets.
Kyrgyz Republic: RAC 2016.
Lao PDR AEM 2020.
Nepal: National Key Population Size Estimates, 2016.
Tajikistan: UNAIDS 2018.

Targets for OVC and linkages to HIV services for India are in Table 4.7.4 for India, attached in Appendix 1.

4.8 Viral Load Optimization

VL coverage has been challenging for the majority of the countries in the region, with the exception of Thailand, with a strong laboratory infrastructure and universal health insurance coverage. Some countries have relatively high coverage and suppression, but all VL equipment, maintenance, and reagents are covered by donor resources, i.e., **Cambodia**.

Several countries have completed or are planning diagnostic network optimization (DNO) assessments in ROP19 (**Burma**, **Cambodia**, **India, Kazakhstan**, and **PNG**). In ROP20, **Burma** will optimize use of its 32 VL testing facilities operating with the use of 4 platforms, Abbott (#4), Biocentric (#3), Biomerieux (#1) and GeneXpert (#24), to ensure 100% access to VL testing among all PLHIV on ART. **Cambodia** is discussing with the National HIV/AIDS Program the renewal of the VL testing platform contract in January 2021. The current platform is an Abbott m2000. The Abbott Alinity system will be considered for the next contract.

Following DNO, **India**, in collaboration with the GF, will implement strategies to meet the clinical test demand through differentiated approaches such as optimizing lab capacity utilization, introducing POC at remote sites, integrating with the centralized lab network hub and spoke model, and DBS to increase

community VL and strengthen the sample transport and result return systems to increase efficiency in the VL testing cascade.

PEPFAR **Thailand** will fully implement POC VL at 5 high-volume KPLHS sites in ROP20 in order to improve retention and VL suppression among KP. Public facilities will sustain their high VL coverage, and PEPFAR will work on optimizing the MOPH VL network strategic plan to leverage access to high-quality VL testing and improve coverage. The **Lao PDR** MOH aims for HIV VL optimization through the use of GeneXpert machines at POC as per recommendations from the WHO HIV-TB Joint Program Review in 2019. **Nepal** provided TA to prepare a VL optimization plan and provide support for its implementation, in collaboration with GF and other stakeholders.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

Through SID, MER, SIMS, and other sources, ARP countries identified numerous key systems gaps or barriers to achieving sustained epidemic control and proposed Table 6 activities with benchmarks and outcomes in close-consultation with MOH, GF PRs, IPs, and CSOs/KPs to address gaps and to avoid duplications of TA by other stakeholders in FY21. Indicated below are the 4 most commonly identified key system gaps or barriers indicated across the region:

1. Inadequate access and capacity to deliver client-centered HIV services (prevention, HTS, care, treatment, VL and retention services (community and facility) tailored to KP needs and consistent with international/ PEPFAR/ WHO standards (**Burma, India, Indonesia, Kazakhstan, Kyrgyz Republic, Lao PDR, PNG, Tajikistan**, and **Thailand**)
2. Limited availability of and ability to use reliable epidemiologic and programmatic data, including KP data, at subnational level. For a number of countries, this included the lack of or weak of standardized reporting systems to track PLHIV from diagnosis to VL suppression and respond to new infections (HIV cascade) (**Burma, Cambodia, India, Indonesia, Kyrgyz Republic, Nepal,** and **PNG)**
3. Inconsistent access to key HIV service commodities and availability and use of supply chain data for decision-making to ensure commodity security across the HIV cascade (**Burma, Indonesia, Nepal,** and **PNG**)
4. Limited domestic financial resources for the HIV response (**Cambodia, Indonesia, Lao PDR,** and **Nepal**)

Client-centered HIV service barriers: Fidelity in implementation to scale of many of the MPRs, index testing, DSD including MMD, sDART, TPT, TLD, especially tailored to KP needs, remains challenging. Across the region, transition to DTG-based regimens has lagged due to delays in changing national and site policies, guidelines, and adding regimens to national health insurance essential drugs lists and forecasting plans.

PEPFAR will support advances in case finding and prevention services through scaling up interventions in all countries. Across the 11 countries in the region, interventions to enhance case finding (i.e., distance learning in **Tajikistan**, community/peer-led approaches in **Burma** and **Nepal**), including index testing, social network approaches (all), self-testing (**Lao PDR** and **Nepal**), online to offline (**Nepal**), and improved risk elicitation (**Cambodia**) will be implemented with fidelity and scaled up. In ROP20, PrEP scale up will continue in **Burma, Cambodia, India**, **Nepal**, and **Thailand**, and be initiated in **Kyrgyz Republic**, accompanied by above-site support for PrEP roll-out through the public and private sectors, including the development of technical/operational guidelines for PrEP implementation and capacity building of health care providers (**Cambodia**, **India, Kazakhstan, Lao PDR, Nepal,** and **Tajikistan**) and national-level M&E and QI and community monitoring (**India**, **Nepal, Thailand**). In several countries (**India, Thailand**) strategic purchasing and social contracting by the government to local CSO and KP-led local providers is improving access to care and retention.

PEPFAR will engage in above-site activities to improve the quality of testing and treatment services for KP and PLHIV. These include: improving access to MMT/ART/TB client-friendly quality services for PWID (**Burma**), quality management system (QMS) development for HIV testing (**Burma**) optimization of ART initiation and patient retention through in-service trainings and tele-mentoring on treatment and VL literacy and U=U (**Burma, Cambodia**); TLD transition (**India, Kazakhstan**), initiating a database for the management of KP cohorts in target areas; and development and/or strengthening of M&E and patient tracking systems for retention and LTFU (**all**). PEPFAR is committed to improving services and confronting stigma and discrimination by developing KP advisory boards (**Burma**), influencing laws and policies (**Burma, India**), HCW trainings (**Thailand**), working with CSOs to increase capacity to implement interventions (**Cambodia, Lao PDR**) and initiate community monitoring of HIV services (**Cambodia, India, Nepal,** and **PNG**). Monitoring the process and outcomes of these interventions will be undertaken by strengthening site-level continuous QI activities (**Burma, India, Lao PDR,** and **Thailand**) across the HIV cascade and nationally by measuring progress towards 95-95-95. In **Indonesia**, strengthening the VL program through advocacy for changes in the military policy to include mandatory VL testing as part of routine health

screening and coordination for specimen sample referral system at health facilities. In strengthening retention in care among military clients, a robust client engagement protocol will be set up as guidance.

Improvements in national and site-level laboratory systems will also be necessary to provide quality diagnostic services to ensure appropriate client management. Gaps in coverage, lab capacity, and efficiency identified by diagnostic network optimization assessments conducted in ROP19-20 will be addressed to ensure improved access and uptake of routine VL testing and timely receipt of results for patients to reinforce improve adherence and increase early detection of treatment failure (**India, Indonesia, Kazakhstan, Nepal, PNG**, and **Thailand**). In **Burma** and **Cambodia**, PEPFAR will continue to optimize the laboratory quality management system, EQA, and maintain and expand ISO accreditation.

Strategic Information Utilization and Surveillance Capacity: PEPFAR will support improvements and address weaknesses in data utilization and health information and surveillance systems across the region at national and subnational levels. In ROP20, PEPFAR will continue to advance support for data QI activities (**Nepal**) and the development and strengthening of case-based surveillance systems (**Burma**, **Cambodia, India, Nepal**, and **Thailand**) to inform better programming. PEPFAR will provide guidelines, training, and TA to support development and implementation of unique identifier systems (**Burma**, **Lao PDR**).

Support for recency will occur at both site and national levels with PEPFAR support to develop and disseminate policy, guidelines, training curricula for health care providers and laboratory staff, and tools (**Burma, Kazakhstan, Lao PDR**, and **Tajikistan**); and through expansion, monitoring, and data utilization to identify geographic and demographic hotspots of recent infections (**Cambodia, Lao PDR, Thailand**).

In **Kyrgyz Republic**, PEPFAR will collaborate with GF and government on IBBS for PWID and MSM, and **Thailand** will expand IBBS RDS to other KP. In **India**, PEPFAR will support improvement of national- and district-level PLHIV estimations. Across the region, PEPFAR will work to improve the quality of the collection of program and surveillance data, cascade monitoring, and data analysis and utilization to assess performance, decision making, and improving the quality of services (**Burma, India**).

Supply chain: Due to limited government capacity and resources, public health supply chain systems across a number of countries within the region are weak and are heavily reliant on donor support. In **Burma**, **Indonesia, Kazakhstan, Kyrgyz Republic, Nepal, PNG,** and **Tajikistan**, PEPFAR will invest in logistics management information systems and training to improve stock management, forecasting, procurement, and logistics and strengthen planning, forecasting, and procurement of HIV commodities at national level (**Cambodia, PNG**). These investments will also occur in **Kazakhstan,** which is not heavily reliant on donor support. Also in **Kazakhstan,** PEPFAR will facilitate policy dialogues with country stakeholders on ensuring appropriate pricing and procurement of ARVs to improve supply.

Sustainable Financing of the HIV response: Domestic resource mobilization for HIV services, especially prevention services and those for KP, remain critical challenges. Only **Kazakhstan** and **Thailand** government resources support >90% of their annual HIV clinical response (Table 2.3.1). Other countries struggle to invest adequately. In **Indonesia,** support will be provided at the national level to assist in transition of GF purchasing to domestic resources and VL testing coverage will be included in the national health insurance plan, enabling patient access to both public and private providers. **Cambodia** will work closely with the government to strengthen budget execution at the national and subnational levels. In **Kazakhstan**, efforts will focus on expansion of health insurance benefits to include HIV-related services, social contracting, and sustainability of funding for the HIV response. In **India,** activities will engage the private sector role to contribute to the national response through advocacy. Licensing and certification programs for CBO services will be promoted to allow these organizations to tap into domestic resources from private and public sectors (**Cambodia, Lao PDR,** and **Thailand**). **Lao PDR** and **Kazakhstan** plan to incorporate findings from a PEPFAR-supported costing assessment into domestic financing plans**.**

The Table 6-E tab of the Excel workbook is attached in Appendix C.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

Most countries have conducted staffing analyses to align staffing, management and operations in accordance with the outcome from the Asia Regionalization Meeting held in November 2018. Nine new positions were requested in ROP20 to stand up the PEPFAR Philippines office (CDC: 2 USDH; 3 locally employed staff; USAID: 3 senior FSNs; DOD: 1 locally employed staff). In order to fulfill programmatic gaps, countries will continue to identify and request additional support from regional and HQ support when possible.

In ROP20, PARCU will have a separate budget, which is a change from ROP19, when PARCU staffing and operating costs were covered by CDC and USAID within the PEPFAR Thailand budget. In ROP20, salaries for the PEPFAR coordinator position, 2 agency representatives, an administrative assistant, and 25% of an USAID SI advisor position will be covered within the PARCU budget as well as rent, Embassy office operating costs, regional TA travel (for PARCU and country teams), technical exchanges, and routine meeting costs. Of note, $997,427 allocated for regional KPIF activities (Appendix 2) were placed in the PARCU ROP20 budget but will not be directed or monitored by PARCU. USAID RDMA will be responsible for all direction, oversight, and accountability of those activities and funds.

Annex 1 - Country Specific Context Tables and Figures for SDS

Table 2.1.1 Host Country Government Results by Country

Burma

Table 2.1.1 Host Country Government Results (Burma)															
	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population (2019)	54,340,000	100	7,318,000	13	7,507,000	14	4,825,000	9	4,821,000	9	16,147,000	30	13,722,000	25	Union population projections3
HIV Prevalence (%)		0.57		ND		ND		0.3		0.4		ND		ND	AEM estimates Apr 2019; UNAIDS 2019 estimates
AIDS Deaths (per year)	7,800		ND		ND		ND		ND		ND		ND		AEM estimates 2019
# PLHIV	240,000		ND		ND		ND		ND		ND		ND		UNAIDS Factsheet Myanmar 2018
Incidence Rate (Yr)		0.2		ND		ND		ND		ND		ND		ND	UNAIDS Factsheet Myanmar 2018
New Infections (Yr)	11,000														UNAIDS Factsheet Myanmar 2018
Annual births	943,000	100													UNICEF: State of the World's Children 2019
% of Pregnant Women with at least one ANC visit	NA	81	ND	ND			ND	ND			ND	ND			DHS 2015 - 2016
Pregnant women needing ARVs	5,400	2													AEM estimates 2019
Notified TB cases (2018)	139,518		ND		ND		ND		ND		ND		ND		WHO: TB Country Profile 2019
% of TB cases that are HIV infected (2018)	10,536	9	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	WHO: TB Country Profile 2019
Estimated Population Size of MSM*	252,000	1.3													MSM BBS 2015
MSM HIV Prevalence	NA	11.6													MSM BBS 2015
Estimated Population Size of FSW	66,000	0.3													FSW BBS 2015
FSW HIV Prevalence	NA	14.6					NA	3.7			NA	6.8			FSW BBS 2015 and HHS 2018
Estimated Population Size of PWID	93,000	0.5													PWID BBS 2017
PWID HIV Prevalence	NA	34.9													PWID BBS 2017
Note: ND = non-disaggregated; NA = not available															

Cambodia

Table 2.1.1 Host Country Government Results (Cambodia)															
	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	15,288,489 M=7,418,577 F=7,869,912	100%													Provisional Census Report, 2019
HIV Prevalence (%)		0.60													AEM, 2019
AIDS Deaths (per year)	1,252 M 15+: 583 F 15+: 603		32		34										AEM, 2019
# PLHIV	72,148		1,469		1,530		1,694		1,534		34,964		30,957		AEM, 2019
Incidence Rate (Yr)		0.01													AEM, 2019
New Infections (Yr)	844 M 15+: 398 F 15+: 345		50		51										AEM, 2019
Annual births (2019)	336,346	22 per 1,000													UN - World Population Prospects
% of Pregnant Women with at least one ANC visit	419,535	100													# PMTCT LR 2018, % PMTCT Eval 2011
Pregnant women needing ARVs	665														AEM, 2019
Orphans (maternal, paternal, double)	36,000		N/A		N/A		N/A		N/A		N/A		N/A		UNAIDS Cambodia Factsheet, 2018
Notified TB cases (2018)	30,017		2,603		3,684		884		831		9,707		12,308		CENAT Report, 2019
% of TB cases that are HIV infected	580	2.0													CENAT Report, 2018
Estimated Population Size of MSM*	72,000														AEM, 2019
MSM HIV Prevalence		4.0													NCHADS MSM and TG IBBS, 2019
Estimated Population Size of FSW	41,600														AEM, 2019
FSW HIV Prevalence		3.2%													FSW BBS 2016
Estimated Population Size of PWID	3,200														AEM, 2019
PWID HIV Prevalence		15.2%													PWID BBS 2017
Estimated Size of Priority Populations (Transgender)	3,200														AEM, 2019
Estimated Size of Priority Populations Prevalence (Transgender)		9.6%													NCHADS MSM and TG BBS 2019

India

Table 2.1.1 Host Country Government Results (India)															
Indicators	**Total**		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
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
Notified TB cases (Yr.)	2,155,894		NA		NA		NA		NA		NA		NA		Global TB Report, 2019
% of TB cases that are HIV infected	49,047	3	NA												Global TB Report, 2019
Estimated Population Size of MSM*	357,000														NACO Annual Report 2018-19 (this figure was updated from 297,000)

Indonesia

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													Estimates and Projection of HIV/AIDS in Indonesia 2015-2020 (2020 projection)
AIDS Deaths (per year)	48,083		1234		1289		15298*		30261*						Estimates and Projection of HIV/AIDS in Indonesia 2015-2020 (2020 projection)
# PLHIV	652,349		10133		10693		229534*		401990*						
Incidence Rate (Yr.)		0.03													MOH EPI review, Estimates & Projections of HIV/AIDS 2015-2020
New Infections (Yr.)	48,528		1915	3.90	2009	4.10					15176*	31.30	29428*	60.60	Estimates and Projection of HIV/AIDS in Indonesia 2015-2020 (2020 projection)
Annual births	4,840,511														2017 Indonesia Health Profile (no age disaggregation)
% of Pregnant Women with at least one ANC visit	5,076,349	95.41													
Pregnant women needing ARVs	14,298														Estimates and Projection of HIV/AIDS in Indonesia 2015-2020 (2020 projection number of HIV positive pregnant mothers)
Notified TB cases (Yr.)	446,723														2018 Global TB Report
% of TB cases that are HIV infected	127,432	29													
Estimated Population Size of MSM*	754,310														MOH Epi review 2016 (Estimated KP size 2016)
MSM HIV Prevalence	119,566	25.80													MOH Epi review 2016 (HIV prevalence for MSM in 2015) and Estimates and Projection of HIV/AIDS in Indonesia 2015-2020 (Estimated MSM PLHIV in 2020)
Estimated Population Size of Transgender*	38,928														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)

Table 2.1.1 Host Country Government Results (Indonesia)									
	Total		<15		15-24		25+		*Source, Year*
			Female	Male	Female	Male	Female	Male	
FSW (high risk) HIV Prevalence	3993	8%							MOH Epi review 2016 (HIV prevalence for Direct FSW in 2015) and Estimates and Projection of HIV/AIDS in Indonesia 2015-2020 (Estimated Direct FSW PLHIV in 2020)
FSW (low risk) HIV Prevalence	3466	2.20							MOH Epi review 2016 (HIV prevalence for Indirect FSW in 2015) and Estimates and Projection of HIV/AIDS in Indonesia 2015-2020 (Estimated Indirect FSW 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 FSW)	5254065								MOH Epi review 2016, (Estimated size for KP in 2016)
Client of FSW HIV Prevalence	85215								Estimates and Projection of HIV/AIDS in Indonesia 2015-2020 (Estimated Client of FSW PLHIV in 2020)
Source: Indonesia Bureau of Statistics (2020 National Population Projection, MoH Quarterly report December 2019, 2016 PSE **Age disaggregation by below 15 and 15+ only.*									

Kazakhstan

Table 2.1.1 Host Country Government Results (Kazakhstan)															
	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	18,395,567	100.0	2,548,343	13.9	2,701,489	14.7	1,152,559	6.3	1,202,398	6.5	5,781,469	31.4	5,009,309	27.2	National Statistical Committee of the Republic of Kazakhstan (January 01, 2019 (https://stat.gov.kz/)
HIV Prevalence (%)	-	0.17		0.009		0.009	-	0.05	-	0.04	-	0.19	-	0.38	Estimated # PLHIV (UNAIDS data)/Total population
AIDS Death (per year)	<500		<100				<100		<100		<100		<500		UNAIDS data, 2018, https://aidsinfo.unaids.org/
Estimated # PLHIV	31,378		238		253		590		453		10,715		19,129		RAC's data, 2018
Incidence Rate per 1000 population (Yr)	-	0.14													UNAIDS data, 2018, https://aidsinfo.unaids.org/
New Infections (Yr)	2,600		<100				<200		<200		<1000		1,700		UNAIDS data, 2018, https://aidsinfo.unaids.org/
Pregnant Women Needing (ARVs)	204														EHCMS, As of Jan 31, 2020
Notified TB Cases (Yr)	13,361														2019 WHO Global TB report, data from 2018
% of TB cases that are HIV infected	792	5.9													EHCMS, As of Jan 31, 2020; calculated % = TB that are HIV infected/ TB registered cases.
Estimated Population Size of PWID	120,500														~~UNAIDS, most~~ recent data as of 2018
PWID HIV Prev.		7.9%													UNAIDS, most recent data as of 2018
Estimated Population size of MSM	62,000														UNAIDS, most recent data as of 2018
MSM HIV Prev.		6.2%													UNAIDS, most recent data as of 2018
Estimated Population Size of FSW	18,400														UNAIDS, most recent data as of 2018
FSW HIV Prev.		1.9%													~~UNAIDS, 2019~~

Kyrgyz Republic

Table 2.1.1 Host Country Government Results (Kyrgyz Republic)															
	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	6,389,500	100	1,017,452	15.9	1,067,964	16.7	506,386	7.9	526,880	8.2	1,696,028	26.5	1,574,790	24.6	National Statistical Committee of the Kyrgyz Republic As of January 01, 2019 (www.stat.kg)
HIV Prevalence (%)	-	0.13	<0.024				-	<0.039	-	<0.03	-	0.16	-	0.34	Estimated # PLHIV (UNAIDS data)/Total population
AIDS Death (per yr)	<200		<100				<100		<100		<100		<200		UNAIDS data, 2018, https://aidsinfo.unaids.org/
Estimated # PLHIV	8,500		<500				<200		<200		2,700		5,400		UNAIDS data, 2018, https://aidsinfo.unaids.org/
Incidence Rate per 1000 population (Yr)	-	0.09													UNAIDS data, 2018, https://aidsinfo.unaids.org/
New Infections (Yr)	<1000		<100				<100		<100		<200		<500		UNAIDS data, 2018, https://aidsinfo.unaids.org/
Pregnant Women Needing (ARVs)	58														EHCMS, As of Jan 31, 2020
Notified TB Cases (Yr)	7,585														2019 WHO Global TB report, data from 2018
% of TB cases that are HIV infected	133	1.8													EHCMS, As of Jan 31, 2020; calculated % = TB that are HIV infected/ TB registered cases.
Estimated Population Size of PWID	25,000														GFTAM report, 2013
PWID HIV Prev.		14.3													RAC report. IBBS 2016
Estimated Population size of MSM	16,900														Methods and Results of 2016 size estimation exercise in Kyrgyz Republic: 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 Prev.		2.0%													RAC report, IBBS 2016

Lao PDR

Table 2.1.1 Host Country Government Results (Lao PDR)															
	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	7,181,567		1,172,049		1,164,115		744,375		739,336		1,686,554		1,675,138		Spectrum, 2019
HIV Prevalence (%)		0.18		0.02		0.02		0.10		0.11%		0.28		0.37	Spectrum, 2019
AIDS Deaths (per year)	287		15		16		12		14		94		135		Spectrum, 2019
# PLHIV	12,810		237		246		715		765		4707		6141		Spectrum, 2019
Incidence Rate (1000 p/Yr)		0.11													Spectrum, 2019
New Infections (Yr.)	785		29		31		131		199		160		235		Spectrum, 2019
Estimated Population Size of MSM*	56,713														AEM, 2019
MSM HIV Prevalence	1887	3.33													AEM, 2019
Estimated Population Size of TG SW*	688														AEM, 2019
TG SW HIV Prevalence	36	5.29													AEM, 2019
Estimated Population Size of FSW	15,619														AEM, 2019
FSW HIV Prevalence	124	0.80													AEM, 2019
Estimated Population Size of PWID	1661														AEM, 2019
PWID HIV Prevalence	122	7.32													AEM, 2019

Nepal

Table 2.1.1 Host Country Government Results (Nepal)															
	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 TB 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
Estimated Population Size of MSM*	60,333														National size estimates, 2016
MSM HIV Prevalence		4.8 2.9 6.0													IBBS, Kathmandu valley, 2017 IBBS, Pokhara valley, 2017 IBBS, Terai highway districts, 2018
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
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 2.1.1 Host Country Government Results (PNG)			
	Total		***Source, Year***
	N	%	
Total Population	8,889,786		Spectrum Estimates (2020)
HIV Prevalence (%)		0.84	Spectrum Estimates (2020)
AIDS Deaths (per year)	432		Spectrum Estimates (2020)
# PLHIV	51,075		Spectrum Estimates (2020)
Incidence Rate (per year)		0.41	Spectrum Estimates (2020)
New Infections (per year)	3,539		Spectrum Estimates (2020)
Annual births	238,363		Spectrum Estimates (2020)
% of Pregnant Women with at least one ANC visit		54	Annual HIV Program Report (2018)
Pregnant women needing ARVs	1,511	0.63	Spectrum Estimates (2020)
Orphans (maternal, paternal, double)	7,492		Spectrum Estimates (2020)
Notified TB cases (Yr)	27,887		TB Profile PNG, WHO (2018)
% of TB cases that are HIV infected		7	Annual HIV Program Report (2019)
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
Estimated Size of Priority Populations Prevalence (specify)			No Reliable Data exists
**Data presented only for PEPFAR Geographic Focus – NCD*			

Tajikistan

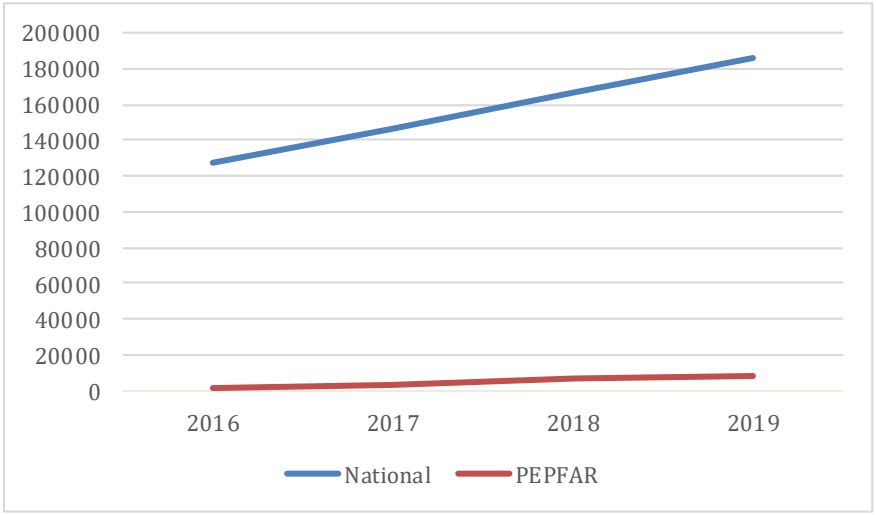
Table 2.1.1 Host Country Government Results (Tajikistan)															
			<15				15-24				25+				Source, Year
	Total		Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	9,126,600	100.0	1,501,800	16.5	1,628,100	17.8	835,300	9.2	870,700	9.5	2,162,200	23.7	2,128,500	23.3	National Statistics Agency, As of January 01, 2019 www.stat.tj/ru/
HIV Prevalence (%)		0.142	<0.032					<0.06		<0.057		0.139		0.395	Estimated # PLHIV (UNAIDS data)/Total population
AIDS Death (per year)	<500		<100				<100		<500		<100		<500		UNAIDS data, 2018, https://aidsinfo.unaids.org
Estimated # PLHIV	13,000		<1000				<500		<500		3,000		8,400		UNAIDS data, 2018, https://aidsinfo.unaids.org
Incidence Rate per 1000 population (Yr)		0.09													UNAIDS data, 2018, https://aidsinfo.unaids.org
New Infections (Yr)	<1000		<100				<100		<100		<200		<1000		UNAIDS data, 2018, https://aidsinfo.unaids.org
Pregnant Women Needing (ARVs)	78														EHCMS, As of Jan 31, 2020
Notified TB Cases (Yr)	5,975														2019 WHO Global TB report, data from 2018
% of TB cases that are HIV infected	170	2.8													EHCMS, As of Jan 31, 2020; calculated % = TB that are HIV infected/ TB registered cases
Estimated Population Size of PWID	22,200	-													UNAIDS data, 2018, https://aidsinfo.unaids.org
PWID HIV Prev.	-	12.1													UNAIDS data, 2018, https://aidsinfo.unaids.org
Estimated Population size of MSM	13,400	-													UNAIDS data, 2017, https://aidsinfo.unaids.org
MSM HIV Prev.	-	2.3													UNAIDS data, 2017, https://aidsinfo.unaids.org
Estimated Population Size of FSW	17,500	-													UNAIDS data, 2018, https://aidsinfo.unaids.org/
FSW HIV Prev.	-	2.9													UNAIDS data, 2018, https://aidsinfo.unaids.org/

Thailand

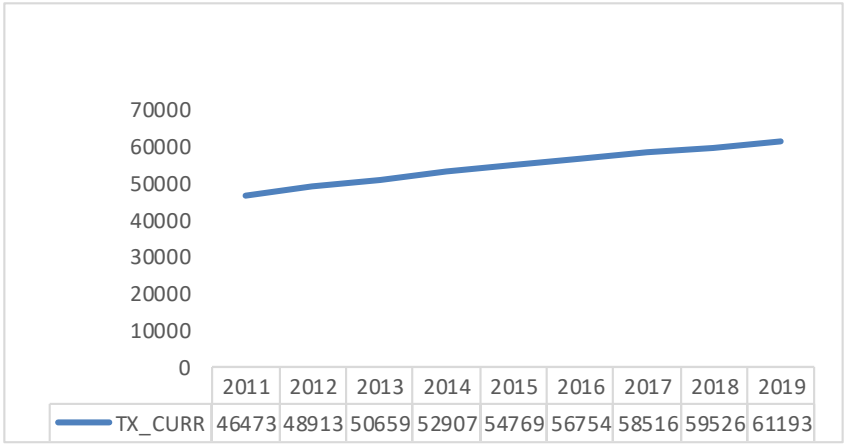
Table 2.1.1 Host Country Government Results (Thailand)															
	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	68,541,727		5,551,526		5,875,388		4,265,500		4,296,688		30,587,982		29,391,557		Spectrum AEM V5.756, updated 11 April 2019
HIV Prevalence (%)		0.68		0.02		0.02		0.21		0.31		0.64		0.84	
AIDS Deaths (per year)	16,172		26		28		132		230		6,898		8,912		
# PLHIV	467,587		1,193		1,249		8,993		13,515		196,750		248,329		
Incidence Rate (Yr)		0.008		0.000		0.000		0.017		0.044		0.003		0.006	
New Infections (Yr)	5,542		17		18		741		1,905		939		1,957		
Annual births	666,109	10.1/1,000													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	3,497														Spectrum 11 April 2019
Notified TB cases (Yr)	70,114														National TB Control Program Guideline 2018
% of TB cases that are HIV infected		11.0													
Estimated Population Size of MSM*	603,600														AEM 11 April 2019
MSM HIV Prevalence		11.9							8	6.17			37	15.12	IBBS 2018
Estimated Population Size of FSW	119,000														AEM 11 April 2019
FSW HIV Prevalence		1.8					8	0.36			32	1.44			IBBS, 2018
Estimated Population Size of PWID	25,800														AEM, 2018
PWID HIV Prev.		20.5													IBBS, 2014
Estimated Population Size of TGSW (Hot spot)	20,400														AEM 11 April 2019
TG HIV Prevalence		11.0							20	10.21			24	12.76	IBBS 2018
Estimated Population Size of MSW	18,800														AEM 11 April 2019
MSW HIV Prevalence		3.8							8	2.81			15	4.59	IBBS 2018
Sources: AEM, SPECTRUM-AEM, IBBS led by Division of Epidemiology, Thailand MOPH															

Figure 2.1.3 Updated National and PEPFAR Trend for Individuals currently on Treatment, by Country

Burma

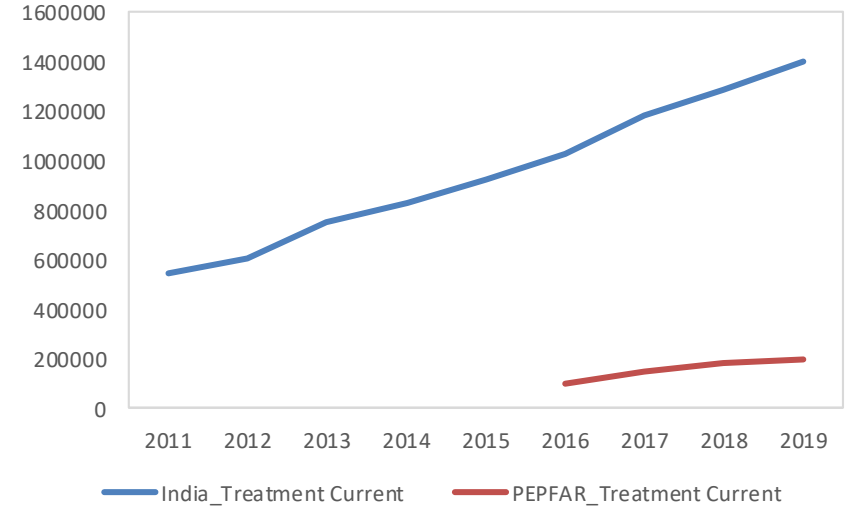


Cambodia

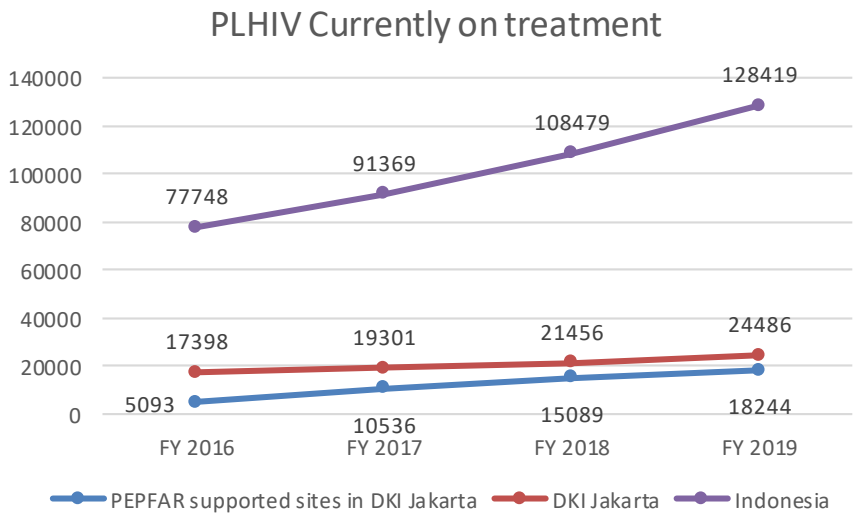


PEPFAR does not support site-level activities in Cambodia. The trend line reflects national data (AEM, 2019).

Updated National and PEPFAR Trend for Individuals currently on Treatment, **India**

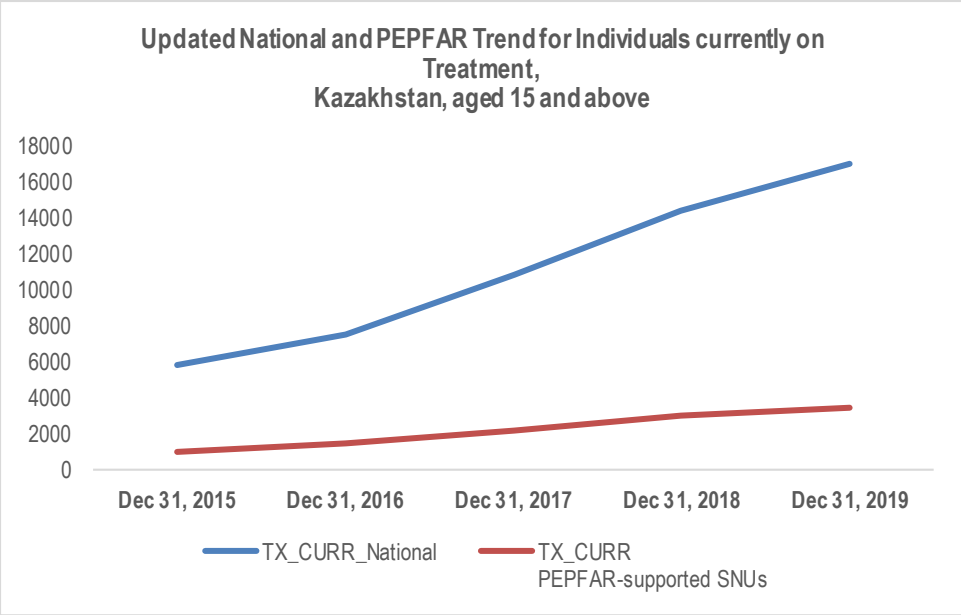


Indonesia

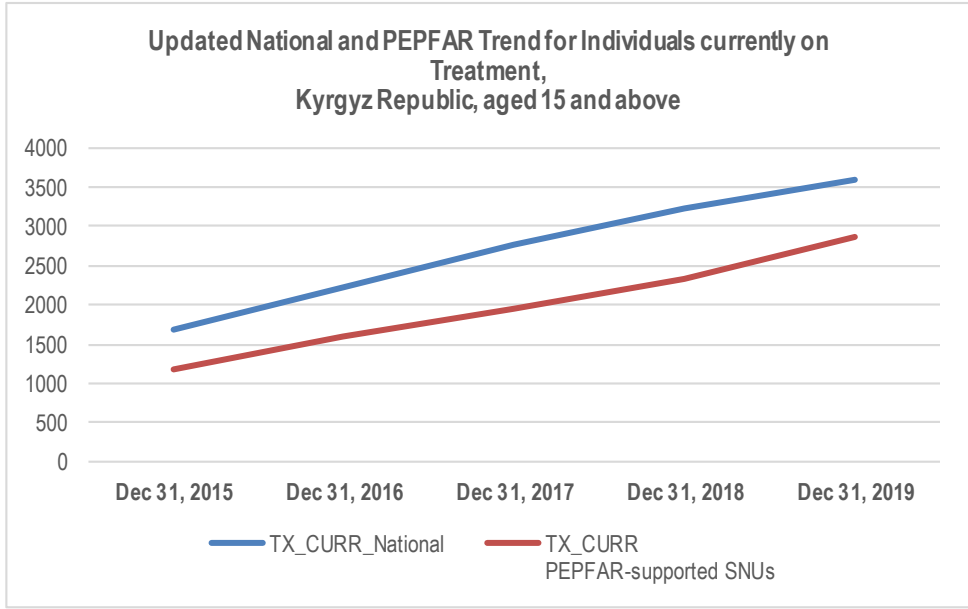


Source: MoH December 2019 Quarterly Report and DATIM

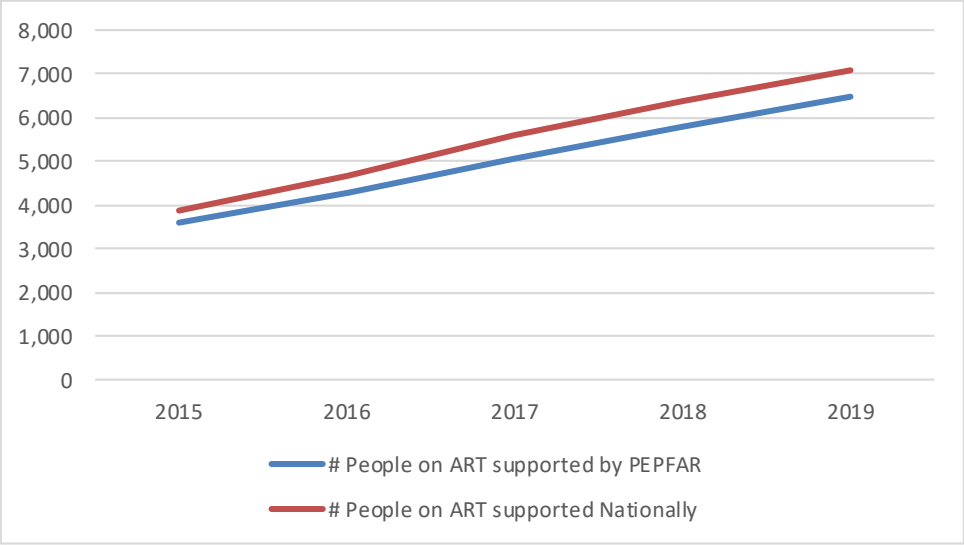
Kazakhstan



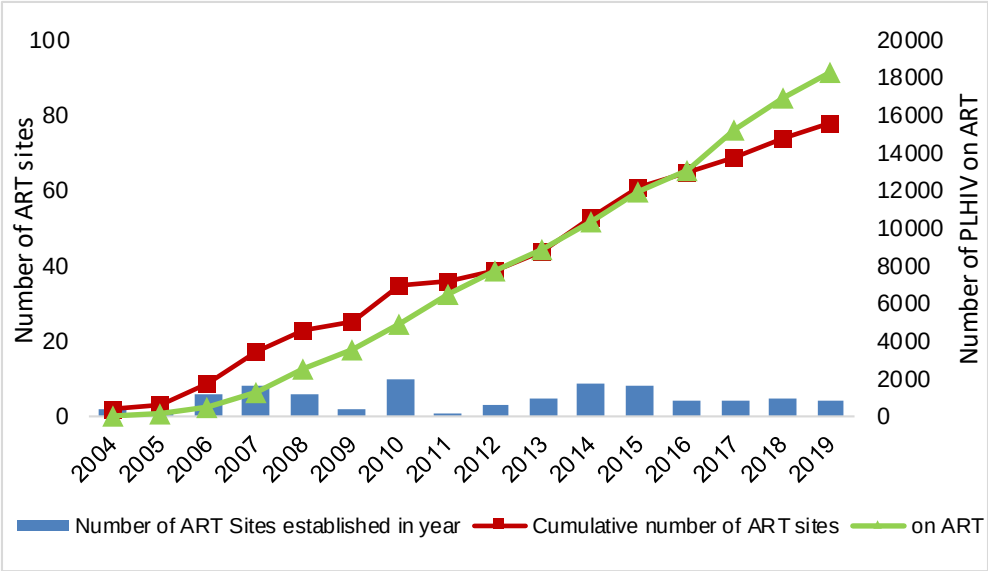
Kyrgyz Republic



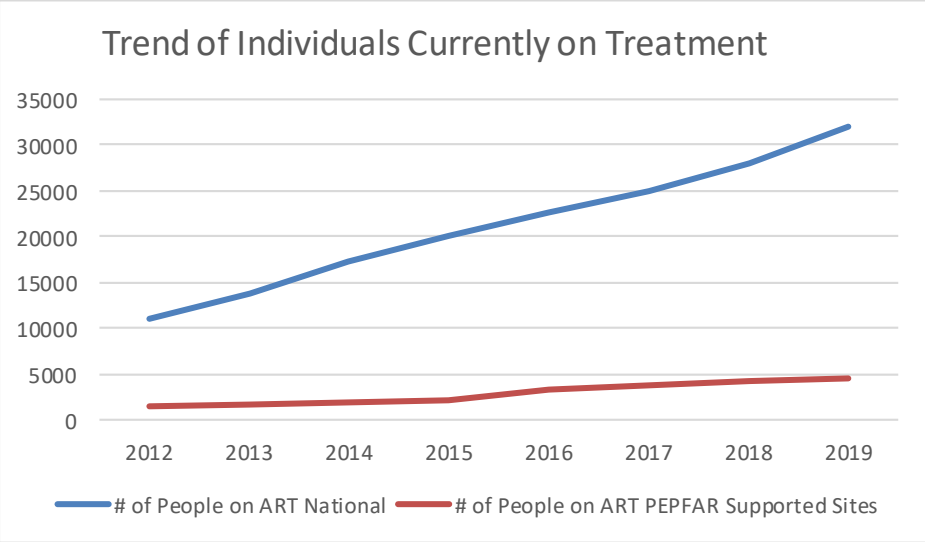
Lao PDR



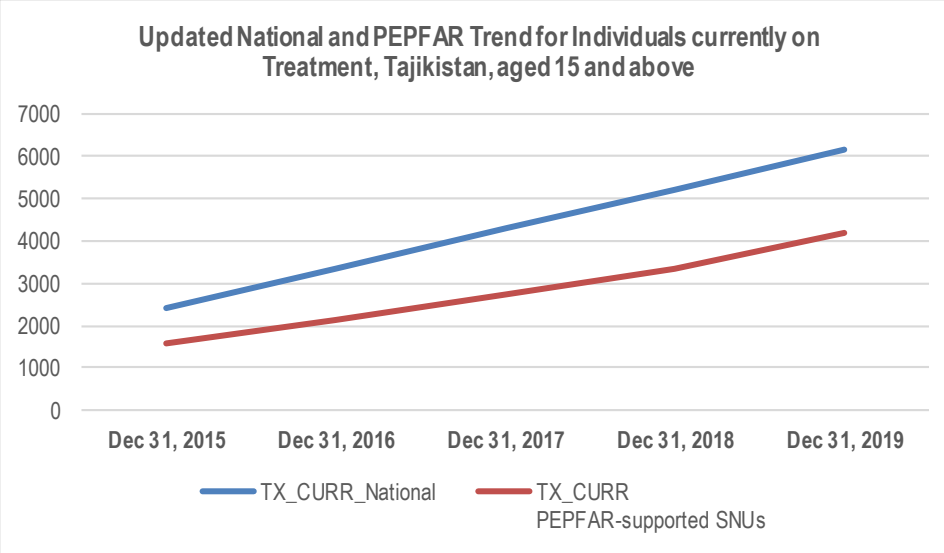
Nepal



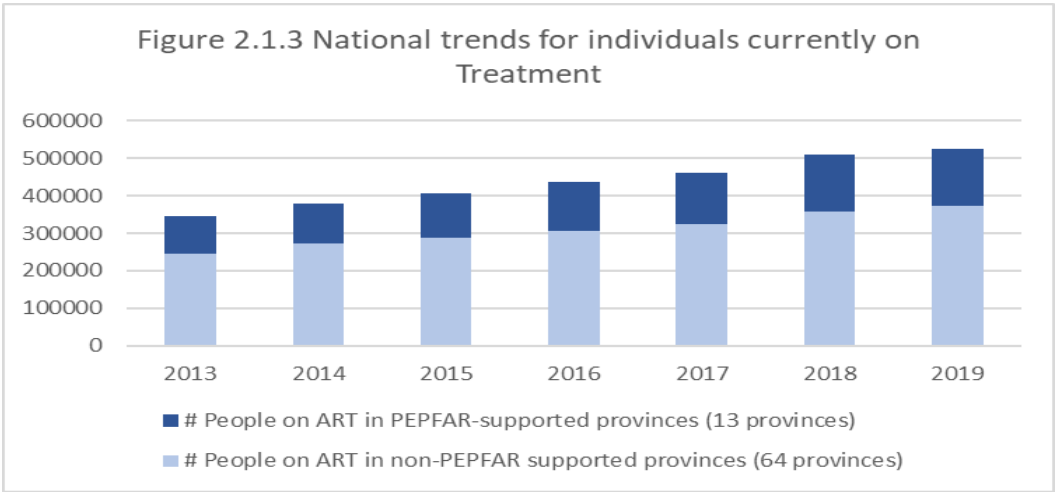
Papua New Guinea



Tajikistan



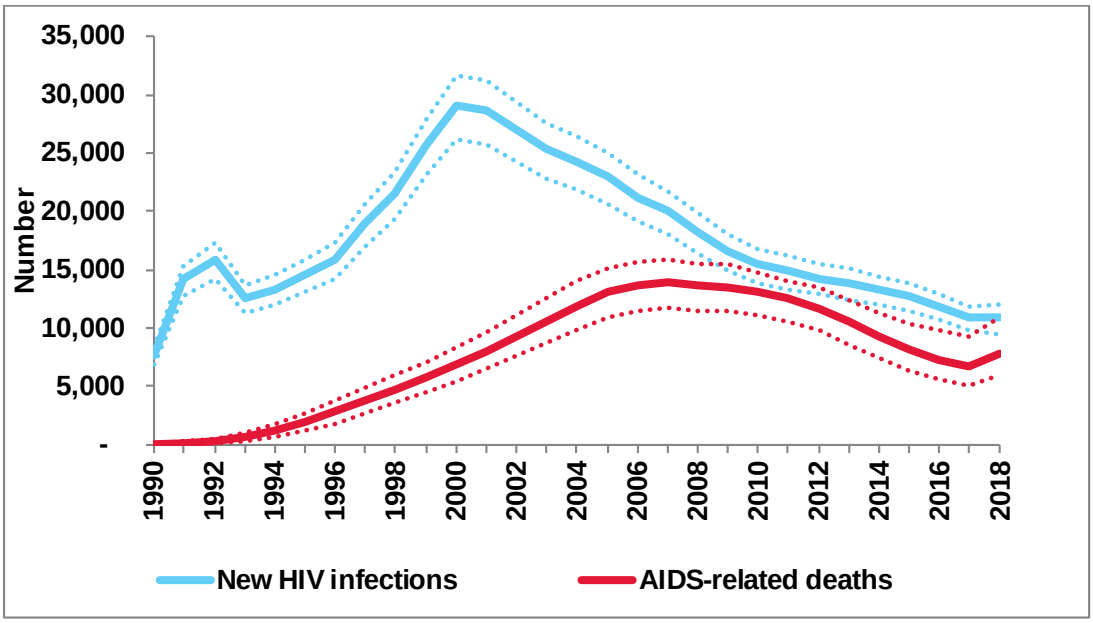
Thailand



Source: *National AIDS Program (NAP) web report FY2019, as of October 2019*

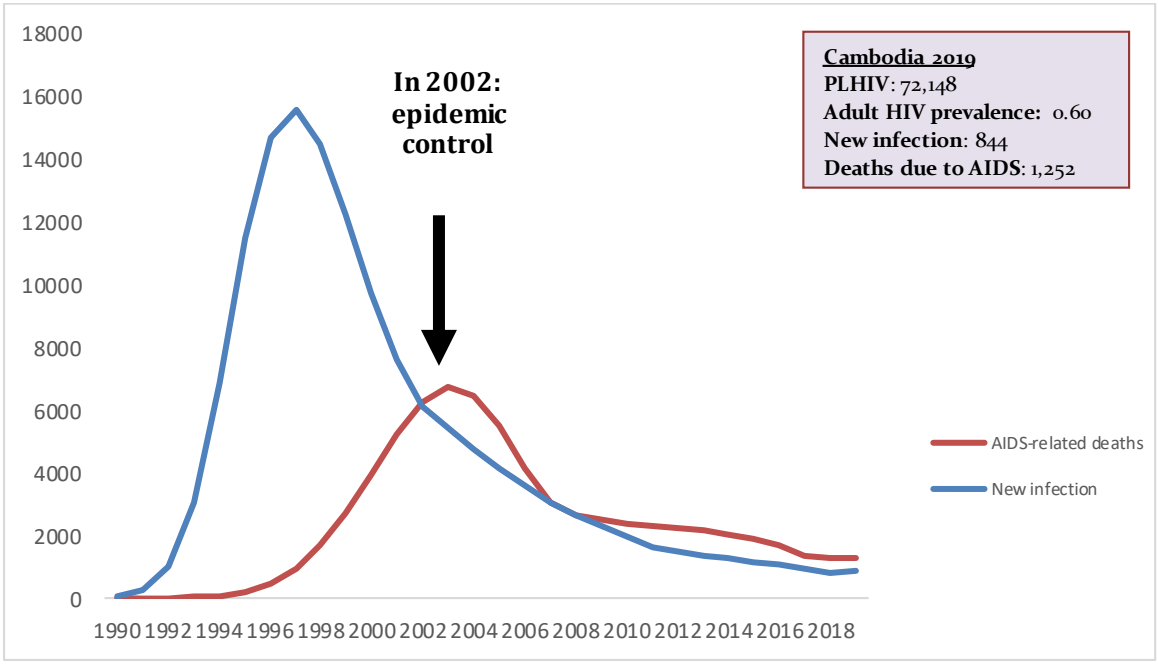
Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality Among PLHIV, by Country

Burma

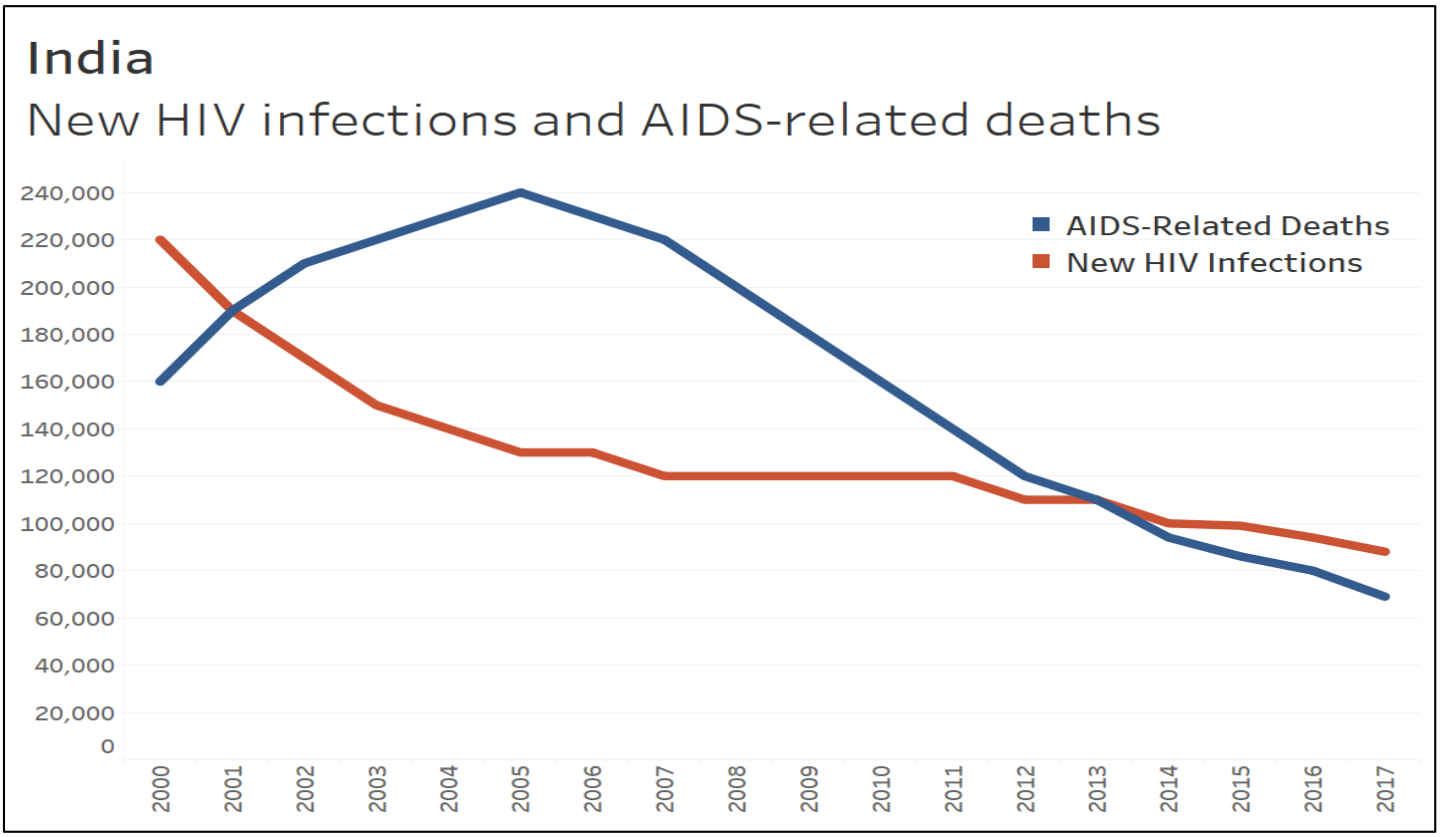


Source: www.aidsdatahub.org based on UNAIDS 2018 HIV Estimates

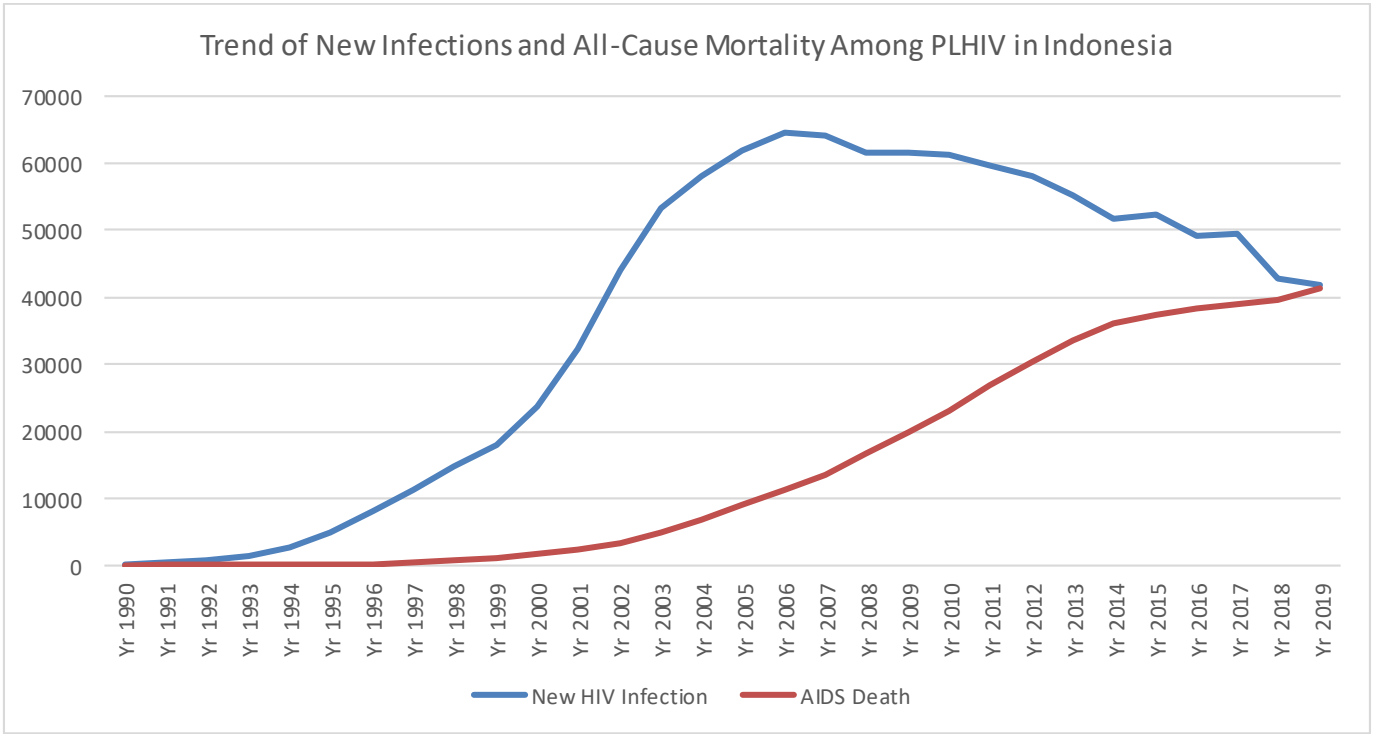
Cambodia



India

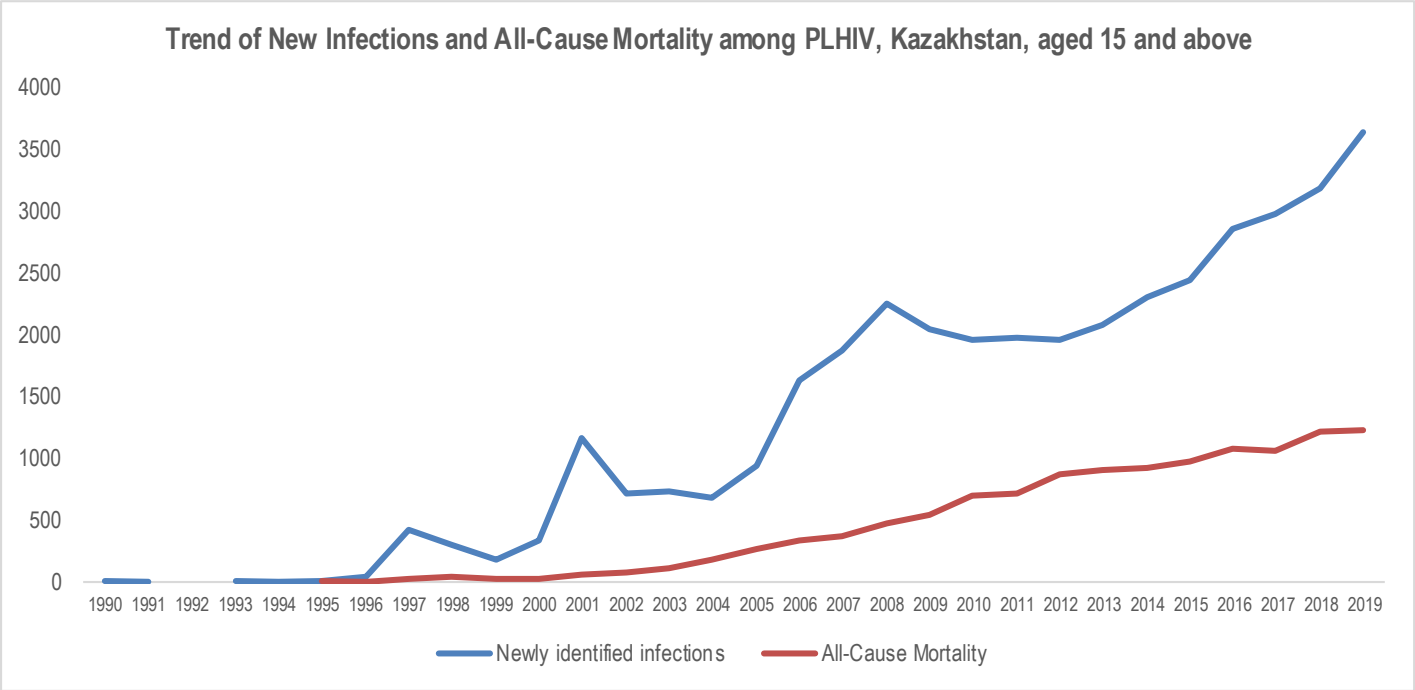


Indonesia

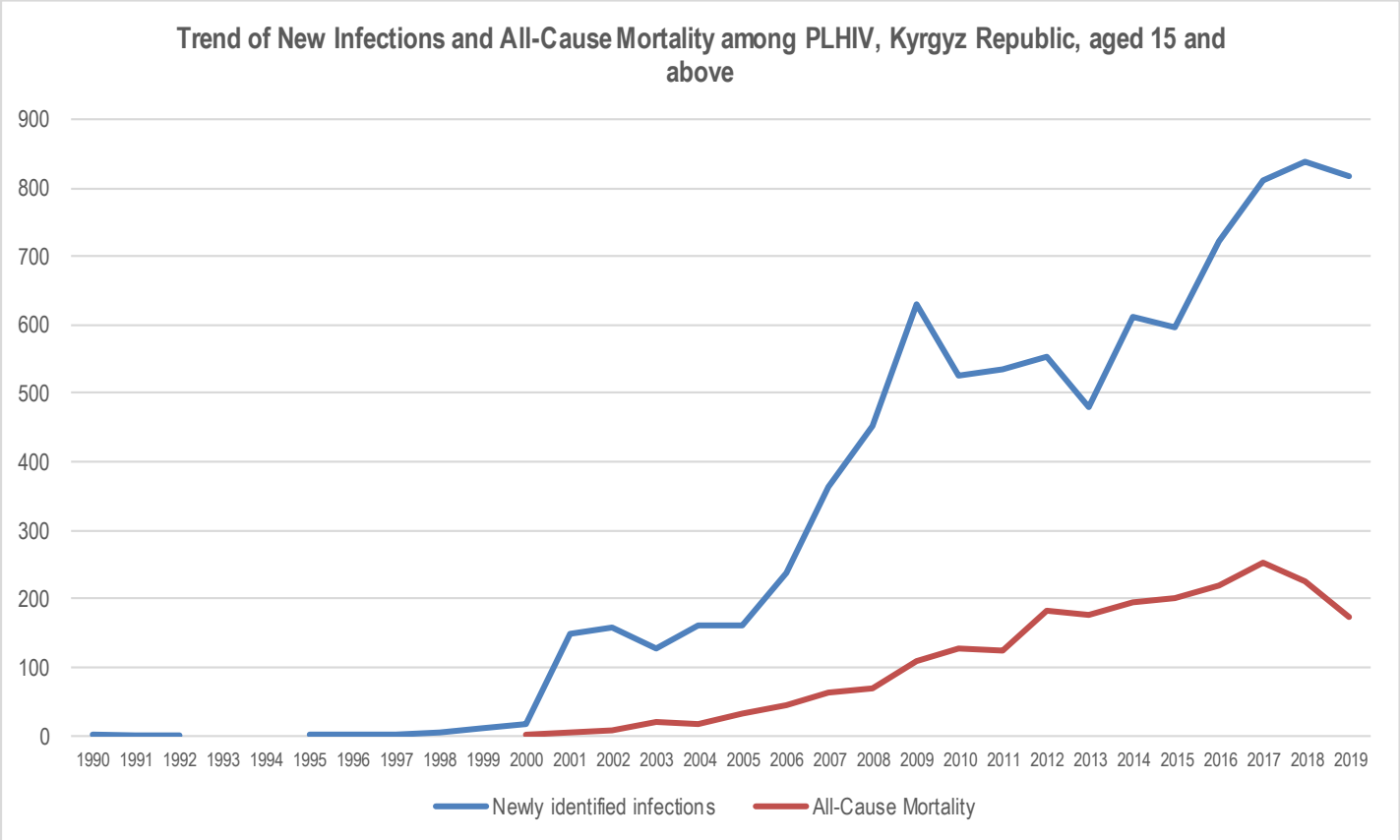


Source: Spectrum 2019 using 2018 program data

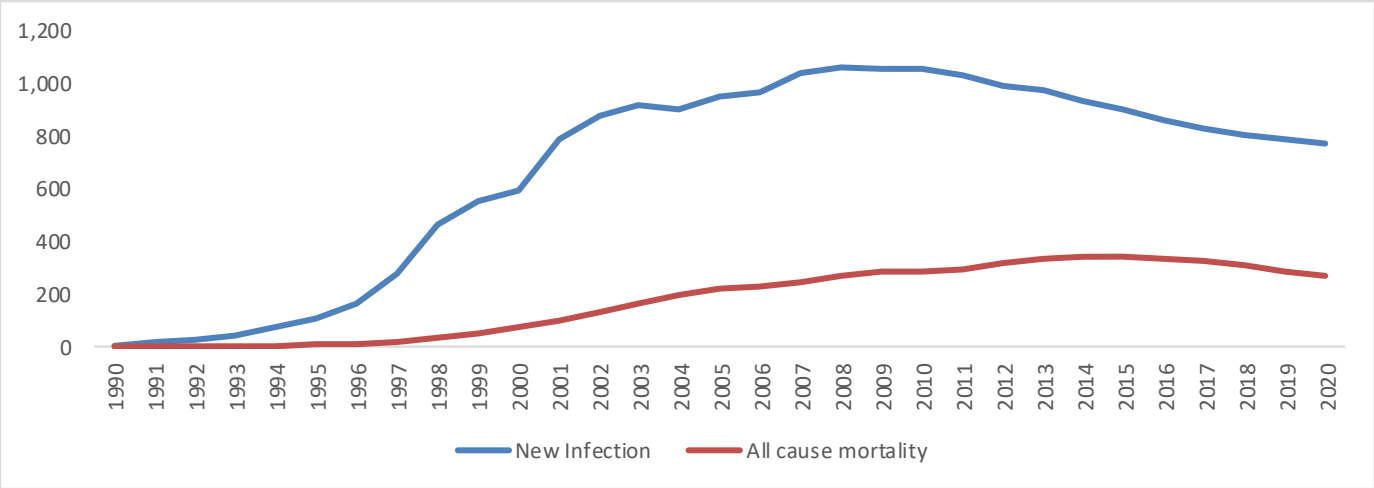
Kazakhstan



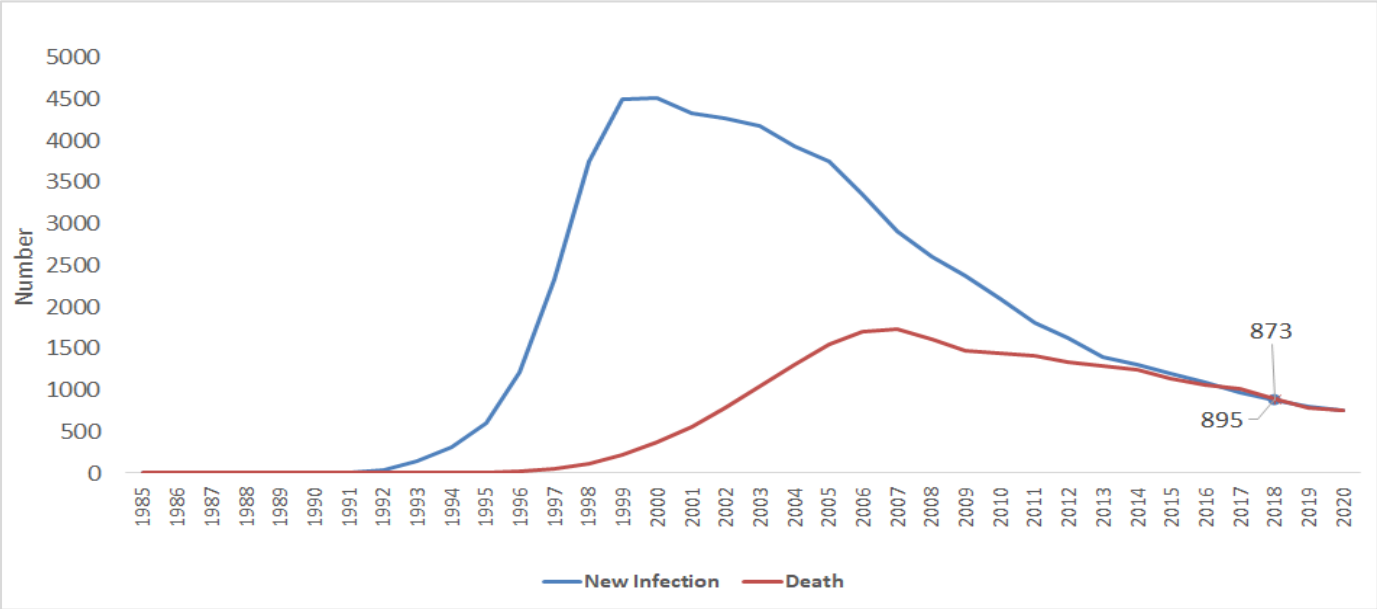
Kyrgyz Republic



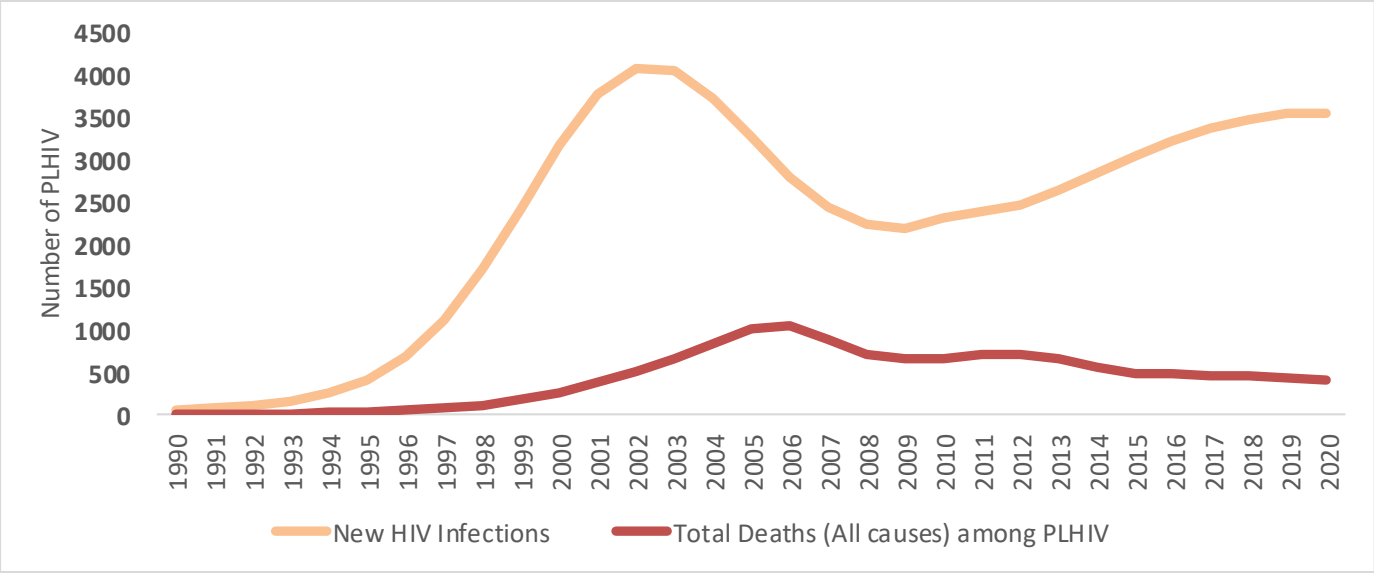
Lao PDR



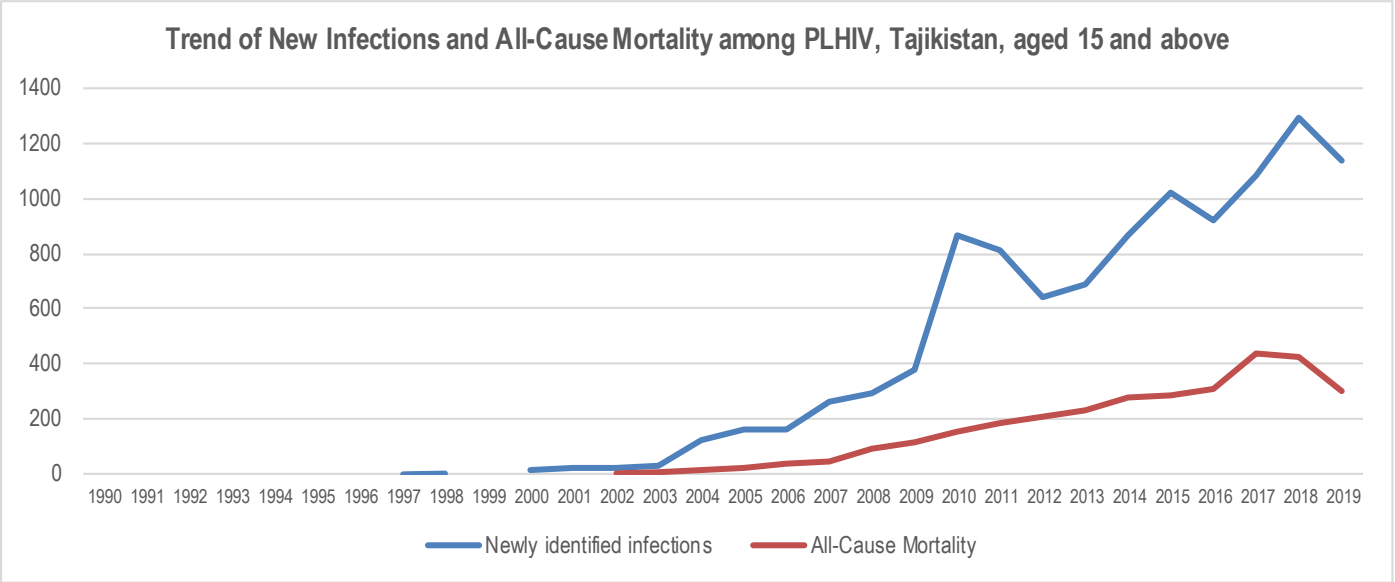
Nepal



Papua New Guinea



Tajikistan



Thailand

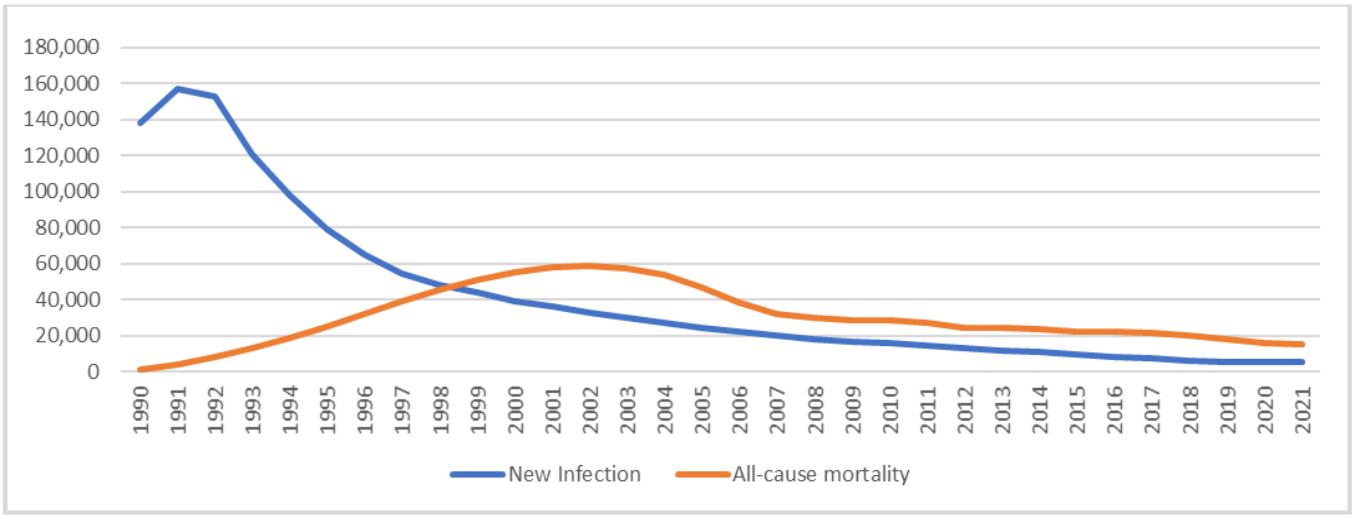
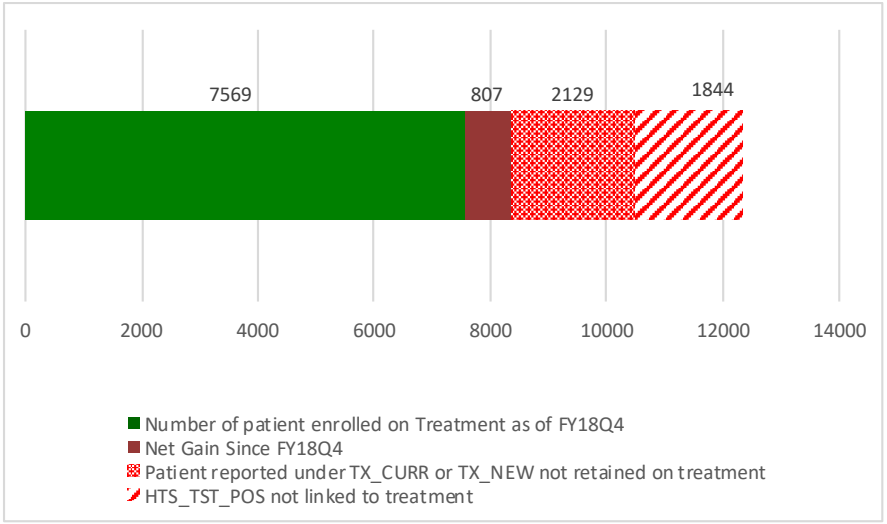
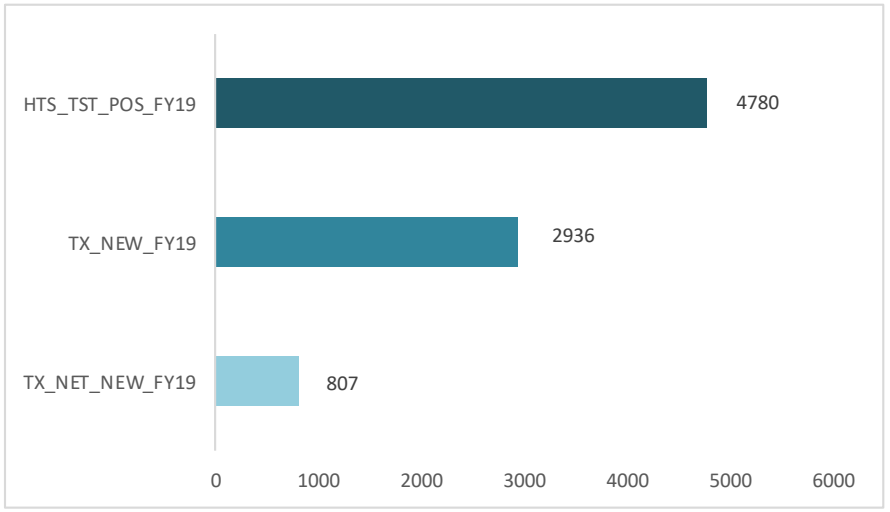


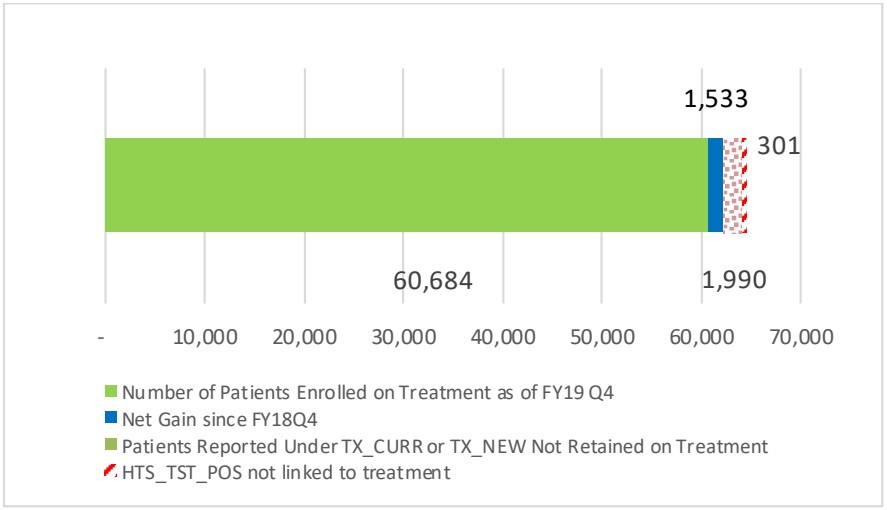
Figure 2.1.5 Progress retaining individuals in lifelong ART in FY19, by country

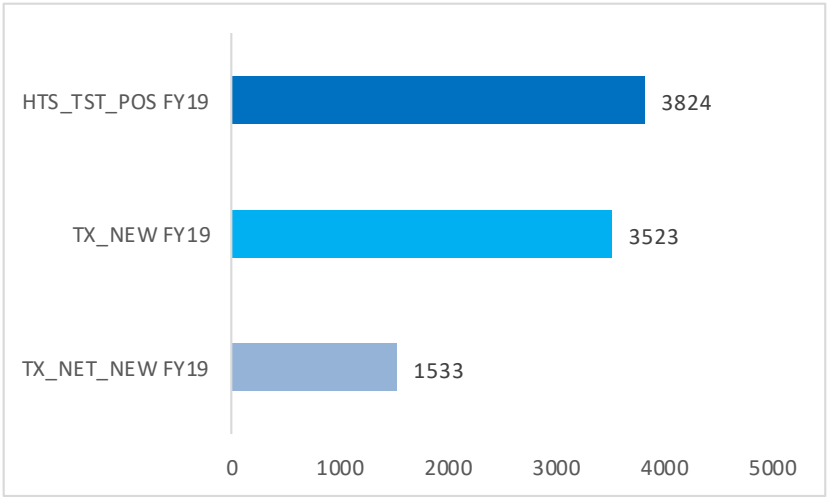
Burma



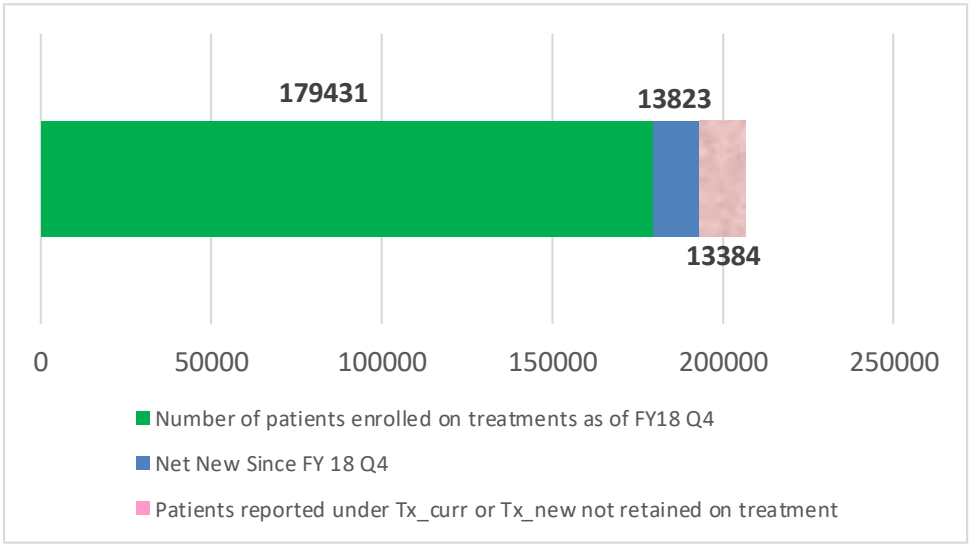


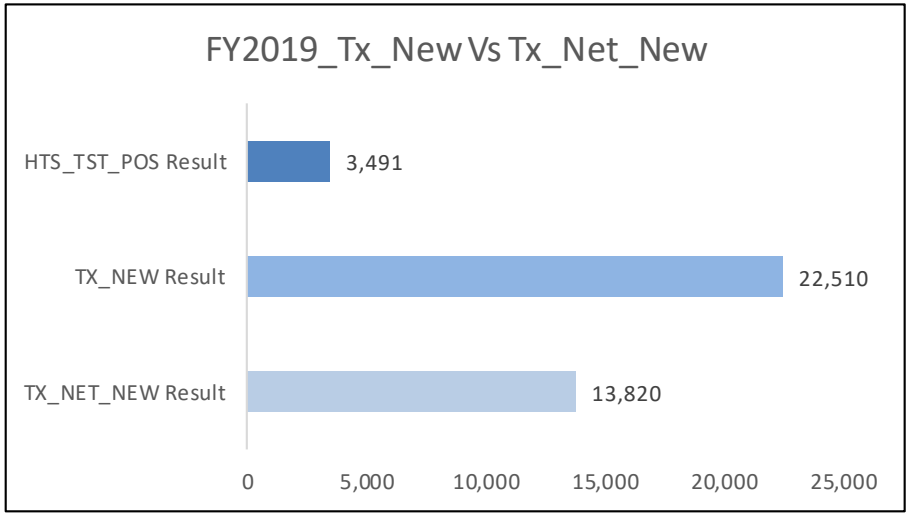
Cambodia





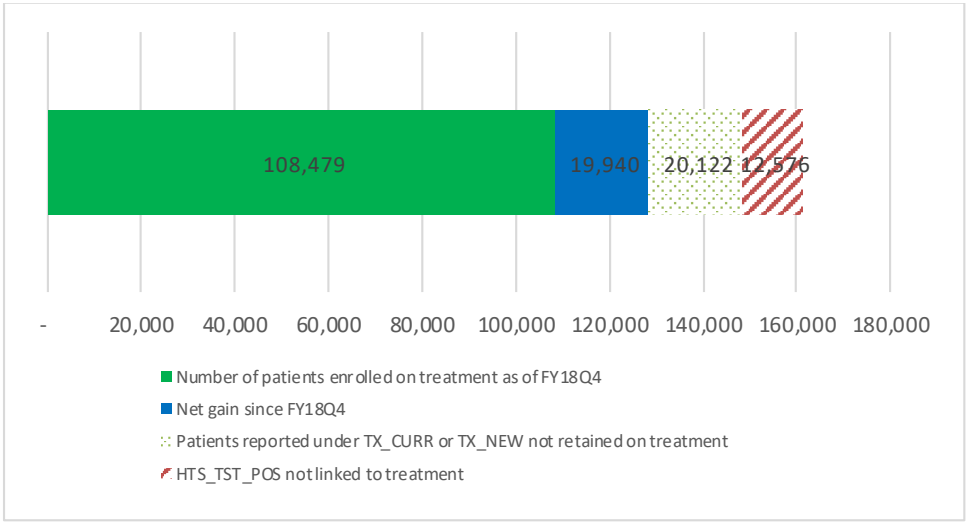
India

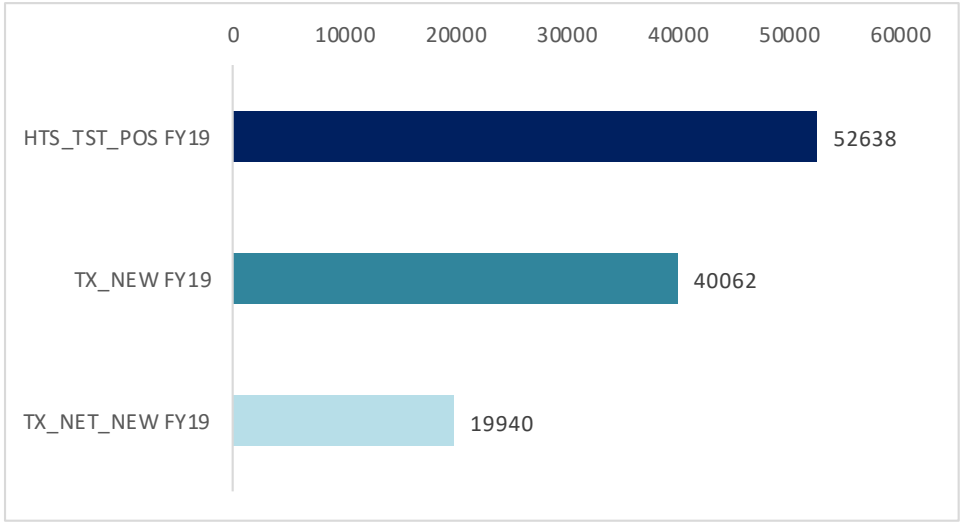




Note: Since HTS_POS KPs is from a subset of KPs trained whereas Tx_CURR is for all populations, the HTS_TST_POS not linked was not possible to present.

Indonesia

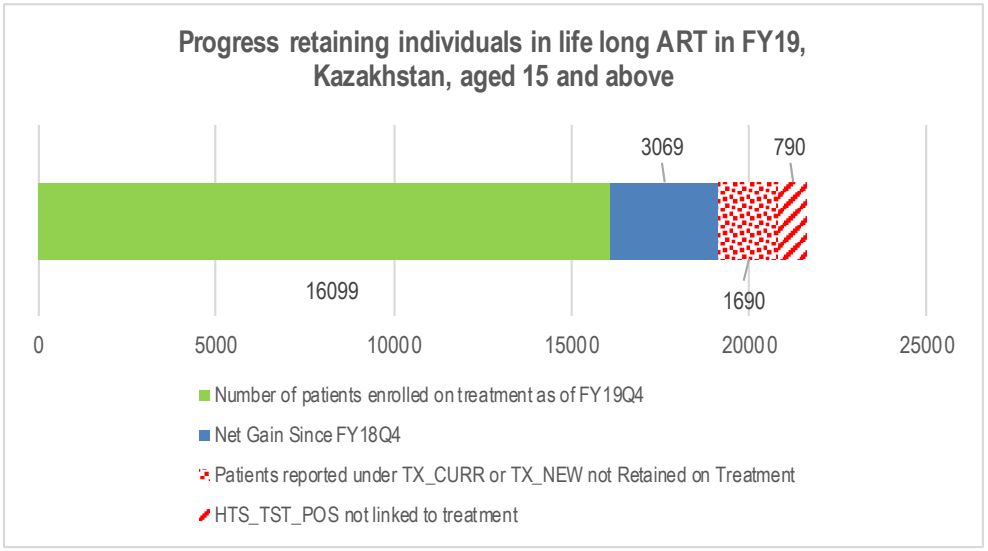


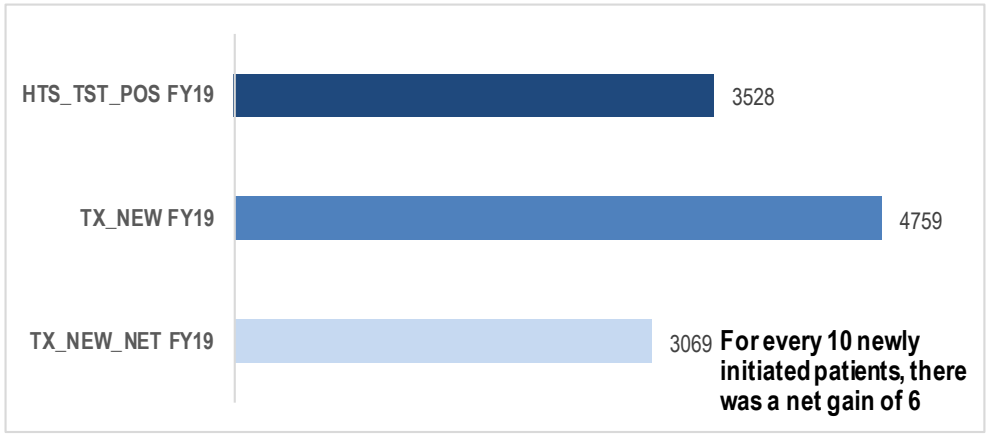


Source: MoH Quarterly Report December 2019

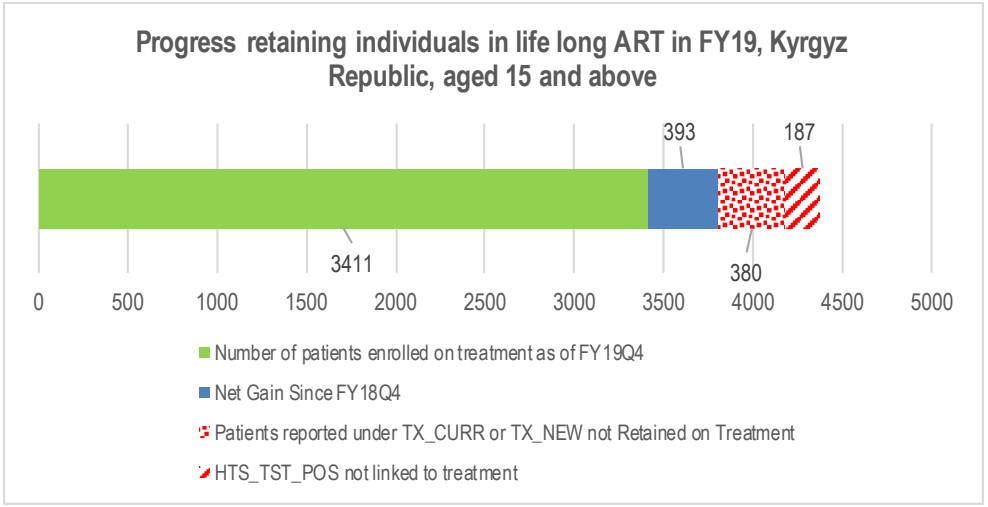
Note: Lost to follow-up number derived from 2019 LTFU cumulative minus by 2018 LTFU cumulative

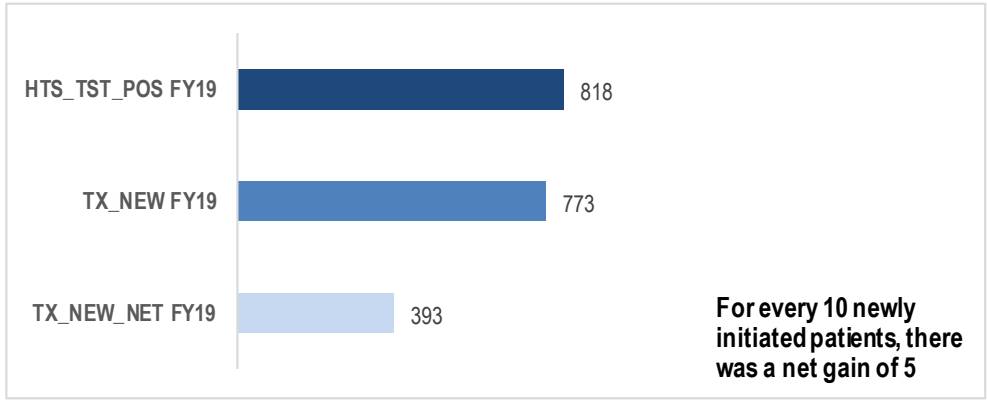
Kazakhstan



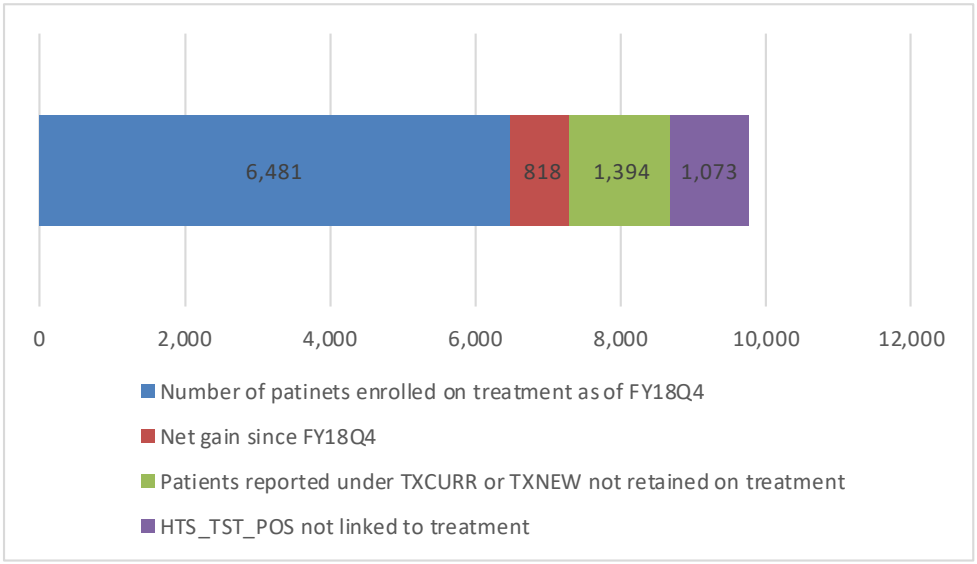


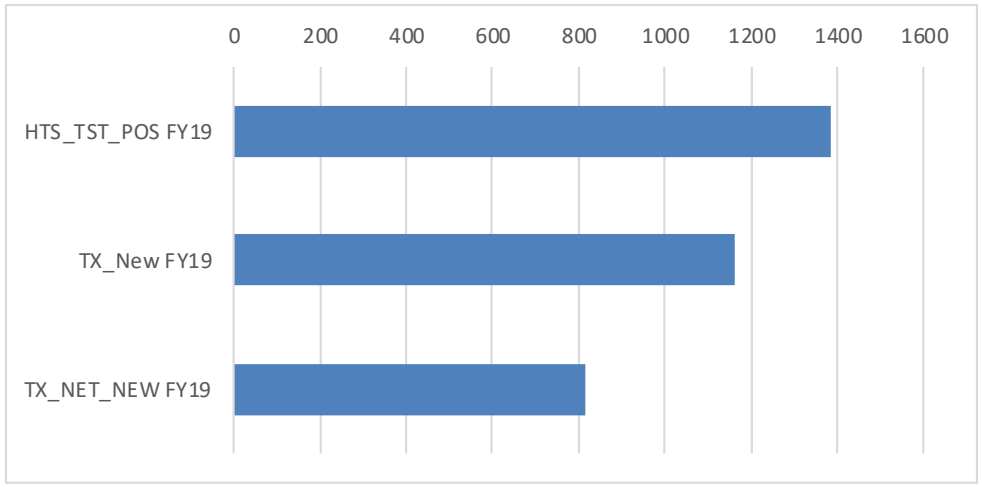
Kyrgyz Republic



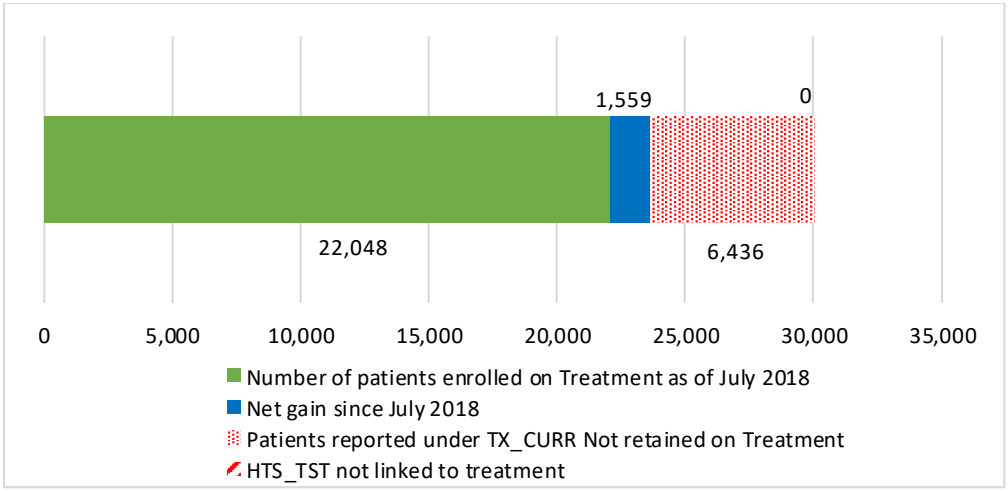


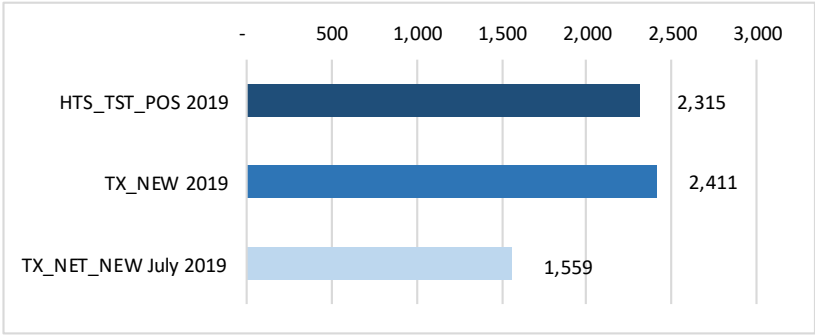
Lao PDR



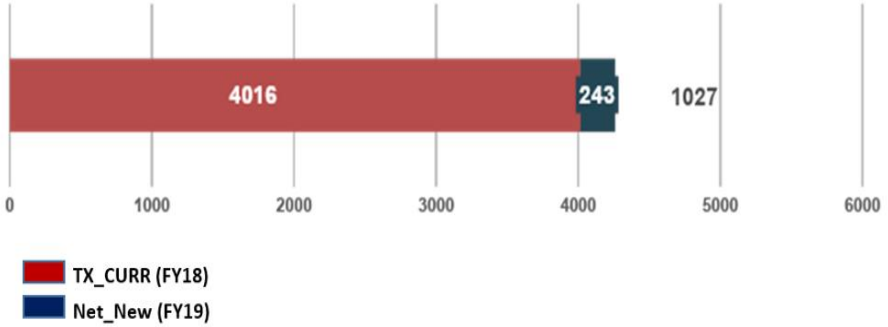


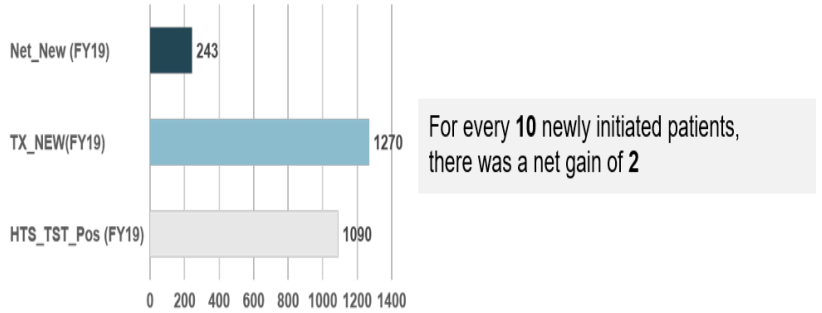
Nepal





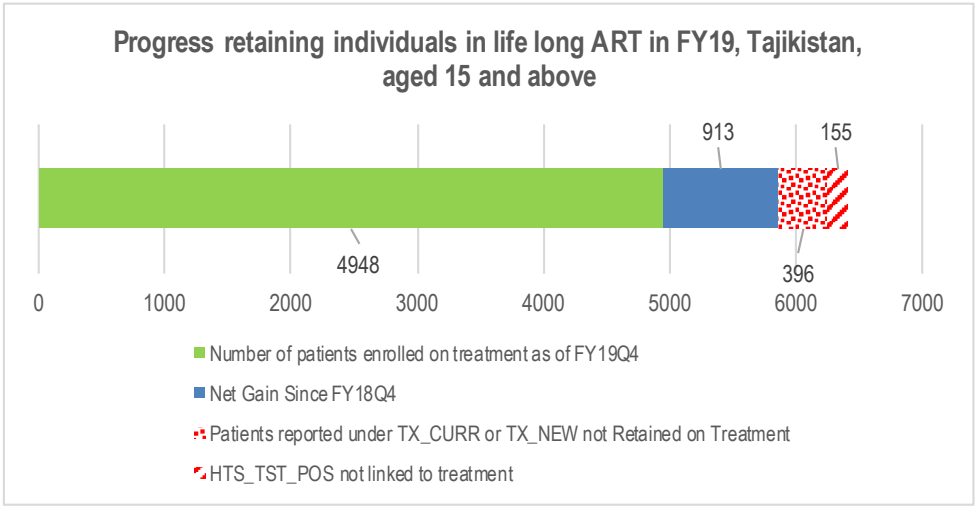
Papua New Guinea

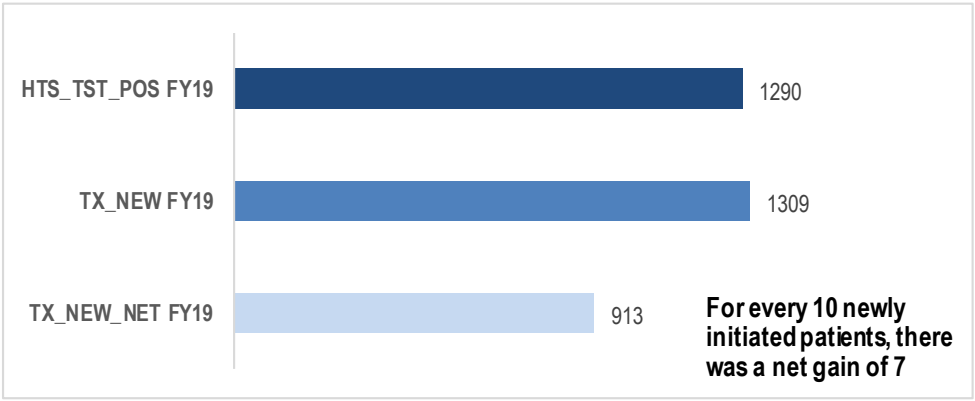




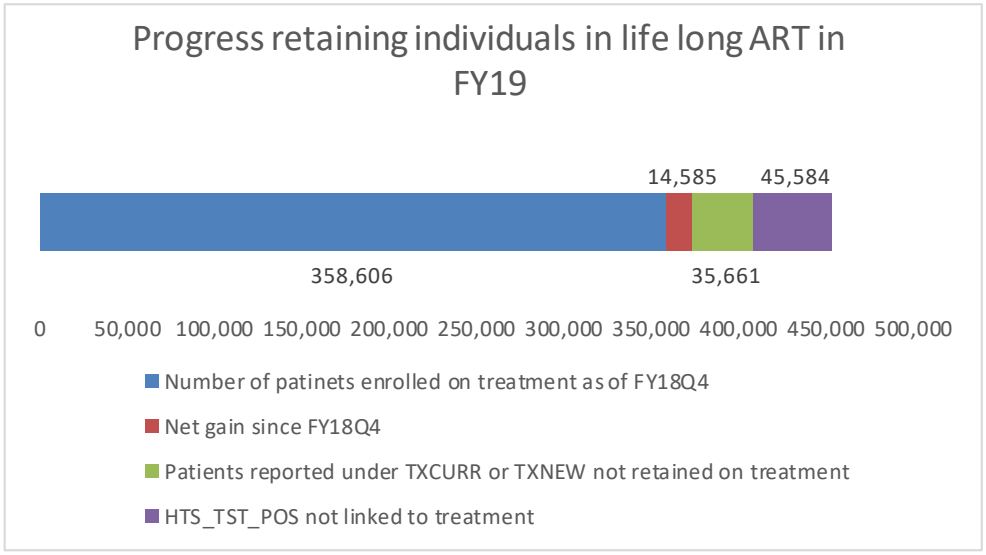
Source: HIV Patient Database (HPDB) / DATIM

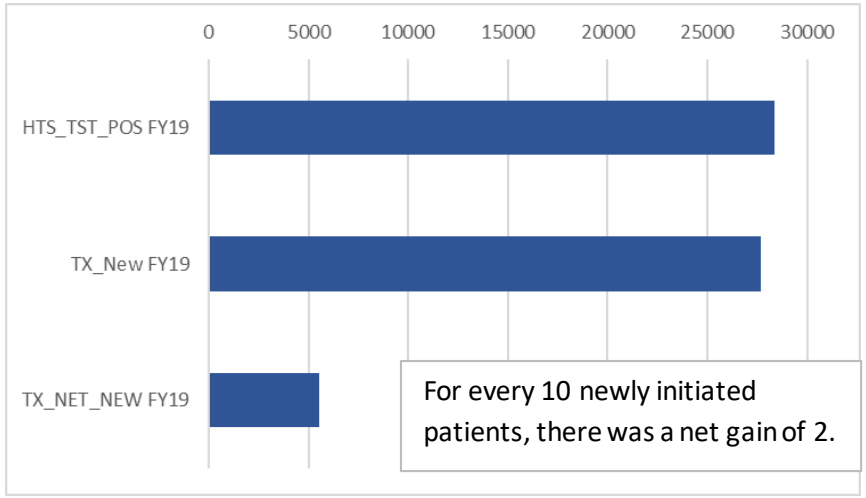
Tajikistan





Thailand



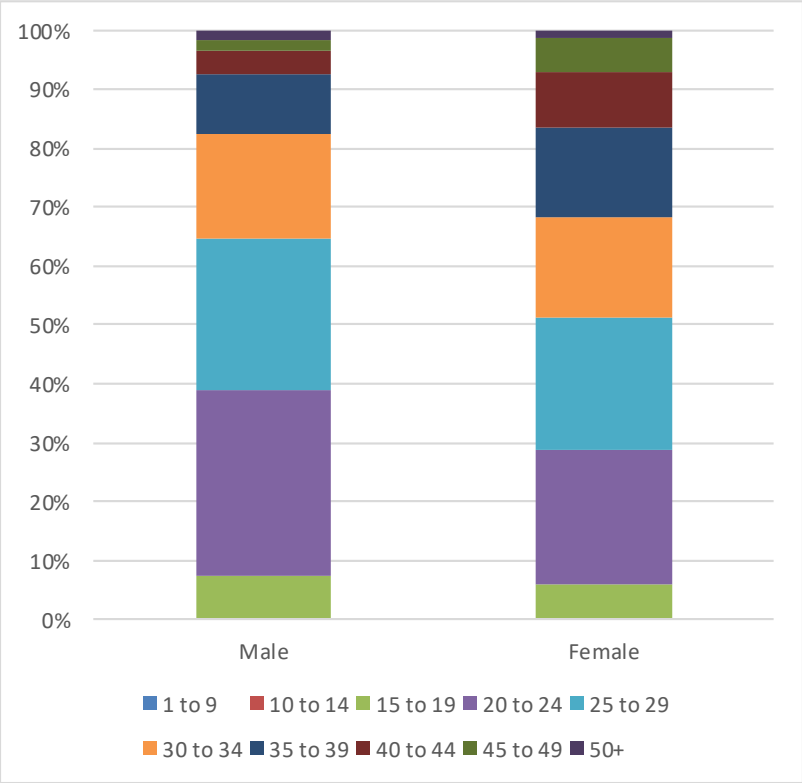


Source: *National AIDS Program (NAP) web report FY2019, as of October 2019*

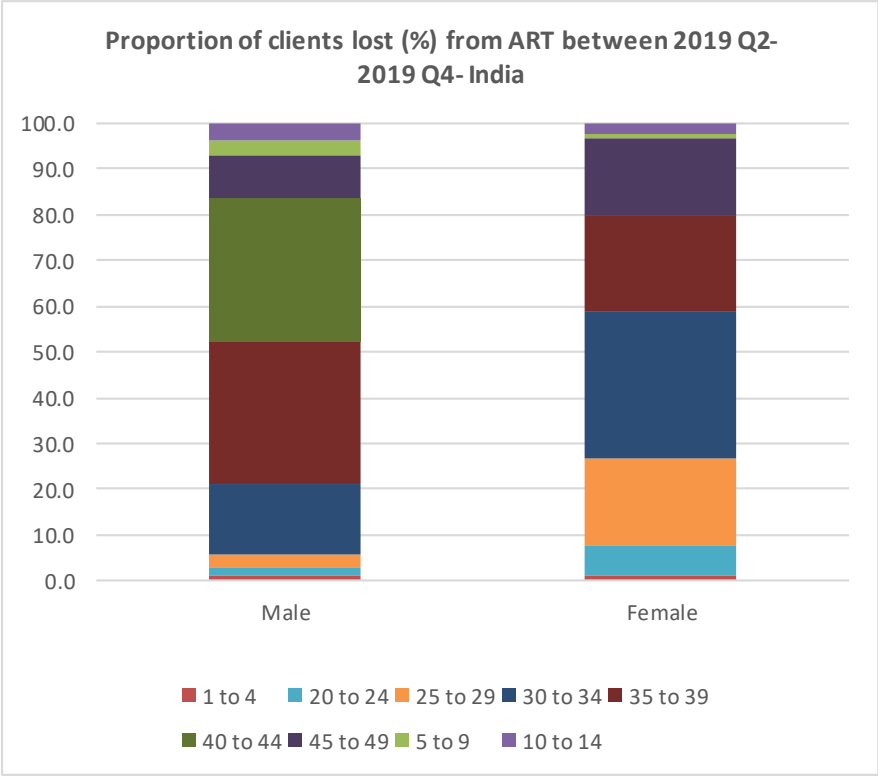
Figure 2.1.6 Proportion of clients lost from ART 2018 Q4 to 2019 Q4

Note: There is no data available for Cambodia, Indonesia or Nepal to produce this figure

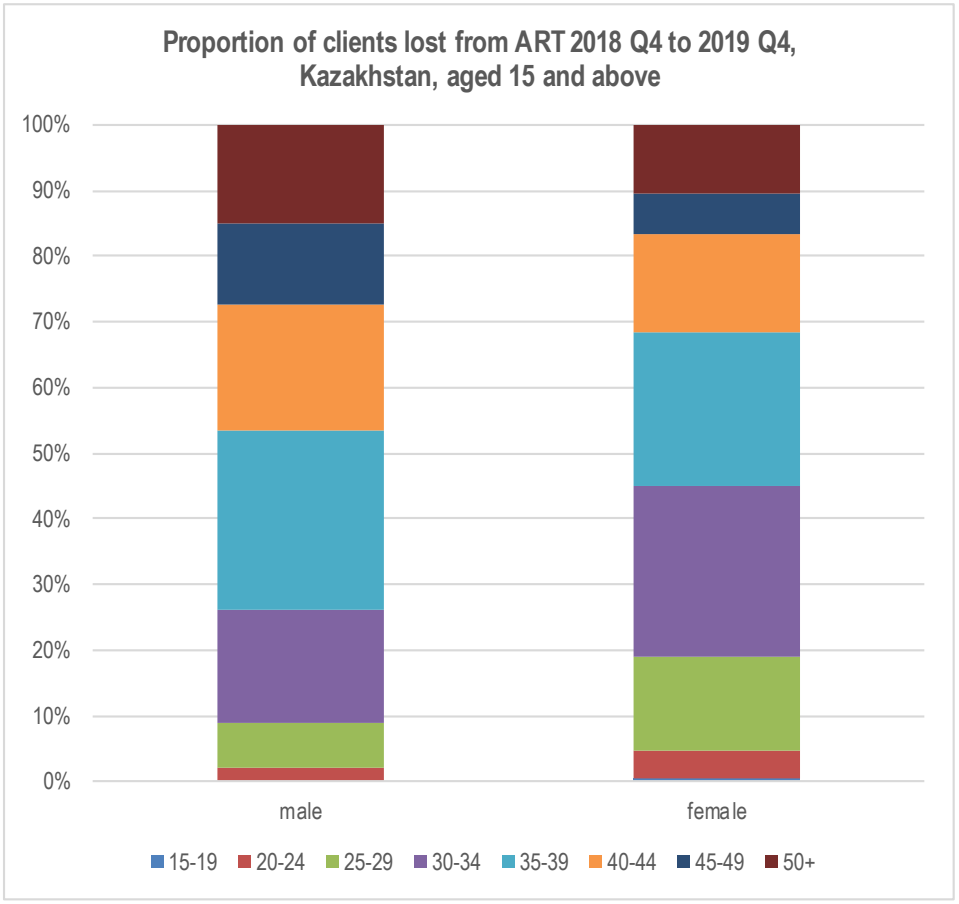
Burma:



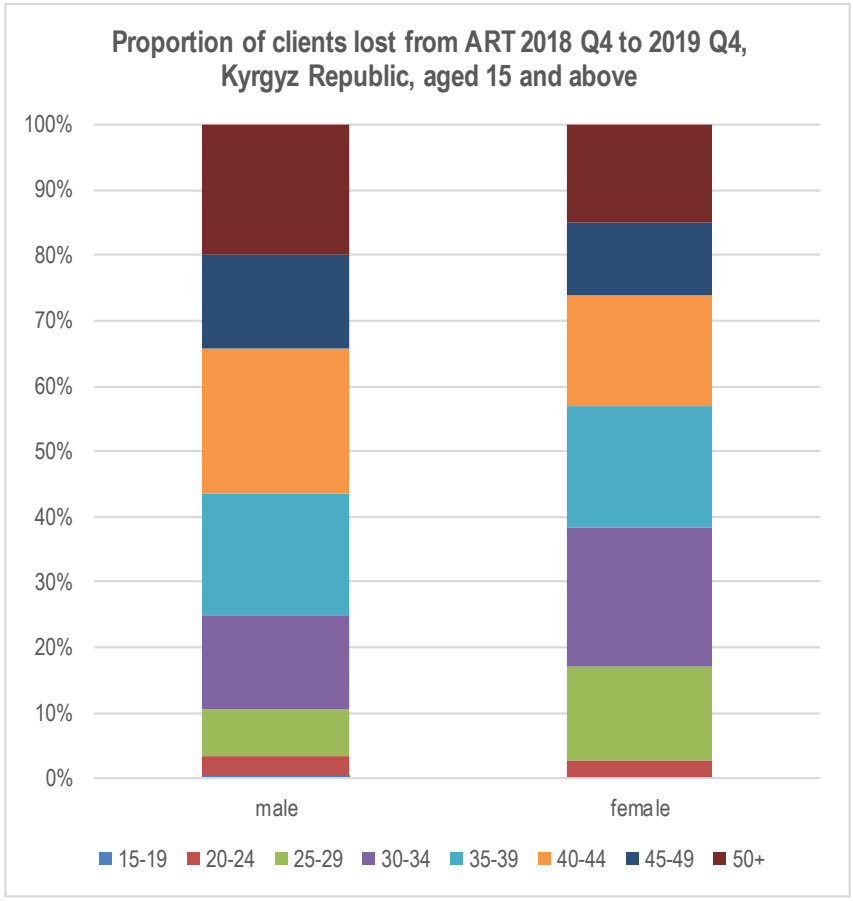
India:



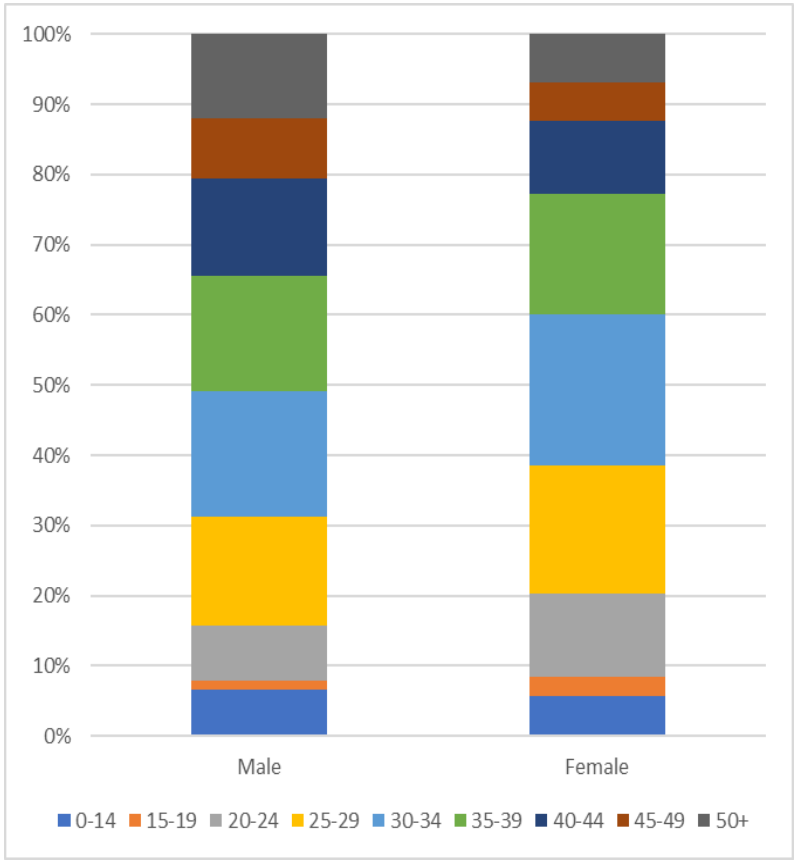
Kazakhstan



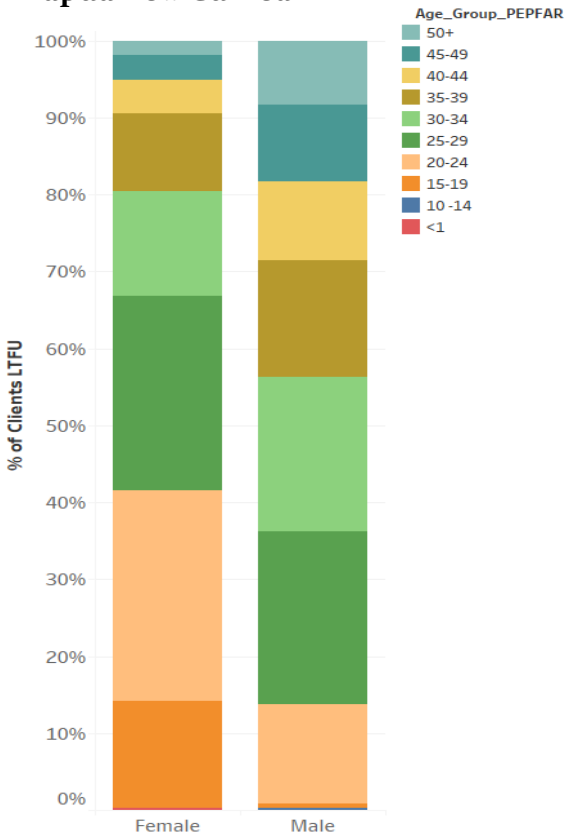
Kyrgyz Republic



Lao PDR

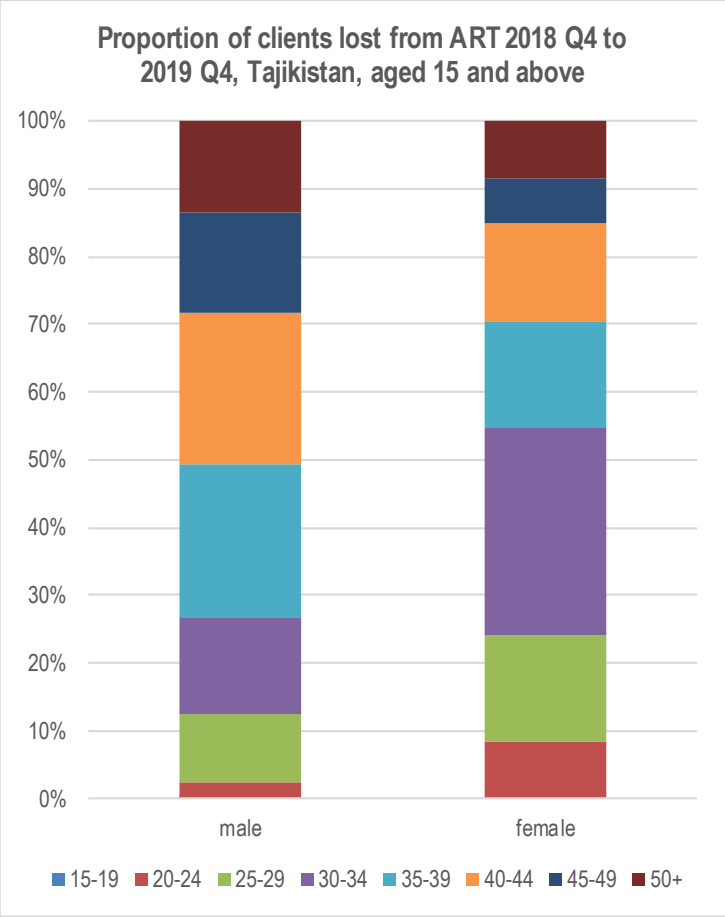


Papua New Guinea

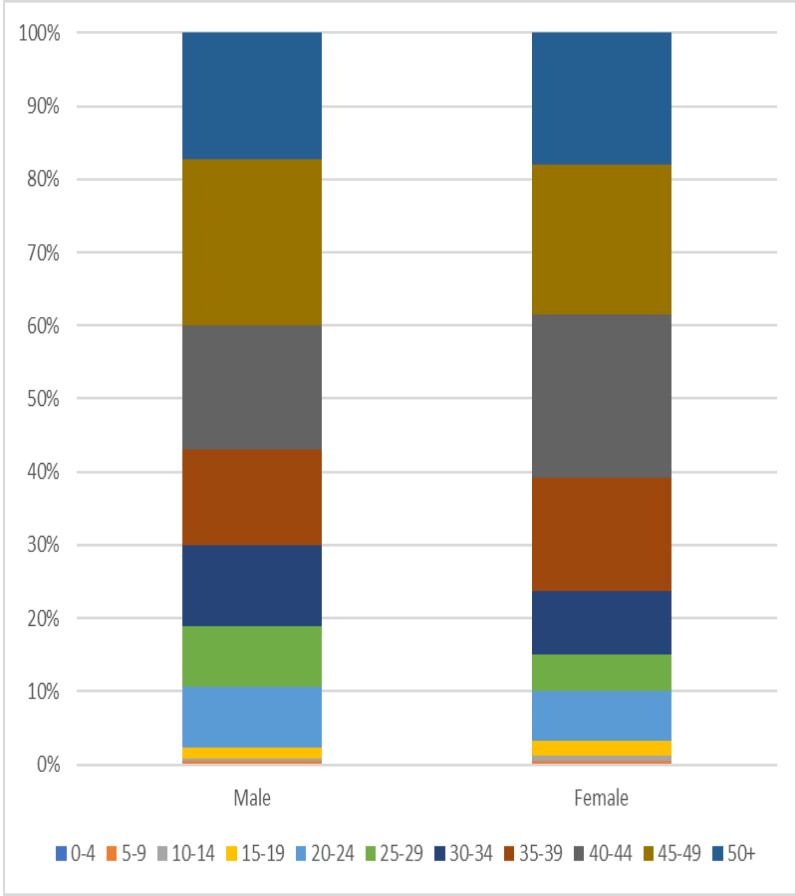


Source: HIV Patient Database (HPDB) / DATIM

Tajikistan



Thailand

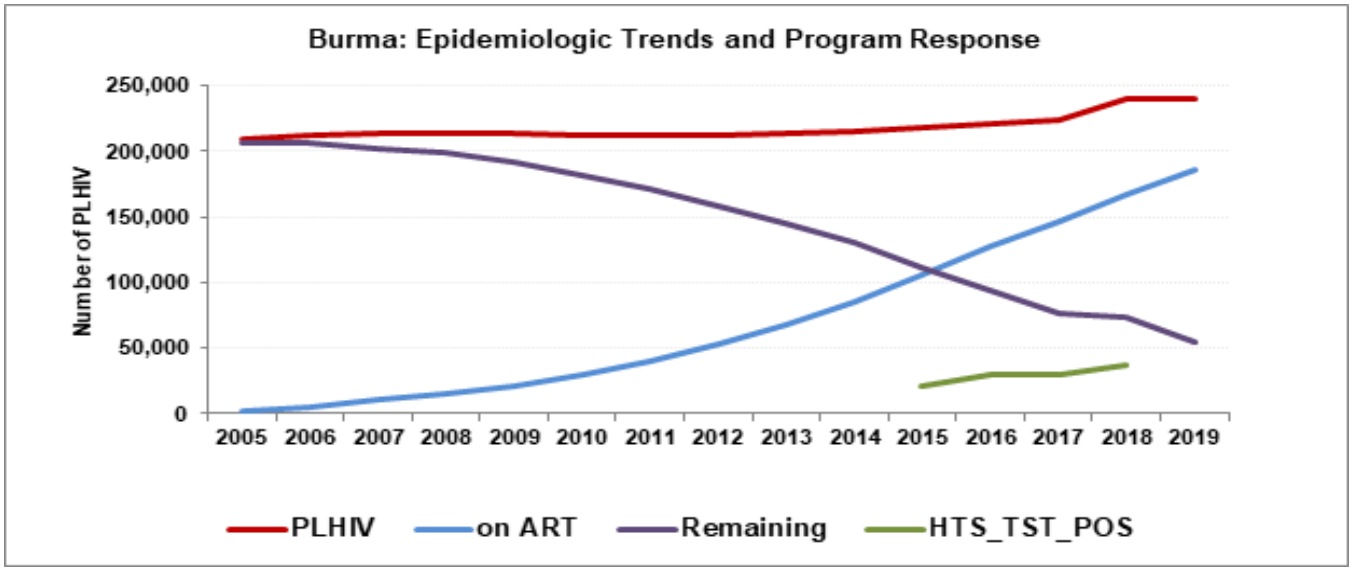


Proportion of clients lost from ART after 12, 24 and 60 months after ART initiation by age group

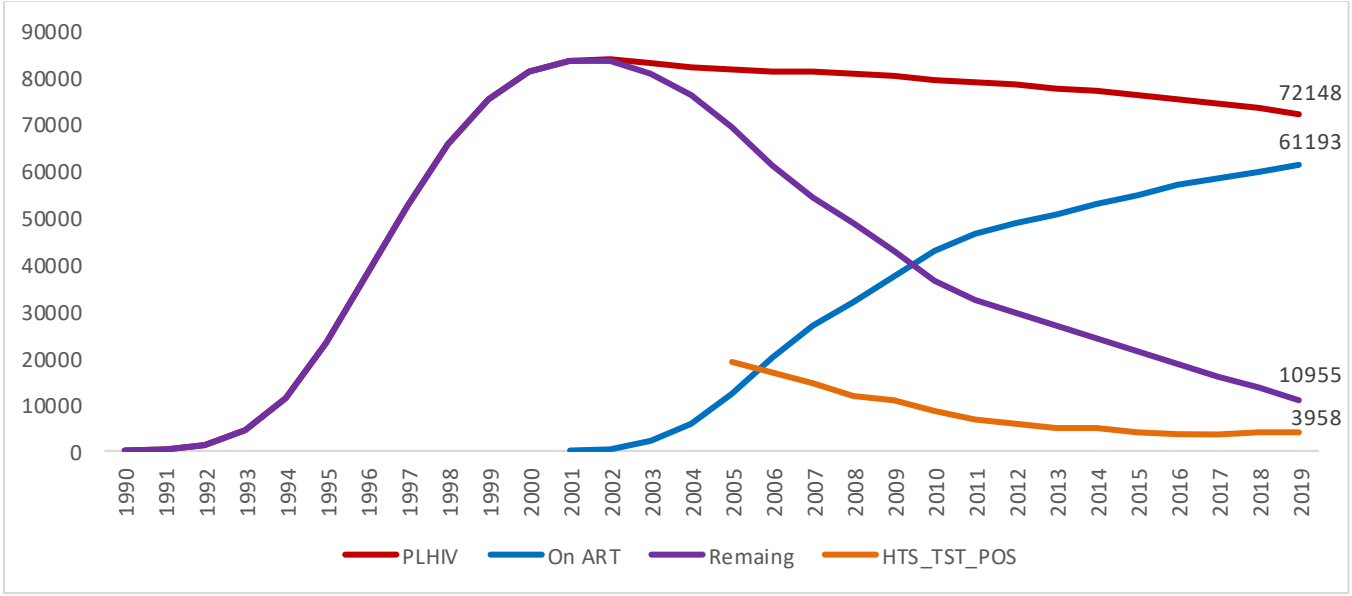
Source: *NAP web report FY2013-2019*

Figure 2.1.7 Epidemiologic Trends and Program Response, by Country

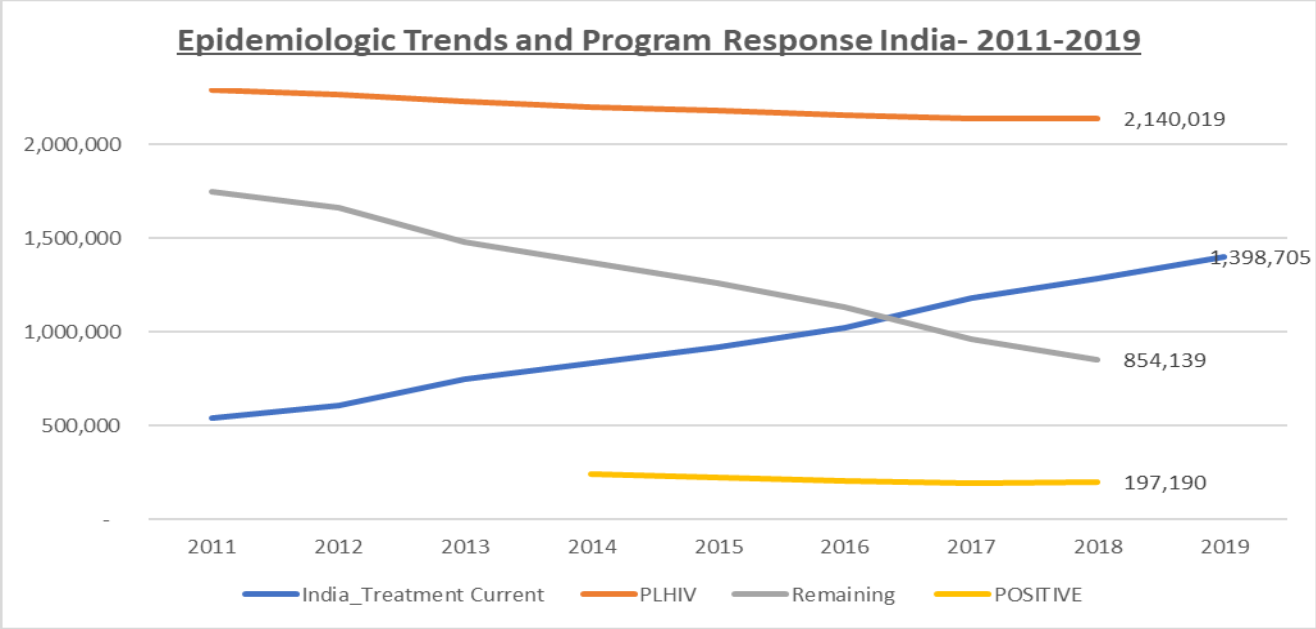
Burma



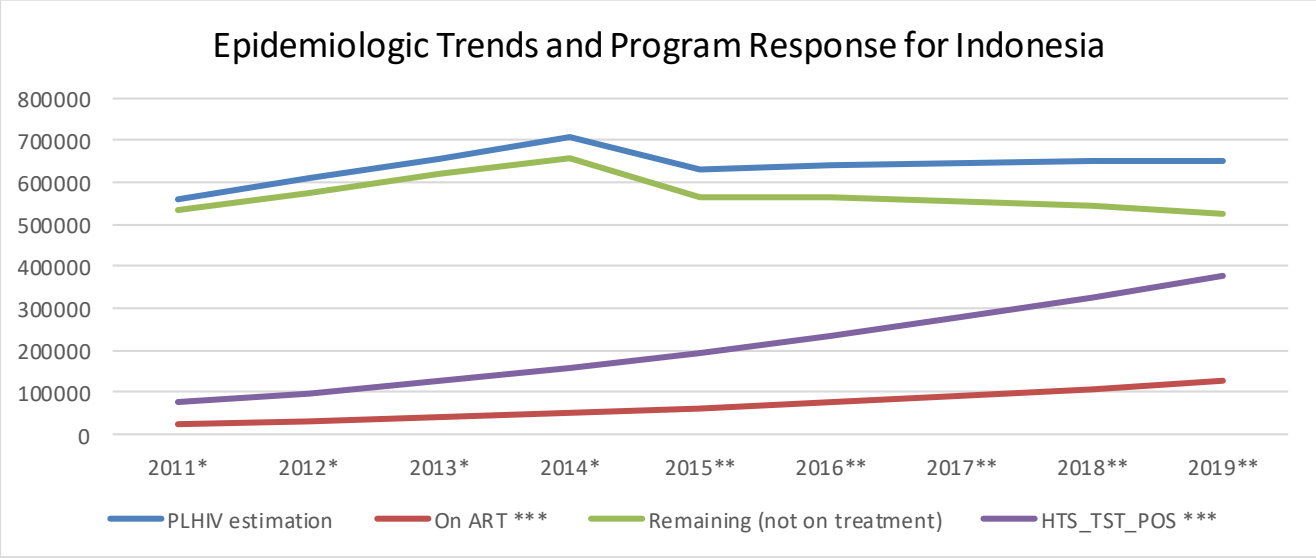
Cambodia



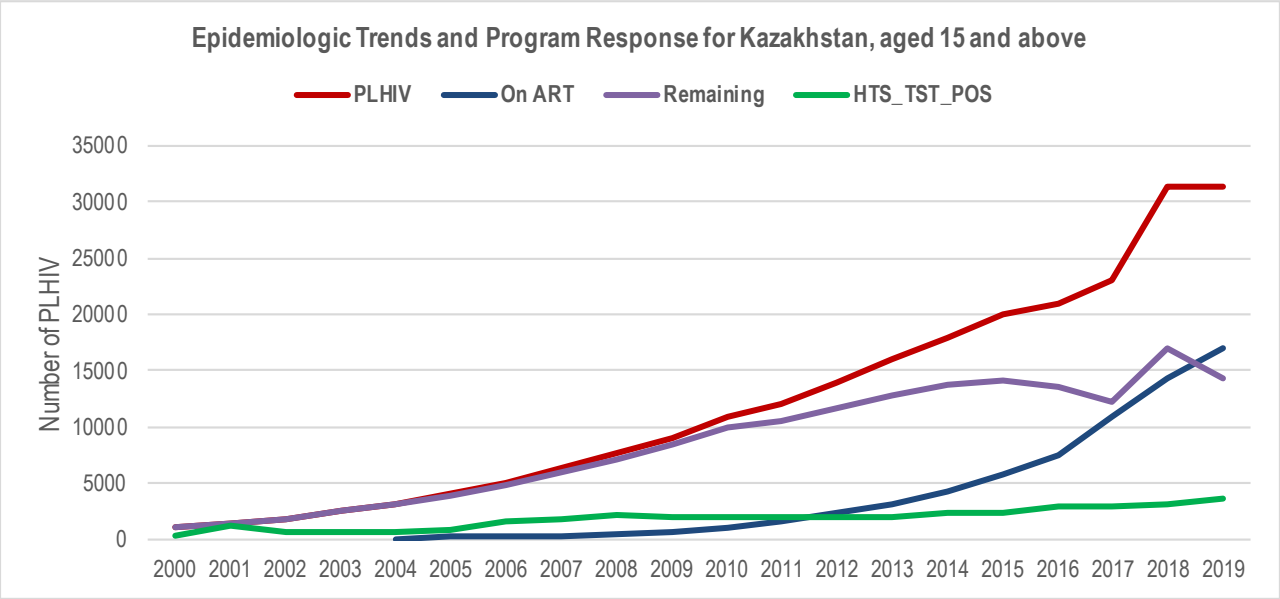
India



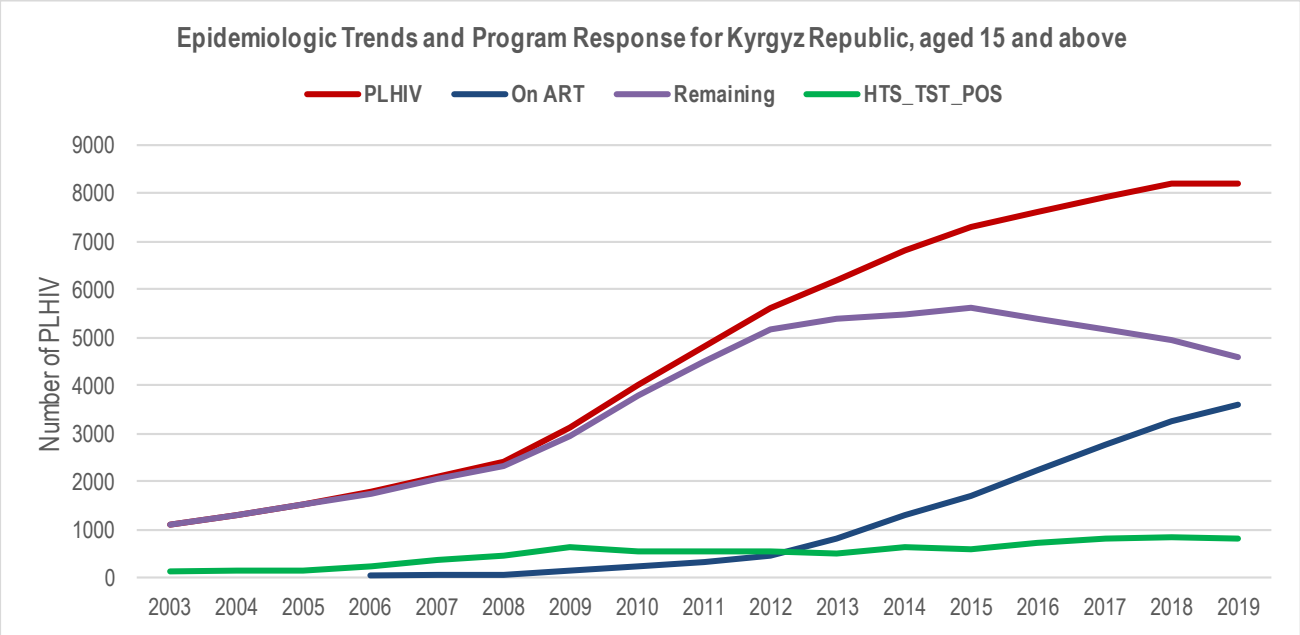
Indonesia



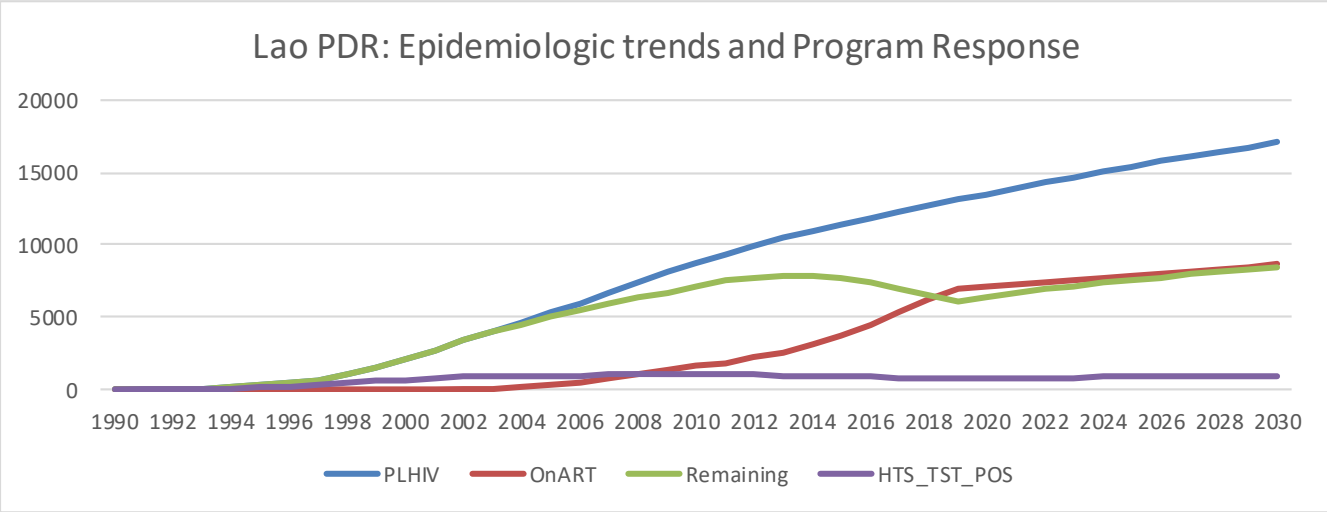
Kazakhstan



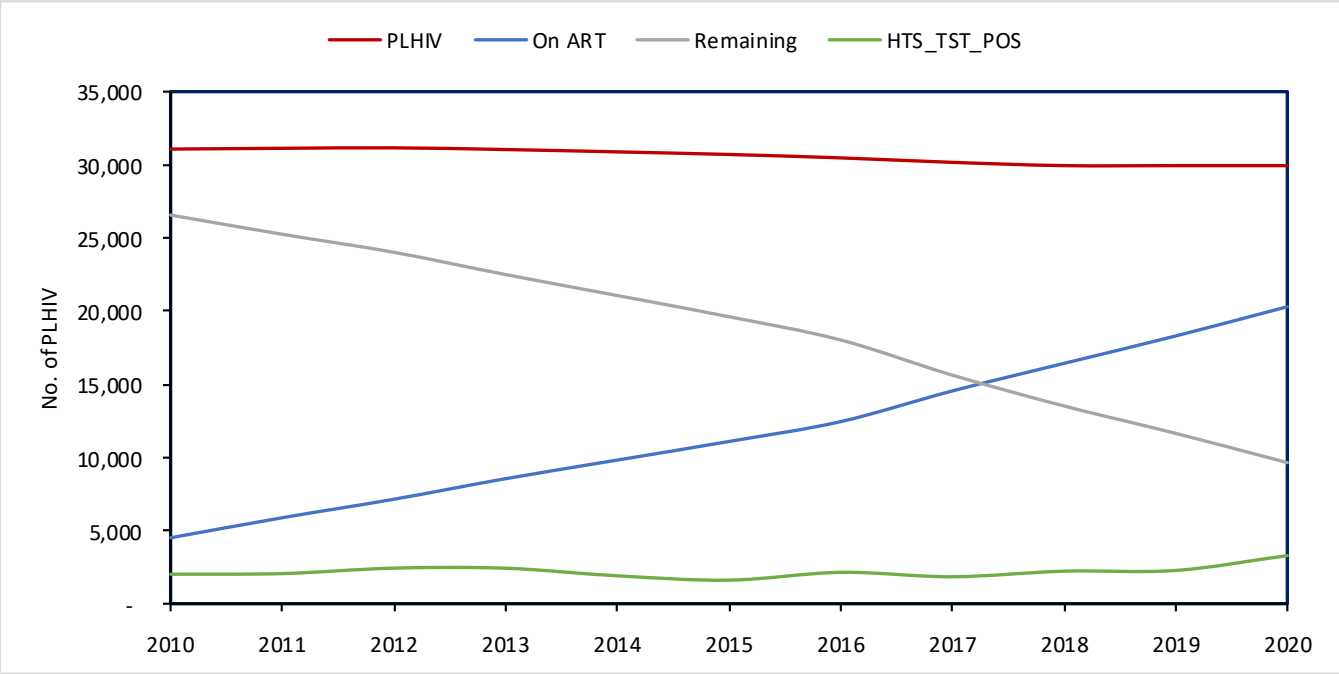
Kyrgyz Republic



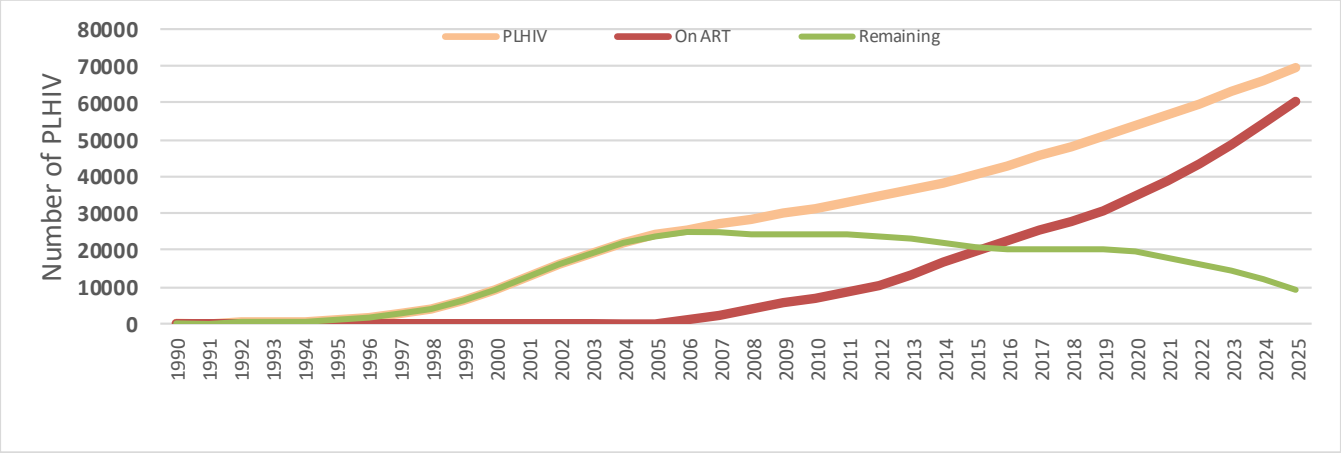
Lao PDR



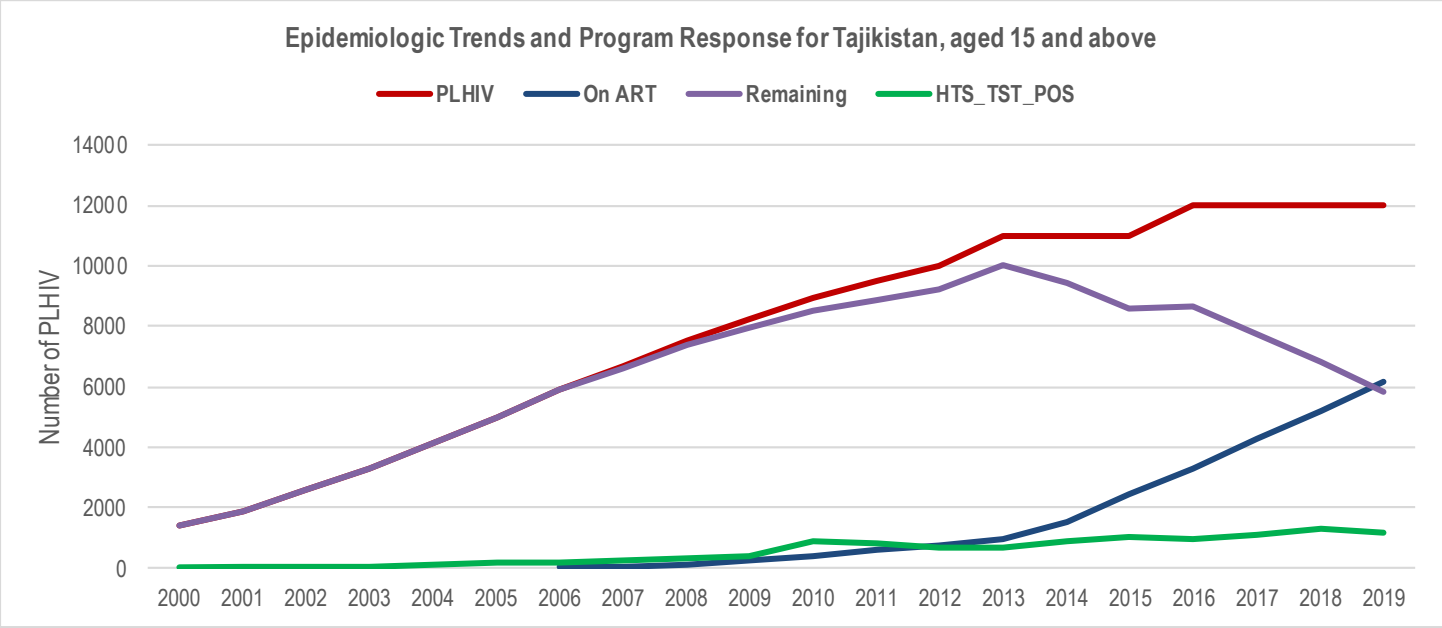
Nepal



Papua New Guinea



Tajikistan



Thailand

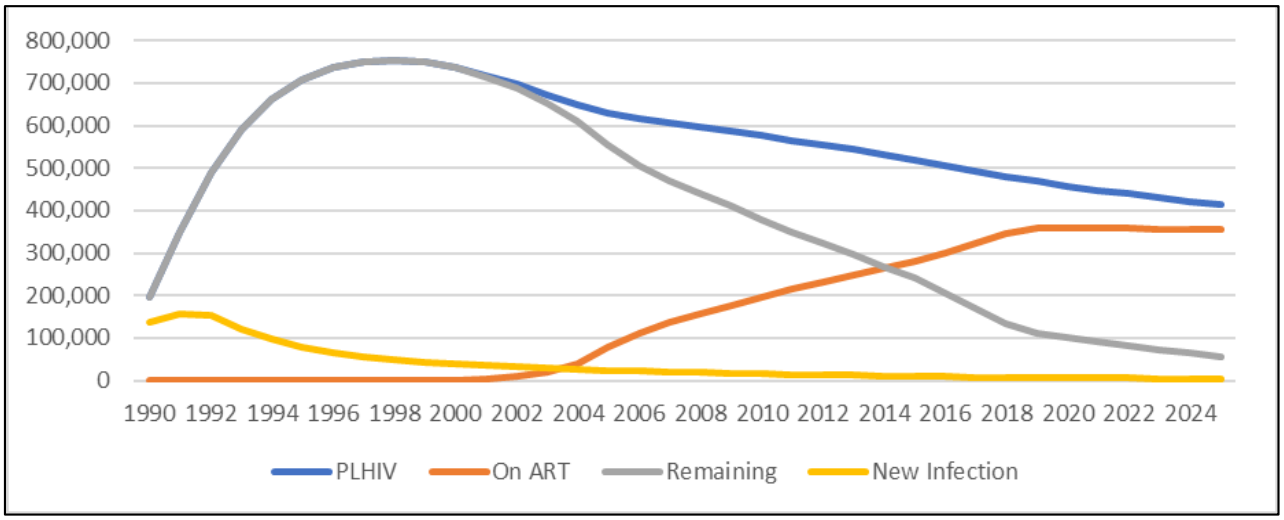
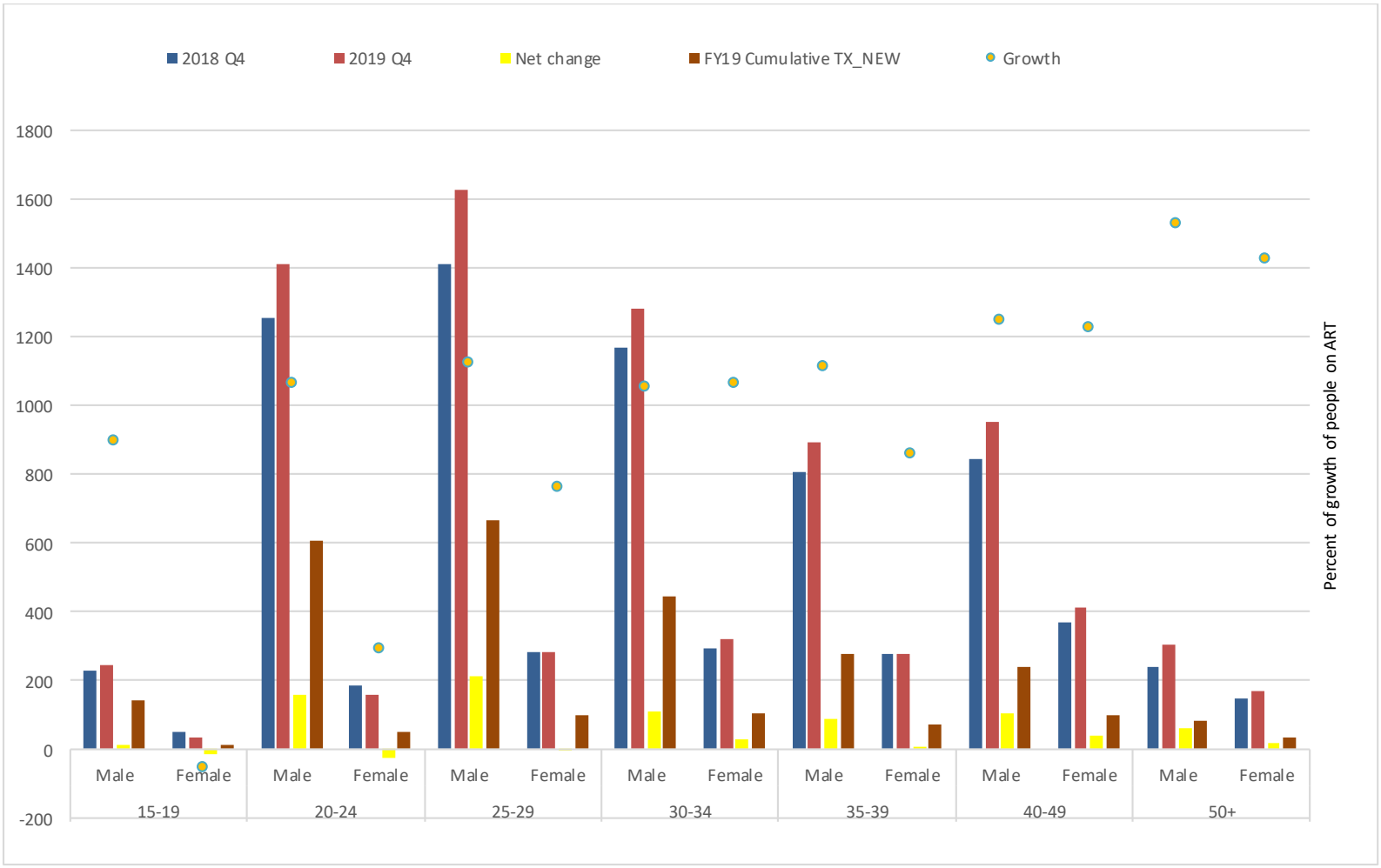

800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000
0
1990 1992 1994 1996 1998 2000 2002 2004 2006 2008 2010 2012 2014 2016 2018 2020 2022 2024
PLHIV
On ART
Remaining
New Infection

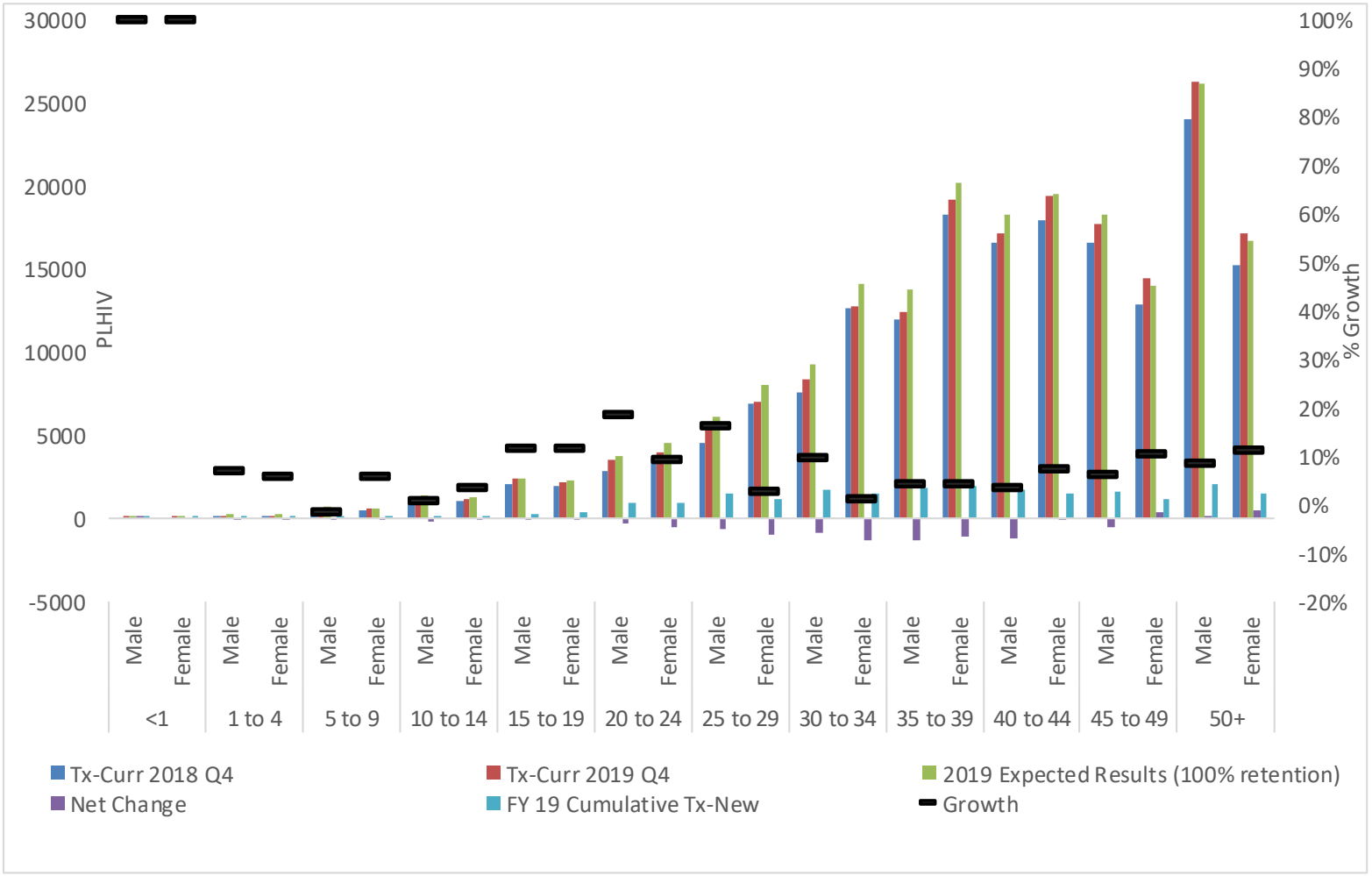
Figure 2.1.8 Net change in HIV treatment by sex and age bands 2018 Q4 to 2019 Q4 by Country

Note: There is no data available for Cambodia & Nepal to produce this figure

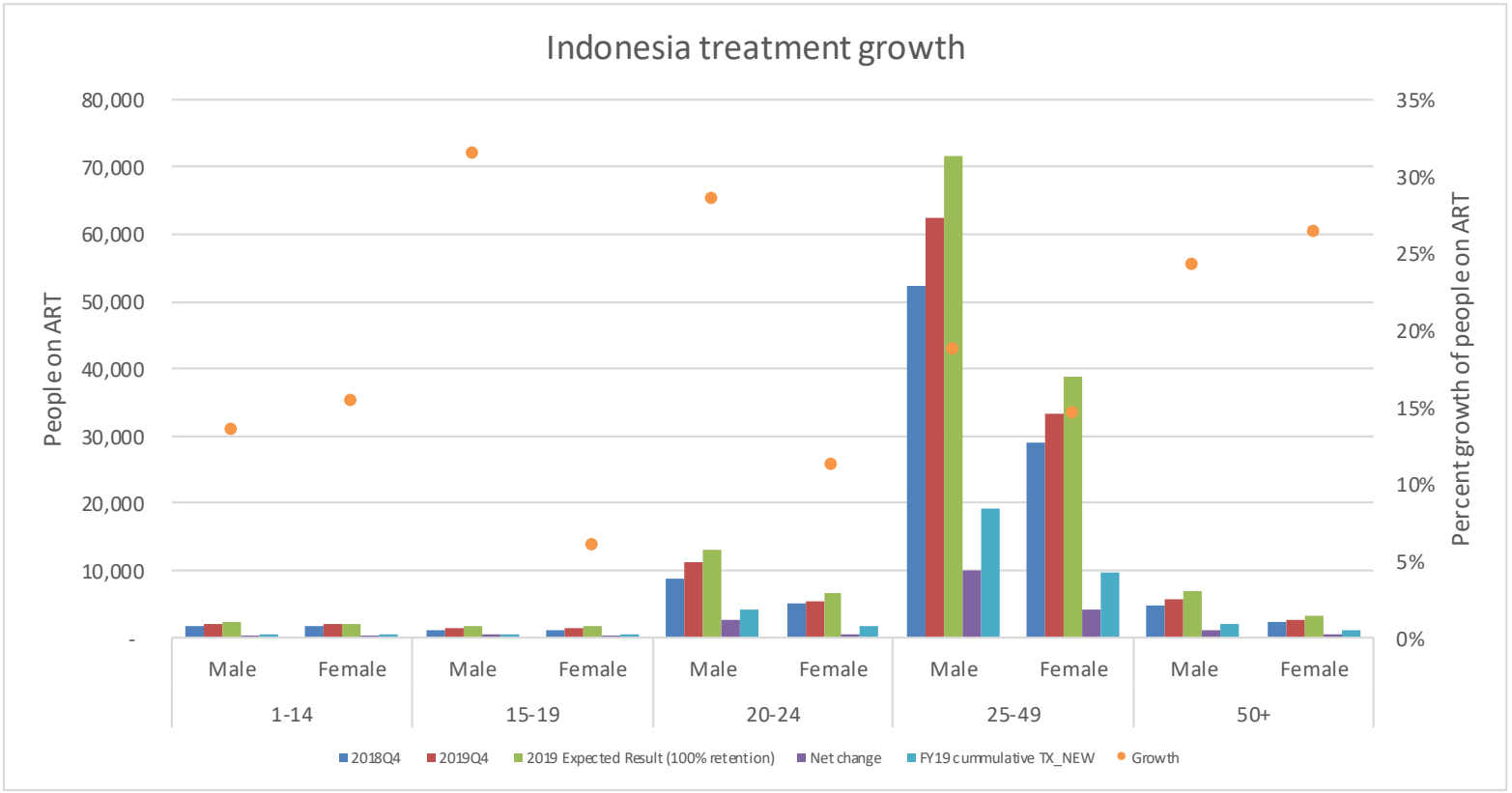
Burma



India

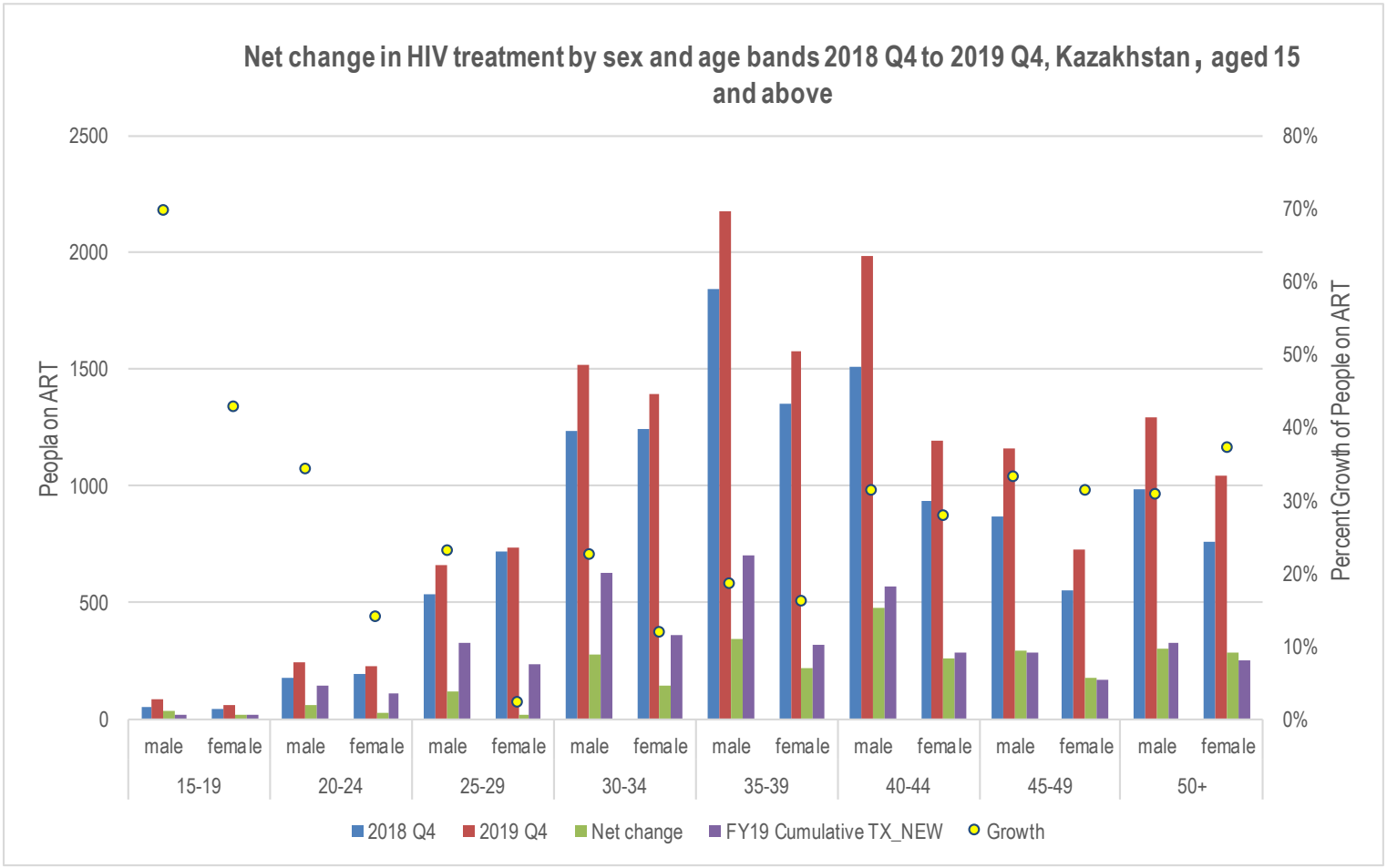

30000
25000
20000
15000
10000
5000
0
-5000
PLHIV
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
-10%
-20%
% Growth
Male
Female
<1
1 to 4
5 to 9
10 to 14
15 to 19
20 to 24
25 to 29
30 to 34
35 to 39
40 to 44
45 to 49
50+
Tx-Curr 2018 Q4
Tx-Curr 2019 Q4
2019 Expected Results (100% retention)
Net Change
FY 19 Cumulative Tx-New
Growth

Indonesia

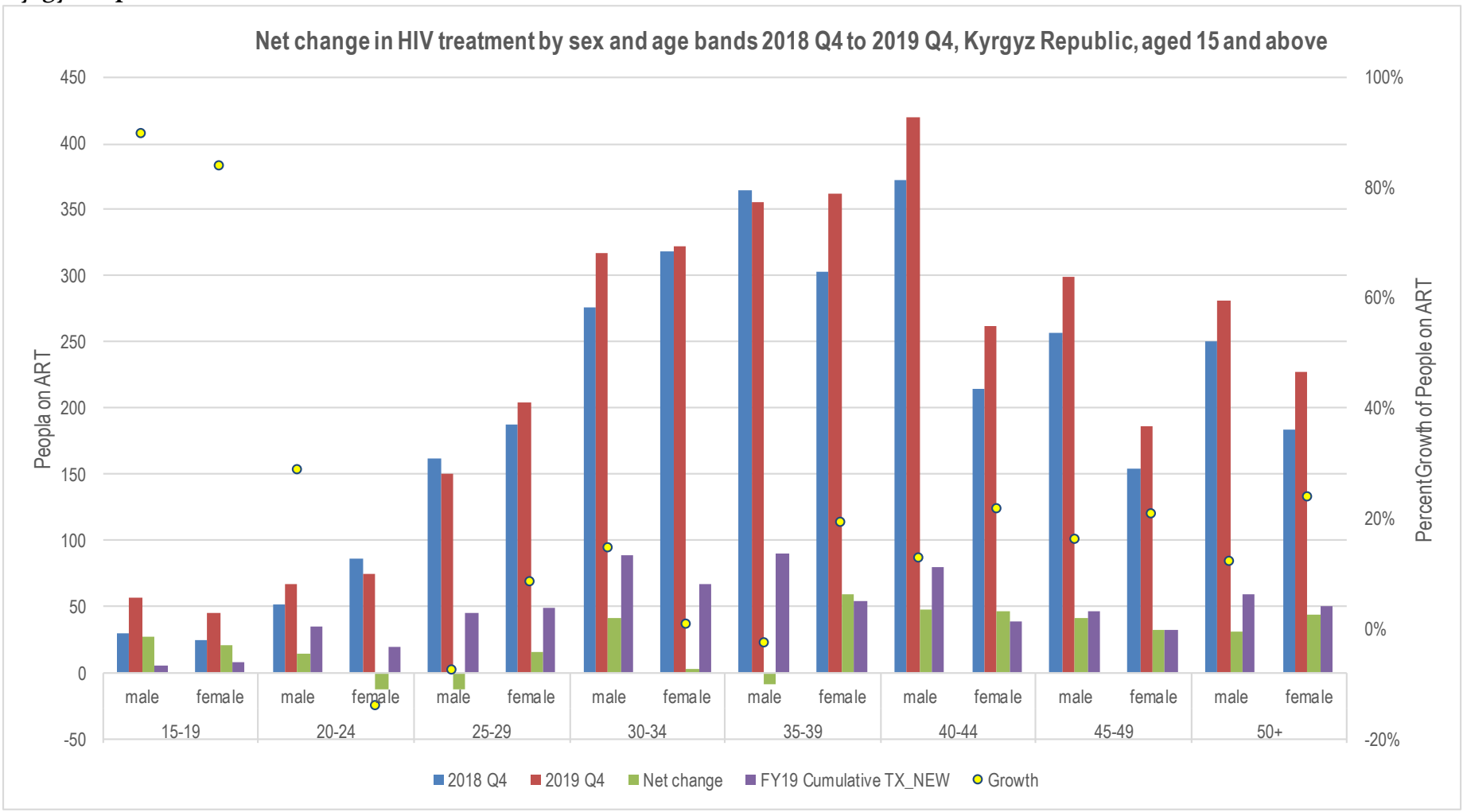


Source: MoH Quarterly Report December 2019

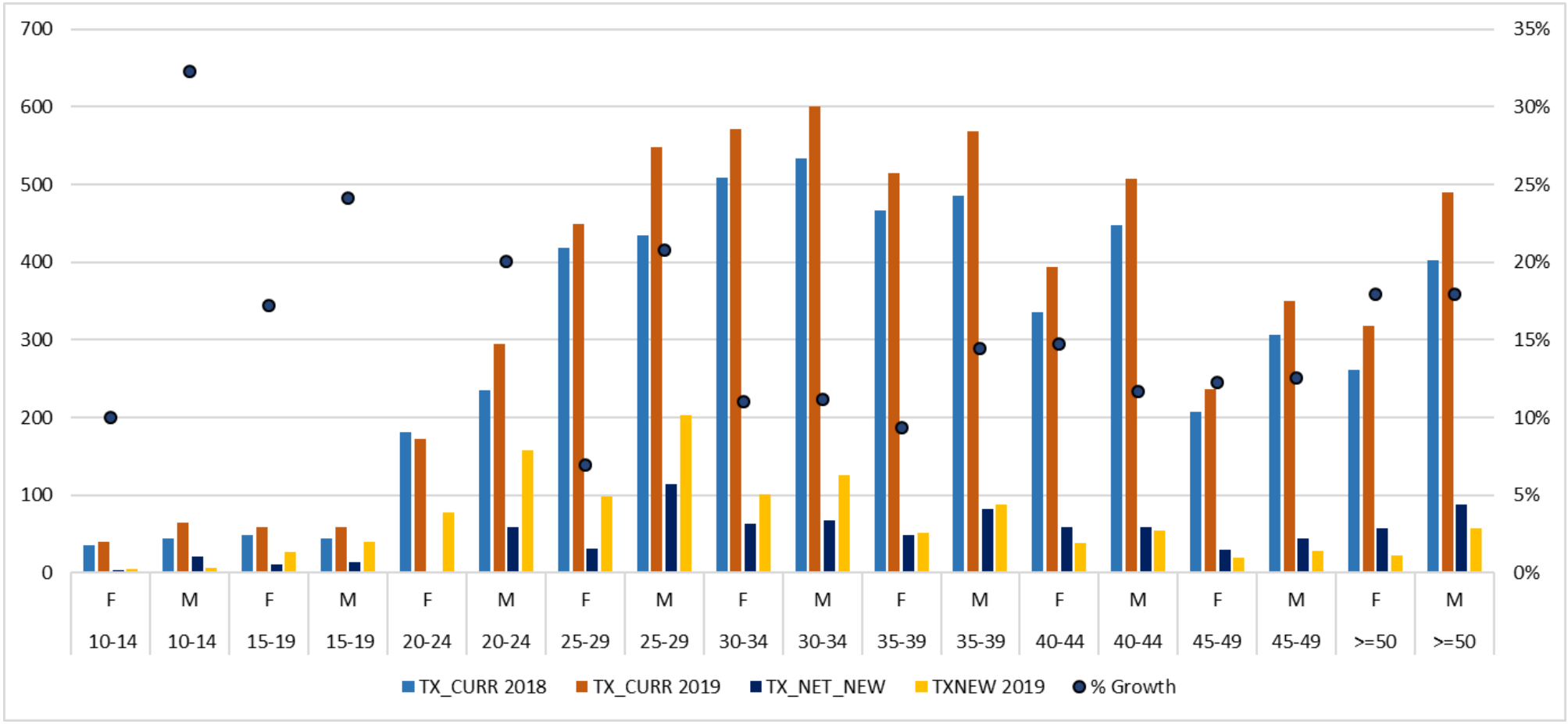
Kazakhstan


Net change in HIV treatment by sex and age bands 2018 Q4 to 2019 Q4, Kazakhstan , aged 15 and above
Peopla on ART
Percent Growth of People on ART
2500
2000
1500
1000
500
0
80%
70%
60%
50%
40%
30%
20%
10%
0%
male
female
15-19
20-24
25-29
30-34
35-39
40-44
45-49
50+
2018 Q4
2019 Q4
Net change
FY19 Cumulative TX_NEW
Growth

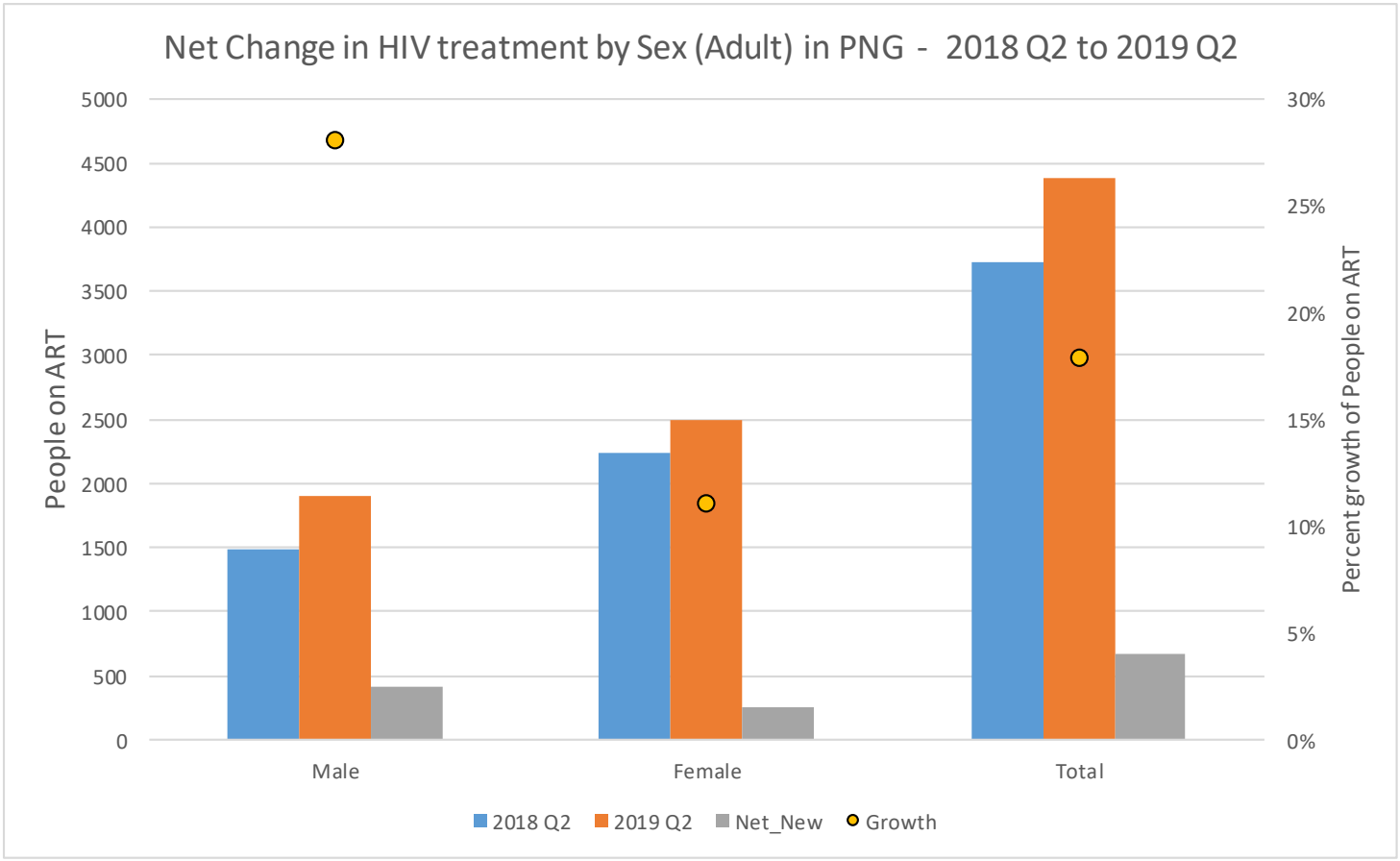
Kyrgyz Republic



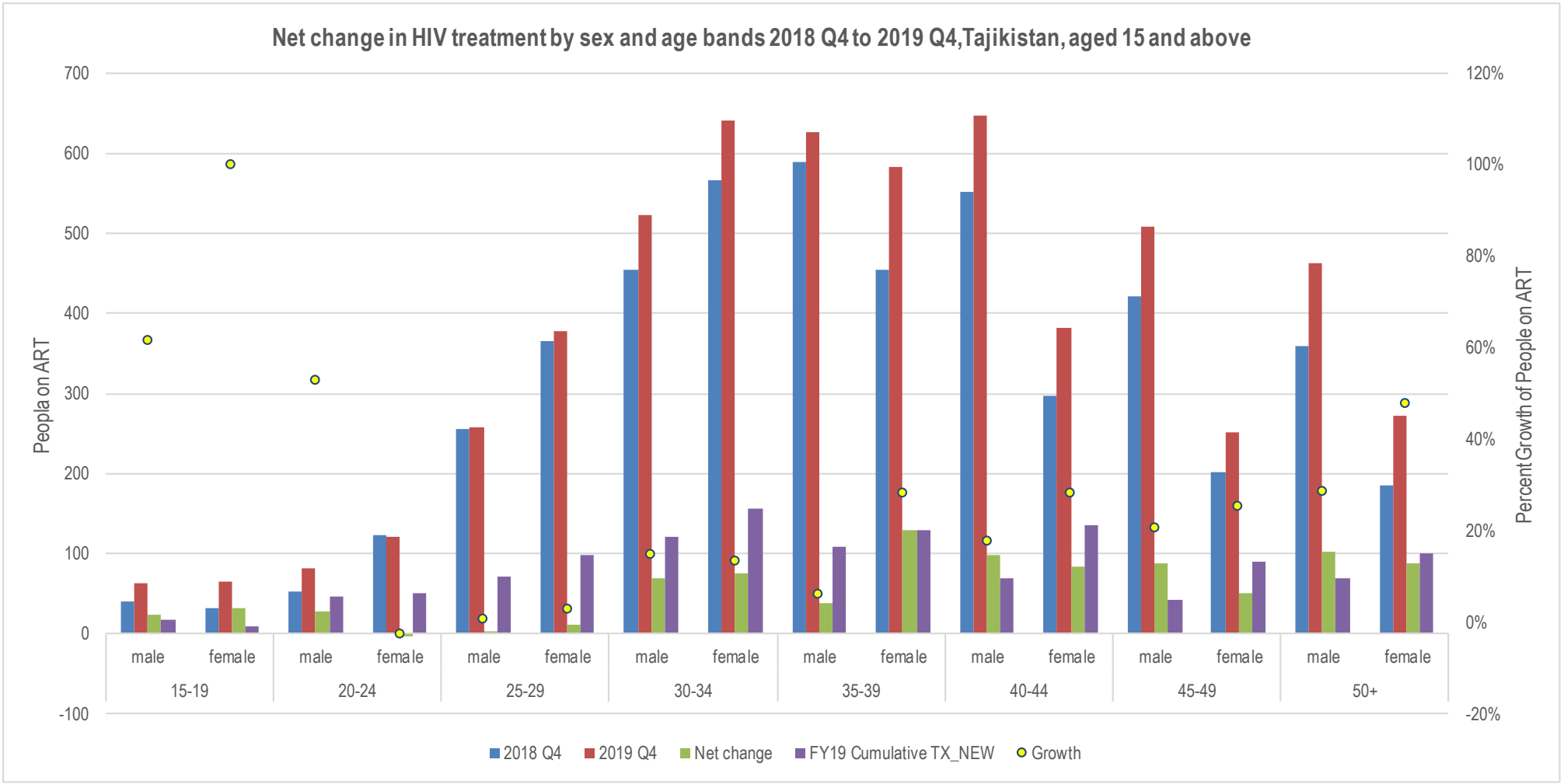
Lao PDR


700
600
500
400
300
200
100
0
35%
30%
25%
20%
15%
10%
5%
0%
F 10-14
M 10-14
F 15-19
M 15-19
F 20-24
M 20-24
F 25-29
M 25-29
F 30-34
M 30-34
F 35-39
M 35-39
F 40-44
M 40-44
F 45-49
M 45-49
F >=50
M >=50
TX_CURR 2018
TX_CURR 2019
TX_NET_NEW
TXNEW 2019
% Growth

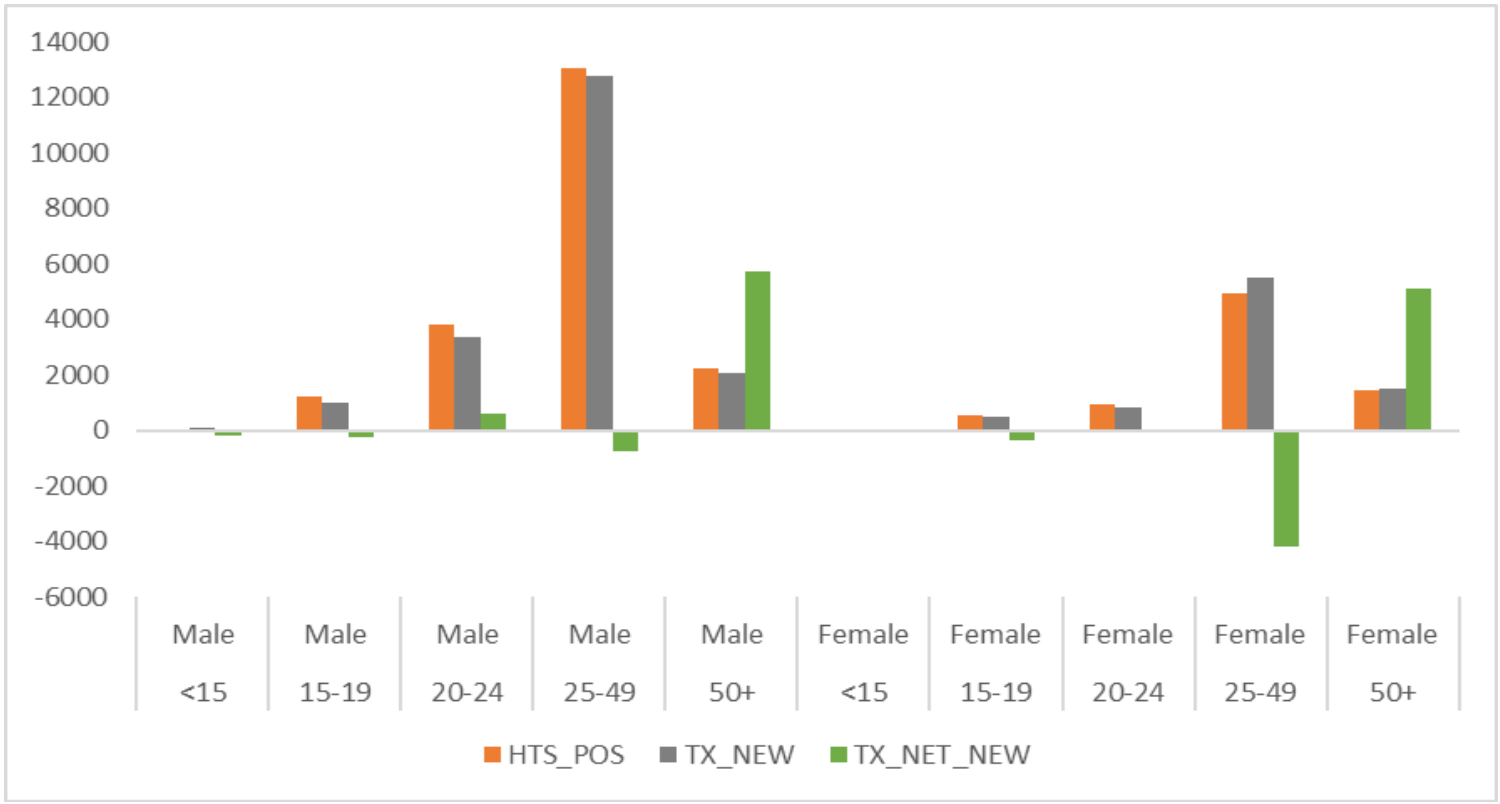
Papua New Guinea



Tajikistan


Net change in HIV treatment by sex and age bands 2018 Q4 to 2019 Q4,Tajikistan, aged 15 and above
Peopla on ART
Percent Growth of People on ART
700
600
500
400
300
200
100
0
-100
120%
100%
80%
60%
40%
20%
0%
-20%
male
female
15-19
20-24
25-29
30-34
35-39
40-44
45-49
50+
2018 Q4
2019 Q4
Net change
FY19 Cumulative TX_NEW
Growth

Thailand



National AIDS Program (NAP) web report FY2019, as of October 2019

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration by Country

Burma

Table 2.3.3 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 ROP Co-Funding Contribution**	**Objectives**
USAID MCH	5,000,000				
USAID TB	8,000,000				
USAID Malaria	10,000,000				
Other (specify)	3,900,000				
Total	**26,900,000**				

Cambodia

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration (Cambodia)					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR ROP Co-Funding Contribution**	**Objectives**
USAID MCH	$4,100,000	$1,509,366	2	$1,050,000	Quality Improvement & Health Finance
USAID TB	$5,500,000	$1,300,000	2	$1,050,000	Quality Improvement & Health Finance
USAID Nutrition	$1,000,000	$50,000	1	$1,050,000	Quality Improvement & Health Finance
USAID FP/RH	$2,000,000	$1,121,927	2	$1,050,000	Quality Improvement & Health Finance

India

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration (India)					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR ROP Co-Funding Contribution**	**Objectives**
USAID MCH	$6,000,000				
USAID TB	$10,500,000				
Family Planning	$6,500,000				
CDC (Global Health Security)	$6,822,526				
Total	**$29,822,526**				

Indonesia

Table 2.3.3 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 ROP Co-Funding Contribution**	**Objectives**
USAID MCH	$ 6m	$ 5.3m	2	$ 0.6m	
USAID TB	$ 13.5m	$ 3m	3	$ 1.32m	
Total	**$ 19.5m**	**$ 8.3m**	**5**	**$ 1.92m**	

Kazakhstan

Table 2.3.3 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 ROP Co-Funding Contribution**	**Objectives**
USAID TB	$569,000				
Total	**$569,000**				

Kyrgyz Republic

Table 2.3.3 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 ROP Co-Funding Contribution**	**Objectives**
USAID MCH	$500,000				
USAID TB	$4,300,000				
Total	**$4,800,000**				

Lao PDR

Table 2.3.3 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 ROP Co-Funding Contribution**	**Objectives**
USAID MCH	$1,115,889				This integrated nutrition, hygiene, and sanitation activity aims to reduce child stunting in 2 southern provinces (Khammoune and Savannakhet) in Lao PDR.
USAID Malaria	$1,121,075				(IP1 - 1) Strengthen malaria surveillance systems in Thailand and Lao PDR; 2) Support national programs to evaluate elimination models and strategies for implementation and scale-up; and 3) Support national malaria programs to generate, analyze, use and document strategic information.) (IP2 - This Activity procures and supports distribution of insecticide treated bed nets, rapid diagnostic tests, and artemisinin-based combination therapies as part of effort to ensure the availability and access to quality malaria services. This program also provides technical assistance for supply chain management.) (IP3 - Regional program for technical assistance to strengthen drug efficacy monitoring network (Therapeutic Efficacy Studies) and regional capacity building in diagnostics, entomology, and program management and regional insecticide resistance coordination.)
Total	**$2,236,964**				

Nepal

Table 2.3.3 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 ROP Co-Funding Contribution**	**Objectives**
USAID MCH	$15,250,000				
Family Planning	$15,500,000				
Total	**$30,750,000**				

Papua New Guinea

Table 2.3.3 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 ROP Co-Funding Contribution**	**Objectives**
CDC (Global Health Security)	350, 000				
Department of Defense (DOD)	70, 000				
Total	**420,000**				

Tajikistan

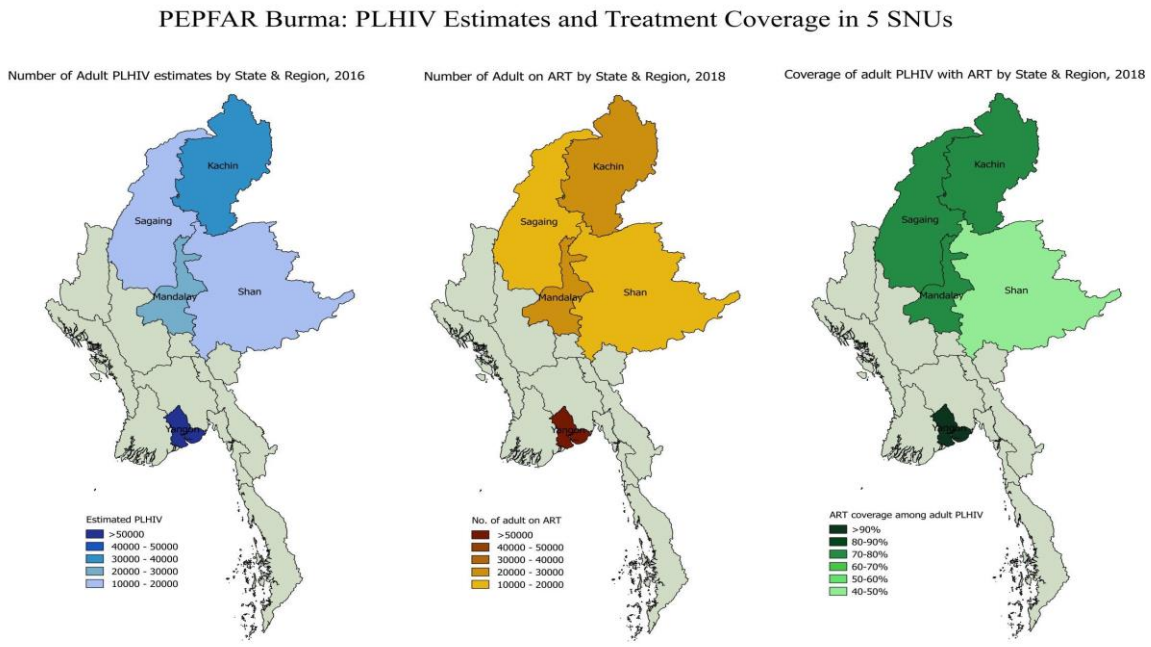
Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR ROP Co-Funding Contribution**	**Objectives**
USAID MCH	$2,799,728				
USAID TB	$4,353,316				
NIH (nutrition)	$344,444				
Total	**$7,497,488**				

Thailand

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration (Thailand)					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR ROP Co-Funding Contribution**	**Objectives**
USAID Malaria	$3,000,000	0	0	0	N/A
Total	**$3,000,000**	**0**	**0**	**0**	0

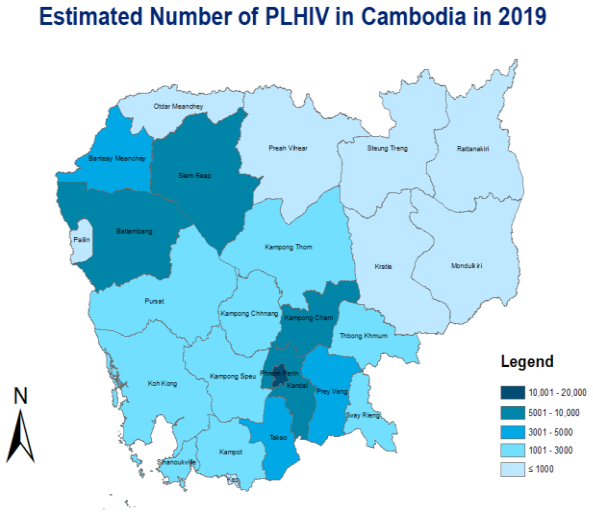
Figure 2.5.1 PEPFAR Asia Region Countries: People Living with HIV (PLHIV), Treatment Coverage, and VL Monitoring Coverage, by Country

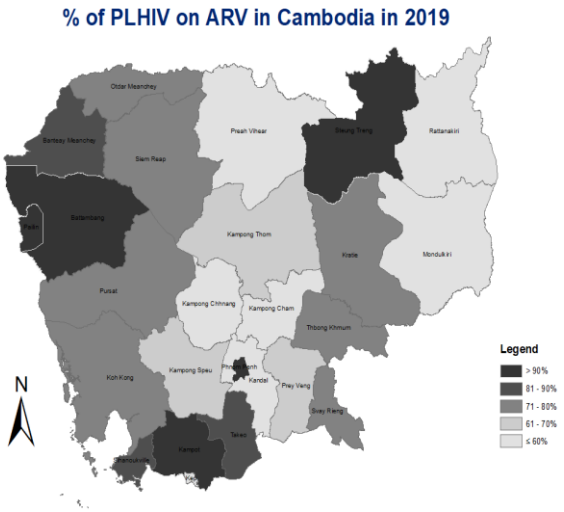
Burma



State/ Region	Total no. of Township	High Priority Township	% of High Priority Township	KP coverage in High Priority Township (Estimated number and %)		
				FSW	MSM	PWID
Yangon	45	37	82%	11,240(97%)	27,108 (92%)	2,484 (87%)
Mandalay	28	22	79%	11,965 (97%)	20,095 (92%)	9,754 (97%)
Kachin	18	15	83%	3,239 (100%)	5,719 (100%)	21,819 (100%)
Shan (North)	24	17	71%	3,737 (96%)	2,506 (88%)	18,220 (92%)
Sagaing	37	22	59%	5,537 (95%)	10,227 (85%)	18,119 (95%)
Other	178	54	30%	24,020 (40%)	35,235 (35%)	12,874 (16%)
Total	330	167	51%	59,739 (90%)	100,941 (80%)	83,270 (89%)

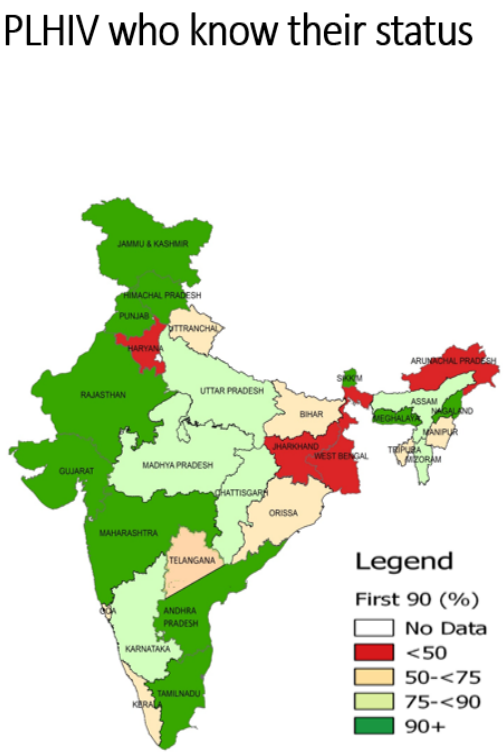
Cambodia





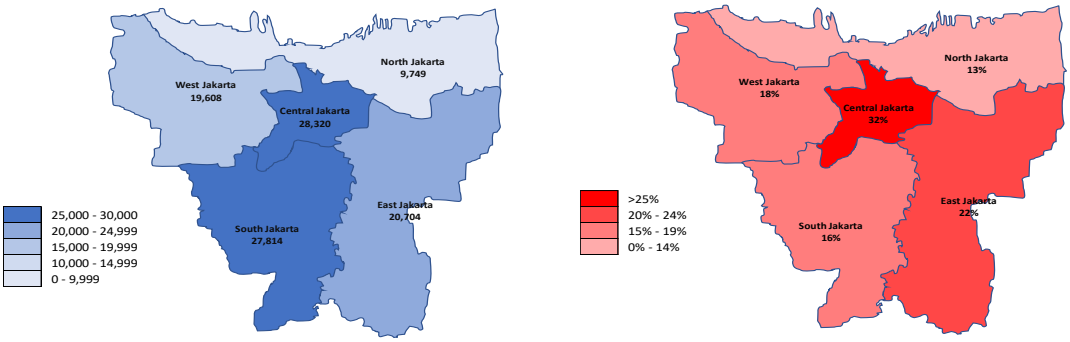
India

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

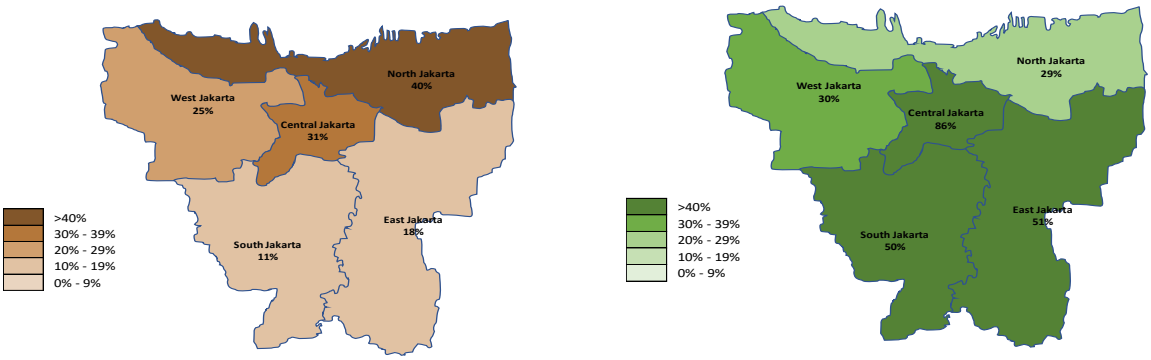


Indonesia

Jakarta Estimated PLHIV and proportion diagnoses/district December 2019

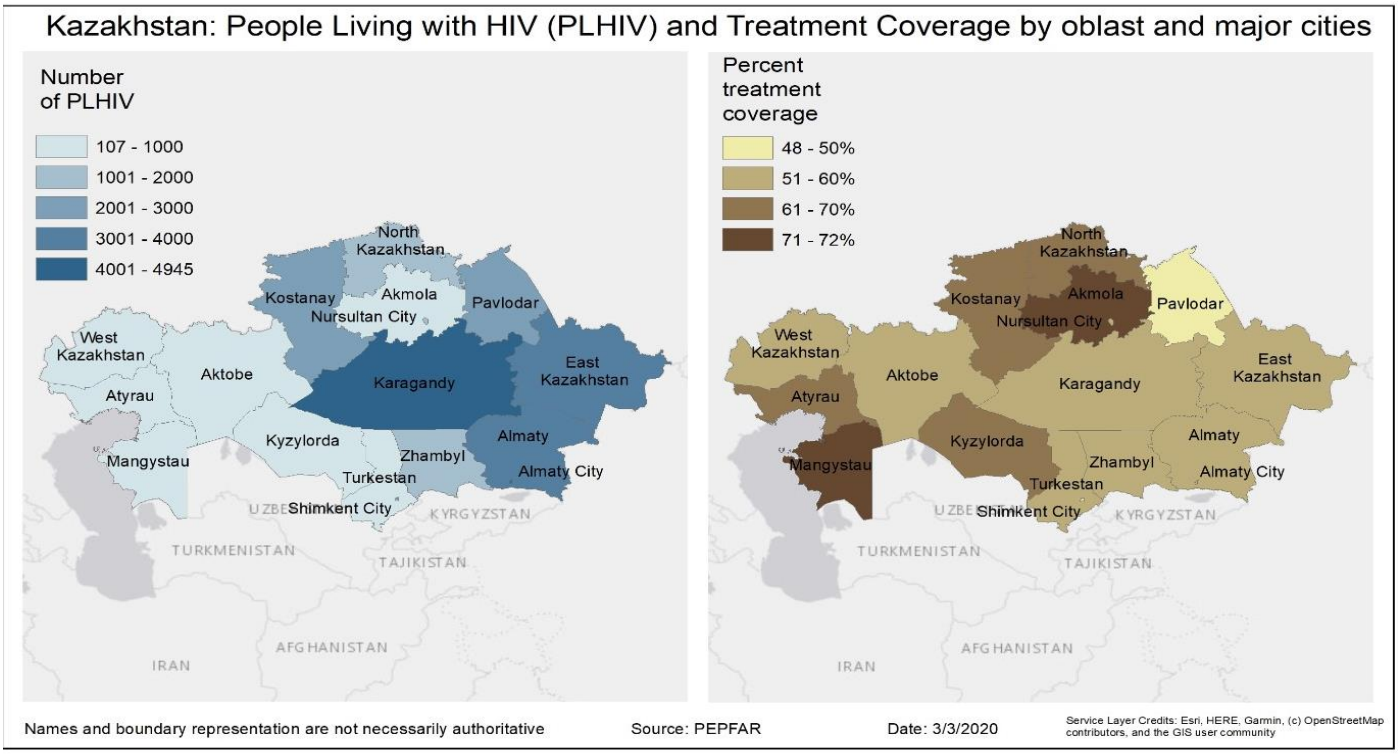


Jakarta: ART and VL testing coverage/district December 2019

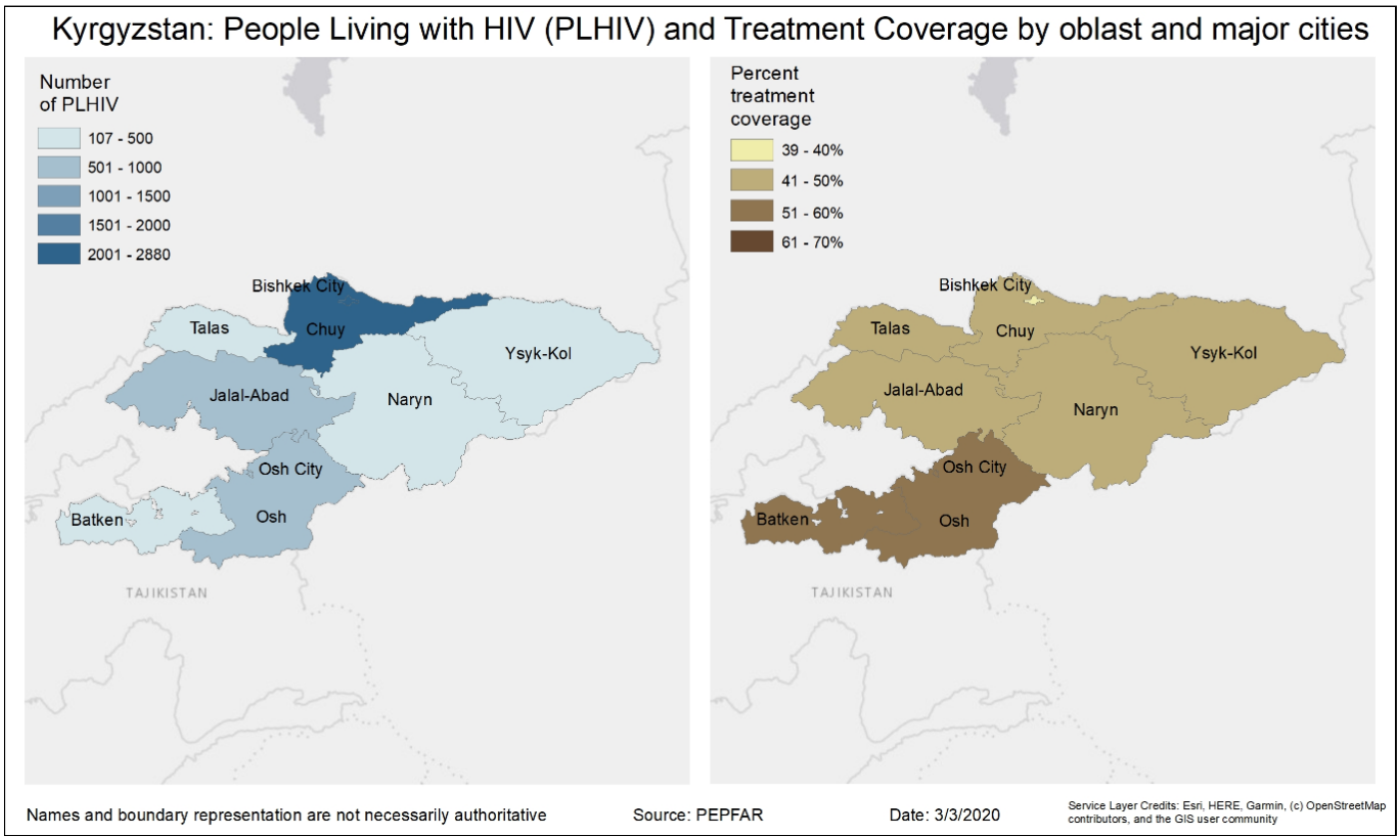


Source: 2016 PLHIV estimation and MoH Quarterly report December 2019

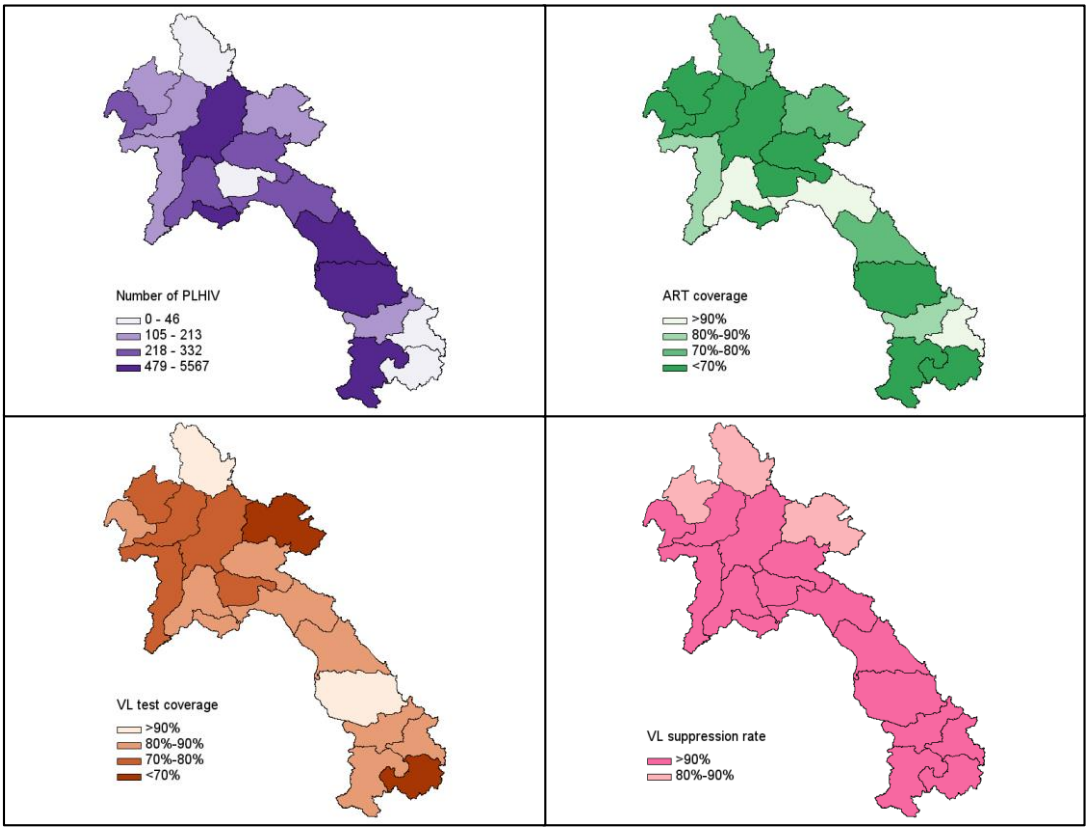
Kazakhstan



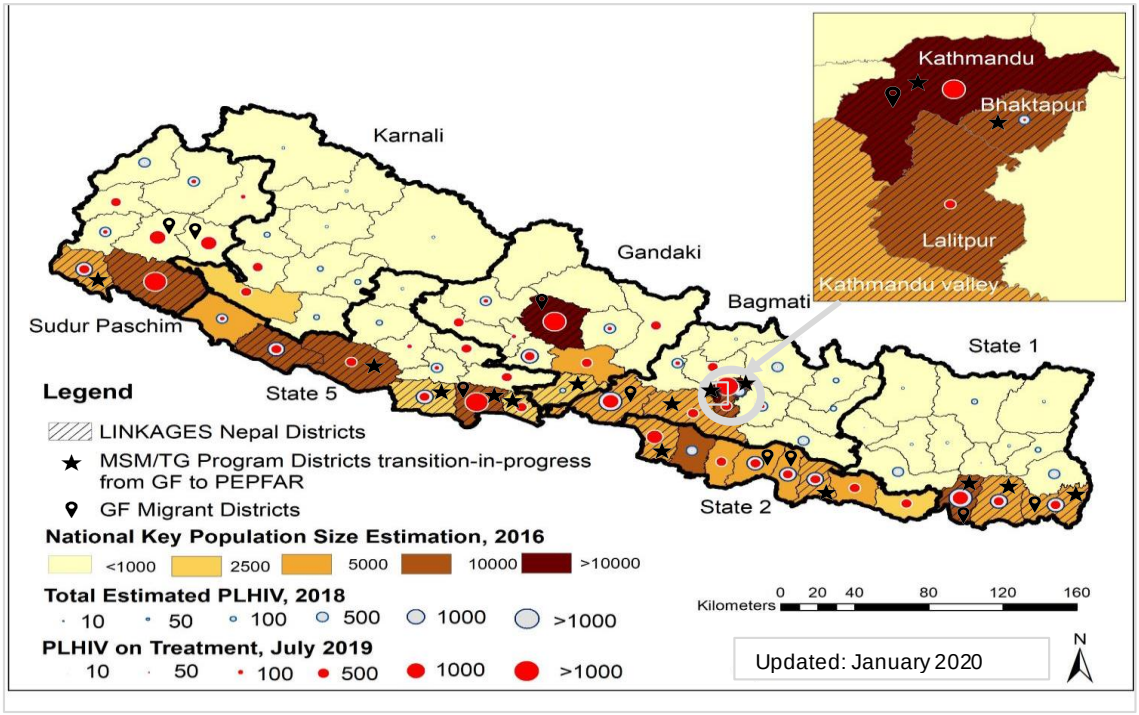
Kyrgyz Republic



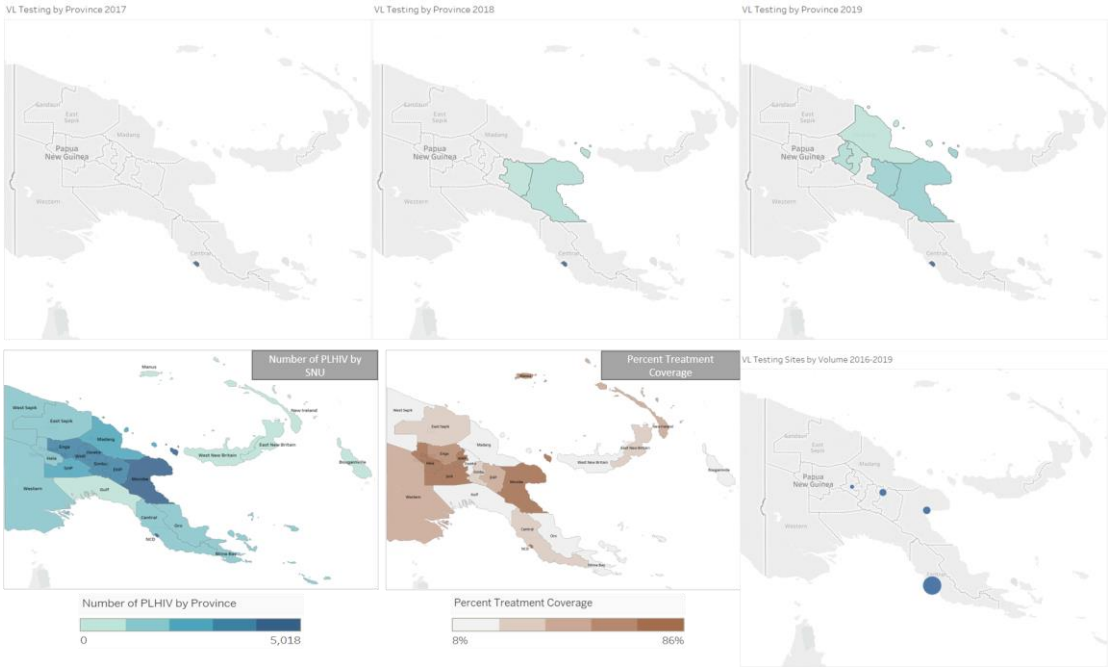
Lao PDR:



Nepal

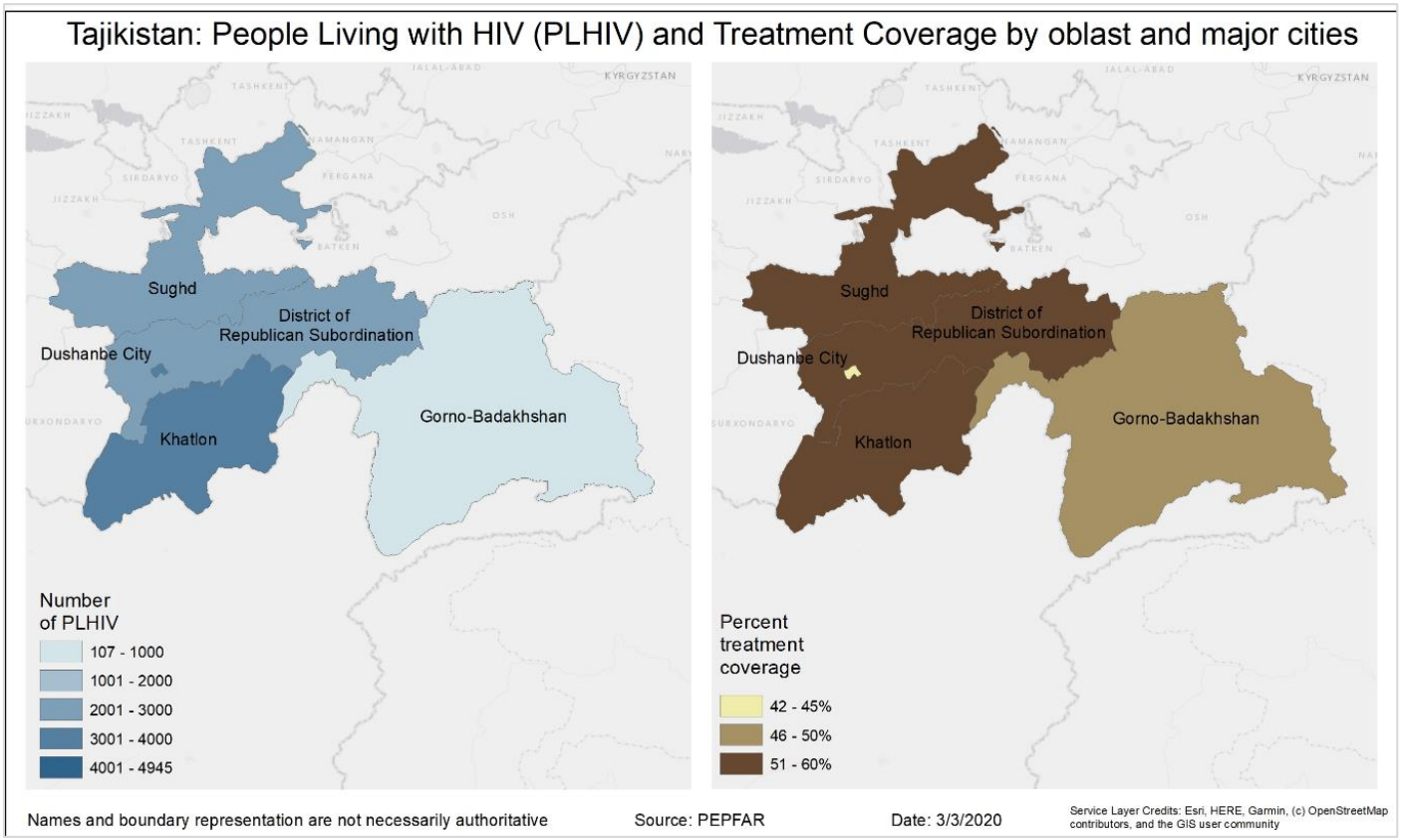


Papua New Guinea:

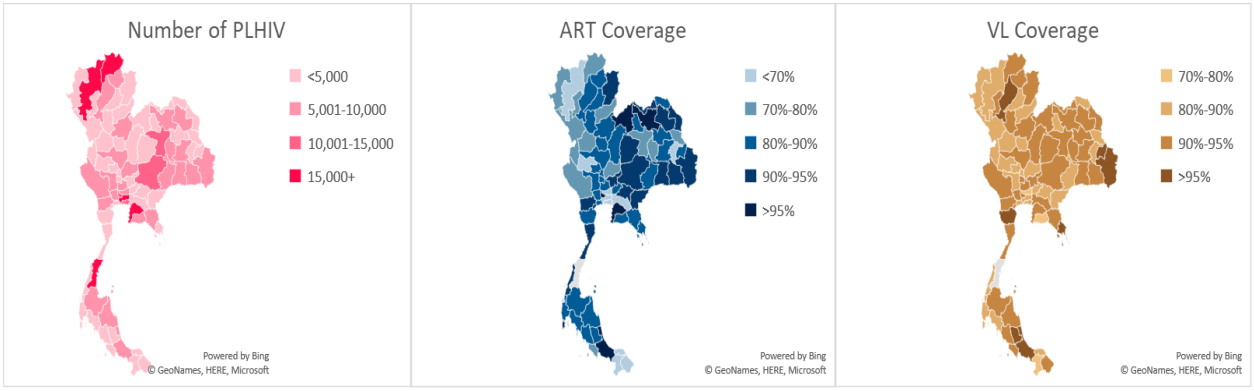


Source: National Spectrum Draft Estimates (2020) / HIV Patient Database (HPDB) / VL Sample Management System (VLSM)

Tajikistan



Thailand



Source: *National AIDS Program (NAP) web report FY2019, as of October 2019*

Table 4.4.1 Additional country-specific priorities listed in the planning level letter

BURMA
Significantly reduce PITC, ensure PITC testing is targeted and risk-based; should achieve minimum 10% yield. Shift PITC (10% yield) to targeted KP testing in Yangon and Kachin with improved reporting of peer-led confirmatory testing that connects to PrEP.
Recency in infancy stage; ROP 19 is focused on advocacy, TA, and training; scale up in only 1 SNU; ROP20 should ensure further scale up. Above-Site: Conduct lab training of trainers with ≥ 1 rapid recency assays currently pending WHO pre-qualification and availability. Provide trainings on the clinical utility of recency testing in the context of integrating it with index testing and SNS. Continue advocacy and TA to the national program with the goal of replacing one of the confirmatory tests in the current testing algorithm with the recency assay. As recency testing is scaled up as part of

routine HTS, ensure its incorporation into CBS. Site-level: No recency testing at site level planned (not WHO pre-qualified).
National TA focus for ROP19 is on MMS; need to further scale and focus on MMD. Scale MMD at PEPFAR sites, focusing on 6-month MMD.
Viral Load Coverage (VLC) still largest gap; acceleration planned in ROP19; ROP20 activities should aim for 100% coverage and 95% VLS nationally. PEPFAR TA will accomplish this through the following: institutionalize quarterly VL coordination/ monitoring meetings at 5 PEPFAR PSNUs and at national level to close operational gaps between clinics and labs; promote PLHIV clients and service provider literacy on U=U through revision of counseling messages; optimize VL plasma samples flow and scaling up implementation of DBS for VL testing based on clinic caseloads and laboratory capacity; address gaps identified by DNO; develop SOPs and operational manuals for high VL case management and VL testing tracker.
Along with UIC scaling, ensure there is a robust partner-wide patient case/ management/ support/ tracking strategy and associated SOPs. Working with national government to develop national Master patient index UIC will be scaled up, along with laying the foundations of CBS in ROP20.
Multilateral deep dive country: need to ensure coordinated planning and messaging with GF and UNAIDS. PEPFAR is on the CCM, active on HIV TSG and TWGs, and MOHS understands that 1/3 of GF pooled resources are from USG; Burma GF PM/team meets with PEPFAR on each visit. Burma is a focus country for enhanced GF-UNAIDS-PEPFAR coordination following September 2019 Bangkok meeting. Extensive TA provided for National Strategic Plan (2021-2025) and GF concept note development for 2021-2023 focusing on efficiency and more aggressive target setting. GF procures all commodities for PEPFAR services. Better coordination, de-duplication anticipated at sites and among partners receiving support from both PEPFAR and GF (also a top GoB priority).
Ensure completion of PLHIV Stigma Index 2.0 (1.0 last done in 2016). In ROP20, PEPFAR plans to work with key stakeholders to complete Stigma Index 2.0.
Continue to monitor site performance where HCW sensitization is rolled out; scale at national level. Performance of public facilities with HCW sensitization support will be monitored by establishing utilization of feedback mechanisms on public ART services, client retention rate including high VLS rate.
Deep dive on declining SID scores in Laboratory and Supply Chain given PEPFAR investments. PEPFAR will increase laboratory SID scores by providing TA on: building domestic capacity and state and regional laboratory workforce capabilities to monitor decentralized labs and POCT, in addition to core TA on national reference labs; formalizing regulation of and functioning national laboratory workforce on site certification and tester certification on HTS; obtaining ISO accreditation for national reference HIV lab. Supply Chain: Operationalize and strengthen the Logistics Management Information System (LMIS); continue TA to strengthen supply chain management system; conduct supply chain assessment.
CAMBODIA
Immediately approve recency testing and initiate rapid implementation. Recency testing approved. Training completed at 24 sites; site implementation started in early March 2019. Implementation will be scaled up nationally by the end of ROP19.
Case-based surveillance (CBS) should be implemented in ROP19 and scaled up in ROP20. In early ROP20, conduct a mid-term evaluation; use results to improve implementation. At end of ROP20, an annual review will further improve program and document and disseminate "best practices." Complete data migration and de-duplication from current databases, finalize functional requirements of new system, and build central data warehouse by the end of ROP19. Implement real-time data collection at site level in Phnom Penh and Siem Reap, develop SOPs for CBS implementation, and roll out CBS nationwide by end of ROP20.
Strengthen CSO-led service delivery by capacitating CSOs to become social enterprises. Make Chhouk Sar clinic model a true social enterprise of delivering KP-friendly services and expand the model in other major urban areas.
Working closely with Government of Cambodia and GF, strengthen budget execution at the national and sub-national levels. Build capacity of sub-national units (provinces) to strengthen budget execution as part of the new sub-decree on decentralization
Develop and implement a plan to sustain the gains made towards epidemic control. In ROP19 and ROP20, PEPFAR will respond quickly to new infections and use a client-focused approach to ensure every PLHIV has access to and stays on lifelong quality ART. Address system and structural barriers and build capacity of the government and civil society to adopt and scale up WHO policies, and use CBS to detect and respond to outbreaks and use community-led monitoring to ensure continuous ART support.
INDIA
sDART and 6MMD should be scaled up in FY20 with monthly benchmarks and monitoring of commodity distribution. sDART is increasing in India, with some sites implementing ART at the testing center.

PrEP and Community dispensing of ARVs should be initiated in ROP19 with scale-up in ROP20.
There has been significant acceleration in the private and public sector.

Surge activities in Andhra Pradesh and Telangana should be managed with clear weekly monthly benchmarks. A phased/ tiered strategy should be adopted based on TX_CURR.
Teams are working on a surge dashboard to report.

Scale-up VL coverage with a target of at least 80% VLC for the surge states by ROP19 and achieve 100% VLC in ROP20.
With PEPFAR support, the remaining public sector labs will be operationalized by September 2020.

Agencies should strive for one agency/ partner per SNU strategy by the end of ROP19/ FY20.
Agencies have rationalized geographies to limit overlap across the 3 90s.

The OVC_SERV achievement for OVC beneficiaries under age 18 was 31% in India for FY19. All agencies and implementing partners should work to improve the OVC_SER achievement to 90% or higher.
The OVC_SERV results for Q1 have been very promising, having reached out to more than 21,573 beneficiaries, out of which 70% are children less than 18 years. PEPFAR will reach out to over 60% of the OVC_SERV targets by end of Q2. USAID will continue to be the lead OVC agency across all SNUs and will collaborate across agencies and implementing partners to improve the OVC_SER achievement to 90% or higher.

INDONESIA

Need for more aggressive site-level TX milestones (from 19% to 50% in 12 months and 80% by 2022).
Established aggressive site-level TX milestones under ROP19 initiatives. ART acceleration to be accomplished through: (a) index testing systemization among newly diagnosed and TX_CURR PLHIV; (b) TA to 45 new ART sites under Jakarta's ART acceleration strategy; and (c) city-wide roll out of Lost and Link community-facility teams to enhance retention and ART engagement of never registered, missed appointment, and LTFU PLHIV.

Expand partnerships with civil society/greater community-based engagement
Expand civil society partnerships and strengthen community-based engagement by: (a) strengthening civil society data interpretation and use for ART acceleration goals, ensuring access of community-based partners to the MOH HMIS online analysis database; (b) operationalizing quarterly ART acceleration program reviews, bringing together community, facility, Government and other stakeholders for joint action planning; and (c) supporting GF IPs to roll out community-based monitoring framework establishing service feedback mechanisms and community oversight functions to ensure HIV service access and uptake.

Sustained and coordinated high-level engagement with GOI, multilaterals (GF), and USG agencies to address key barriers to HIV services in Jakarta.
PEPFAR IPs are currently involved in Indonesia GF proposal development, which emphasizes collaboration and joint implementation to accelerate ART coverage and address key service barriers. Under the Jakarta Provincial Health Office leadership, monthly thematic consultations and joint action planning continually foster coordination across Government, GF IP and PEPFAR, while direct support to the National HIV TWG will ensure that all key stakeholders share intervention strategies, review programmatic results, and develop coordinated plans. In collaboration with the MOH, PEPFAR will also (a) introduce and/or strengthen utilization of data visualization dashboards that track ART acceleration progress and identify programmatic challenges across priority provinces/districts; (b) adapt promising ART acceleration models for utilization in other locales.

Work aggressively to scale VL coverage.

Develop sustainability plan.
Sustainability planning will encompass: (a) efforts to institutionalize quality technical and programmatic performance through the development and roll out of technical guidance, SOPs, and M&E platforms that are formally endorsed/supported by provincial and/or national Governmental bodies; (b) efforts to enhance financial sustainability through support to the government for strategic purchasing and costing analyses, and/or TA to CSOs for accessing domestic financing; and (c) efforts to strengthen CSO organizational performance to become GF Principal Recipients, recipients of direct PEPFAR funding, or direct Government of Indonesia funding.

Institutionalize MPRs.
Test and Start, TLD initiation, MMD, and index testing have been incorporated into key policy documents at the national and provincial levels. PEPFAR will strengthen institutionalization of these and other MPRs at district and site levels by supporting the (a) development and/or operationalization of technical guidance and SOPs; (b) capacity development of province and district-level TA providers; (c) ensuring the availability of systems, tools and/or job aides that assist implementers in delivering interventions and recording/reporting on programmatic implementation; and (d) supporting CQI measure development and roll out, including performance thresholds and quality assurance checklists.

KAZAKHSTAN

TA to MOH to develop guidelines and SOPs for self-testing, and PrEP.
Support RAC to develop guidelines and SOPs for PrEP and self-testing.

TA to improve and decentralize commodities planning and support access to lower-cost commodities.
Provide supply chain technical assistance to ensure adequate and consistent supply of ARVs in PEPFAR SNUs.

Support policy change to prioritize social contracting for KP HIV services. Continue providing ASP to promote social contracting.
Provide TA to the government to implement SDART at scale. Develop policies and SOPs related to rapid initiation of ART.
TA to develop guidelines and SOPs for peer navigator and community-based linkage and adherence approaches, including formalizing roles for community providers. Promote and support innovative peer and community-based linkage and adherence programs, such as SUPPORT4HEALTH.
TA to MoH to ensure full adoption and management of 6 MMD. Work with RAC to identify and resolve policy and implementation barriers that impede full adoption of MMD.
TA to MOH to implement LTFU approaches through community and facility-based interventions. Provide clinical mentoring and intensive monitoring to implement and expand LTFU interventions at the facility and community level.
KYRGYZ REPUBLIC
Establish weekly/monthly targets with IPs to meet ROP 19 acceleration goals. Rigorous and frequent review of partner performance – link outlays to performance metrics. IPs have weekly/monthly/quarterly targets. CDC has weekly/monthly IP meetings to review performance linked to results-based component financing (funding provided upon quarterly achievements and the detailed description of planned activities for the next quarter). USAID holds high frequency reporting meetings with the IPs, and tracks performance and course correction whenever needed.
Analysis presented at March Bangkok meeting should detail needed revisions to ROP 1 targets, given target achievement challenges in ROP 18 and DQA results in Chui. During the pre-ROP20 meeting it was agreed ROP19 targets would remain without revisions, after a discussion of ROP18 challenges and DQA findings. Chui penitentiary facilities were not covered by the DQA; however, DATIM includes prisons under Chui oblast AIDS center. Overall the Chui AIDS center's performance is on an adequate level, similar to other PEPFAR-supported SNUs.
MAT: focus on take home dosing, low-threshold intervention, referrals and coordination between AIDS Center and MAT sites. Continued implementation of methadone "Take-Away-Dosing" for stable patients and strengthened active collaboration between RNC and RAC to ensure linkage and referrals of PWID ART patients to MAT, facilitated by integrated/linked HIV and Narcology e-surveillance systems. Narcology and AIDS services will collaborate on customized indicator development and target setting for active and successful referrals of PWID from ART and TB services to MAT.
Set benchmarks for government purchase of ART, with necessary support, and provide TA to support supply chain forecasting and management. Benchmarks for Gov ARV purchase are set for ROP20 (15% increase from baseline), with TA provision on supply chain forecasting and management in ROP19 and ROP20.
Full implementation of SDART. With Test & Start implemented since 2017, the country is accelerating to sDART (mean ART start after diagnosis reduced to 6.5 days in Q2FY20). Clinical protocols updated for sDART and MOH approval anticipated in April 2020. Full implementation of sDART trainings for service providers and demand generation at community level.
Strengthen nurse initiated and managed ART and peer consultant interventions to support linkage, ART retention, and adherence. Continued strengthening of nurse-initiated and managed ART and peer consultant interventions to support linkage, ART retention, and adherence through effective SUPPORT4HEALTH and HERE4YOU models.
Execute transition to TLD by FY20 Q4. TLD transition is being implemented according to the transition plan and will be fully executed by Q4FY20.
LAO PDR
Support recency testing policy and implementation. Integrate recency in high burden provinces. The recency protocol is in development. TOT training and QA/QC are planned. Recency testing will be introduced and integrated into the HIV CBS in all ART sites in early 2021.
Advocate for institutionalization and implementation of community-based screening and community-based ART dispensation. PEPFAR will strengthen capacity of KP CHW to improve case finding, referral, and adherence; and to provide community-based ART dispensation to key populations.
Address linkage and retention; enhance case management training and coordination. Program data indicate high linkage of 90-92% and declining in LTFU. PEPFAR will further enhance adherence counseling and DSD including point-of-care ART service to reduce travel cost and time for patients.
Institutionalize differentiated service delivery models with MMD for stable patients/PLHIV. Support MMD implementation and monitoring; strengthen TLD transition nationally.

MMD and TLD were adopted in national ART guidelines in 2017 and implementation has progressed. PEPFAR will further strengthen national ART/QI forum and coaching at sites.
Support KP CSO-led service delivery and monitoring mechanisms. Work with stakeholders and government to establish CBO and CBO-based CHW certification and accreditation process.
NEPAL
PrEP policy progress and commitments in F-OP 18 and continuing in ROP 19; PEPFAR has limited targets: need to ensure PrEP is saturating most at risk populations. In ROP20, PEPFAR will scale up PrEP over 800 percent to ensure PrEP is saturated to the highest risk populations.
Improved yields since joining the region, but need to eliminate lower-yield strategies now and in ROP20; eliminate the "general" modality. Further improve yields through KP-network-based testing modalities. PEPFAR moved to targeted HTS strategies that improved yields. In ROP20, PEPFAR reduced its HTS as Nepal reaches epidemic control. However, the program will employ HIVST and other targeted strategies to try to reach increasingly fewer PLHIV and hard-to-reach KP.
ROP 19 features PEPFAR-supported Community-based ART as part of the surge, a new activity for USAID/PEPFAR; team + partners need to ensure adequate processes are in place for tracking/ documenting/remediating retention continuing in ROP 19 and for ROP20. In ROP20, PEPFAR will expand CBART and institute community monitoring as part of broader efforts to retain PLHIV in the cascade.
Team reports 91% VLS among those tested, but testing coverage remains low. ROP19: TA to optimize VL testing network and address bottlenecks including shortage of machines (purchase, coordinate w/TB GeneXpert machines in isolated areas, repair/maintain, advocate to address sub-optimal use); ROP20 benchmark is for all eligible PLHIV to have access to VL test. PEPFAR will meet the ROP20 VL benchmark. Nepal now has additional, functional VL machines and increased testing capacity. They recently developed a VL optimization plan and rapidly scaled up VL testing in ROP19 Q1. In ROP20, PEPFAR ensured enough VL testing supplies and support so that all eligible PLHIV will be able to have VL testing.
Nepal has shown strong collaboration with the GF in jointly developing service packages; concur with agency recommendation to support harmonized UIC, DHIS2 system; focus on CBS. Identify appropriate partner as necessary. Nepal will roll out the One HIV information system in April 2020. In ROP20, PEPFAR will provide additional support to ensure that the system is functional and to train key health staff in data collection, analysis and use. There are currently insufficient funds to adapt the system to a CBS, but the program will identify steps needed to adapt the system to a CBS in ROP20 with the goal of adapting the system to a full CBS at a future date.
PAPUA NEW GUINEA
ROP20 funds to focus on supporting ASAP with critical above site and M&O, further focus on retention. ROP20 above-site TA activities will complement ASAP site-level activities to achieve saturation in NCD, and improve retention and achieve VL suppression.
Support national scale up of index and recency. PEPFAR has no plans for recency testing in ROP20. Index testing is currently halted due to the certification issues for KP testing.
Close monitoring of TLD transition and commodities. TLD transition is nearing completion in NCD, and TLD monitoring is a key element of ROP20. PEPFAR will be instrumental in providing initial plans, furnishing commodities for scale up, and will support NDOH with forecasting to ensure that adequate TLD stock, including 6-month buffer, is replenished. Support training and mentoring of HCW on TLD.
Deep dive on ongoing above site LTFU activity (significant retention issues despite Tab 6 investments). ROP20 interventions will focus on addressing key barriers to successful 'back to care initiatives' involving CSO groups.
Develop game-changing VLC strategy. In ROP19, support NDOH to review national VL strategy with GF, using a DNO activity to optimize GF GeneXperts in NCD to complement aging Roche platform to ensure NCD reaches saturation and provide TA for national scale up.
TAJIKISTAN
Categorize the undiagnosed PLHIV. Continue to support Tajikistan to strengthen understanding about undiagnosed PLHIV through better case finding reporting and analysis and strengthened outreach to community.
Integration of community-based ART and HIV self-testing into supply chain.

Test a community-based ART model and expand availability of HIV self-testing. PEPFAR will provide supply chain TA to ensure adequate/consistent supply of self-testing kits and ARVs for community-based distribution in PEPFAR SNUs.
TA to MOH to expand VLS approaches beyond PEPFAR SNUs (Q4 result for PEPFAR SNUs is 83% VLS; National Results 51%). Identify best practices at the PEPFAR SNUs and expand into non-PEPFAR SNUs.
Establish weekly/monthly targets with IPs to meet ROP19 acceleration goals. Institute weekly/monthly targets with government and community partners to meet the ROP19 acceleration goals (CDC and USAID). Continue high frequency data reporting and analysis (USAID).
Analysis presented at March Bangkok meeting should detail needed revisions to ROP19 targets given target achievement challenges in ROP18. Consistent with the direction of the S/GAC chairs, PEPFAR will retain the ROP19 targets for ROP20.
Develop a provider training package for advanced HIV. Work with ICAP and RAC to develop and roll-out a training package for advanced HIV.
In collaboration with GF, strengthen supply chain systems to improve quantification and forecasting. Provide supply chain TA to ensure adequate and consistent supply of ARVs in PEPFAR SNUs.
Strengthen NIMART training and mentoring to improve nurse initiated and managed ART Promote and support innovative nurse-initiated/managed ART (SUPPORT4HEALTH) and support peer- and community-based linkage and adherence programs.
THAILAND
Strengthen case-based surveillance system for HIV performance, morbidity & mortality surveillance. Developed protocol to include recency testing in the CBS, improve data quality of current CBS (EIIS) through DQA and ICD10 training.
Accelerate PrEP services for the highest risk populations. PEPFAR will add about 7000 more PrEP users (incl KPIF), contributing to 5.4% of the national target. PrEP best practices shared among PrEP providers.
Institutionalize KP-led health services. KPLHS -PrEP delivery model accelerated by 10%. Support national PrEP M&E and provide evidence for NHSO to allocate targeted free PrEP under national prevention fund. PEPFAR is working with GF and NHSO to increase targeted reimbursement from NHSO to CBOs by costing services to the reimbursable. This is important to providing a fully DSD model to KP clients, the sustainability of CSOs, and better planning and execution for the national program.
Continue to serve as regional resource providing technical expertise and support through targeted TA from local KP competent local organizations. PEPFAR continues to plan for the export of Thailand's best practices through regional funds set aside in ROP20 and in the KPIF regional workplan—this includes CBO-CBO TA, comprehensive prevention training curricula, and S&D reduction training with co-funding from MOF.
Expand index and recency testing in the 4 high burden provinces and BKK and leverage index testing to reengage long-term lost to follow-up. Build capacity of health care providers for index testing (in community and facility) and recency service, strengthen monitoring, and provide supportive supervision through site visits and case conferences.
Enhance linkage to ART through scaling SDART. Develop a national manual for sDART including lessons learned. Implement SDART at PEPFAR-supported sites. Monitor time for ART initiation and CQI.
Given achievements at local site levels, have CSOs take on direct program implementation and become primes. Working with a prime IP to establish fiscal and admin benchmarks with current sub-CBOs who implement.
Integrate HIV-self testing into current strategies. Provide HIVST results of pharmacy delivery models to MOPH and support system through hotlines and model for linkage to confirmatory HTS and ART. KPLHS models to integrate HIVST into community-based targeted HTS and distribution.
Pivot to MMD for ROP20. Distribute differentiated care for ART service delivery manual to hospitals, including examples of 6 month MMD. Monitor MMD data and fidelity at national and site level and CQI.
Monitor TLD transition nationally as well as scale up and monitor the 1-month short course TPT implementation. Training conducted on new national guidelines recommending TLD as preferred first line regimen in FY20. Work with MOPH to monitor TLD transition nationally.

Table 4.7.4 Targets for OVC and Linkages to HIV Services in India

Table 4.7.4 Targets for OVC and Linkages to HIV Services			
SNU	**Estimated # of Orphans and Vulnerable Children[1]**	**Target # of active OVC (FY21Target) OVC_SERV**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY21 Target) OVC[2]***
Andhra Pradesh	Not Available	17,000	13,600
Maharashtra	Not Available	14,000	11,200
Manipur	Not Available	2,900	2,320
Mizoram	Not Available	2,800	2,240
Nagaland	Not Available	2,300	1,840
Telangana	Not Available	11,000	8,800
TOTAL		50,000	40,000

[1] 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.

[2] The targets for OVC_HIV_STAT are lower as they have been calculated on the basis of 2 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.

Annex 2 – Asia Regional KPIF Activities

Asia Regional KPIF Factsheet_V1.pdf

KPIF Asia Regional objectives.pdf

APPENDIX A: Prioritization

Table A.1 Continuous Nature of SNU Prioritization to Reach Epidemic Control

Note: Table not applicable for Cambodia

Burma

SNU	COP/ ROP	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	
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	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	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	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	NA	NA	77%
Burma	ROP 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	NA	NA	81%
Burma	ROP20	Scale-up aggressive	APR 21	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	88%

India

SNU	ROP	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	ROP 20	Scale-up: Aggressive	APR 21			333	252	75	74	75	75	119	97	101	93	88	76	75	75	76	75	75	75	75	75	75	75	64%
Bishunupur	ROP 20	Scale-up: Aggressive	APR 21					211	200	82	51	28	28	34	26	44	30	82	51	40	62	37	38	27	27	27	28	23%
Champai	ROP 20	Scale-up: Aggressive	APR 21			150	267	50	73	63	63	70	69	182	101	102	79	59	64	58	58	58	57	58	57	58	58	50%
Chandel	ROP 20	Scale-up: Aggressive	APR 21						1	1	4	3	3	25	7	10	76	8	69	26	53	22	41	29	35	27	58	5%
Churachandpur	ROP 20	Scale-up: Aggressive	APR 21			256		374	222	99	72	65	58	105	66	102	119	105	95	73	84	51	51	51	51	51	51	43%
Dimapur	ROP 20	Scale-up: Aggressive	APR 21			172	335	223	142	123	118	111	112	203	207	163	194	130	150	110	110	111	111	110	110	110	111	100%
East Godavari	ROP 20	Attained	APR 21			410	366	264	281	171	150	72	67	170	76	193	186	118	168	67	118	67	67	67	67	67	67	56%
Guntur	ROP 20	Attained	APR 21			566	1048	302	337	140	166	122	67	221	109	199	195	104	150	67	106	67	67	67	67	67	67	63%
Imphal East	ROP 20	Attained	APR 21			78	104	161	184	154	124	120	151	67	67	163	85	235	247	103	234	67	102	67	67	67	67	61%
Imphal West	ROP 20	Scale-up: Aggressive	APR 21					112	140	84	84	259	252	281	215	186	175	183	229	167	271	89	118	89	89	89	89	84%
Kiphiri	ROP 20	Scale-up: Aggressive	APR 21				118	113				645		59	210	82	147	45	51	48	46	32	43	65	48	48	45	32%
Kohima	ROP 20	Scale-up: Aggressive	APR 21			211	85	88	89	116	116	131	98	129	102	105	139	87	95	70	75	69	70	70	69	70	70	60%
Kolasib	ROP 20	Scale-up: Aggressive	APR 21			483	869	161	97		97	104	700	148	155	176	121	108	109	106	106	105	106	106	107	106	103	97%
Krishna	ROP 20	Attained	APR 21			1338	589	382	539	341	307	169	128	289	191	340	322	187	236	117	178	116	116	116	116	116	116	111%
Lunglei	ROP 20	Scale-up: Aggressive	APR 21			135	237	99	79	79	118	101	93	214	108	102	98	85	85	88	85	85	86	87	85	85	84	79%
Mamit	ROP 20	Scale-up: Aggressive	APR 21				69		26			52	29	48	21	22	21	37	22	28	24	22	22		26	26	22	17%
Mokchung	ROP 20	Scale-up: Aggressive	APR 21			44		198	66	53		72	44	83	100	86	78	61	66	51	59	51	50	50	51	51	50	44%
Mumbai	ROP 20	Scale-up: Aggressive	APR 21			461	497	164	191	120	129	99	89	146	101	185	145	169	177	116	161	80	109	80	80	80	80	79%
Pune	ROP 20	Scale-up: Aggressive	APR 21	1140	1244	781	479	328	346	227	229	135	104	189	104	262	191	217	236	114	193	104	126	104	104	104	104	104%

Tamenglong	ROP 20	Scale-up: Aggressive	APR 21						9	7		33		23		27	40	16	10	8	8	8	8	7		8	8	7%
Thane	ROP 20	Scale-up: Aggressive	APR 21			406	615	208	204	151	131	145	117	203	117	195	158	151	187	94	135	91	92	91	91	91	91	90%
Thoubal	ROP 20	Scale-up: Aggressive	APR 21				25	62	41	27	22	31	12	14	14	50	37	24	32	27	40	14	19	14	14	15	15	12%
Tuensang	ROP 20	Scale-up: Aggressive	APR 21			204	153	62	74	63	62	87	74	123	61	81	89	61	68	61	61	61	61	60	61	60	60	56%

Indonesia

SNU	COP/ROP	Prioritization	Results Reported	Attained: 90-90-90 (81%) by Each Age and Sex Bands to Reach 95-95-95 (90%) Overall				
				Treatment Coverage at APR by Age and Sex				
				<15		15+		Overall TX Coverage
				F	M	F	M	
SNU 1	COP 17		APR 18					103%
	COP 18		APR 19	126%	59%	90%	135%	120%
	ROP 19		APR 20	122%	56%	89%	141%	124%

Kazakhstan

SNU	COP/ ROP	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	
East Kazakhstan	COP 15		APR 16	75%		22%	22%	34%	24%	35%	33%	36%	39%	36%	39%	51%	43%	45%	41%	36%
	COP 16		APR 17	60%		54%	33%	55%	40%	56%	42%	49%	50%	49%	50%	63%	50%	55%	52%	49%
	COP 17		APR 18	75%	100%	77%	57%	64%	53%	68%	50%	54%	53%	55%	56%	68%	55%	68%	54%	57%
	COP 18		APR 19	75%	100%	63%	65%	58%	54%	64%	52%	58%	57%	59%	58%	66%	56%	62%	56%	58%
	ROP 19		APR 20	60%	50%	65%	66%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%
Pavlodar	COP 15		APR 16	38%		10%	11%	17%	12%	27%	18%	31%	21%	28%	21%	38%	27%	39%	25%	24%
	COP 16		APR 17	67%	100%	21%	29%	39%	19%	43%	26%	46%	34%	43%	34%	51%	34%	59%	36%	37%
	COP 17		APR 18	67%		53%	100%	62%	45%	54%	41%	59%	46%	60%	47%	60%	50%	65%	48%	52%
	COP 18		APR 19	60%	67%	63%	50%	61%	47%	55%	47%	51%	44%	55%	47%	62%	53%	62%	53%	51%
	ROP 19		APR 20	67%	67%	63%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%
Akmola	COP 15		APR 16	100%		0%	33%	42%	21%	44%	29%	35%	32%	33%	46%	58%	34%	52%	40%	37%
	COP 16		APR 17			100%	83%	61%	61%	56%	50%	55%	24%	59%	32%	75%	43%	58%	22%	46%
	COP 17		APR 18	100%		69%	57%	64%	55%	74%	51%	70%	69%	57%	59%	64%	64%	69%	59%	63%
	COP 18		APR 19	100%		93%	71%	68%	67%	81%	69%	72%	66%	75%	69%	77%	67%	81%	64%	71%
	ROP 19		APR 20	67%		79%	79%	75%	74%	75%	75%	75%	75%	74%	74%	73%	74%	74%	74%	74%
Aktobe	COP 15		APR 16	0%	0%	0%	40%	52%	9%	32%	32%	32%	26%	58%	25%	33%	28%	33%	23%	30%
	COP 16		APR 17			100%	83%	61%	61%	56%	50%	55%	24%	59%	32%	75%	43%	58%	22%	46%
	COP 17		APR 18		100%	50%	80%	82%	67%	71%	59%	58%	36%	81%	38%	71%	43%	62%	15%	54%
	COP 18		APR 19		100%	40%	67%	68%	59%	58%	57%	60%	38%	61%	35%	54%	37%	63%	29%	50%
	COP 19		APR 20		100%	60%	56%	63%	59%	60%	61%	60%	60%	61%	60%	62%	60%	63%	59%	61%
Almaty obl	COP 15		APR 16	50%	67%	19%	39%	28%	22%	32%	23%	33%	32%	43%	27%	30%	34%	26%	34%	30%
	COP 16		APR 17	80%	100%	51%	19%	41%	36%	48%	36%	48%	40%	47%	40%	49%	45%	43%	44%	43%
	COP 17		APR 18	60%	100%	49%	42%	55%	54%	61%	50%	67%	55%	59%	55%	63%	56%	61%	57%	57%
	COP 18		APR 19	67%	100%	60%	40%	57%	52%	52%	49%	61%	50%	58%	52%	63%	47%	61%	57%	54%
	ROP 19		APR 20	67%	80%	67%	65%	65%	65%	66%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%
Atyrau	COP 15		APR 16			0%	0%	61%	60%	59%	31%	33%	48%	38%	24%	50%	50%	80%	13%	43%

	COP 16		APR 17			67%	33%	69%	46%	68%	50%	56%	36%	73%	48%	75%	75%	82%	29%	56%
	COP 17		APR 18			100%	38%	67%	70%	75%	50%	67%	36%	50%	42%	78%	92%	85%	54%	60%
	COP 18		APR 19			100%	55%	67%	70%	59%	64%	64%	49%	39%	48%	75%	67%	76%	45%	58%
	ROP 19		APR 20			100%	73%	78%	74%	72%	72%	75%	71%	73%	74%	75%	78%	76%	70%	73%
Zhambyl	COP 15		APR 16	0%		47%	20%	36%	39%	46%	39%	50%	46%	56%	45%	63%	50%	54%	43%	46%
	COP 16		APR 17	50%	50%	67%	67%	71%	60%	59%	49%	61%	50%	74%	54%	70%	58%	64%	63%	58%
	COP 17		APR 18		100%	86%	60%	80%	74%	62%	68%	69%	63%	79%	63%	82%	62%	81%	68%	69%
	COP 18		APR 19	100%	100%	71%	67%	69%	53%	58%	56%	61%	57%	65%	59%	67%	50%	71%	62%	60%
	ROP 19		APR 20	100%	100%	71%	75%	69%	70%	70%	70%	69%	70%	69%	70%	70%	70%	71%	70%	70%
West-Kazakhstan	COP 15		APR 16	100%		45%	100%	52%	37%	33%	45%	41%	42%	71%	40%	55%	28%	42%	38%	43%
	COP 16		APR 17	100%	100%	50%	83%	53%	52%	43%	44%	63%	58%	68%	43%	58%	47%	71%	37%	53%
	COP 17		APR 18		100%	67%	86%	62%	59%	57%	54%	73%	63%	70%	50%	71%	44%	67%	45%	59%
	COP 18		APR 19	100%	100%	56%	80%	62%	59%	59%	56%	59%	57%	59%	55%	59%	48%	63%	42%	57%
	ROP 19		APR 20	100%	100%	67%	70%	69%	69%	68%	67%	68%	68%	68%	67%	71%	67%	67%	67%	68%
Karaganda	COP 15		APR 16	56%	50%	22%	15%	23%	21%	30%	26%	36%	30%	44%	36%	43%	45%	53%	37%	33%
	COP 16		APR 17	67%	100%	38%	36%	46%	32%	51%	41%	48%	43%	52%	46%	57%	55%	63%	49%	48%
	COP 17		APR 18	73%	100%	63%	64%	54%	44%	62%	48%	58%	52%	59%	52%	64%	59%	71%	54%	56%
	COP 18		APR 19	58%	79%	56%	64%	59%	44%	54%	49%	53%	45%	56%	47%	54%	47%	63%	50%	52%
	ROP 19		APR 20	58%	57%	58%	57%	57%	57%	57%	57%	57%	57%	57%	57%	57%	57%	57%	57%	57%
Kostanay	COP 15		APR 16	0%		24%	23%	29%	14%	29%	18%	26%	21%	39%	29%	22%	38%	24%	22%	25%
	COP 16		APR 17	100%		50%	38%	48%	20%	39%	35%	48%	36%	54%	43%	56%	46%	59%	42%	42%
	COP 17		APR 18	100%	100%	57%	69%	69%	57%	62%	51%	68%	56%	63%	53%	74%	63%	70%	59%	60%
	COP 18		APR 19	83%	75%	67%	64%	60%	56%	57%	50%	62%	49%	54%	51%	68%	54%	64%	50%	65%
	ROP 19		APR 20	83%	75%	71%	71%	72%	72%	71%	71%	71%	71%	71%	71%	71%	71%	72%	71%	71%
Kyzylorda	COP 15		APR 16			0%	33%	27%	9%	20%	13%	36%	27%	0%	29%	20%	40%	50%	30%	25%
	COP 16		APR 17	0%		50%	0%	78%	40%	80%	50%	50%	38%	25%	45%	75%	43%	50%	33%	45%
	COP 17		APR 18	100%		67%	33%	100%	75%	89%	62%	100%	55%	80%	80%	100%	36%	83%	22%	65%
	COP 18		APR 19	0%		50%	60%	75%	50%	86%	50%	50%	40%	83%	65%	83%	50%	63%	18%	57%
	ROP 19		APR 20	100%		50%	60%	67%	60%	71%	67%	100%	68%	67%	70%	67%	71%	75%	64%	67%
Mangystau	COP 15		APR 16			0%	33%	27%	9%	20%	13%	36%	27%	0%	29%	20%	40%	50%	30%	25%
	COP 16		APR 17			0%	14%	55%	43%	45%	24%	38%	43%	67%	56%	50%	50%	50%	30%	42%
	COP 17		APR 18			0%	63%	43%	52%	80%	59%	69%	41%	70%	67%	40%	67%	63%	65%	59%

	COP 18		APR 19		100%	0%	46%	50%	55%	59%	55%	60%	50%	57%	63%	33%	48%	54%	48%	54%
	ROP 19		APR 20		100%	67%	69%	75%	75%	70%	73%	75%	73%	70%	73%	83%	70%	69%	70%	72%
North-Kazakhstan	COP 15		APR 16	0%	0%	22%	10%	23%	13%	38%	24%	43%	36%	54%	38%	50%	40%	41%	26%	31%
	COP 16		APR 17	100%		44%	43%	38%	36%	57%	41%	61%	49%	57%	54%	74%	54%	68%	61%	49%
	COP 17		APR 18	67%		77%	57%	56%	57%	70%	64%	77%	61%	75%	66%	71%	60%	73%	60%	65%
	COP 18		APR 19	67%	100%	61%	61%	52%	55%	66%	56%	70%	55%	59%	55%	61%	63%	69%	57%	70%
	ROP 19		APR 20	67%	100%	74%	72%	77%	76%	75%	75%	76%	76%	75%	75%	76%	76%	75%	75%	76%
Turkestan obl	COP 15		APR 16	64%	64%	27%	44%	32%	15%	48%	24%	46%	35%	45%	37%	44%	32%	51%	36%	38%
	COP 16		APR 17	89%	79%	55%	45%	48%	46%	63%	40%	59%	47%	61%	46%	66%	44%	61%	44%	52%
	COP 17		APR 18	82%	94%	68%	71%	65%	52%	65%	47%	69%	50%	62%	50%	66%	54%	68%	47%	59%
	COP 18		APR 19	25%	50%	50%	44%	33%	28%	32%	30%	42%	31%	42%	32%	40%	32%	39%	37%	36%
	ROP 19		APR 20	50%	33%	38%	39%	38%	39%	38%	38%	39%	38%	39%	39%	39%	38%	38%	38%	38%
Shymkent city	COP 15		APR 16																	
	COP 16		APR 17																	
	COP 17		APR 18																	
	COP 18		APR 19	100%	98%	65%	83%	71%	84%	76%	61%	82%	55%	71%	53%	78%	65%	79%	53%	69%
	ROP 19		APR 20	77%	77%	74%	79%	77%	76%	77%	77%	77%	77%	78%	77%	77%	77%	78%	78%	77%
Almaty city	COP 15		APR 16	75%	100%	53%	33%	48%	37%	52%	38%	51%	39%	48%	39%	44%	40%	55%	43%	43%
	COP 16		APR 17	67%	67%	59%	46%	55%	42%	55%	46%	59%	43%	51%	44%	53%	44%	61%	52%	49%
	COP 17		APR 18	100%	88%	59%	64%	64%	52%	65%	49%	64%	50%	55%	45%	52%	46%	65%	53%	54%
	COP 18		APR 19	0%	73%	47%	51%	43%	47%	45%	42%	47%	39%	42%	37%	42%	36%	49%	39%	42%
	ROP 19		APR 20	100%	55%	53%	52%	52%	52%	52%	52%	52%	52%	52%	52%	52%	52%	52%	52%	52%
Nur-Sultan city	COP 15		APR 16		0%	14%	7%	20%	13%	35%	22%	26%	23%	26%	27%	25%	28%	27%	18%	24%
	COP 16		APR 17	100%	0%	14%	32%	36%	25%	41%	31%	36%	31%	35%	34%	44%	31%	34%	41%	34%
	COP 17		APR 18	67%	0%	40%	62%	48%	38%	49%	40%	54%	43%	47%	45%	61%	40%	51%	49%	46%
	COP 18		APR 19	57%	57%	62%	53%	44%	47%	52%	43%	44%	43%	44%	45%	56%	40%	51%	48%	46%
	ROP 19		APR 20	57%	57%	62%	63%	65%	63%	64%	64%	64%	64%	64%	63%	65%	63%	64%	63%	64%

Kyrgyz Republic:

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	
Bishkek city	COP 15		APR 16	33%	67%	23%	30%	27%	20%	24%	21%	25%	21%	27%	17%	30%	15%	34%	20%	22%
	COP 16		APR 17	33%	60%	41%	27%	33%	28%	26%	28%	31%	22%	31%	23%	34%	25%	42%	22%	27%
	COP 17		APR 18	0%	44%	35%	36%	33%	32%	32%	34%	34%	24%	32%	27%	41%	23%	37%	24%	30%
	COP 18		APR 19	33%	44%	35%	33%	37%	30%	37%	31%	40%	28%	36%	31%	40%	27%	34%	21%	31%
	ROP 19		APR 20	67%	77%	74%	75%	76%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
Chui oblast	COP 15		APR 16	14%	0%	31%	16%	39%	25%	32%	27%	34%	28%	34%	30%	32%	30%	36%	27%	30%
	COP 16		APR 17	33%	0%	33%	44%	45%	36%	39%	34%	44%	32%	42%	34%	35%	35%	44%	32%	36%
	COP 17		APR 18	57%		49%	45%	49%	42%	46%	41%	43%	38%	47%	40%	40%	40%	47%	38%	42%
	COP 18		APR 19	100%	0%	53%	44%	55%	33%	41%	38%	48%	35%	48%	35%	41%	39%	44%	36%	40%
	ROP 19		APR 20	67%		79%	79%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Osh city	COP 15		APR 16	0%	50%	50%	50%	42%	26%	47%	27%	39%	27%	42%	25%	37%	20%	42%	24%	32%
	COP 16		APR 17	33%	33%	55%	46%	51%	33%	47%	37%	49%	25%	49%	33%	43%	24%	42%	28%	37%
	COP 17		APR 18	44%	75%	54%	67%	62%	53%	52%	43%	57%	36%	56%	41%	48%	37%	55%	37%	47%
	COP 18		APR 19	61%	61%	50%	50%	55%	61%	59%	48%	57%	52%	61%	52%	61%	49%	55%	44%	54%
	ROP 19		APR 20	76%	76%	76%	75%	77%	78%	78%	78%	77%	78%	78%	78%	77%	78%	77%	78%	77%
Osh oblast	COP 15		APR 16	40%	57%	54%	43%	41%	50%	47%	27%	49%	22%	33%	26%	33%	31%	44%	26%	37%
	COP 16		APR 17	20%	55%	57%	55%	49%	46%	54%	32%	53%	39%	52%	40%	47%	31%	54%	33%	46%
	COP 17		APR 18	38%	63%	68%	57%	50%	42%	57%	40%	56%	31%	53%	41%	53%	33%	57%	33%	48%
	COP 18		APR 19	63%	64%	52%	56%	47%	40%	59%	42%	58%	33%	52%	37%	53%	35%	60%	31%	49%
	ROP 19		APR 20	79%	80%	82%	80%	81%	80%	80%	81%	81%	81%	80%	81%	81%	81%	81%	79%	80%
Talas oblast	COP 15		APR 16	0%		0%		20%	20%	10%	0%	27%	27%	0%	40%	0%	33%	50%		20%
	COP 16		APR 17			67%		25%	25%	8%	0%	0%	25%	36%	38%	33%	33%	50%	50%	25%
	COP 17		APR 18			33%		67%	67%	18%	25%	17%	22%	27%	17%	50%	38%	33%	67%	31%
	COP 18		APR 19			100%		75%	67%	50%	67%	43%	20%	46%	44%	33%	57%		75%	44%
	ROP 19		APR 20			100%		75%	67%	63%	56%	71%	60%	62%	56%	67%	71%		75%	61%

Batken oblast	COP 15		APR 16	50%	50%	60%	33%	28%	0%	28%	35%	31%	40%	43%	11%	38%	13%	25%	41%	31%
	COP 16		APR 17	33%	50%	50%	0%	29%	38%	40%	31%	37%	38%	50%	32%	67%	13%	38%	43%	36%
	COP 17		APR 18	100%	100%	56%	33%	62%	57%	32%	33%	42%	67%	56%	44%	57%	6%	44%	56%	43%
	COP 18		APR 19	100%	67%	67%		69%	56%	37%	50%	46%	50%	57%	52%	57%	17%	43%	63%	49%
	ROP 19		APR 20	100%	67%	50%		62%	56%	58%	56%	57%	60%	57%	57%	57%	58%	57%	56%	58%
Naryn oblast	COP 15		APR 16	0%	0%	0%	0%	33%	14%	43%	13%	50%	46%	40%	19%	0%	25%		40%	28%
	COP 16		APR 17	50%		33%	0%	33%	50%	38%	0%	44%	38%	45%	27%	33%	29%	50%	21%	30%
	COP 17		APR 18	100%		67%	0%	20%	67%	43%	22%	67%	30%	42%	32%	50%	32%	67%	38%	37%
	COP 18		APR 19			75%	33%	43%	50%	57%	38%	57%	43%	47%	42%	100%	43%	75%	35%	45%
	ROP 19		APR 20			50%	67%	57%	50%	57%	54%	57%	57%	53%	53%	100%	52%	50%	53%	52%
Jalalabad oblast	COP 15		APR 16	25%	20%	39%	23%	32%	17%	33%	17%	33%	19%	29%	20%	30%	21%	33%	25%	26%
	COP 16		APR 17	33%	33%	55%	25%	39%	20%	41%	21%	30%	24%	43%	23%	32%	21%	39%	27%	30%
	COP 17		APR 18	29%	50%	57%	40%	53%	26%	45%	31%	40%	32%	48%	26%	41%	30%	44%	38%	38%
	COP 18		APR 19	70%	75%	60%	33%	54%	43%	48%	33%	45%	44%	42%	27%	51%	37%	48%	38%	43%
	ROP 19		APR 20	50%	50%	53%	50%	51%	50%	51%	50%	51%	50%	51%	50%	51%	50%	50%	51%	50%
Issykkul oblast	COP 15		APR 16			42%	14%	40%	23%	28%	28%	50%	20%	40%	15%	20%	43%	67%	40%	32%
	COP 16		APR 17			56%	13%	45%	25%	36%	36%	47%	22%	67%	13%	33%	44%	40%	33%	33%
	COP 17		APR 18			57%	30%	52%	33%	38%	36%	43%	21%	67%	32%	29%	37%	60%	31%	38%
	COP 18		APR 19	100%		43%	25%	54%	40%	43%	51%	32%	41%	56%	23%	50%	27%	20%	30%	38%
	ROP 19		APR 20	100%		57%	50%	54%	47%	50%	51%	53%	52%	44%	50%	50%	50%	47%	50%	51%

Lao PDR

SNU	COP/ ROP	Prioritization	Results Reported	Attained 90-90-90 (81%) by each Age and Sex Band to Reach 95-95-95 (90%) Overall																								Overal l TX Covera ge
				<1		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	
Champasak	ROP20	Scale-up Aggressive	APR 21			75 %	100 %	70 %	40 %	133 %	100 %	50 %	67 %	34 %	76 %	69 %	94 %	43 %	67 %	64 %	59 %	61 %	48 %	62 %	59 %	62%	53 %	83%
Suvannakhet	ROP20	Scale-up Aggressive	APR 21				100 %	100 %	100 %	100 %	0%	0%		71 %	83 %	54 %	14 %	50 %	75 %	58 %	23 %	86 %	56 %	75 %	125 %	200 %	56 %	79%

Vientiane capital	ROP20	Scale-up Aggressive	APR 21			50 %	46 %	100 %	83 %	67 %	200 %	38 %	100 %	46 %	47 %	69 %	51 %	55 %	42 %	67 %	56 %	63 %	64 %	50 %	63 %	58%	65 %	74%
Luangnamtha	ROP20	Scale-up Aggressive	APR 21			50 %	50 %	86 %	42 %	60 %	91%	100 %	50 %	43 %	76 %	57 %	57 %	54 %	57 %	62 %	54 %	64 %	58 %	65 %	60 %	66 %	58 %	76%
Luangprabang	ROP20	Scale-up Aggressive	APR 21	0 %	33 %	27 %	64 %	69 %	49 %	65 %	91%	58 %	63 %	53 %	65 %	50 %	66 %	54 %	62 %	58 %	61 %	59 %	56 %	51 %	52 %	57%	55 %	73%

Nepal

SNU	COP/ ROP	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	ROP 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	ROP 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	ROP 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	ROP 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	ROP 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	ROP 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	ROP 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	ROP 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	ROP 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	ROP 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	ROP 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%

SNU	COP/ ROP	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	
Lalitpur	ROP 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	ROP 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	ROP 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	ROP 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
Nawalparasi West	ROP 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	ROP 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	ROP 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	ROP 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%

Papua New Guinea

			Treatment Coverage																		
SNU	COP/ ROP	Prioritization	<15		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		Overall Coverage
			F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
NCD	ROP19	Sustained	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%
	ROP20	Scale-up Aggressive (ROP20 + ASAP)	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%

Tajikistan

SNU	COP/ ROP	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	
Dushanbe city	COP 15		APR 16	20%	25%	29%	10%	30%	15%	29%	16%	26%	18%	23%	15%	27%	14%	24%	15%	19%
	COP 16		APR 17	29%	24%	27%	29%	31%	20%	30%	21%	29%	20%	29%	17%	28%	18%	31%	17%	22%
	COP 17		APR 18	45%	45%	33%	29%	35%	31%	35%	21%	31%	27%	32%	23%	38%	24%	38%	21%	28%
	COP 18		APR 19	57%	57%	54%	46%	50%	42%	51%	34%	47%	42%	47%	36%	46%	33%	53%	35%	41%
	ROP 19		APR 20	82%	83%	82%	82%	82%	83%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%
RRS	COP 15		APR 16	43%	40%	35%	29%	32%	21%	34%	24%	35%	25%	38%	24%	35%	28%	30%	31%	31%
	COP 16		APR 17	50%	45%	47%	38%	39%	31%	40%	32%	40%	36%	44%	33%	46%	32%	35%	39%	37%
	COP 17		APR 18	50%	55%	53%	47%	45%	42%	47%	38%	47%	40%	50%	38%	49%	39%	47%	48%	44%
	COP 18		APR 19	62%	60%	49%	53%	55%	49%	57%	48%	56%	46%	56%	44%	57%	46%	53%	53%	51%
	ROP 19		APR 20	90%	90%	90%	91%	91%	91%	91%	91%	91%	91%	91%	91%	92%	91%	91%	91%	91%
Sogd oblast	COP 15		APR 16	35%	43%	36%	37%	34%	31%	34%	29%	36%	29%	33%	35%	30%	34%	32%	30%	33%
	COP 16		APR 17	44%	43%	46%	44%	36%	43%	43%	38%	41%	38%	43%	39%	41%	38%	35%	38%	40%

	COP 17		APR 18	50%	50%	51%	46%	47%	50%	49%	48%	47%	48%	46%	47%	49%	45%	44%	47%	47%
	COP 18		APR 19	62%	50%	59%	51%	56%	58%	57%	56%	57%	56%	57%	55%	59%	54%	59%	55%	56%
	ROP 19		APR 20	86%	80%	83%	85%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	83%	84%	84%
Khatlon oblast	COP 15		APR 16	29%	40%	30%	33%	31%	30%	27%	25%	32%	27%	33%	26%	34%	30%	30%	25%	29%
	COP 16		APR 17	53%	42%	37%	38%	38%	39%	35%	32%	37%	35%	37%	30%	38%	37%	35%	31%	35%
	COP 17		APR 18	52%	46%	46%	38%	42%	45%	41%	38%	44%	40%	39%	39%	45%	42%	46%	37%	41%
	COP 18		APR 19	58%	59%	51%	49%	54%	50%	51%	47%	52%	44%	51%	44%	52%	47%	50%	46%	49%
	ROP 19		APR 20	58%	59%	60%	59%	59%	59%	59%	59%	59%	59%	60%	59%	59%	59%	60%	59%	59%
GBAO	COP 15		APR 16		50%	50%	50%	24%	30%	23%	31%	33%	23%	28%	24%	36%	19%	36%	28%	27%
	COP 16		APR 17			50%	50%	44%	32%	25%	35%	37%	32%	33%	30%	46%	27%	36%	32%	32%
	COP 17		APR 18	50%		33%	50%	43%	50%	39%	43%	49%	40%	43%	36%	47%	39%	45%	33%	40%
	COP 18		APR 19	50%		67%	60%	33%	60%	40%	48%	60%	55%	51%	44%	58%	45%	59%	39%	48%
	ROP 19		APR 20	50%		67%	60%	58%	60%	57%	56%	58%	57%	57%	59%	58%	58%	59%	58%	58%

Thailand

SNU	COP/ ROP	Prioritization	Results Reported	Attained 90-90-90 (81%) by each Age and Sex Band to Reach 95-95-95 (90%) Overall																						Overall TX Coverage
				<1		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	

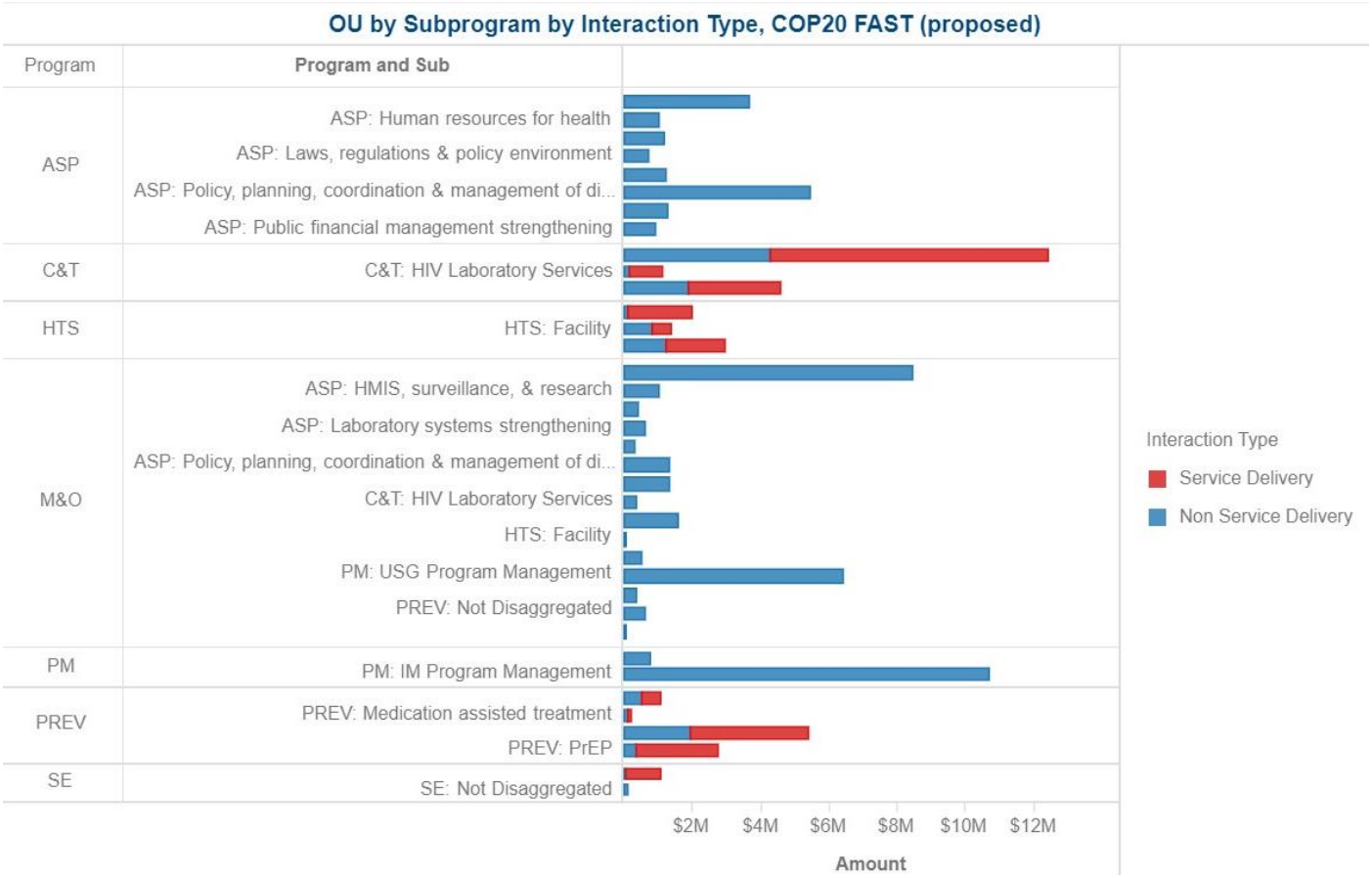
Bangkok	ROP 20	Scale up aggressive	APR 21	0%	0%	63%	67%	68%	65%	67%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%
Chiang Mai	ROP 20	Scale up aggressive	APR 21	0%	0%	100%	100%	80%	80%	76%	76%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%
Chiang_Rai	ROP 20	Scale up saturate	APR 21	0%	0%	50%	100%	100%	100%	86%	90%	88%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%
Chon Buri	ROP 20	Sustained	APR 21	0%	0%	100%	100%	100%	100%	103%	100%	102%	102%	102%	102%	102%	102%	102%	102%	102%	102%	102%	102%	102%	102%	102%	102%	102%
Khon Kaen	ROP 20	Scale up saturate	APR 21	0%	0%	100%	100%	67%	100%	81%	82%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%
Nakhon Ratchasima	ROP 20	Attained	APR 21	0%	0%	100%	100%	100%	100%	95%	95%	97%	97%	97%	98%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%
Nontaburi	ROP 20	Sustained	APR 21	0%	0%	100%	100%	100%	100%	105%	105%	108%	108%	108%	108%	108%	108%	108%	108%	108%	108%	108%	108%	108%	108%	108%	108%	108%
Pathum Thani	ROP 20	Scale up aggressive	APR 21	0%	0%	0%	100%	50%	33%	47%	47%	48%	48%	48%	48%	48%	49%	49%	49%	49%	49%	49%	49%	49%	49%	49%	49%	49%
Phuket	ROP 20	Attained	APR 21	0%	0%	100%	100%	100%	100%	113%	100%	108%	107%	107%	108%	107%	107%	108%	108%	108%	107%	107%	107%	107%	107%	108%	108%	107%
Samut Prakan	ROP 20	Scale up saturate	APR 21	0%	0%	100%	100%	67%	67%	67%	68%	69%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
Songkhla	ROP 20	Sustained	APR 21	0%	0%	100%	100%	100%	100%	100%	107%	104%	104%	105%	105%	105%	105%	105%	105%	105%	105%	105%	105%	105%	105%	105%	105%	105%

Ubon Ratchathani	ROP 20	Sustained	APR 21	0%	0%	100%	100%	100%	100%	100%	100%	100%	100%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
Udon Thanai	ROP 20	Sustained	APR 21	0%	0%	100%	100%	100%	100%	107%	106%	104%	104%	104%	103%	103%	103%	103%	103%	103%	103%	103%	103%	103%	103%	103%	103%	103%

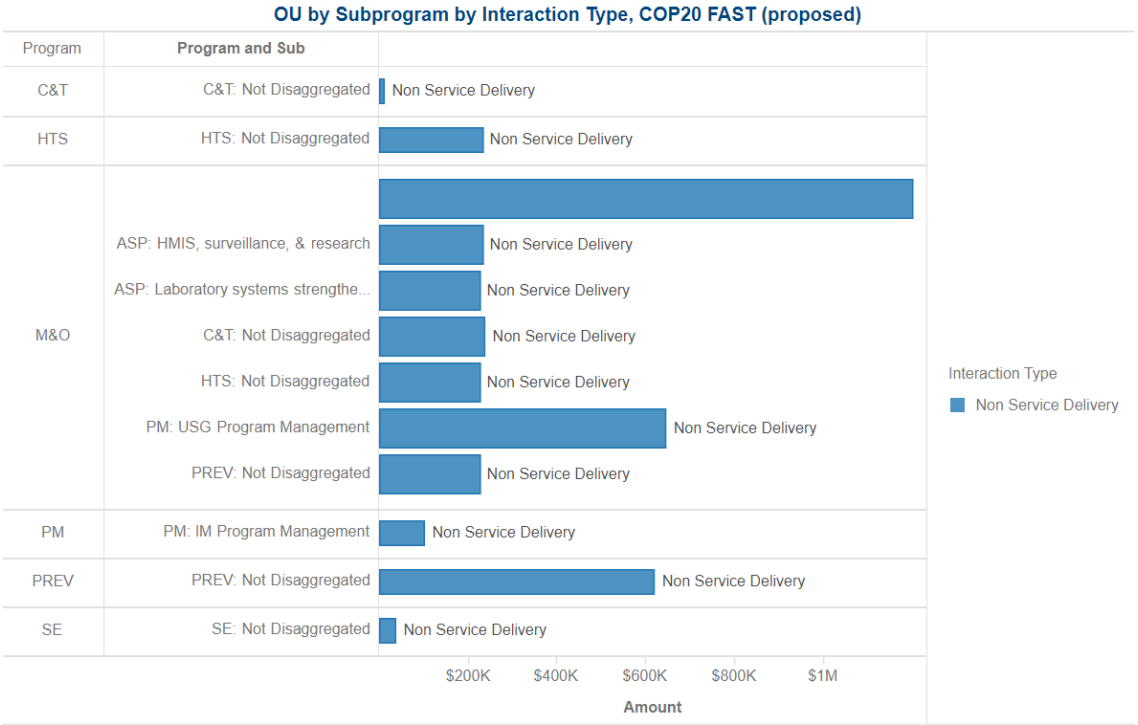
APPENDIX B: Budget Profile and Resource Projections, Asia Region and by Country

Table B.1.1 ROP20 Budget by Program Area

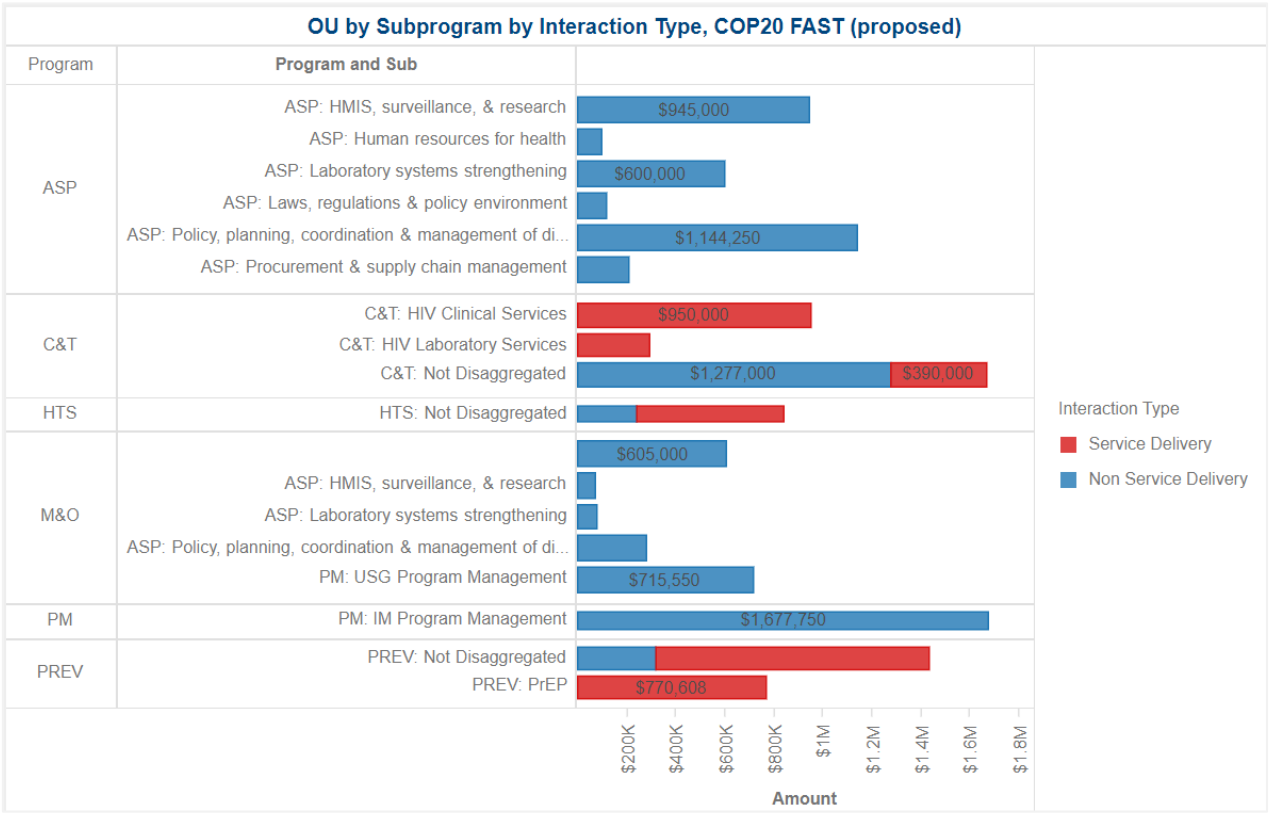
Asia Region



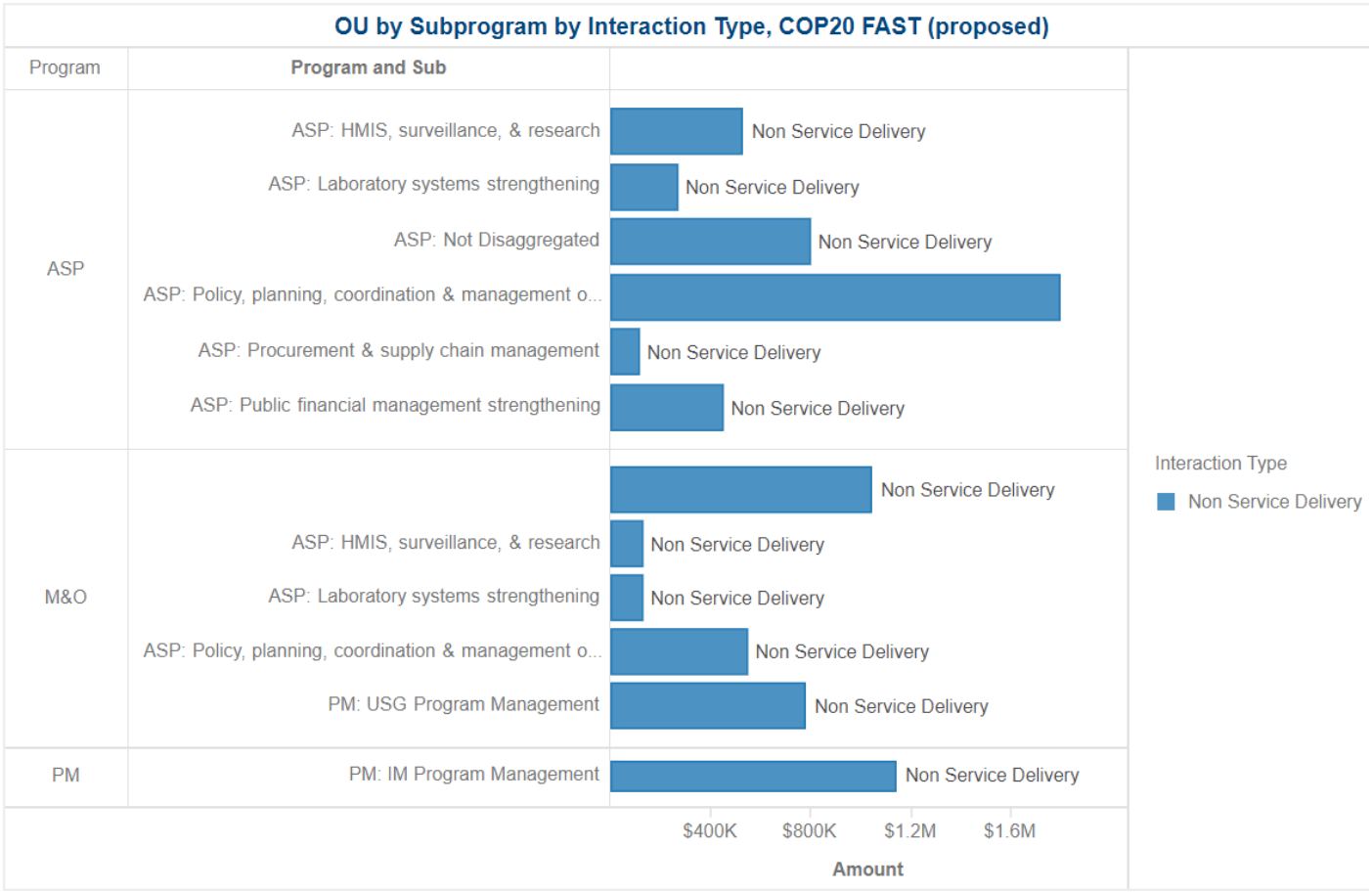
PARCU


OU by Subprogram by Interaction Type, COP20 FAST (proposed)
Program
Program and Sub
C&T
C&T: Not Disaggregated
Non Service Delivery
HTS
HTS: Not Disaggregated
Non Service Delivery
M&O
ASP: HMIS, surveillance, & research
Non Service Delivery
ASP: Laboratory systems strengthe...
Non Service Delivery
C&T: Not Disaggregated
Non Service Delivery
HTS: Not Disaggregated
Non Service Delivery
PM: USG Program Management
Non Service Delivery
PREV: Not Disaggregated
Non Service Delivery
PM
PM: IM Program Management
Non Service Delivery
PREV
PREV: Not Disaggregated
Non Service Delivery
SE
SE: Not Disaggregated
Non Service Delivery
$200K
$400K
$600K
$800K
$1M
Amount
Interaction Type
Non Service Delivery

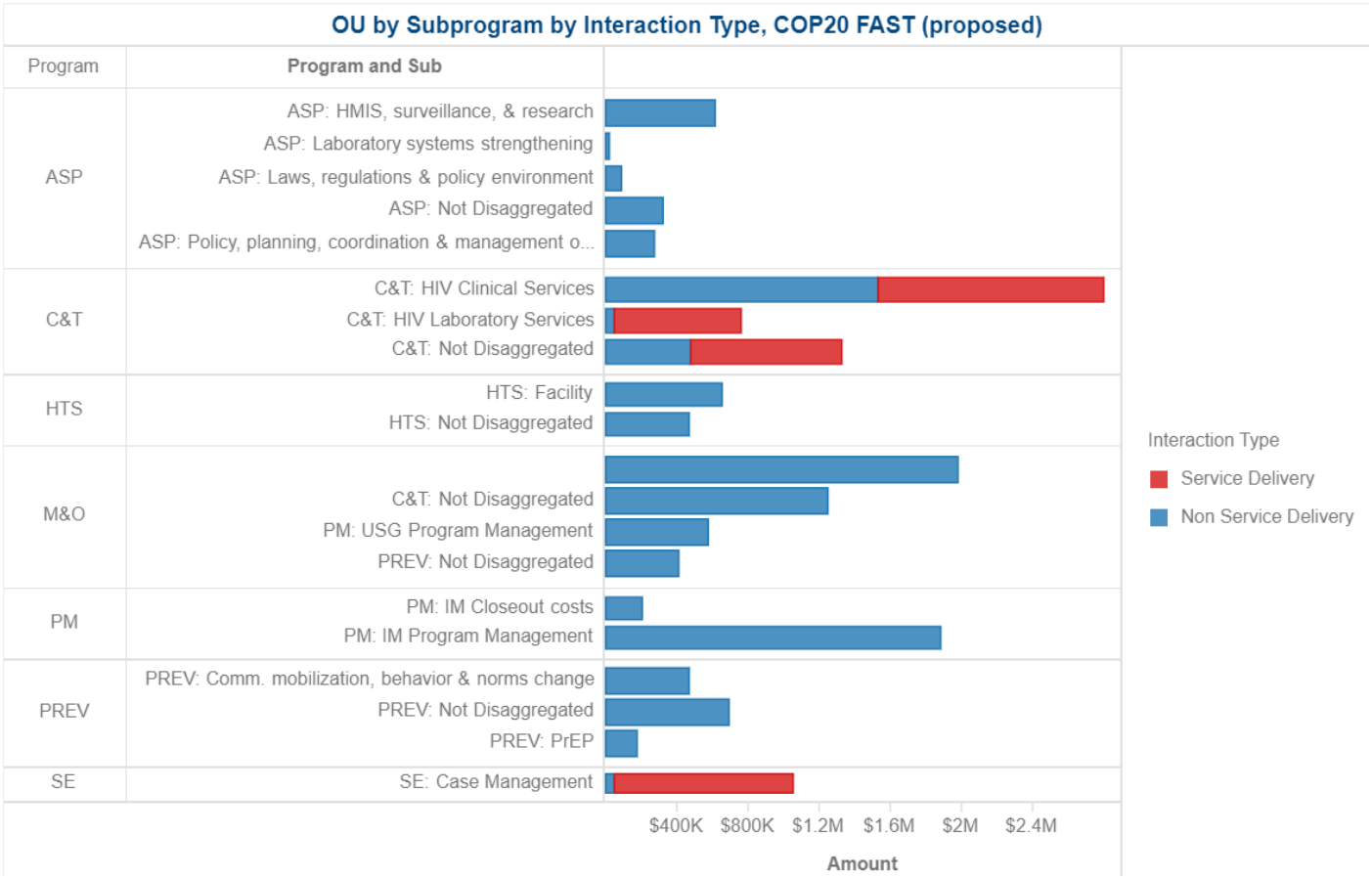
Burma


OU by Subprogram by Interaction Type, COP20 FAST (proposed)
Program
Program and Sub
ASP
ASP: HMIS, surveillance, & research
$945,000
ASP: Human resources for health
ASP: Laboratory systems strengthening
$600,000
ASP: Laws, regulations & policy environment
ASP: Policy, planning, coordination & management of di...
$1,144,250
ASP: Procurement & supply chain management
C&T
C&T: HIV Clinical Services
$950,000
C&T: HIV Laboratory Services
C&T: Not Disaggregated
$1,277,000
$390,000
HTS
HTS: Not Disaggregated
M&O
$605,000
ASP: HMIS, surveillance, & research
ASP: Laboratory systems strengthening
ASP: Policy, planning, coordination & management of di...
PM: USG Program Management
$715,550
PM
PM: IM Program Management
$1,677,750
PREV
PREV: Not Disaggregated
PREV: PrEP
$770,608
$200K
$400K
$600K
$800K
$1M
$1.2M
$1.4M
$1.6M
$1.8M
Amount
Interaction Type
Service Delivery
Non Service Delivery

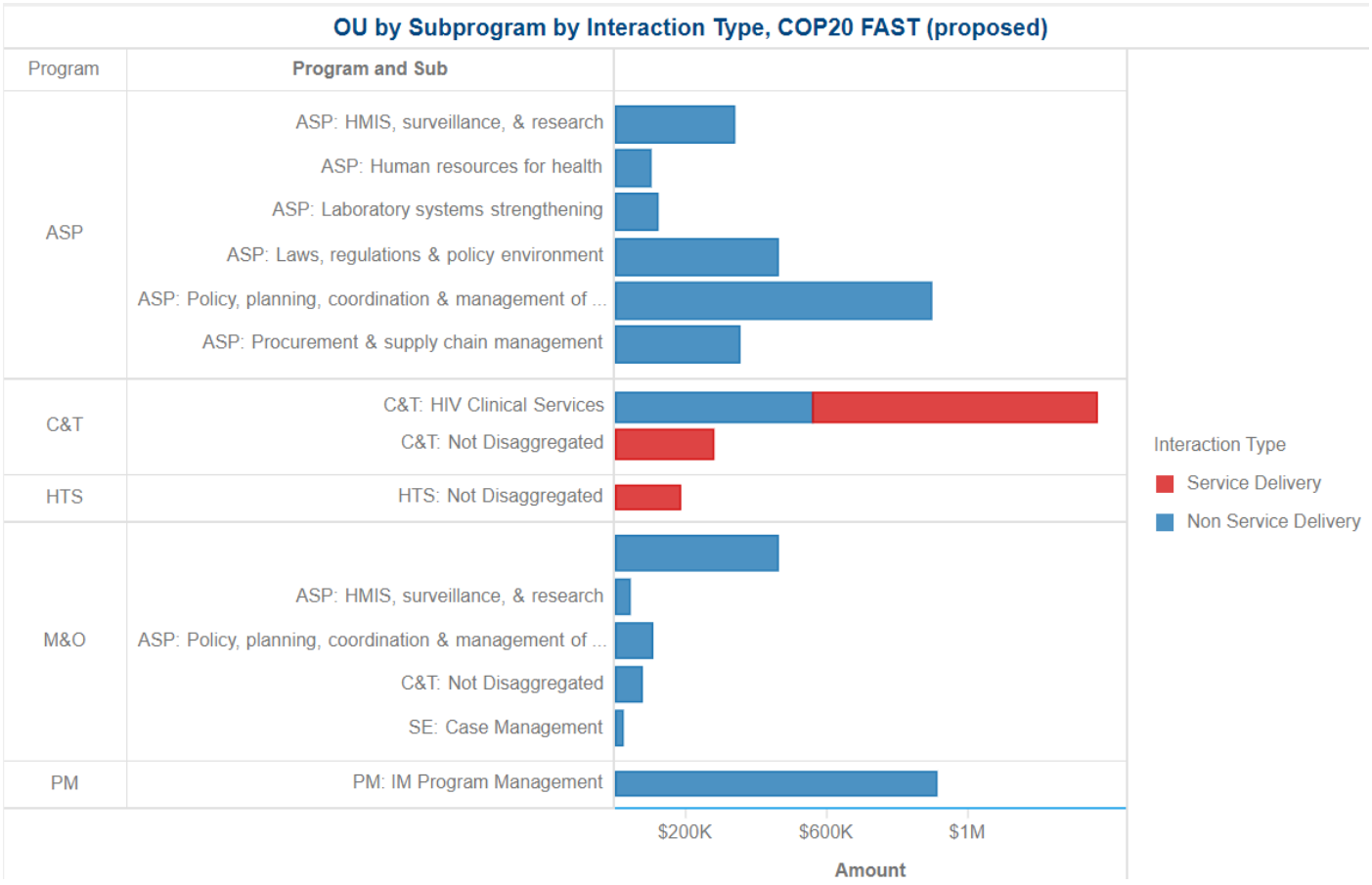
Cambodia



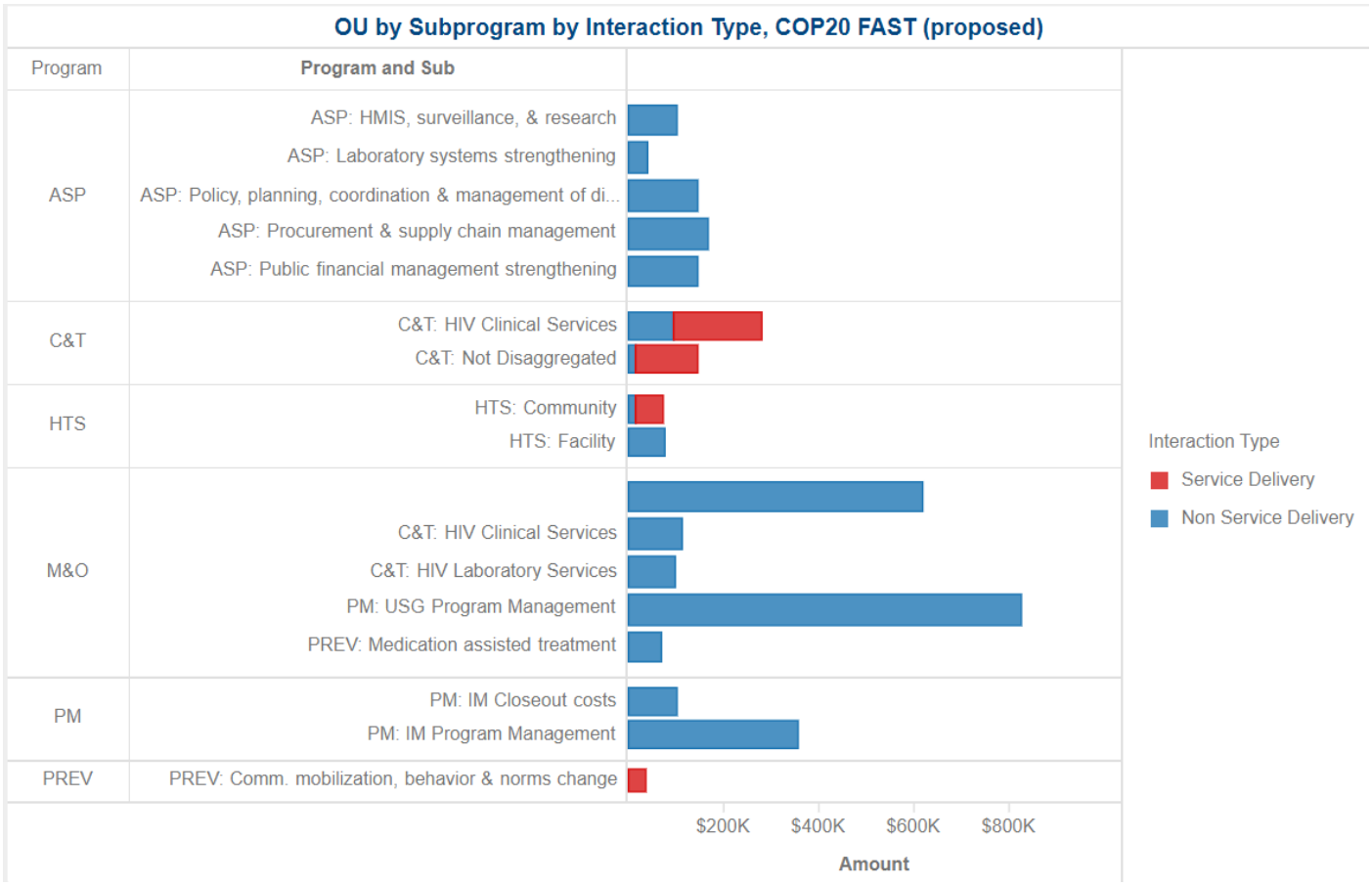
India



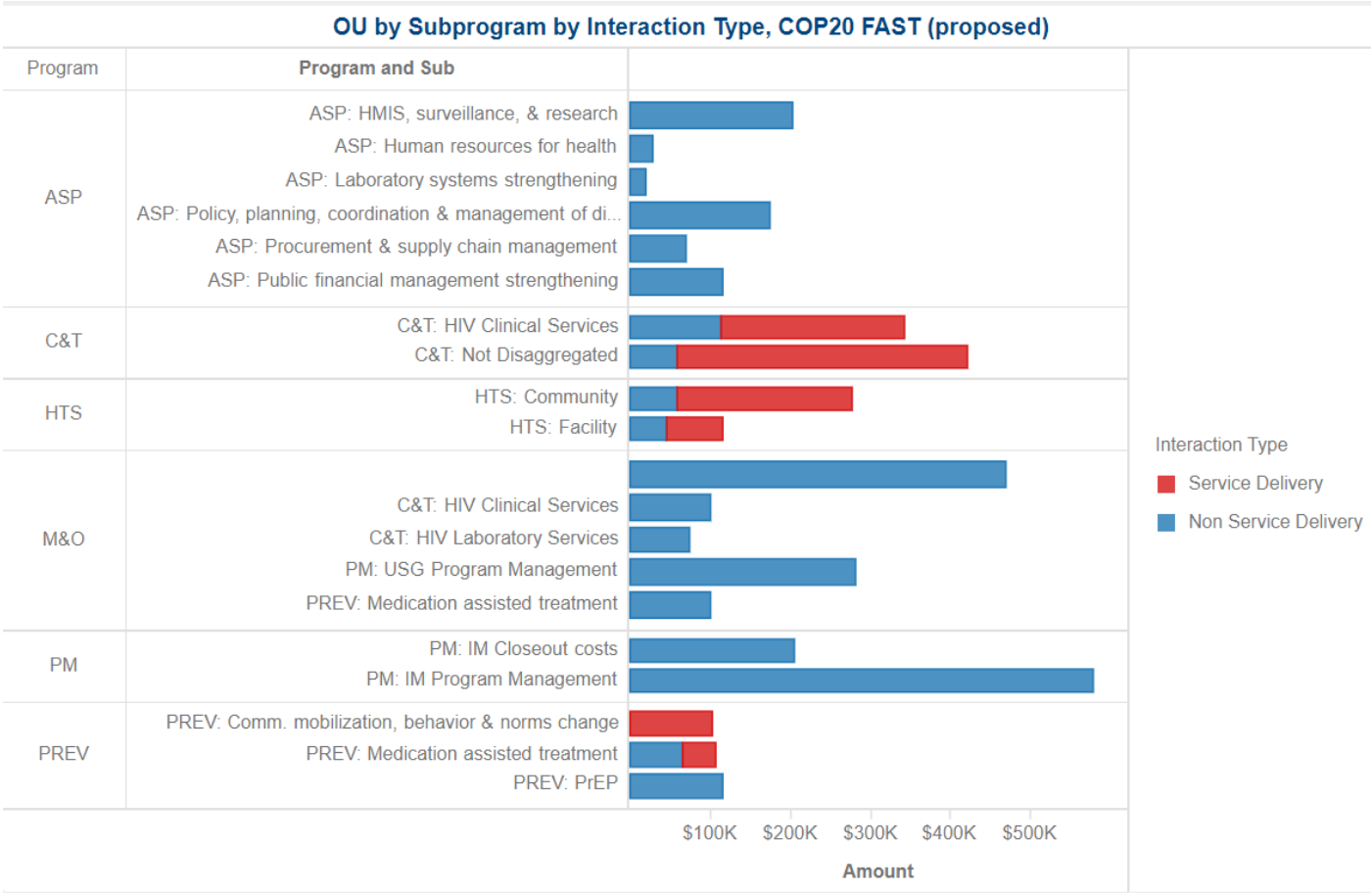
Indonesia



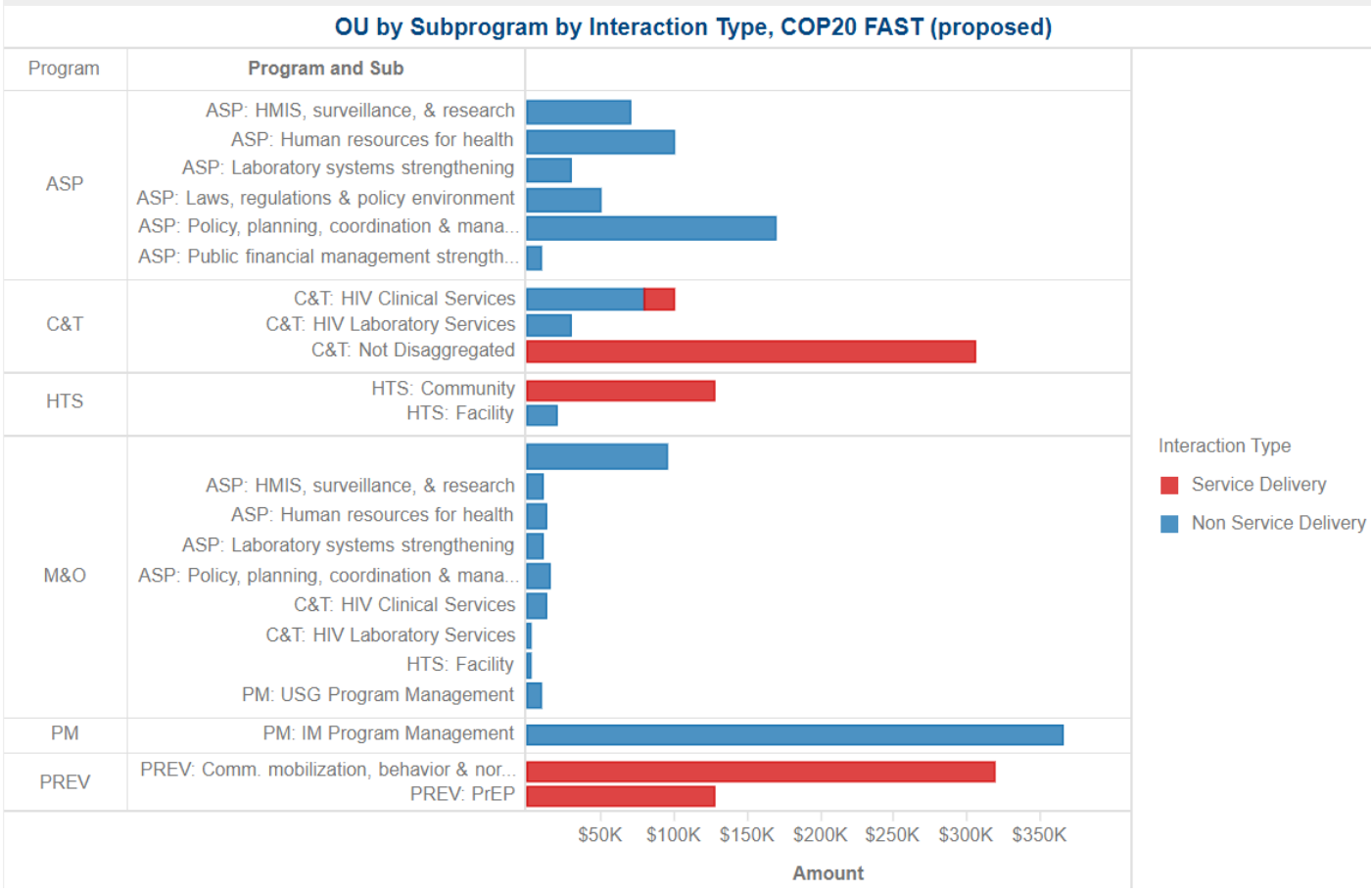
Kazakhstan



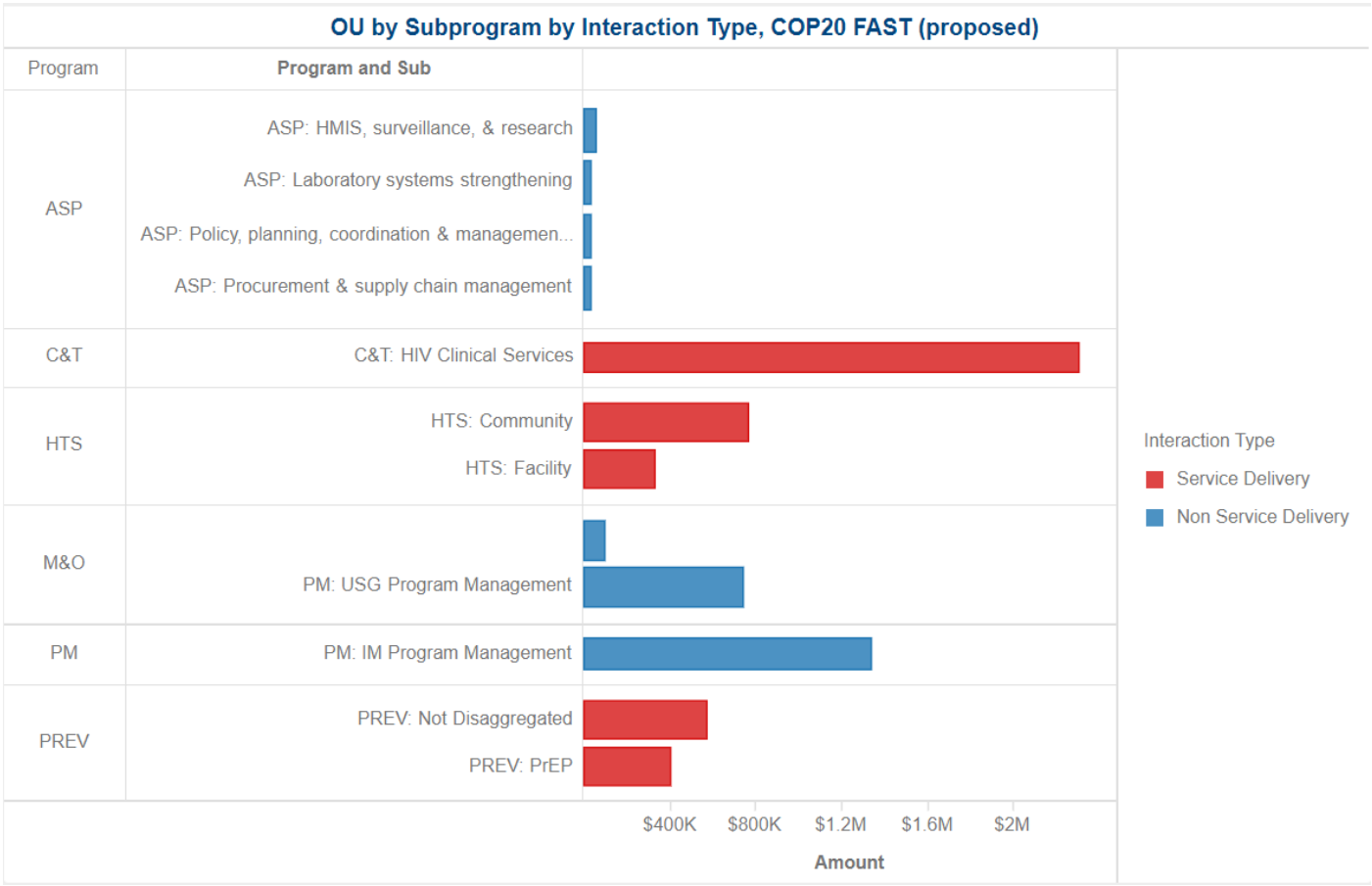
Kyrgyz Republic



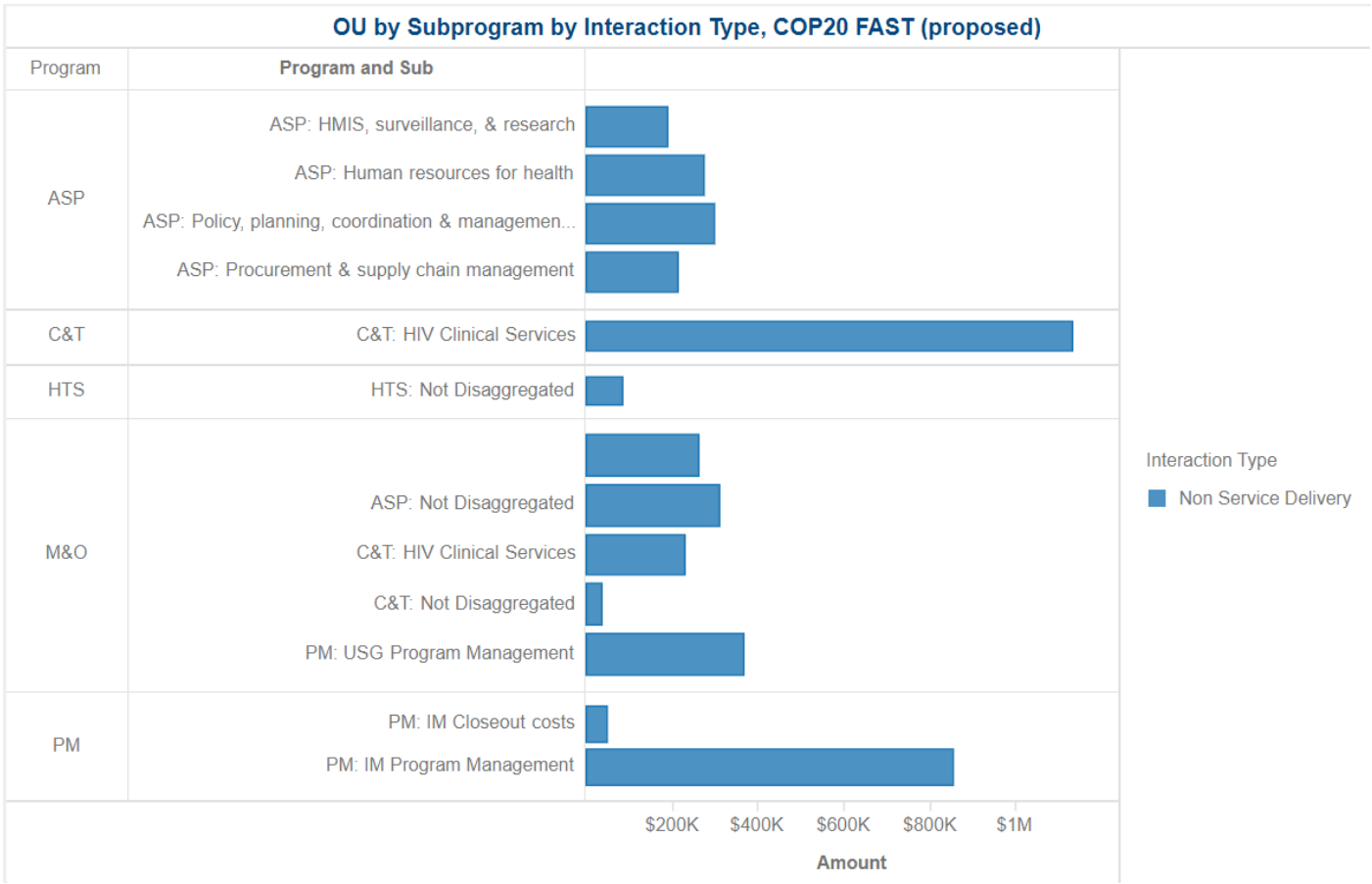
Lao PDR:



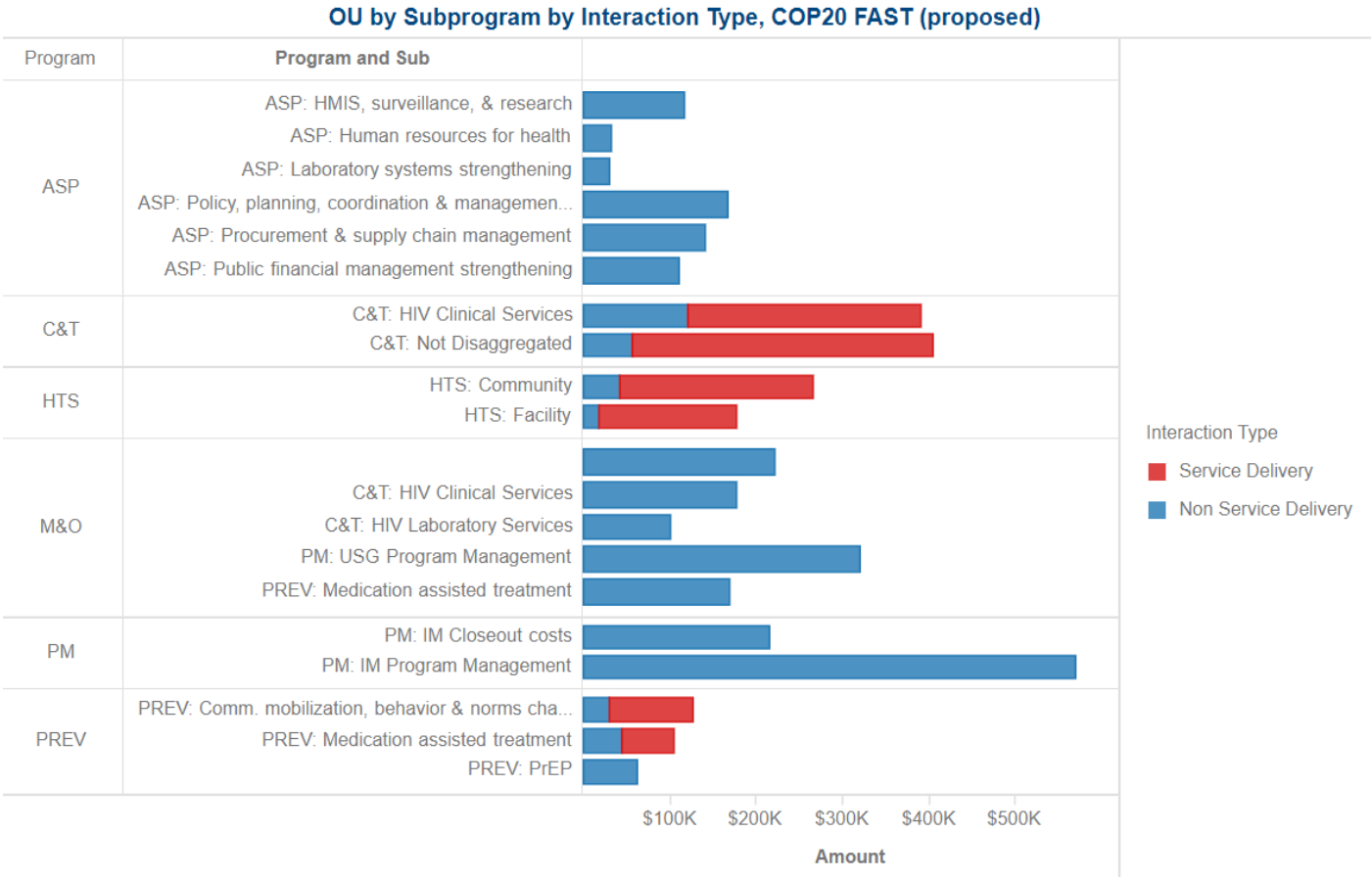
Nepal



Papua New Guinea



Tajikistan



Thailand

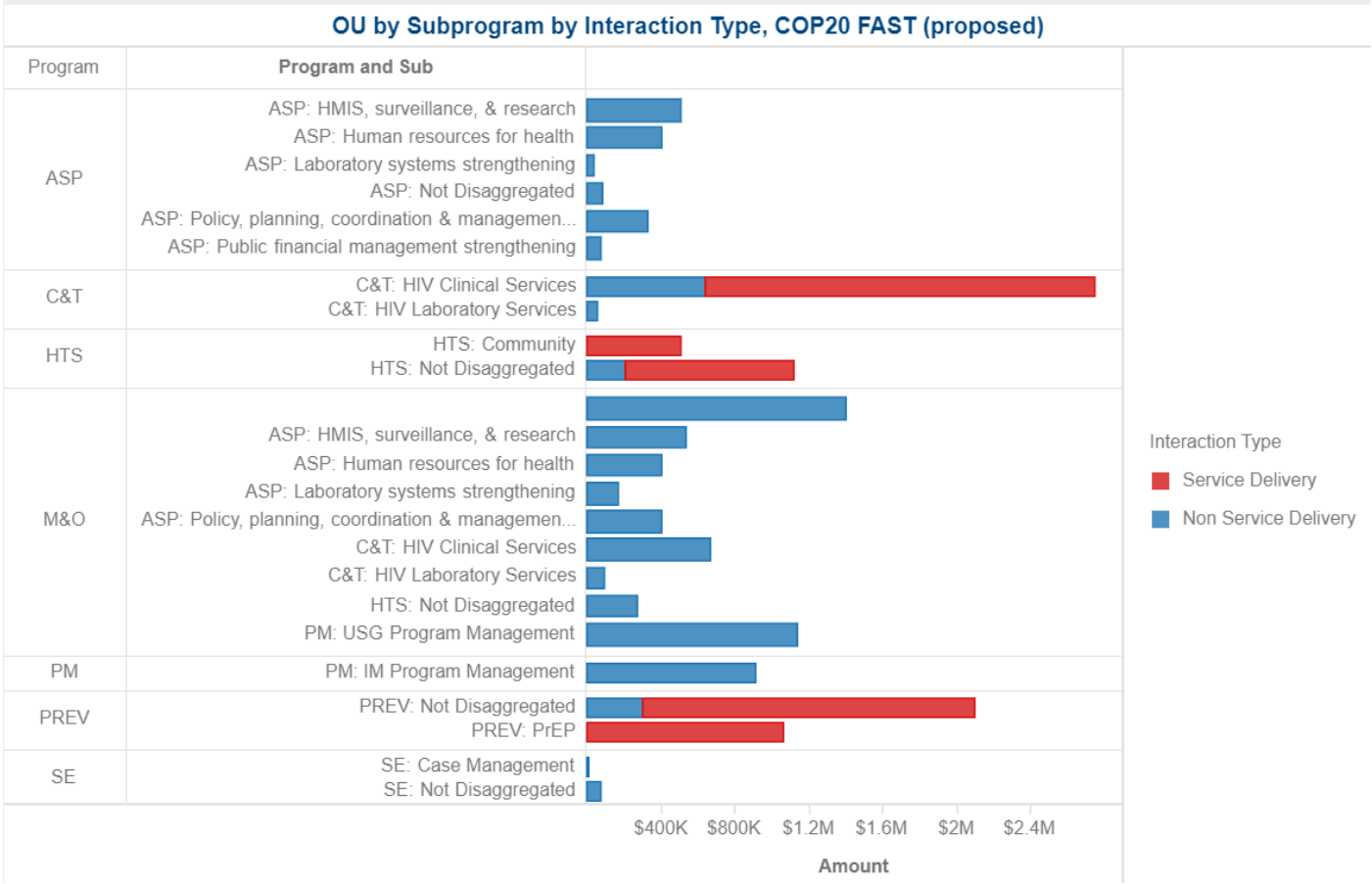


Table E.1.2 ROP20 Total Planning Level in Asia Region

Table E.1.2 ROP20 Total Planning Level				
	Applied Pipeline	**New Funding**	**Ambition Funds**	**Total Spend**
	$US	**$US**	**$US**	**$US**
PARCU	$997,427	$3,000,000	-	$3,997,427
Burma	$1,8741,392	$10,625,608	-	$12,500,000
Cambodia	$922.94	$6,477,057	$300,000	$7,700,000
India	$1,312,523	$14,687,477	-	$16,000,000
Indonesia	$ 983,206	$ 4,716,794	-	$ 5,700,000
Kazakhstan	$563,635	$2,836,365	-	$3,400,000
Kyrgyz Republic	$291,506	$3,608,494	-	$3,900,000
Lao PDR	-	$2,000,000	-	$2,000,000
Nepal	$899,486	$3,800,514	$2,000,000	$6,700,000
PNG	$1,375,828	$2,924,172	-	4,300,000
Tajikistan	$760,223	$3,139,777	-	3,900,000
Thailand	$3,432,313	11,662,687	$395,000	$15,095,000
Total Asia Region	**$13,413,482**	**69,083,945**	**$2,695,000**	**$85,192,427**

Table E.1.2 ROP20 Total Planning Level – Acceleration 20			
	Applied Pipeline	**New Funding**	**Total Spend**
	$US	**$US**	**$US**
India	$11,000,000	-	$11,000,000
Indonesia	$8,595,000	-	$8,595,000
PNG	$895,000	-	$895,000
Philippines	$4,510,000	-	$4,510,000
Total ASAP Year 2	**$25,000,000**	**$0**	**$25,000,000**

Table E.1.3 Resource Allocation by PEPFAR Budget Code by Country (new funds only)

Asia Region

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
HVOP	Other Sexual Prevention	$8,608,334
IDUP	Injecting and Non-Injecting Drug Use	$1,426,144
HVCT	Counseling and Testing	$8,073,960
HBHC	Adult Care and Support	$3,176,644
PDCS	Pediatric Care and Support	$154,720
HKID	Orphans and Vulnerable Children	$1,244,726
HTXS	Adult Treatment	$21,435,646
HTXD	ARV Drugs	$175,500
PDTX	Pediatric Treatment	$25,000
HLAB	Lab	$2,096,443
HVSI	Strategic Information	$5,109,956
OHSS	Health Systems Strengthening	$9,332,416
HVMS	Management and Operations	$10,919,462
TOTAL		$71,778,951

Burma

Table B.1.3 Resource Allocation by PEPFAR Budget Code (Burma)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
HVOP	Other Sexual Prevention	$1,202,828
IDUP	Injecting and Non-Injecting Drug Use	$587,754
HVCT	Counseling and Testing	$1,127,277
HTXS	Adult Treatment	$3,163,397
HLAB	Lab	$829,268

HVSI	Strategic Information	$1,229,675
OHSS	Health Systems Strengthening	$1,164,859
HVMS	Management and Operations	$1,320,550
TOTAL		**$10,625,608**

Cambodia

Table B.1.3 Resource Allocation by PEPFAR Budget Code (Cambodia)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
HVOP	Other Sexual Prevention	$190,000
HVCT	Counseling and Testing	$261,400
HBHC	Adult Care and Support	$142,500
HTXS	Adult Treatment	$278,500
HLAB	Lab	$393,369
HVSI	Strategic Information	$932,339
OHSS	Health Systems Strengthening	$3,018,877
HVMS	Management and Operations	$1,560,072
TOTAL		**$6,777,057**

India

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
HVOP	Other Sexual Prevention	2,015,202
HVCT	Counseling and Testing	1,341,941
PDCS	Pediatric Care and Support	153,409
HKID	Orphans and Vulnerable Children	1,244,726
HTXS	Adult Treatment	5,311,971
PDTX	Pediatric Treatment	25,000

HLAB	Lab	17,045
HVSI	Strategic Information	633,750
OHSS	Health Systems Strengthening	829,982
HVMS	Management and Operations	1,607,635
TOTAL		**13,180,661**

Indonesia

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	$234,646
HBHC	Adult Care and Support	$1,236,114
HTXS	Adult Treatment	$1,847,175
HTXD	ARV Drugs	$175,500
HLAB	Lab	$24,818
HVSI	Strategic Information	$269,128
OHSS	Health Systems Strengthening	$609,981
HVMS	Management and Operations	$319,432
TOTAL		4,716,794

Kazakhstan

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
HVOP	Other Sexual Prevention	$18,250
IDUP	Injecting and Non-Injecting Drug Use	$100,093
HVCT	Counseling and Testing	$287,987
HBHC	Adult Care and Support	$146,000
HTXS	Adult Treatment	$507,349
HLAB	Lab	$48,529
HVSI	Strategic Information	$124,103
OHSS	Health Systems Strengthening	$551,687
HVMS	Management and Operations	$1,052,367
TOTAL		$2,836,365

Kyrgyz Republic

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
HVOP	Other Sexual Prevention	$188,572
IDUP	Injecting and Non-Injecting Drug Use	$330,207
HVCT	Counseling and Testing	$507,306
HBHC	Adult Care and Support	$421,950
HTXS	Adult Treatment	$727,743
HLAB	Lab	$22,059
HVSI	Strategic Information	$222,647
OHSS	Health Systems Strengthening	$426,494
HVMS	Management and Operations	$761,516
TOTAL		$3,608,494

Lao PDR

Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
HVOP	Other Sexual Prevention	$127,500
HVCT	Counseling and Testing	$41,875
HTXS	Adult Treatment	$106,450
HLAB	Lab	$23,325
HVSI	Strategic Information	$23,325
OHSS	Health Systems Strengthening	$111,650
HVMS	Management and Operations	$105,875
TOTAL		**$540,000**

Nepal

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
HVOP	Other Sexual Prevention	$1,190,009
HVCT	Counseling and Testing	$1,446,271
HBHC	Adult Care and Support	$806,260
HTXS	Adult Treatment	$1,987,582
HLAB	Lab	$270,359
HVSI	Strategic Information	$80,000
HVTB	TB/HIV Care	$14,442
HVMS	Management and Operations	1,102,149
TOTAL		$5,800,514

Papua New Guinea

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	98,307

HTXS	Adult Treatment	1,535,951
HVSI	Strategic Information	217,663
OHSS	Health Systems Strengthening	1,106,536
HVMS	Management and Operations	219,867
TOTAL		**$3,178,324**

Tajikistan

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
HVOP	Other Sexual Prevention	$158,878
IDUP	Injecting and Non-Injecting Drug Use	$376,822
HVCT	Counseling and Testing	$373,195
HBHC	Adult Care and Support	$404,550
HTXS	Adult Treatment	$874,860
HLAB	Lab	$33,333
HVSI	Strategic Information	$126,720
OHSS	Health Systems Strengthening	$231,360
HVMS	Management and Operations	$560,059
TOTAL		**$3,139,777**

Thailand

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
HVOP	Other Sexual Prevention	$2,856,929
IDUP	Injecting and Non-Injecting Drug Use	$31,268
HVCT	Counseling and Testing	$1,749,008

HBHC	Adult Care and Support	$19,270
HTXS	Adult Treatment	$3,474,845
HLAB	Lab	$180,714
HVSI	Strategic Information	$950,925
OHSS	Health Systems Strengthening	$972,728
HVMS	Management and Operations	$1,427,000
TOTAL		**$11,662,687**

APPENDIX C: Tables and Systems Investments for Section 6.0

Burma

Funding Agency	PrimePartner	COP20 Program Area	COP20 Beneficiary	COP20 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP20 Benchmark	COP20 Benchmark
HHS/CDC	World Health Organization	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Clinical guidelines, policies for service delivery	Inadequate capacity to deliver client centered HIV care, treatment and retention services tailored to the needs of key populations; and significant legal barriers for key populations.	COP19	COP20	Review on current HIV National Strategic Plan for 2016-2020 completed; HIV National Strategic Plan for 2021-2025 drafted; Revised clinical guidelines / SOPs for TLD transition; Operationalization of PrEP and optimized mix of testing modalities (Index testing, partner notification, social network testing) and Case finding for 1st 90 improved from 79% to 90% by accelerating the implementation of recommended testing modalities and partner notification.	1) National HTS guidelines amendment (to incorporate self-testing, and latest WHO/PEPFAR recommendations, particularly on safe scale up of index testing and SNS case-finding innovations). 2) National TB guidelines revision to include newer TPT regimens. 3) Coordination and advocacy on scaling up Minimum Program Requirements at national level (MMD, TLD). 4) Advocacy for operational research, M&E Framework for tracking effecitveness of PWID interventions including MMT and needle and syringe program.
HHS/CDC	0	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Clinical guidelines, policies for service delivery	Inadequate capacity to deliver client centered HIV care, treatment and retention services tailored to the needs of key populations; and significant legal barriers for key populations.	COP19	COP20	HIV National Strategic Plan for 2021-2025 drafted; GF Concept note reflects emphasis on comprehensive HIV/STI/hepatitis prevention plans using tools like PrEP, new HTS modalities, and STI and hepatitis prevention/testing/treatment for at-risk KP populations	Strategic policies, guidelines and SOPs developed to operationalize NSP refecting PEPFAR minimum program requirements and client centered service delivery
HHS/CDC	0	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	Lack of standardized reporting system across to track PLHIV from diagnosis to viral load suppression (HIV cascade); limited availability of and ability to use reliable epidemiologic and	COP19	COP21	A national framework/ roadmap for Case Based Surveillance finalized; SOPS for strengthening of case based surveillance system developed; Standardized/ updated case reporting form developed;	A blue print and phase-approach plan for case based surveillance system developed. National and sub-national HIV cascades updated and available. National M&E system incorporated routine data quality monitoring and improvement
HHS/CDC	0	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Inadequate capacity and laboratory resources to monitor high quality HIV testing services and lack of an ISO accredited national HIV reference laboratory.	COP19	COP20	RTCQI rollout plan initiated in 2 HB regions along with site certification; Updated VL Scale up Plan; Corrective actions plan being implemented for findings with regular VL scorecard assessments at all high throughput machines	National QA/QM guideline and QA interventions for HIV rapid testing endorsed at national level to implement continuous quality improvement for HIV testing facilities. VL diagnostic network optimization excercise completed.
HHS/CDC	0	ASP: Policy, planning, coordination & management of disease control programs-NSD	Key Pops: Not disaggregated	Clinical guidelines, policies for service delivery	Inadequate capacity to deliver client centered HIV care, treatment and retention services tailored to the needs of key populations; and significant legal barriers for key populations.	COP19	COP20	N/A	HCW senstitization training and structural interventions tailored to ART sites designed and implemented in 50% of public ART sites in 5 high burden regions. M&E system to improve quality and use of MMT and ART data developed and integrated into facility based quality improvement process. PrEP capacity building at subnational level for 5 PEPFAR priority states and regions. Increased uptake of HIV testing services through optimized mix of testing modalities as peer led activities in 5 PEPFAR priority states and regions
USAID	UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Training in HMIS systems or processes	Lack of standardized reporting system across to track PLHIV from diagnosis to viral load suppression (HIV cascade); limited availability of and ability to use reliable epidemiologic and programmatic data at subnational level.	COP16	COP21	1) Establishment of a database of trainees and trainers on startegic information data collection and use; 2) M&E focal points from high burden townships are trained on how to improve data collection, reporting and use; 3) Research agenda defined and national committee for research operational;	1) National AIDS Spending Assessment conducted 2) Annual HIV Progress Report developed 3) PWID PrEP feasbility assessment completed
USAID	UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS	ASP: Laws, regulations & policy environment-NSD	Key Pops: Not disaggregated	Assessing impact of policies and regulations on HIV	Inadequate capacity to deliver client centered HIV care, treatment and retention services tailored to the needs of key populations; and significant legal barriers for key populations.	COP17	COP21	Local Partner capacity building assessments conducted (KP led health services)	1) Policies in place which improve access and quality of HIV services for KPs and PLHIV 2) Law to protect PLHIV endorsed by Parliament 3) KP-led CSOs involved with PrEP implementation 4) Support provided for new transgender CSO
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	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	COP21	1) >90% of HIV storage facilities (depots and sub-depots) reporting on time in electronic LMIS system. 2 >80% data availability & accuracy from state/Regional/Central Warehouses 3) 0% stockout rate at sentinal high-volume Service Delivery Points. 4) Procurement aligned for 40% of new ART initiation with TLD regimen achieved at national level.	1) >95% of HIV storage facilities (depots and sub-depots) reporting on time in electronic LMIS system. 2 >90% data availability & accuracy from state/Regional/Central Warehouses 3) 0% stockout rate at sentinal high-volume Service Delivery Points. 4) Procurement aligned for 46% of new ART initiation with TLD regimen achieved at national level.

Cambodia

Funding Agency	PrimePartner	COP20 Program Area	COP20 Beneficiary	COP20 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP20 Benchmark	COP20 Benchmark
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP19	COP21	ROP 19 Benchmark: 100% of sites implementing MMS; in alignment with guidance that states six month drug supply for all virally suppressed clients.	ROP 20 Benchmark: • More than 80% of patients are receiving MMD of 6 months or more. • Assess existing capacity for procurement and specifically for ARV and HIV commodities procurement • Develop a competency framework for procurement of ARV's and HIV commodities • Design capacity building initiatives to address competency gaps in procurement and logistics management and information systems SID score 8.5: 0.63 SID score 8.7: 1.67 SID score 8.8: 1.67
USAID	Family Health International	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Insufficient market approaches for sustainable epidemic control	COP20	COP20	N/A	HIV and chronic care model developed and piloted in three hospitals
USAID	Family Health International	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregated	HMIS systems	lack of efficient data systems to track PLHIV across the cascade and respond to new infections.	COP19	COP20	KP LIC tracking, performance management system functional for major proportion of national KP response. 90% KP disaggregated data available for prevention, testing, case identification, linkage to care, and VL suppression	>80% of ART clinics able to do data entry in real-time. 100% of provinces are able to analyze and use data for monitoring and strategic planning purposes.
USAID	Family Health International	ASP: Policy, planning, coordination & management of disease control programs-NSD	Key Pops: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP17	COP20	At least 90% of facilities with CAA provides active identification of stable patients and routine ART visits managed by protocol (community or facility) by CAA team or lower cadre workers. At least 50% of Current on Treatment categorized as stable patients	• 100% of facilities with CAA provide active identification of stable patients and routine ART visits managed by protocol (community or facility) by CAA team or lower cadre workers. • More than 80% of patients are receiving MMD of 6 months or more. • More than 90% of patients are receiving TLD.

USAID	Family Health International	ASP: Policy, planning, coordination & management of disease control programs-NSD	Key Pops: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP17	COP20	Optimized case finding (3,000 new case identified through HIVST, index, social and sexual network and mobile testing) Greater efficiency in fully scaled index testing and HIVST with specific focus on MSM and TG Linkage improved for all subpopulations	Optimized case finding (3,000 new case identified through HIVST, index, social and sexual network and mobile testing) 100% of newly identified PLHIV with more than 1 partner tested 60% of newly identified PLHIV with 2 or more partners tested PrEP services scaled up to all HIV high burden areas based on new positives identified and recency testing results.
USAID	Family Health International	ASP: Policy, planning, coordination & management of disease control programs-NSD	Key Pops: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP17	COP20	Targeted KP prevention strategies developed to respond quickly to new infections and prevent further transmissions. 10% increase in patient satisfaction from KP services 25% of provinces with GBV referral system for KP	PSF expanded to all HIV high burden provinces 50% increase in patient satisfaction from KP services GBV referral system for KPs expanded into 4 HIV high burden provinces
USAID	Family Health International	ASP: Not Disaggregated-NSD	Non-Targeted Pop: Not disaggregated	Private sector engagement	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP20	COP21	N/A	Approval for 1 HIV certification program for provision of certified HIV services in the private sector. Develop HIV certification program standards for private sector certification SID Private Sector Engagement Score: >5.0
USAID	Family Health International	ASP: Not Disaggregated-NSD	Key Pops: Not disaggregated	Private sector engagement	Insuffident market approaches for sustainable epidemic control	COP20	COP21	N/A	Chhouk Sar (KP friendly) clinic branding model developed and implemented by GF Chhouk Sar clinic model replicated in 2 additional HIV high burden areas
HHS/CDC	NATIONAL CENTER FOR HIV/AIDS DERMATOLOGY AND STDS (NCHADS)	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP18	COP21	100% of newly identified PLHIV with at least 1 partner tested	60% of newly identified PLHIV with 2 or more partners tested

HHS/CDC	NATIONAL CENTER FOR HIV/AIDS DERMATOLOGY AND STDS (NCHADS)	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP19	COP20	Re-engage 50% PLHIV who are LTFU on ART	Re-engage 80% PLHIV who are LTFU on ART
HHS/CDC	NATIONAL CENTER FOR HIV/AIDS DERMATOLOGY AND STDS (NCHADS)	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP19	COP21	(A) >85% (B) 100% of all viral load tests are returned to site level in less than 14 days	(A) >95% (B) 100% of all viral load tests being returned to site level in less than 10 days
HHS/CDC	NATIONAL CENTER FOR HIV/AIDS DERMATOLOGY AND STDS (NCHADS)	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP19	COP20	(A) More than 45% of patients are receiving MMD of up to 6 months (B) More than 40% of patients are receiving TLD (C) Median of 5 days	(A) More than 80% of patients are receiving MMD of 6 months or more. (B) More than 90% of patients are receiving TLD. (C) Median of 3 days
HHS/CDC	NATIONAL INSTITUTE OF PUBLIC HEALTH	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab accreditation	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP18	COP21	(A) 68 labs enrolled in HIV EQAS obtain an EQAS score >90% (B) NIPHL maintains ISO 15189 Accreditation	(A) 68 labs enrolled in HIV EQAS obtain an EQAS score >95% (B) NIPHL maintains ISO 15189 Accreditation
HHS/CDC	NATIONAL CENTER FOR HIV/AIDS DERMATOLOGY AND STDS (NCHADS)	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP19	COP21	Greater than 60% of PSHIV have completed a TPT course	Greater than 90% of PLHIV have completed a TPT course
HHS/CDC	NATIONAL CENTER FOR HIV/AIDS DERMATOLOGY AND STDS (NCHADS)	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Lack of efficient data systems to track PLHIV across the cascade and respond to new infections.	COP19	COP21	30% of ART clinics able to generate and use data from case-based surveillance	> 80% of ART clinics able to generate and use data from case-based surveillance
HHS/CDC	NATIONAL CENTER FOR HIV/AIDS DERMATOLOGY AND STDS (NCHADS)	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP19	COP21	39/66	100%

HHS/CDC	NATIONAL CENTER FOR HIV/AIDS DERMATOLOGY AND STDS (NCHADS)	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP20	COP21	25/25	25/25
HHS/CDC	NATIONAL INSTITUTE OF PUBLIC HEALTH	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab accreditation	Inefficient quality management systems to improve outcomes for PLHIV and sustaining epidemic control.	COP19	COP21	60% of non-conformities identified are addressed	80% of non-conformities identified are addressed
USAID	Family Health International	ASP: Not Disaggregated-NSD	Key Pops: Not disaggregated	Private sector engagement	Insufficient market approaches for sustainable epidemic control	COP20	COP21	N/A	Chhouk Sar (KP friendly) clinic branding model developed and implemented by GF Chhouk Sar clinic model replicated in 3 additional HIV high burden areas

India

Funding Agency	PrimePartner	COP20 Program Area	COP20 Beneficiary	COP20 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	Relevant Indicator or Measurement Tool	COP20 Benchmark	COP20 Benchmark
HHS/CDC	UNAIDS JOINT UNITED NAT	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Adults	HMIS systems	Slow progress in strengthening institutional capacity for integrated data systems and real time epidemic monitoring, as well as sustainable financing in optimal utilization and leveraging of resources.	COP20	COP21	# districts with PLHIV burden estimated # states with PLHIV burden estimated # districts with epidemic profile generated # of districts with updated key population (KP) size estimates (FSW, MSM, PWID, TG)	National HIV Estimations Report prepared and disseminated. New denominators explained to policymakers and program managers at national and sub-national level. New methods, to improve key popylation size estimations in collaboration with partners tested and finalized in selected districts. District-level estimations supported with operational guidelines and cluster-level methodology, in preparation for generating district estimates for entire country.	Next round of estimates supported-National HIV Estimations Report prepared and disseminated. District level estimations supported for the entire country. Consultations to review and provide way forward for epidemic monitoring till end of AIDS 2030.
HHS/CDC	UNAIDS JOINT UNITED NAT	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Slow progress in strengthening institutional capacity for integrated data systems and real time epidemic monitoring, as well as sustainable financing in optimal utilization and leveraging of resources.	COP20	COP21	# of publications with strategic information for epidemic monitoring # of high-level strategic committees held to assimilate data for decision-making The above, in addition to custom indicators will serve as monitoring tools	National and state bulletins prepared with minimal support from PEPFAR. Progress monitoring on 90-90-90, assisted by national dashboard, with ability to drill down to sub-populations and geographies, for an enhanced understanding of programmatic and operational issues.	Continued support for prioritization of response towards achievement of 95-95-95.Enhanced understanding of epidemic and response through national dashboard bulletin, district and state epidemiological fact sheets, national secondary data analysis plan, technical briefs Support for robust data generation to inform the next phase of the national AIDS control program. Vital decisions on **scale-up** of existing interventions to be based on strategic information generated through PEPFAR support. Capacities in data generation, knowledge translation strengthened.
HHS/CDC	World Health Organization	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Slow progress in strengthening institutional capacity for integrated data systems and real time epidemic monitoring, as well as sustainable financing in optimal utilization and leveraging of resources.	COP20	COP21	Priority indicators for epidemic monitoring, district cascades and data dashboards for national and sub-national epidemiological analysis # districts where KP surveillance conducted # of districts where prisoner surveillance is implemented # districts where program based surveillance tested White paper on mapping and size estimation of virtual populations prepared	1. HSS Plus, BSS Lite rolled out in pilot districts with lessons learned for scale up, and innovative PSE methodology tested in select districts, for scalability and validity of estimates 2. Development and dissemination of district cascades by each administration unit in cluster district by key and priority populations	1. Case-based surveillance planning for integration into Strengthening Overall Care for HIV patients (SOCH). Surveillance activities (program-based surveillance for KPs, Stigma surveillance, mortality surveillance, incidence surveillance, HSS Plus, sentinel surveillance among KP, ANC, prisoners) supported through operational guidelines development, training, monitoring, supervision. Virtual key population estimation methodology field tested in collaboration with Indian Council of Medical Research (ICMR). 2. Cohort cascades generated include KP cascade, geo mapping of cases for surveillance and identification of "hot spots". Capacity of district and state staff further strengthened to use program and surveillance data for more targeted prevention and testing services to most affected geographical areas and populations groups. Technical support to HIV Drug Resistance Survey and facility -based support such as monitoring HIV Drug Resistance Early Warning Indicators (DR EWI) and quality of care indicators (QCI) (WHO recommended) 3. Capacities in data generation, knowledge translation strengthened and in-depth translation of new evidence to drive program impact.
HHS/HRSA	UNIVERSITY OF WASHING	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Limited scale up of client-centered, integrated, community-based/customized service delivery and community monitoring to enhance retention including 6 month multi-month dispensation, ARV optimization, and TPT implementation	COP19	COP21	National technical guidelines developed; 100% of new/existing PLHIV and Children on DTG regimen; Tools for monitoring pharmacovigilence developed; 4 Centre of Excellence initiate HIVDR surveillance for PLHIV on TLD	1a. Implement TLD transition of TRG guidance, through phase in for naive patients, 2nd line patients and informed choice for women of childbearing age 1b. TLD sensitization by developing treatment literacy material for key stakeholders including health care providers and community 2. New Activity 3. New Activity	1a. Support national and state program in transition of 100% new/existing PLHIV and CLHIV to DTG based regimen 1b. TA to national program to monitor TLD uptake and support pharmacovigilence monitoring 1c. Support revision of national ART technical guidelines 2. Support HIVDR surveillance for DTG at Centres of Excellence to inform ART regimen switch algorithms, and provide guidance for the clinical management of the anticipated small proportion of patients who may not achieve virologic suppression on TLD 3.75% of eligible clients receiving 6 MMD in Mumbai, and NE India with implementation of community score card for monitoring 4. 50% of eligible KP (TG,MSM,FIDU/FSW) are linked with DSDM and patient centered packages of care in NE and Mumbai
HHS/HRSA	UNIVERSITY OF WASHING	ASP: Policy, planning, coordination & management of disease control programs-NSD	Key Pops: Not disaggregated	Assessing impact of policies and regulations on HIV	Populations at substantial risk for HIV do not have a full awareness of PrEP as a proven prevention strategy and limited implementation of community led service delivery	COP19	COP21	Number of people trained on National PrEP guidelines and policies; Number and Proportion of high risk KPs initiated on PrEP; Number of PrEP users retained through quarterly HIV+STI testing	Implement PrEP among PWID, MSM, FSW and TG populations at 3 sites in cluster districts. 75% of all clients at substantial risk or self seeking, initiate PrEP.	National PrEP operational guidelines, and modules for HCW for implementation of PrEPdeveloped; Train pool of master trainers,80% of KP at substantial risk linked to PrEP in PEPFAR geographies
HHS/CDC	PATH	ASP: Not Disaggregated-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	Slow progress in strengthening institutional capacity for integrated data systems and epidemic monitoring as well as challenges in optimal utilization and leveraging of resources.	COP20	COP21	% increase of linkage of HIV positive cases from ICTC to ART center % decrease in LFU cases % increase in retention of patients on ART	Modules added to data systems to strengthen comprehensive tracking of patients and incorporate client-feedback mechanisms, to strengthen prevention-to-care cascade	CQI implemented in PEPFAR priority districts to leverage existing MER indicators and establish new indicators to track key client-centered quality measures (e.g., linkage rates, wait times, gaps across index testing cascades) and to monitor the progress of quality improvement processes. Strengthen the District AIDS Prevention and Control Units (DAPCU) for effective real time monitoring, data for decision making and engagement with community for solutions through gap analysis, training modules, and DAPCU score card.
USAID	UNAIDS JOINT UNITED NAT	ASP: Laws, regulations & policy environment-NSD	Key Pops: Not disaggregated	Assessing impact of policies and regulations on HIV	Slow progress in strengthening institutional capacity for integrated data systems and real time epidemic monitoring, as well as sustainable financing in optimal utilization and leveraging of resources.	COP20	COP20	Number of states implementing HIV Act and TG Bill. Provide patient centered packages for TG.	Four states implementing HIV Act and TG Bill and providing patient centered packages for TG	Eight states implementing HIV Act and TG Bill and providing patient centered packages for TG
USAID	Johns Hopkins University, T	ASP: Not Disaggregated-NSD	Key Pops: Not disaggregated	Assessing impact of policies and regulations on HIV	Populations at substantial risk for HIV do not have a full awareness of PrEP as a proven prevention strategy and limited implementation of community led service delivery	COP20	COP20	1.PrEP policy guidelines implemented. 2. Number of prividers certified via on line certification program. 3. Scale up PrEp (PrEP _NEW, PrEP _CURR); 1. Number of HIV Self tests conducted. 2.Number private and public sector settings providing HIV Self test kits	1. Four states with PrEP roll-out. 2 .Over 150 provider certified to provide prEP via online certification program.	1. National level PrEP roll out in both public and private sector
USAID	World Health Organization	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	Limited scale up of client-centered, integrated, community-based/customized service delivery and community monitoring to enhance retention including 6 month multi-month dispensation, ARV optimization, and TPT implementation	COP20	COP20	Reporting of numbers start from at last 3 high burden states for private sector	2 states have formal reporting	6 states have formal private sector reporting

Indonesia

Funding Agency	PrimePartner	COP20 Program Area	COP20 Beneficiary	COP20 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP20 Benchmark	COP20 Benchmark
USAID	FHI Development 360 LLC	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	National HIV program lacks implementation of international standard best practices for retaining PLHIV in HIV services	COP18	COP21	39% viral load testing coverage; 80% rapid ART/63% SDART among newly enrolled PLHIV at sub-district levels; 80% diagnosis - enrollment linkages; initiation of TLD	PEPFAR minimum requirements for VL test coverage and SDART achieved in at least three out of five districts and 100% of PEPFAR-supported sites ; and 60% continuation of TLD roll out across PEPFAR-supported facilities. To continue providing TA to PHO/DHO and HF to adapot Stigma & Discrimination tools and Standard Operation Procedure to improve retention and reduce loss to follow up in 60 health facilities in Jakarta
USAID	FHI Development 360 LLC	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	Institutionalization of in-service training	National HIV program lacks implementation of international standard best practices for retaining PLHIV in HIV services	COP20	COP22	39% viral load testing coverage; 80% rapid ART/63% SDART among newly enrolled PLHIV at sub-district levels; 80% diagnosis - enrollment linkages; initiation of TLD	100% of PEPFAR-supported facilities will implement PEPFAR minimum requirements, specifically for VL test coverage and SDART; implementation of differentiated servide delivety and 80% of PEPFAR-supported facilities will continue to roll out TLD . In close collaboration with the Health Facilities, CSOs have access to data in the health facilities to re-engage patients who have loss to follow upwith health facilities. CSOs developed and utilized result from patients satisfactory data to provide advocacy to local government for improvement of service delivery.
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	Inconsistent access to key HIV service commodities limits PLHIV retention and impedes achievement of 95-95-95 goals	COP20	COP22	Procured 35,000 VL Reagents Nationally, Allocation to Jakarta 15,000 to support TX_PVLS (D) testing targets. TLD Registered by at least 1 manufacturer in Indonesia. TLD adopted and 100% of new patients initiated on TLD in Jakarta; 25% (TX_Curr on TLD) of eligible patients in Jakarta Transitioned to TLD. 30% of Eligible Patients have access for MMD in PEPFAR Sites. Reducing # of patients with non optimum regimen at Pefpar sites.	Procured 40,000 VL Reagents Nationally, Allocation to Jakarta 18,000 to support TX_PVLS (D) testing targets. TLD Registered by at least 2 manufacturers in Indonesia. TLD adopted and 100% of new patients initiated on TLD in Jakarta; 35% of eligible patients in Jakarta Transitioned to TLD. 35% of TX_Curr on TLD. Reducing # of ARV patients using Non optimum regimen in Pefpar Site, 70% of eligible patients have access for MMD in Pefpar sites. Stock out rate for key tracer product is less than 5%. Support TX_PVLS at PEPFAR SITES.15% of TX_Curr access VL testing services through a private provider/laboratory chain.
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Product selection, registration, and quality monitoring	Inconsistent access to key HIV service commodities limits PLHIV retention and impedes achievement of 95-95-95 goals	COP20	COP21	TLD adopted and 100% of new patients initiated on TLD in Jakarta; 25% (TX_Curr on TLD) of eligible patients in Jakarta Transitioned to TLD.	TLD adopted and 100% of new patients initiated on TLD in Jakarta; 35% (TX_Curr on TLD) of eligible patients in Jakarta Transitioned to TLD. Consistent supply of TLD nationally and to support PEPFAR sites in Jakarta. TLD Transition Plan developed and implemented. At least 50% of TLD procured using GOI resources.
USAID	Chemonics International, Inc.	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Accessibility to and visibility of essential logistics data for management decision-making are fundamental components of effective and efficient public health supply chains	COP19	COP21	Stock out rate of key tracer commodities (ie TLD, VL Reagents <5%) at all PEPFAR supported sites and across Jakarta. 100% of all sites reporting monthly on stock levels.Data reviewed and action taken by Provincial/District Health Offices.SIHA NIK Mobile rolled out at 10% of facilities across Jakarta.	Stock out rate of key tracer commodities (ie TLD, VL Reagents <5%) at all PEPFAR supported sites and across Jakarta. 100% of all sites reporting monthly on stock levels. Data reviewed and action taken by Provincial/District Health Offices. SIHA NIK Mobile rolled out at 50% of facilities across Jakarta.
USAID	Chemonics International, Inc.	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Inconsistent access to key HIV service commodities limits PLHIV retention and impedes achievement of 95-95-95 goals	COP19	COP21	VL lab reporting system developed. Optimized and strengthened network and specimen referral system. Standardized VL testing cost in Jakarta. Optimized GenXpert utilization for VL testing in Jakarta. # VL reagent is sufficient to acheive VL testing target in Jakarta.	Logistic and Lab data linked in # Jakarta Pefpar sites, Procured 40,000 VL Reagents Nationally, Allocation to Jakarta 18,000 to support TX_PVLS (D) testing targets. Reduce Turn around time and improve lab machine utilization rate at 5 lab facilities in Jakarta by #. 5 Lab Facilities regularly participate on PT panel program. # VL reagent is sufficient to acheive VL testing target in Jakarta.
USAID	Palladium International, LLC	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	National HIV program lacks implementation of international standard best practices for retaining PLHIV in HIV services	COP18	COP22	MOH sends regular feedback of ARV coverage to at least 50% of 12 priority GF-supported provinces, and 75% of relevant provinces use the feedback for course-correct for HIV program.	40% of 12 priority GF-supported provinces submit reports on improvements for MMD and TLD transition.
DOD	YAYASAN SIKLUS SEHAT INDONESIA	ASP: Policy, planning, coordination & management of disease control programs-NSD	Priority Pops: Military & other uniformed services	Assessing impact of policies and regulations on HIV	Low number of military health facilities in providing test and treat, Low number of VL test within the military	COP17	COP20	5 military hospitals to be able to provide HIV testing, care and treatment services	5 military hospitals to be able to provide HIV testing, care and treatment services
USAID	Health Financing Activity	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	HIV care within UHC agenda is fragmented due to the lack of willingness of central government to transfer comprehensive package of HIV services into National Health Insurance (JKN), including community HIV services and PLHIV retention services	COP18	COP21	N/A	At least 50% of national TLD need Procured using GOI resources. Provider payment mechanisms established in Jakarta that promote client-centered services (ie. MMD, TLD, VL testing). VL testing included as an outpatient service for at least 1 of 5 districts in Jakarta. Sustainability plan developed.
USAID	Health Financing Activity	ASP: Laws, regulations & policy environment-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	HIV care within UHC agenda is fragmented due to the lack of willingness of central government to transfer comprehensive package of HIV services into National Health Insurance (JKN), including community HIV services and PLHIV retention services	COP18	COP21	N/A	Guidelines developed and national policies endorsed to include provider payment mechanisms for HIV Retention and treatment services into the national health insurance scheme. Roadmap to implement Provider payment mechanisms in at least 2 other provinces that promote client-centered services (ie. MMD, TLD, VL testing). Sustainability plan developed.

Kazakhstan

Funding Agency	PrimePartner	COP20 Program Area	COP20 Beneficiary	COP20 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP20 Benchmark	COP20 Benchmark
HHS/CDC	AIDS CENTER OF THE REPU	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Adults	Forecasting, supply chain plan, budget, and implementation	Structural and key population-specific barriers result in low treatment initiation and retention.	COP20	COP21	Transition Plan fully adopted (COP19)	TLD Transition for 90% of patients compelted by end of COP20
HHS/CDC	Trustees Of Columbia Univ	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Adults	Program and data quality management	Quality of HIV cascade services is not consistently applied with international/ PEPFAR/ WHO standards	COP20	COP21	PrEP and recency protocol approved (COP19)	PrEP and recency testing protocols implemented
HHS/CDC	AIDS CENTER OF THE REPU	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Adults	Lab quality improvement and assurance	Quality of HIV cascade services is not consistently applied with international/ PEPFAR/ WHO standards	COP20	COP21	VLO assessment completed (COP19)	VLO recommendations implemented by RAC
HHS/CDC	AIDS CENTER OF THE REPU	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Adults	HMIS systems	Host country support of national HIV response is strong, but gaps remain.	COP20	COP21	Ongoing reporting in EHCMS (ROP20) Data used to conduct program quality improvement	Ongoing reporting in EHCMS (ROP20) Data used to conduct program quality improvement

Kyrgyzstan

Funding Agency	Prime Partner	COP10 Program Area	COP10 Beneficiary	COP10 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP20 Benchmark	COP20 Benchmark
USAID	Family Health International	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	Quality of HIV cascade services is not consistently applied with international/PEPFAR/WHO standards.	COP19	COP21	Pilot community-based ART distribution in PEPFAR-supported SNU; increase uptake of HVAT by 30%.	Expand community-based ART distribution to all PEPFAR-supported SNUs; increase in reported results of HIVST by 20%.
USAID	Family Health International	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	Quality of HIV cascade services is not consistently applied with international/PEPFAR/WHO standards.	COP20	COP21	HIV communication strategy developed and disseminated to facility and community-based sites.	Health care workers and other community stakeholders trained on U=U messaging in all PEPFAR-supported PSNUs.
USAID	Family Health International	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	Quality of HIV cascade services is not consistently applied with international/PEPFAR/WHO standards.	COP20	COP21	Increase by 5 fold the number of persons at high risk for HIV on PrEP from ROP19.	Increase by 5 fold the number of persons at high risk for HIV on PrEP from ROP20
USAID	Family Health International	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	National HIV response not fully monitored, managed, and financed by the host country.	COP20	COP21	Increase in domestic resources for HIV response by 10% from ROP19.	Increase in domestic resources for HIV response by 15% from ROP20
USAID	Family Health International	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	National HIV response not fully monitored, managed, and financed by the host country.	COP20	COP21	HIV testing offered under Mandatory Health Insurance Program	HIV prevention services offered under Mandatory Health Insurance Program
USAID	Family Health International	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	National HIV response not fully monitored, managed, and financed by the host country.	COP20	COP21	New HIV strategy implemented in line with PEPFAR and international guidelines	Updates occur as PEPFAR and international guidelines change
USAID	Family Health International	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	National HIV response not fully monitored, managed, and financed by the host country.	COP20	COP21	New program on social procurement developed and approved. Existing CBOs funded under social contracting continue services.	Increased resources available to expand HIV services offered by CBOs.
USAID	Chemonics International, In	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	National HIV response not fully monitored, managed, and financed by the host country.	COP20	COP21	Reduction in stock out of ARV, test kits and other HIV commodities. Improved forecasting of ARV, test kits and other HIV commodities.	No stock outs
USAID	Family Health International	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	National HIV response not fully monitored, managed, and financed by the host country. [MPR: Policy and Public Health Systems Support]	COP20	COP21	20% increase of PLH HIV in PEPFAR supported PSNU access essential health services via Mandatory Health Insurance Program from ROP19	50% increase in PEPFAR supported PSNUs access essential health services via Mandatory Health Insurance Program from ROP20
HHS/CDC	Trustees Of Columbia Unive	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Adults	Program and data quality management	Lack of sound, current health and epidemiologic data for decision making.	COP20	COP21	PrEP and recency testing protocols implemented	TBD; EHCMS Reports
HHS/CDC	Trustees Of Columbia Unive	ASP: Human resources for health-NSD	Non-Targeted Pop: Adults	Institutionalization of in-service training	Lack of sound, current health and epidemiologic data for decision making.	COP20	COP21	Improved results in returning LTFU and VLS	Improved results in returning LTFU and VLS
HHS/CDC	Kyrgyzstan AIDS Center	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Adults	Program and data quality management	Lack of sound, current health and epidemiologic data for decision making.	COP20	COP21	PrEP and recency testing protocols implemented; PrEP expanded to sites that have significant numbers of discordant partners, PWID and MSM. MER target for PrEP is 106 for ROP19	PrEP and recency testing protocols implemented; PrEP expanded to sites that have significant numbers of discordant partners, PWID and MSM. MER target for PrEP is 140 for ROP19
HHS/CDC	Kyrgyzstan AIDS Center	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregated	Surveillance	Lack of sound, current health and epidemiologic data for decision making.	COP20	COP21	Formative Assessment approved; IBB Protocol developed	Formative Assessment conducted; IBBS Protocol approved

Laos

Funding	PrimePartn	COP20 Program Area	COP20 Beneficiary	COP20	Key Systems Barrier	Intervention	Intervention	COP20 Benchmark	COP20 Benchmark	Notes
HHS/CDC	World Health Organizatio n	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	3. Limited system capacity (organizational and staff) forces reliance on the international community to fund the implemention, update, and	COP20	COP21	1) Complete review variables and database migration 2) initiate template reports for DHIS2	1) Complete report template for DHIS2 2) The Existing Health Care Core Teams at central, provincial and ART site levels received training on administering, generating required reports, analyse and use data for program planning and improving quality of services.	Global Fund and MOH will support the DHIS2 Unfractured hardware, connectivity. CDC will work with WHO to provide Technical Assistance (training and supportive supervision) to ART facilities and Center for HIV/AIDS and STI (CHAS), Ministry of Health
HHS/CDC	World Health Organizatio n	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	Institutionaliz ation of in-service training	1. Low coverage of KP case finding and, linkage to care, ART initiation, and high rate of LTFU and death among PLHIV due to limit ART site access (ART sites in only 8 in 18 provinces and merely one in 148	COP19	COP21	1. 4 POC ART sites established in provinces with high case load and no ART sites 2. >90% of PLHIV referred to ART POC satisfy with the services 3. Retention among PLHIV referred to POC >98%	1. Lessons learnt for POC ART sites and outcomes of PLHIV receiving care in the POC documented 2. POC ART sites expanded to additional provinces where PLHIV identify need in accordance to the national plan.	CDC will collaborate with CHAS Ministry of Health, Global Fund, World Bank and WHO and PLHIV group to ensure evident based planning. Oversight, technical assistance, and supervision to subnational levels
USAID	Family Health Internation al	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	Institutionaliz ation of in-service training	3. Limited system capacity (organizational and staff) forces reliance on the international community to fund the implemention, update, and monitoring of the application of global policies and innovations to	COP20	COP22	70-80% tx cascade	90% tx cascade	
USAID	Family Health Internation al	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Information and sensitization for public and government officials	3. Limited system capacity (organizational and staff) forces reliance on the international community to fund the implemention, update, and	COP20	COP22	index, HIVST in 3 provinces and PrEP in VTE	ongoing support	
USAID	Family Health Internation al	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations	2. Heavy reliance on external financial and technical assistance due to a	COP20	COP22	findings incorporated into DRF plan	15% increase in DRF	
USAID	Family Health Internation al	ASP: Laws, regulations & policy environment-NSD	Non-Targeted Pop: Not disaggregated	Information and sensitization for public and	4. Social and community organizations (networks) are	COP20	COP22	develop system for Laos endorsed by CHAS	2 CBOs and all their CHW staff received certfication	

Nepal

Funding Agency	PrimePartner	COP20 Program Area	COP20 Beneficiary	COP20 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP20 Benchmark	COP20 Benchmark
USAID	Family Health Inte	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggrega	Information and sensitization for public and government officials	GON is currently considering how to take over activities funded by international sources while ensuring sustainable financing of community-based approaches and services Gender and human rights impede access to services and will be a challenge to sustainability Country does not have a sustainability plan	COP19	COP20	1. GON approves CB-ART as an intervention in national guidance. 2. SOP for CB-ART developed. 3. CB-ART implemented in at least 12 sites. 4. Minimum service packge for HIV services with unit costing developed, agreed upon and used for planning and implemented with fidelity 5. PEPFAR to collaborate with GF and stakeholders for Stigma Index 2.0	1. Twelve CB-ART sites continue providing ART services 2. Minimum service packge for HIV services with unit costing used for planning and implemented with fidelity 3. The PEPFAR program will provide TA national HIV program an dGlobal Fund to prepare action plan based on key recommendations from the Stigma Index 2.0 . 5. The development of a national SOP and training package for PrEP 6. Advocacy activities for domestic resource mobilization, and multisectoral engagement
USAID	Family Health Inte	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggrega	Lab quality improvement and assurance	GON is currently considering how to take over activities funded by international sources while ensuring sustainable financing of community-based approaches and services	COP19	COP20	1. VL testing optimization strategy and plan revised and updated 2. GeneXpert machine utilized for HIV VL testing 3. Guidelines, and SOPs for use of DBS completed 4. PEPFAR to collaborate with GF, NPHL and stakeholders to develop national lab stratgegic plan	1. VL testing networks and machines are optimally functional and used, 2. All eligible PLHIV get access to VL testing 3. PEPFAR to collaborate with GF, NPHL and stakeholders to implement national lab stratgegic plan
USAID	Family Health Inte	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggrega	Forecasting, supply chain plan, budget, and implementation	Barrier #1: The country does not currently have an integrated LMIS. Therefore, the country cannot track HIV commodities at the site level. Barrier #2: For the last two years, procurement has been delayed because of the current public procurement policy and guidelines and this has resulted in higher costs for the GON's local HIV commodity procurements. Barrier #3: MOHP is currently not receiving a multi-year budget from MOF for HIV commodity procurement because of the current practice annual working planning and budgeting system.	COP19	COP20	1. TLD included in national procurement plan as first line regemin. 2. TLD transition plan developed, approved and implemented. Around 90% of PLHIV on ART will be transitioned to TLD by the end of ROP19 3. National quantification takes into account quantities needed for MMS 4. All sites provide MMD and all eligible PLHIV received MMD	1. TLD transition will be completed and TLD resimen contnued by all PLHIV 2. All sites provide MMD and all eligible PLHIV received MMD 3.
USAID	Family Health Inte	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggrega	Program and data quality management	The national one HIV information system is not fully integrated with the national HMIS. ART sites are overburdened by a dual recording system (HMIS and HIV) . Data analysis and use is minimal and this also threatens sustainability of HIV and HMIS system. There is funding gap for IBBS survey among FSWs and MSM & TG people	COP19	COP20	1. Integrated national HIV databse system developed. 2. Training on the integrated national HIV datsbase system conducted to all government and non-government HIV service delivery sites. 3. Intergrated national HIV databses system rolled out in all government and non-government HIV service delivery sites,	1. Integrated national HIV database fully functional and all government and non-gorvenment HIV services sites use the database for recording and reporting, analysus and use.

Philippines

Funding Agency	PrimePartner	COP20 ProgramArea	COP20 Beneficiary	COP20 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP20 Benchmark
HHS/CDC	World Health Organizatio	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Clinical guidelines, policies for service delivery	Inadequate capacity to deliver client centered HIV care, treatment and retention services tailored to the needs of key populations.	COP20	COP21	1. National HIV & TB guidelines developed to incorporate latest WHO/PEPFAR recommendations for MPPs (e.g. Index, SDA, MMS, TLD, TPT, recency, etc). 2. HCW sensitization training and structural interventions tailored to ART sites designed and implemented in 25% of high-burden public ART sites in Cebu City and Davao City. 3. 25% of HCW undergo S&D trainings in the major facilities in Cebu City and Davao City.
HHS/CDC	World Health Organizatio	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab policy, budgets, and strategic plans	Insufficient access to HIV testing services and VL testing platforms among key and priority populations	COP20	COP21	Percentage of VL testing coverage for ART patients in the 5 PEPFAR Priority regions increased by 10%, and maintain VL suppression rate of 90% among those tested.
HHS/CDC	Trustees Of Columbia Uni	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Lack of sound, current and health, epidemiologic data for decision-making and quality improvement implementation.	COP20	COP21	Formative Assessment & BBS protocol developed
HHS/CDC	Trustees Of Columbia Uni	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Lack of sound, current and health, epidemiologic data for decision-making and quality improvement implementation.	COP20	COP21	1. Four provincial coaches trained on data quality assurance for the KP monitoring in two regions. 2. Two regions implemented DQA/DQI. 3. Recency interoperability introduced to HARP
HHS/CDC	Trustees Of Columbia Uni	ASP: Policy, planning, coordination & management of disease control programs-NSD	Key Pops: People who inject drugs	Clinical guidelines, policies for service delivery	Inadequate capacity to deliver client centered HIV care, treatment and retention services tailored to the needs of key populations.	COP20	COP21	National guidelines developed for MAT services
HHS/CDC	0	ASP: Not Disaggregated-NSD	Non-Targeted Pop: Not disaggregated	Description required	Lack of sound, current and health, epidemiologic data for decision-making and quality improvement implementation.	COP20	COP21	1. Formative Assessment/BBS protocol developed 2. DQA/DQI trainings completed and two regions have implemented DQAs in limited sites. 3. Introduction of recency to case-based surveillance system 4. National HIV & TB guidelines developed to incorporate latest WHO/PEPFAR recommendations for MPPs (e.g. Index, SDA, MMS, TLD, TPT, recency, etc).
HHS/HRSA	TBD	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	National strategic plans, operational plans and budgets	Inadequate capacity to deliver client centered HIV care, treatment and retention services tailored to the needs of key populations.	COP20	COP21	Benchmark determined by use of virtual platform and the results of the evaluation.
HHS/HRSA	TBD	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	National strategic plans, operational plans and budgets	Lack of sound, current and health, epidemiologic data for decision-making and quality improvement implementation.	COP20	COP21	Benchmark determined by use of virtual platform and the results of the evaluation.
HHS/HRSA	TBD	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	National strategic plans, operational plans and budgets	Inadequate capacity to deliver client centered HIV care, treatment and retention services tailored to the needs of key populations.	COP20	COP21	Benchmark determined by use of virtual platform and the results of the evaluation.
DOD	TBD	ASP: Human resources for health-NSD	Priority Pops: Military & other uniformed servic	Institutionalization of in-service training	Barriers to military member's ability to access prevention, testing, and treatment services due to anticipated, perceived, experienced, internalized, and compounded stigma and concerns about confidentiality of medical history within the military and policies related to PLHIV's opportunity for career advancement within the military.	COP20	COP21	1. Workshop delivered; 2. Code of Conduct and Action Plan developed; 3. Plan for follow-on sessions conducted by master facilitators developed

DOD	TBD	ASP: Laws, regulations & policy environment-NSD	Priority Pops: Military & other uniformed servic	Assessing impact of policies and regulations on HIV	Barriers to military member's ability to access prevention, testing, and treatment services due to anticipated, perceived, experienced, internalized, and compounded stigma and concerns about confidentiality of medical history within the military and policies related to PLHIV's opportunity for career advancement within the military.	COP20	COP21	1. Policy development committee formed; 2. Draft policy created or existing policy revised; 3. Meetings with key military leadership held.
DOD	TBD	ASP: HMIS, surveillance, & research-NSD	Priority Pops: Military & other uniformed servic	Surveillance	Lack of sound, current and health epidemiologic data for decision making and quality improvement implementation.	COP20	COP21	Preliminary data on military HIV burden, HIVDR, and epidemiologic relationship to the civilian epidemic available for program planning
USAID	Family Health International	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pops: Not disaggregated	Clinical guidelines, policies for service delivery	Inadequate capacity to deliver client centered HIV care, treatment and retention services tailored to the needs of key populations.	COP20	COP21	Development and adoption of updated national guidelines with PrEP and aligned to WHO guidelines Training materials are developed for clinics to proactively identify patients that are eligible for MMD and transition them
USAID	Family Health International	ASP: Laws, regulations & policy environment-NSD	Non-Targeted Pops: Not disaggregated	Clinical guidelines, policies for service delivery	National HIV response not fully monitored, managed, and financed by host country.	COP20	COP21	Joint technical consultations to support alignment and implementation of PrEP/health package, with WHO
USAID	Management Sciences for	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pops: Not disaggregated	Clinical guidelines, policies for service delivery	Inadequate capacity to deliver client centered HIV care, treatment and retention services tailored to the needs of key populations.	COP20	COP21	TLD and dolutegravir registration completed; Medications are added to essential medicines list; Procurement mechanism identified and procurement of TLD conducted by DOH; Medications are entered in LMIS; Completed immediate forecast/supply plan for transitioning patients; Medications are put under active pharmacovigilance
USAID	Management Sciences for	ASP: Procurement & supply chain management-NSD	Non-Targeted Pops: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	National HIV response not fully monitored, managed, and financed by host country.	COP20	COP21	Plans for warehousing and distribution for MMS/D formulated; Analysis of pack age size current and quantification completed for 3 month (for TLD); Programmatic strategy and guidelines developed for MMS and MMD; MMD considerations are incorporated in product selection, quantification, procurement and distribution cycles
USAID	Management Sciences for	ASP: Procurement & supply chain management-NSD	Non-Targeted Pops: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	National HIV response not fully monitored, managed, and financed by host country.	COP20	COP21	Protocol for receipt checks instituted and reviewed; All sites have quantification projections regularized; Support to optimize cost considerations (e.g. commodity pricing); Electronic logistic management information system used for real time data visibility; Procurement and supply chain management systems and business processes
USAID	Management Sciences for	ASP: Procurement & supply chain management-NSD	Non-Targeted Pops: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	National HIV response not fully monitored, managed, and financed by host country.	COP20	COP21	Current national procurement process analysis completed, including contracting overview and supplier selection; alternative procurement mechanisms identified/ designed and introduced to ensure strategic and appropriate procurement of commodities

PNG

Funding Agency	PrimePartner	COP20 Program Area	COP20 Beneficiary	COP20 Activity Description	COP20 Activity	Key Systems Barrier	Intervention Start	Intervention End	COP20 Benchmark	COP20 Benchmark
USAID	Family Health International	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disag	Strengthen leadership, coordination and support national rollout of quality HIV/GBV intergrated services		Leadership, commitment and coordination gaps in GBV and HIV Integration	COP18	COP21	50% of GBV integration sites meet GBV minimum standard requirement for GBV service quality.	100% of GBV integration sites meet GBV minimum standard requirement for GBV service quality.
USAID	Family Health International	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disag	Provide above site (NDoH and NCDHS) TA QA/QI, data for strategic decisions on HIV GBV integration to improve post-GBV services uptake		Leadership, commitment and coordination gaps in GBV and HIV Integration	COP20	COP22		Increased GBV service provision with 100% GEND_GBV achievement
USAID	Family Health International	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disag	Provide TA to NDOH and NCDHS to optimize approaches to improve retention and treatment service quality (ACM, DSDM, MMD, ART decentralization).		Low Retention/High LTFU	COP19	COP21	xx	Improved TX_ML_%, AOM fully implemented in all sites, 75 % of eligible clients on MMD,
USAID	Family Health International	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disag	Implement innovative approaches to improve retention among inter-provindal clients (Central and Gulf Provinces).		Low Retention/High LTFU	COP20	COP21		Reduction in inter-provincial silent transfers/LTFU
USAID	Family Health International	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disag	Implement innovative approaches to improve retention among inter-provindal clients (Central and Gulf Provinces).		Low Retention/High LTFU	COP20	COP21		
USAID	Family Health International	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disag	Support mSupply mobile deployment and integration into HPDB in NCD to improve stock management, forecasting, procurement and logistics.		Weak procurement and supply chain management system for HIV commodities	COP19	COP21	no integration between mSupply and HPDB	Interoperability exist between m_supply and HPDB
USAID	Family Health International	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disag	Strengthen planning, forecasting and procurement of HIV commodities at national level.		Weak procurement and supply chain management system for HIV commodities	COP19	COP21		Reduce number of facilities with a stockout in the last year by a third.

USAID	Family Health International	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disag	Strengthen CSOs capacity to implement interventions aimed at improving retention, VL coverage, GBV integration) through the sub-grant component.		Weak CSO capacity to support HIV Response	CDP19	COP22	2 additional CSOs provided a subgrant	5 CSO Sub-grantees
USAID	Family Health International	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disag	Strengthen CSO's participation in community monitoring and continous quality improvement and stigma reduction		Weak CSO capacity to support HIV Response	CDP19	COP22	KP advocacy activities,	CSOs identified for community monitoring and quality improvement framework and tools established. CSOs use community monitoring tools effectively.
USAID	Family Health International	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disag	Optimize VL testing via near POC GeneXpert to complement VL testing using the Roche platform		High level of drug resistance/low VL testing coverage	CDP20	COP22		95% VL testing coverage
USAID	Family Health International	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disag	Improve VL testing uptake at site level by generating demand for VL testing		High level of drug resistance/low VL testing coverage	CDP18	COP21		50% increase to site level weekly VL testing
USAID	Family Health International	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disag	Strengthen client-centered approaches (ACM, EAC, TLD, MMD, DSDM) to achieve viral suppression		High level of drug resistance/low VL testing coverage	CDP18	COP21		90% VL suppression rate
USAID	Family Health International	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disag	Support rollout of revised surveillance tools, operationalization of HIV Data Hub and migrate HPDB (EMR) to OpenMRS		Weak case-base surveillance for quality patient care	CDP19	COP20	Revised tools rolled out in all high burden provinces	Revised tools rolled out to all SNUs
USAID	Family Health International	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disag	Increased utilization of data at site and SNU level for CQI		Weak case-base surveillance for quality patient care	CDP18	COP20	Establishment of data review team in NCD	Data review platforms established in high burden provinces
USAID	Family Health International	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Support the NDOH and NCDHS with the rollout of TLD in accordance with the NDOH TLD Transition Plan		High level of drug resistance/low VL testing coverage	CDP19	COP20	TLD rolled out to the entire country as first line drug - legacy drugs phased out.	75% of patients on TLD MMD retained

Tajikistan

Funding Agency	PrimePartner	COP20 Program Area	COP20 Beneficiary	COP20 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP20 Benchmark	COP20 Benchmark
HHS/CDC	Trustees Of Columbia Univ	ASP: Human resources for health-NSD	Non-Targeted Pop: Adults	Institutionalization of in-service training	Structural and key populations-specific barriers related to case finding. [MPR: Case Finding]	COP19	COP20	Improved case finding in MER reporting	Improved case finding in MER reporting
USAID	Family Health Internationa	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Information and sensitization for public and government officials	Structural and personal barriers result in low case finding.	COP20	COP21	HIV communication strategy developed and disseminated to facility and community-based sites.	All Health care workers and other community stakeholders trained in U=U messaging in all PEPFAR-supported PSNUs.
USAID	Family Health Internationa	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Market openess	Structural and personal barriers result in low case finding.	COP20	COP21	Collaborate with MoH to pilot one new strategy.	Achieve saturation of KP communities in PEPFAR SNUs.
USAID	Family Health Internationa	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	Structural and personal barriers result in low case finding.	COP20	COP21	Pilot community confirmatory testing algorithm in PEPFAR-supported SNU; reduce average positive confirmation time by 50%	Same day confirmation in PEPFAR SNUs
USAID	Family Health Internationa	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Market openess	Quality of HIV prevention and treatment services not consistent with international/PEPFAR/WHO standards.	COP20	COP21	Pilot community-based ART distribution in PEPFAR-supported SNU; increase yield from self-testing by 15%	Expand community-based ART distribution to all PEPFAR-supported SNUs; maintain self-testing yield at 15% or greater.
HHS/CDC	Trustees Of Columbia Univ	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Adults	Program and data quality management	Quality of HIV prevention and treatment services not consistent with international/PEPFAR/WHO standards. [MPR: Care & Treatment; Prevention]	COP20	COP21	PrEP rolled out in pilot sites	PrEP rolled out in pilot sites
HHS/CDC	Trustees Of Columbia Univ	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Adults	Program and data quality management	Structural and key populations-specific barriers related to case finding. [MPR: Case Finding]	COP20	COP21	Recency rolled out in pilot sites	Recency reporting from RAC and expansion nationally
USAID	Family Health Internationa	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	National HIV response not fully monitored, managed, and financed by host country.	COP20	COP21	Increase in domestic resources for HIV response to 15%.	Increase in domestic resources for HIV response to 20%
USAID	Family Health Internationa	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	National HIV response not fully monitored, managed, and financed by host country.	COP19	COP21	Social contracting guidelines and policy in place.	Three local NGOs funded through social contracting.
USAID	Chemonics International, In	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	National HIV response not fully monitored, managed, and financed by host country.	COP20	COP21	Reduction in stock out of ARV, test kits and other HIV commodities.	No stock outs
USAID	Family Health Internationa	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	Quality of HIV prevention and treatment services not consistent with international/PEPFAR/WHO standards. [MPR: Care &	COP20	COP21	Expand PrEP offering to all high risk. Increased number of persons on PrEP by 50% from ROP19 level.	Increased number of persons at high risk for HIV on PrEP by 50% from ROP20 level.

Thailand

Funding Agency	Prime Partner	COP20 Program Area	COP20 Beneficiary	COP20 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP20 Benchmark	COP20 Benchmark
HHS/CDC	MINISTRY OF PUBLIC HEALTH	ASP: HMIS, surveillance, & research-NSD	Key Pops: Men having sex with men	Surveillance	3. Inconsistencies in KP data and limited capacity to use data at provincial and site levels to inform program	COP18	COP21	1. The web RDS with BBS expanded in at additinoal 10 provinces for MSM, TG, online SW 2. Report on synthesis of startegic	COP21 1. Complete IBBS web-base RDS data synthesis and report 2. Transtion of Web RDS with
HHS/CDC	MINISTRY OF PUBLIC HEALTH	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregated	Program and data quality management	3. Inconsistencies in KP data and limited capacity to use data at provincial and site levels to inform program	COP18	COP21	1. Data quality assurance and improvement guidelines are developed to improve KP reporting and monitoring. 2. DOA/DOL guidelines to improve quality of	COP21 1. Transition the system to full government support for
HHS/CDC	MINISTRY OF PUBLIC HEALTH	ASP: Human resources for health-NSD	Non-Targeted Pop: Adults	Institutionalization of in-service training	5. Varied levels of implementation of existing policies regarding specific client-centered services (e.g.	COP19	COP21	100 hospitals with trained staff in 13 provinces.	Expand training to other provinces Disseminated treatment literacy manual nationally
HHS/CDC	MINISTRY OF PUBLIC HEALTH	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	Institutionalization of in-service training	1. Low coverage of KP case finding, linkage to care, viral load coverage, ART initiation and retention among PLHIV	COP18	COP21	1. HCWs from 13 provinces trained to be national/provincial coach 2. 60% trained coach provided TA to support coaching in 13 provinces	1. HCWs from 13 provinces trained to be national/provincial coach 2. 80% trained coach provided
HHS/CDC	MINISTRY OF PUBLIC HEALTH	ASP: Human resources for health-NSD	Key Pops: Men having sex with men	Institutionalization of in-service training	1. Low coverage of KP case finding, linkage to care, viral load coverage, ART initiation and retention among PLHIV	COP19	COP21	1. E-learning for S&D for HCWs developed 2. 80% of participating sites achieve 2.1 80% of health care workers who actively engaged with PLHIV are trained	2. 80% of participating sites achieve 2.1 80% of health care workers who actively engaged with
HHS/CDC	MINISTRY OF PUBLIC HEALTH	ASP: Human resources for health-NSD	Key Pops: Not disaggregated	Institutionalization of in-service training	1. Low coverage of KP case finding, linkage to care, viral load coverage, ART initiation and retention among PLHIV	COP18	COP21	1. One regional training and/or workshop held. 3. At least 1 country received training on S&D reduction in health care setting	COP21 1. A follow-up regional workshop held. 3. At least additional one
HHS/CDC	MINISTRY OF PUBLIC HEALTH	ASP: Human resources for health-NSD	Key Pops: Not disaggregated	Institutionalization of in-service training	1. Low coverage of KP case finding, linkage to care, viral load coverage, ART initiation and retention among PLHIV	COP19	COP20	Targeted HIV case findings implemented in at least 50 faciities	Integrated as part of routine service
HHS/CDC	MINISTRY OF PUBLIC HEALTH	ASP: Human resources for health-NSD	Key Pops: Not disaggregated	Institutionalization of in-service training	4. Lack of effective mobilization of central and domestic resources for KP-led community based services	COP18	COP20	1. the MOPH community health worker (CHW) certification program and certified CBO HIV service program developed 2. 50 CHW were trained and certified according to the approved training training curriculum	the system integrated into the MOPH program
HHS/CDC	MINISTRY OF PUBLIC HEALTH	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	1. Low coverage of KP case finding, linkage to care, viral load coverage, ART initiation and retention among PLHIV, including KP LHIV.	COP18	COP21	1. National coaching teams available in 13 provinces in Thailand 2. Standard coaching form used in routine services 3. 60% of participating sites (23 tertiary hospitals in 8 provinces) achieve	1. National coaching teams available in all 13/13 health regions in Thailand 2. Standard coaching form used in routine services 3. At least 2 learning centers for
HHS/CDC	MINISTRY OF PUBLIC HEALTH	ASP: Not Disaggregated-NSD	Key Pops: Not disaggregated	Information and sensitization for public and government officials	2. Low PrEP coverage among eligible KP and sero-discordant couples	COP19	COP21	At least 52/90 sites of government facilities reported to the system	1.By the end of FY2021, At least 72/90 (80%) of government PrEP providers reported number of PrEP users through national data base

HHS/CDC	MINISTRY OF PUBLIC HEALTH	ASP: Not Disaggregated-NSD	Key Pops: Not disaggregated	Assessing impact of policies and regulations on HIV	2. Low PrEP coverage among eligible KP and sero-discordant couples	COP19	COP20	National guideline revised and PrEP operational roadmap clearly identified	Guideine avaialble for nationwide implementation
HHS/CDC	MINISTRY OF PUBLIC HEALTH	ASP: Policy, planning, coordination & management of disease control programs-NSD	Key Pops: Not disaggregated	Assessing impact of policies and regulations on HIV	1. Low coverage of KP case finding, linkage to care, viral load coverage, ART initiation and retention among PLHIV, including KPLHIV.	COP19	COP20	29 sites actively offer index partner testing and are being routinely monitored	Best practices/ successful elements available to guide implementation and expansion in at least 5-10 government and GF support sites. 70% of sites implemented with index testing
HHS/CDC	MINISTRY OF PUBLIC HEALTH	ASP: Not Disaggregated-NSD	Key Pops: Not disaggregated	Information and sensitization for public and government officials	1. Low coverage of KP case finding, linkage to care, viral load coverage, ART initiation and retention among PLHIV, including KPLHIV.	COP19	COP20	Concept for communication strategies developed	Communication materials implemented in at least 29 sites and adopted for use at least in 5-10 large public health facilities in Thailand
HHS/CDC	MINISTRY OF PUBLIC HEALTH	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab policy, budgets, and strategic plans	3. Inconsistencies in KP data and limited capacity to use data at provincial and site levels to inform program improvement	COP19	COP21	1. Finalize VL strategies 2. VL network performance optimized to ensure quality of specimen storage, currier support and report systems 3) implemented a software to automaticlly enter VL data into NAP database to avoid a	1. VL testing centers in 9 focused provinces implement VL alert system and reduce TAT to within 1 week 2. 90% of KP on ART had VL tested and 90% had VL
HHS/CDC	MINISTRY OF PUBLIC HEALTH	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Research	3. Inconsistencies in KP data and limited capacity to use data at provincial and site levels to inform program improvement	COP20	COP22	1) Expansion of recency testing to CDC supported sites in 4 provinces 2) number and % recent infection cases identified 3) tools for recency implementation and data collection developed	1) Integration of recency testing in the national HIV case based surveillance 2) use recency data for target program planning 3) integration of recency testing
HHS/CDC	MINISTRY OF PUBLIC HEALTH	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not dis	Program and data quality management	1. Low coverage of KP case finding, linkage to care, viral load coverage, ART initiation and retention among PLHIV, including KPLHIV.	COP16	COP21	COP20 1. Maintianed timely quarterly updated of EIIS database (abstracted HIV-related data from central MOPH database) from 1,000 hospitals in 77 provinces reported HIV related morbidity and mortality among	COP21 1. Additional 15 provinces implemented DQA and improve data coding quality for HIV-related morbidity and mortality and ARVs
HHS/CDC	MINISTRY OF PUBLIC HEALTH	ASP: Policy, planning, coordination & management of disease control programs-NSD	Key Pops: Not disaggregated	Information and sensitization for public and government officials	1. Low coverage of KP case finding, linkage to care, viral load coverage, ART initiation and retention among PLHIV, including KPLHIV.	COP20	COP21	1. Training provided to health care providers in 8 PEPFAR supported provinces 2. 80% of trained facilities implemented rapid TB diagnostic test	1. Monitoring report available and present to national TB/HIV working group
HHS/CDC	BANGKOK METROPOLITAN ADMINISTRAT	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not dis	Information and sensitization for public and government officials	1. Low coverage of KP case finding, linkage to care, viral load coverage, ART initiation and retention among PLHIV, including KPLHIV.	COP19	COP21	1. 18 hospitals in Bangkok had referral network with health centers 2. Comprehensive guildeline for ART referral network developed	1. 18 hospitals and private hospitals in Bangkok had referral network with health centers 2. Comprehensive guildeline for ART referral network developed

HHS/CDC	BANGKOK METROPOLITAN ADMINISTRAT	ASP: Policy, planning, coordination & management of disease control progrems-NSD	Non-Targeted Pop: Not dis	Information and sensitization for public and government officials	1. Low coverage of KP case finding, linkage to care, viral load coverage, ART initiation and retention among PLHIV, including KPLHIV.	COP19	COP21	1. Additional 10 private/government hospitals in BKK received coaching 2. 80% of coached private/government hospitals implement MMD, TLD, improve ART coverage according to the national guidelines	1. Additional 10 private/government hospitals in BKK received coaching 2. 80% of coached private/government hospitals implement MMD, TLD, improve
HHS/CDC	BANGKOK METROPOLITAN ADMINISTRAT	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregate	Program and data quality management	3. Inconsistencies in KP data and limited capacity to use data at provincial and site levels to inform program improvement	COP18	COP21	COP20 1. At least 60 hospitals in Bangkok routinely submitted HIV data to BSMS system 2. Data quality improvement and UIC SOPs were trained for 50 hospitals in Bangkok and their community networks.	COP21 1. At least 90 hospitals in Bangkok routinely submitted HIV data to BSMS system 2. Data quality improvement and UIC SOPs were trained
HHS/CDC	BANGKOK METROPOLITAN ADMINISTRAT	ASP: Policy, planning, coordination & management of disease control progrems-NSD	Key Pops: Not disaggregate	Assessing impact of policies and regulations on HIV	2. Low PrEP coverage among eligible KP and sero-discordant couples	COP20	COP20	a minimum of 25 PrEP providers and providers for targeted HIV case findings are collaborating through information exchange and referrals of cases to facilitate PrEP access	Network of providers sustained
HHS/CDC	BANGKOK METROPOLITAN ADMINISTRAT	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Training in laboratory systems strengthening	3. Inconsistencies in KP data and limited capacity to use data at provincial and site levels to inform program improvement	COP19	COP21	1) Expansion of recency testing to all BMA health facilities 2) number and % recent infection cases identified 3) tools for recency implementation and data collection developed	1) Integration of recency testing in the BMA HIV case based surveillance 2) use recency data for target program planning
USAID	Family Health International	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	Institutionalizatio n of in-service training	4. Lack of effective mobilization of central and domestic resources for KP-led community based services	COP18	COP21	1. 100 CHW were trained and certified according to the MOPHI training curriculum 3) at least 10 CBO HIV service sitess were assessed according to the MOPH CBO standard and certified	1) 20% increase in number of certification of CHW to provide Com-based HIV services 2) 20% increase in number of CBO sites to provide com-based HIV services
USAID	Family Health International	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disagg	Institutionalizatio n of in-service	4. Lack of effective mobilization of central and domestic resources for KP-led	COP19	COP21	1. National Social Contrating Strategy launched2. $2M committed by NHSO to PEPFAR-supported sites	1. $3M committed to PEPFAR supported sites
USAID	Family Health International	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregated	Research	1. Low coverage of KP case finding, linkage to care, viral load coverage, ART initiation	COP18	COP20	findings of implementation disseminated, and integrated into national guidelines	HIVST recognized as effective in P
USAID	Family Health International	ASP: HMIS, surveillance, & research-NSD	Key Pops: People who inject drugs	Research	5. Varied levels of implementation of existing policies regarding specific	COP18	COP21	1. Data collection completed2. Findings analysed and disseminated	1. Service model for PWID packaged and endorsed2. National
USAID	Family Health International	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregated	Research	1. Low coverage of KP case finding, linkage to care, viral load coverage, ART initiation	COP18	COP20	1. Implementation of activity and data collection at all sites 2. increased capacity to monitor new STI infections at KP drop-in	STI screening services integrated as a regular HIV service national service (supported through GF)
USAID	Family Health International	ASP: HMIS, surveillance, &	Key Pops: Not disaggregated	HMIS systems	3. Inconsistencies in KP data and limited capacity to use	COP20	COP21	Advocate for NHSO incoorperated KP cascade data (eCascade) into the NAP system	KP cascade (eCascade) data integrated into NAP system comprehensively
USAID	Family Health International	ASP: HMIS, surveillance, &	Key Pops: Not disaggregated	HMIS systems	3. Inconsistencies in KP data and limited capacity to use data at provincial and site levels to inform program	COP20	COP21	Advocate for NHSO incoorperated KP cascade data (eCascade) into the NAP system	KP cascade (eCascade) data integrated into NAP system comprehensively
USAID	Family Health International	ASP: Public financial	Non-Targeted Pop: Not dis	HMIS systems	4. Lack of effective mobilization of central and domestic resources for KP-led community based services	COP20	COP21	Advocate for covering cost reimbursement for operation cost through inter-site learning process between public facilities and CBO	Operating cost reimbursement from NHSO to CBO full allows

APPENDIX D: Minimum Program Requirements

Burma

	Minimum Program Requirement	Status
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[1]	Scaled with fidelity to all regions/sites by expansion of ART facilities including decentralized and satellite sites
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[2]	Policy adopted nationally, but actively rolling out in 2020. 46% of new ARV clients will be put on DTG regimens for Jan-Jun 2020 and increased proportion in later 2020 and 2021 for all ARV clients. PEPFAR sites have begun TLD transition: in FY19 and FY20 Q1, 53% of all new ART clients have started the treatment with TLD regimen at PSI TOP centers. At the end of FY20 Q1, 15% of currently on ART are treated on TLD regimen at PSI TOP centers.
	3. Adoption and implementation of differentiated service delivery models, including 6-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3]	Implemented in high burden regions/sites. Among 40 PEPFAR sites, 38 sites are implementing MMD: 403 clients (4%) are on 6 months MMD and 4496 (68%) are on 3 to 5 months MMD. Plan to expand 6-month MMD in FY21.
	4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of ROP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4]	Aggressive scaling up since 2019. 56% (9,417) of eligible newly enrolled HIV patients started TPT in 2019 (only 15% in 2018).
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual VL testing and results delivered to caregiver within 4 weeks.	Ongoing monitoring for 100% access to VL and TAT. DNO plans to initiate in 2020.
Case Finding	1. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	After certification, scale index testing for KP to PEPFAR sites and share best practices with other implementers. PEPFAR to support a self-testing pilot in 2020 with government and CSOs and national scale-up in 2021.

Prevention and OVC	1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[6]	National PrEP SOP and national DHIS-2 tracker for PrEP cohorts developed in 2019 and 2020. PEPFAR supported a National Consultation in April 2019. Afterward, PEPFAR helped develop a national PrEP SOP and M&E Framework. The project was submitted to the Ministry for project approval. After approval, PEPFAR will immediately roll out among MSM and TG in Yangon and will lead a feasibility assessment among PWID in Kachin.
	2. *Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.*	*Not applicable to the Burma country context*
Policy & Public Health Systems Support	1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[7]	No user fees for service provision at public and INGOs sectors.
	2. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[8]	Ongoing assessment for CQI at selected public sector sites (ART, MMT) and scaling-up in 2021.
	3. Evidence of treatment and VL literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	U=U literacy for health care providers initiated in high burden region and tools for public dissemination of U=U literacy still under development. Plan to roll-out U=U in PEPFAR sites after national approval.
	4. Clear evidence of agency progress toward local, indigenous partner direct funding.	Local organizations were funded by PEPFAR as sub-partners since COP17. In ROP20, PEPFAR program will expand its partnership with KP community networks, CSOs, and other and local partners to enhance case finding, and optimize direct and immediate linkage, retention, and viral suppression among KP, including through a new model at government facilities, in a demonstration of HIV self-testing, community-led monitoring and PrEP demand generation.
	5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	Scaled with fidelity to all regions/sites

	6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Policy adopted nationally, but not actively rolling out
	7. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	Policy adopted nationally, but not actively rolling out. PEPFAR sites have tested biometric tracking at 23 PEPFAR sites. The national government recently tested iris scanning biometric tracking as part of the recent BBS in Yangon.
Site Level MPRs	Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	Linkage to care among PWID is <70%. To address this, PEPFAR will work closely with NAP sites for rapid ART initiation at government sites through the satellite model (and confirmatory testing of sites that are not under the national EQAS system). Peer navigators will accompany PLHIV to government facilities, preparing the client and associated reporting tools (white card). PEPFAR Burma will support case management for identifying and connecting key populations especially for PWID living with HIV with preferred ART facilities, by establishing an appointment system, ensure peer-led patient navigation, follow-up, and accompanied referral for ART initiation, and Index testing services) and ongoing counselling. PEPFAR has also advocated for the government OpenMRS system to track linkage to care and electronically report back to implementing partners. An assessment is planned to assess linkage to care among this group and develop solutions.
	Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.	PEPFAR sites have begun TLD transition: In FY19 and FY20 Q1, 53% of all new ART clients have started the treatment with TLD regimen at PSI TOP centers. At the end of FY20 Q1, 15% of currently on ART are treated on TLD regimen at PSI TOP centers.
	Elimination of all formal and informal user fees affecting access to HIV testing and treatment and prevention in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, Cotrimoxazole, cervical cancer, PrEP and routine clinical services.	No user fees for service provision at public and NGOs sectors.
	Adoption and implementation of differentiated service delivery models for clinically stable clients that ensures choice between facility and community ART refill pick-up location and individual or group ART refill models. All models should offer patients the opportunity to get 6 months of medication at a time without requiring repeat appointments or visits.	Among 40 PEPFAR sites, 38 PEPFAR sites are implementing MMD: 403 clients (4%) are on 6 months MMD and 4496 (68%) are on 3 to 5 months MMD. Plan to expand 6-month MMD in FY21.

Cambodia

	Minimum Program Requirement	Status
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[1]	Current Status: Implemented nationally; Median 7 days Plan for ROP20: Median 3 days
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[2]	Current Status: Implemented nationally; 90% of new PLHIV on TLD Plan for ROP20: >90 % of patients receiving TLD
	3. Adoption and implementation of differentiated service delivery models, including 6-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3]	Current Status: SOPs finalized, roll-out on-going for FY 20 Plan for ROP20: Scale up nationally; >80% of ART on MMD
	4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of ROP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4]	Current Status: Implemented nationally; 30% of new PLHIV on TPT Plan for ROP20: 100 % of new PLHIV identified on TPT
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual VL testing and results delivered to caregiver within 4 weeks.	Current Status: Implemented nationally; VL test 84%; VL Turnaround Time (TAT) < 14days Plan for ROP20: VL test 100%; VL TAT < 10 days
Case Finding	1. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	Current Status: Implemented nationally; 65% of positives identified offered index testing Plan for ROP20: 60% of index cases with at least 2 partners tested
Prevention and OVC	1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[6]	Current Status: Implemented in 2 sites Plan for ROP20: Scale up implementation of CQI system and CamBlitz
	2. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden	*Not applicable for Cambodia context*

	areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	
Policy & Public Health Systems Support	1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[7]	Current Status: Implemented nationally since 2002 Plan for ROP20: Note applicable/Completed
	2. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[8]	Current Status: Adopted and implemented; CQI dashboard developed Plan for ROP20: Scale up implementation of CQI system and CamBlitz
	3. Evidence of treatment and VL literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	Current Status: Adopted and implemented Plan for ROP20: Scale up nationally
	4. Clear evidence of agency progress toward local, indigenous partner direct funding.	Current Status: Local CSOs funded by GF to do prevention and testing services Plan for ROP20: Developing social enterprises and private sector engagement
	5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	Current Status: SorChor Nor 213; RGC commitment to increase domestic resources for ARVs from $1.5 million to $5 million/y by 2023 Plan for ROP20: Shifted
	6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Current Status: MM study will be completed in 2020 Plan for ROP20: Adopted and implemented with fidelity
	7. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	Current Status: CBS working group established; Adopted system and data transitioned Plan for ROP20: Scale up the implementation nationally
Site Level MPRs	*Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.*	*Not applicable to the Cambodia Context*
	Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.	

	Elimination of all formal and informal user fees affecting access to HIV testing and treatment and prevention in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, Cotrimoxazole, cervical cancer, PrEP and routine clinical services.	
	Adoption and implementation of differentiated service delivery models for clinically stable clients that ensures choice between facility and community ART refill pick-up location and individual or group ART refill models. All models should offer patients the opportunity to get 6 months of medication at a time without requiring repeat appointments or visits.	

India

	Minimum Program Requirements	**Status**
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[1]	**Adopted 4/2017:** National implementation via return to care campaign. Lessons learned from PEPFAR supported districts (AP and MH) to track and trace pre-ART clients informed the national strategy, Mission Sampark, an initiative to find those who were lost to follow up and needed to be started on ARVs.
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[2]	**Adopted** 10/2018: DTG will be preferred in first- and second-line regimens for adults, including women of childbearing age (with informed choice), and children (weight-appropriate). TLD has been procured with availability expected 04/2019. Patients on NNRTI-based regimens (e.g., nevirapine and efavirenz) will be transitioned to DTG-based regimens. TLE 400 is also approved (updated GOI guidance 08/27/19).
	3. Adoption and implementation of differentiated service delivery models, including 6-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3]	**Adopted** (3-month MMS) 08/2018: National 3-month MMS and 6-month MMS with decentralized community-based pick-up is being scaled-up.
	4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of ROP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4]	**Adopted 12/2016**: Implemented with the National TB program and NACO. PEPFAR supports improved implementation of TPT focusing on reducing bottlenecks due to stock outs, and advanced disease management TA for increased TPT coverage.
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual VL testing and results delivered to caregiver within 4 weeks.	**Adopted 02/2018:** Routine viral load (RVL) for all PLHIV is policy in PEPFAR-supported districts, and in non-PEPFAR districts, RVL is provided at 30 high-burden ARTCs, and the remaining 423 ARTCs, RVL is currently being phased in (PPs[1]). PEPFAR provides TA to accelerate RVL for all via a differentiated

[1] Priority given to clients with immunologic or clinical failure, KP, pregnant and breastfeeding women, PLHIV on 2nd or 3rd line, and children < 15 and on ART > 5 years.

		approach of rapid scale up of public sector labs, optimizing PPP, expansion of hub and spoke model, and DBS at remote locations (approved 6/24/19), to achieve VL coverage by 2020. **Ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups:** Clinic monthly progress reports track OI's and deaths at site level. National consultation on Verbal Autopsy training (WHO framework, TA provided by PEPFAR India; May 2019). National HIV estimates, using UNAIDS Spectrum, supported by PEPFAR, provide estimates for annual mortality.
Case Finding	1. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	**Adopted 7/2019:** Index testing (national policy) being scaled-up under the release of the revised TI strategy. A regional Index Testing TOT training was conducted (New Delhi, 07/2019). **In progress with milestones reached**: Under India's National Strategic Plan, 2017-2024, is being scaled. Self-testing approved in to start in the private sector. PEPFAR collaborates with UNITAID (PATH India) to improve access to self-testing kits for KP via Yes4me (on-line platform). GOI received $ 1 million (GF 2018-2020) to pilot self-testing.
Prevention and OVC	1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[6]	**Adopted 8/2018 (among those at highest risk):** High level meeting with GOI, PEPFAR, UNAIDS, WHO and stakeholders (January 2019) followed adoption. Technical and operational guidance prepared as of Dec 2019.
	2. *Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.*	**In progress:** PEPFAR India provides comprehensive prevention, index testing and treatment services. PEPFAR coordinates with all relevant line ministries including the Ministries of Health, Education and Social Justice and Family Welfare. PEPFAR India is enlisting all the CLHIV across the PEPFAR priority districts and conducting comprehensive assessment for case management and referral for need based OVC package of services.
Policy & Public Health Systems Support	1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[7]	GOI provides HIV services including testing and treatment, free of cost to all residents.
	2. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[8]	USG plans to support CQI as a routine element of site management, enable real time use of data to identify, understand and analyze barriers, and take action to close the CQI loop

	3. Evidence of treatment and VL literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	**PEPFAR** India is providing continuous quality improvement support for the ongoing scale up of 64 public sector labs throughout the country and continuing to strengthen the lab-clinical interface to improve result uptake **U = U and other updated HIV messaging to reduce stigma:** PEPFAR India is removing barriers for community service access by enlisting multilateral support to empower communities and facilitate community-driven feedback mechanisms to eliminate stigma and improve provision of and access to services.
	4. Clear evidence of agency progress toward local, indigenous partner direct funding.	PEPFAR India supports indigenous partners. There has been an upward trend in the provision of funding to local partners.
	5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	GOI already funds 85% of its program response. There has been increased host country ownership with USG and Global fund funding 15% of the remaining requirement.
	6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	**Adopted.** Clinic monthly progress reports track OI's and deaths at site level. National consultation on Verbal Autopsy training (WHO framework, TA provided by PEPFAR India; May 2019).). National HIV estimates, using UNAIDS Spectrum, supported by PEPFAR, provide estimates for annual mortality. PEPFAR plans to support initiation of mortality surveillance.
	7. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	**Under Progress.** Project "Strengthening Overall Care for HIV" (SOCH) – NACO's integrated data system is under development and the system will integrate case-based surveillance through unique IDs which will be issued across the entire health program, by Ministry of Health. PEPFAR will support the development of unique identifiers to enhance patient tracking and increase retention.
Site Level MPRs	Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	**In process:** Linkage improving quarterly (all age, sex and risk groups) via introduction of peer navigators.
	Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.	**Adopted 10/2018:** DTG will be preferred in first- and second-line regimens for adults, including women of childbearing age (with informed choice), and children (weight-appropriate). TLD has been procured with availability expected 04/2019. Patients on NNRTI-based regimens (e.g., nevirapine and efavirenz) will be transitioned to DTG-based regimens. TLE 400 is also approved (updated GOI guidance 08/27/19).
	Elimination of all formal and informal user fees affecting access to HIV testing and treatment and prevention in the public sector for access to all direct HIV services	GOI provides HIV services including testing and treatment, free of cost to all residents.

	and medications, and related services, such as ANC, TB, Cotrimoxazole, cervical cancer, PrEP and routine clinical services.	
	Adoption and implementation of differentiated service delivery models for clinically stable clients that ensures choice between facility and community ART refill pick-up location and individual or group ART refill models. All models should offer patients the opportunity to get 6 months of medication at a time without requiring repeat appointments or visits.	**Adopted 08/2018:** National 3-month MMS and 6-month MMS with decentralized community-based pick-up is being scaled-up.

Indonesia

	Minimum Program Requirement	Status
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[1]	<u>*Sub National level:*</u> With support from PEPFAR, Jakarta has intensified efforts to institutionalize "Test and Start" following the signing of the July 2018 MOH circular that established Test All guidance and parameters for rapid ART. As of quarter 1 FY20/ROP19, all sub-district facilities (health facilities and direct service delivery clinics) across 5 districts in Jakarta were implementing Test and Start, with 83% of enrolled PLHIV receiving ART between 0 – 7 days, and 73% of diagnosed PLHIV receiving ART between 0 – 7 days. More than 90% of PLHIV have availed ART within each program reporting period. To ensure systematic application of Test and Start across all facilities – including high burden hospitals – the Jakarta provincial Health Office introduced Surat Edaran No. 141/SE/2019 - Acceleration of ART in 2019 – 2020 (Jakarta in December 2019 which institutionalized Test and Start in Jakarta for AIDS acceleration goals. <u>*National Level:*</u> 1. July 2018. Surat Edaran No. HK. 02.02/I/1564/2018 - *PLHIV Management for AIDS Elimination in 2030.* Institutionalized "Treat All" and introduces parameters for rapid ART 2. July 2019. Surat Edaran No. HK. PR.01.05/I/ 1822/2019 31 July 2019) - *Acceleration of ART in 2019 – 2020.* Institutionalized Test and Start across Indonesia for AIDS acceleration goals. December 2019. Surat Edaran No. 141/SE/2019 - *Acceleration of ART in 2019 – 2020 (Jakarta).* Institutionalized Test and Start in Jakarta for AIDS acceleration goals.
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[2]	<u>*Sub national level:*</u> PEPFAR supports the Jakarta Provincial Health Office (PHO) in its transition to TLD and to coordinate with the Indonesian Ministry of Health, USAID, GF, and other key stakeholders to accelerate the phasing out of all TLE600 as well as nevirapine-based regimens, ensuring a reliable supply of TLD and other essential ARVs at all sites in Jakarta. <u>*National level:*</u>

		PEPFAR assists Indonesia's national health goals by facilitating the national transition to tenofovir-lamivudine-dolutegravir (TLD) as the first-line regimen for HIV patients. With PEPFAR support, the National AIDS Program (NAP) has placed 1st order of TLD through the Global Fund with the qty 100,000 bottles to arrive in March 2020. This first order will be used for all new patients in Jakarta Province. New patients in Jakarta will begin to receive TLD in April 2020.
	3. Adoption and implementation of differentiated service delivery models, including 6-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3]	*Sub national level:* In Jakarta, multi-month ARV dispensing increased by 39.6% in Q1/FY20/ROP19 from Q4/FY19 totals to cover approximately 1,427 out of 8,112 eligible PLHIV (or 17.5% of total eligible persons), noting that facilities were not systematically distinguishing 2- and 3-month dispensing options in the ART registers. *National level:* Challenges for MMD rollout remain, particularly with regards to concerns about the timeliness of ARV replenishments at site levels and the MOH definition of MMD, which emphasizes two-month dispensing options. The USAID/ Procurement and Supply Management (PSM) project is now working with the MOH to strengthen supply chain reliability through the systematic use of the e-catalogue for ordering and tracking ARV supplies, and USAID/LINKAGES is working with the WHO, MOH and the Jakarta. PHO to move the program towards normative 3-month MMD. Notwithstanding, comprehensive MMD scale up will be constrained until the health system can reliably guard against ARV stockouts, and the MOH provides clear guidance on MMD parameters to provincial and district health offices, which will come following the dissemination of the National Clinical Guidelines. *Policy:* 1. July 2019. Surat Edaran No. HK. PR.01.05/I/ 1822/2019 31 July 2019) - Acceleration of ART in 2019 – 2020. Establishes up to 3-month MMD parameters across Indonesia. 2. December 2019. Surat Edaran No. 141/SE/2019 - Acceleration of ART in 2019 – 2020 (Jakarta). Establishes up to 3-month MMD parameters in Jakarta. March 2020. National HIV Clinical Guidelines (currently at MOH legal office prior to formalization and dissemination).
	4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of ROP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4]	*National level:* TB preventive therapy (TPT) work is now a routine part of HIV clinical care in PEPFAR programs and should be given to all PLHIV without active TB in medium and high burden countries regardless of tuberculin skin test (TST)/Interferon-Gamma release assays (IGRA).

		PEPFAR supports GOI and in-country partners to improve the quality of TB screening and diagnostic evaluation for HIV patients through an improved TPT commodity forecasting and drug procurement. Also, PEPFAR and USAID TB Resources will promote collaborative TPT forecasting between HIV and TB programs. Increase the use of presumptive TB registers and reporting at different points of care within facilities. Monitor the proportion of TB and HIV testing among presumptive patients and appropriate linkages to HIV and TB care. PEPFAR will work to ensure all PLHIV have access to TPT in Jakarta. *National level Policy* 1. July 2019. Surat Edaran No. HK. PR.01.05/I/ 1822/2019 31 July 2019) - Acceleration of ART in 2019 – 2020. States that all TB-negative PLHIV must be provided with TPT across Indonesia. 2. December 2019. Surat Edaran No. 141/SE/2019 - Acceleration of ART in 2019 – 2020 (Jakarta). States that all TB-negative PLHIV must be provided with TPT in Jakarta.
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual VL testing and results delivered to caregiver within 4 weeks.	<u>*Sub national level*</u> Cumulative Jakarta performance pointed out that VL testing coverage increase from a low of 10% among eligible PLHIV in quarter 1/FY19 to 60% coverage by December 2019 (Q1 FY20/ROP19) at PEPFAR-supported sites. Four out of 5 districts and 69% of PEPFAR-supported facilities are now on track for carrying out VL monitoring among at least 80% of eligible TX_CURR patients. PEPFAR partners supported Jakarta PHO to develop innovative specimen transport in Jakarta. Number of VL testing increased from 44% (1425 VL testing) in Q4 FY19 to 99% (3,045 VL testing) in Q1 FY20. <u>*National level:*</u> With support from PEPFAR, NAP conduct socialization training of the New Lab register template for laboratory staff for selected health facilities (HFs) in DKI Jakarta Province. Two batches of training completed. Twenty-one lab technicians from 9 hospitals and 12 primary health care (PHC) clinics from 3 DHOs participated in the first workshop held on January 28th, 2019. Twenty-six lab technicians from 12 hospitals and 14 PHC clinics from 2 DHOs attended the second held on February 4, 2019. In total, 47 lab technicians trained from 5 DHOs, 21 hospitals, and 26 PHC clinics. PEPFAR supports Indonesia on its trajectory to achieving 95-95-95 goals by collaborating with the Ministry of Health (MOH) to improve national laboratory network performance. PEPFAR supports the development of an independently

		managed external quality assurance system and a laboratory data connectivity software to ensure optimal VL and early infant diagnostics testing is accessible and available to all Indonesians. *National level Policy:* 1. July 2018. Surat Edaran No. HK. 02.02/I/1564/2018 - PLHIV Management for AIDS Elimination in 2030. Institutionalized "Treat All" and introduces parameters for VL reporting 2. July 2019. Surat Edaran No. HK. PR.01.05/I/ 1822/2019 31 July 2019) - Acceleration of ART in 2019 – 2020. Institutionalizes 6-month and annual VL testing parameters across Indonesia. 3. December 2019. Surat Edaran No. 141/SE/2019 - Acceleration of ART in 2019 – 2020 (Jakarta). Institutionalizes 6-month and annual VL testing parameters in Jakarta.
Case Finding	1. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	*Sub national level:* With support from PEPFAR, Jakarta has intensified efforts to institutionalize facility- and community-initiated index testing following the dissemination of the July 2019 MOH circular, the December 2019 PHO circular and the MOH partner notification technical guidance. As of quarter 1 FY20/ROP19, all sub-district facilities (public health facilities and direct service delivery clinics) and targeted hospitals (currently 6) across 5 districts in Jakarta were implementing facility-initiated index testing, while all PEPFAR-supported CSOs were implementing community-initiated index testing among KP PLHIV. *National level policy:* 1. July 2019. Surat Edaran No. HK. PR.01.05/I/ 1822/2019 31 July 2019) - Acceleration of ART in 2019 – 2020. Strengthens PLHIV partner notification, and institutes systematized index testing service offers to all PLHIV across Indonesia. 2. December 2019. Surat Edaran No. 141/SE/2019 - Acceleration of ART in 2019 – 2020 (Jakarta). Strengthens PLHIV partner notification, and institutes systematized index testing service offers to all PLHIV in Jakarta. 3. September 2019 and November 2019. National partner notification technical guidance for facilities and communities.

Prevention and OVC	1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[6]	<u>*National level:*</u> UNAIDS with the Global Fund and PEPFAR will work with the GOI and communities under the new GF grant to implement PrEP in priority locations in accordance with the national HIV/AIDS Expert panel recommendations. 1. July 2019. Indonesia National HIV and AIDS Program: Area-Specific Acceleration Plan establishes provision for PrEP in targeted locales. 2. September 2019. National HIV/AIDS expert panel recommends for use of PrEP in select sites in Jakarta, Bandung, Surabaya and West Java, encouraging non-government subsidized use of PrEP.
	2. *Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.*	*Not applicable to the Indonesia context*
Policy & Public Health Systems Support	1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[7]	<u>*National level:*</u> With the existence of the national social health insurance (JKN), user-related fees can be covered by the national health insurance. 1,138 out of 1,288 PWID PLHIV reached in HIV case management interventions (88.3%) reported having a Jakarta-based ID number, while 23 had Jabodetabek-based ID number (1.7%) and 4 had an ID number with residence outside of Jabodetabek (0.3%). 123 PWID PLHIV (9.5%) stated that they did not have an ID number. 1,025 PWID PLHIV stated that they had JKN (79.5%), 169 had KJS (13.1%), 94 had other insurance (7.2%) and 0 (0%) said that they did not have insurance.
	2. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[8]	<u>*Sub national level:*</u> PEPFAR has established a number of technical performance thresholds (based on PEPFAR minimum requirements) and developed CQI procedures and tools that have been adopted by the Jakarta Provincial Health Office and integrated into supervision and mentoring visits. CQI has not yet been institutionalized into MOH policy, noting that this will be a TA focus under ROP19 and ROP20

	3. Evidence of treatment and VL literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	<u>*Sub national level:*</u> In Jakarta, PEPFAR is supporting the Jakarta PHO to activate the "Let's be meaningful [because] life is precious" U=U initiative at all facility-based settings and with KP CSO implementing partners. PEPFAR's differentiated community-based case management strategy further establishes customized treatment literacy for individuals based on length of time on ART and their individual treatment experiences. <u>*National level:*</u> At the national levels, WHO is playing the key technical role in supporting MOH to launch treatment and VL literacy promotions and interventions across Indonesia. *National level – policy:* 1. July 2019. Surat Edaran No. HK. PR.01.05/I/ 1822/2019 31 July 2019) - Acceleration of ART in 2019 – 2020. Emphasizes treatment and VL literacy as important for treatment acceleration aims across Indonesia. 2. December 2019. Surat Edaran No. 141/SE/2019 - Acceleration of ART in 2019 – 2020 (Jakarta). Emphasizes treatment and VL literacy as important for treatment acceleration aims in Jakarta.
	4. Clear evidence of agency progress toward local, indigenous partner direct funding.	1. 2019. National Public Procurement Agency (LKPP) (No 8 2018). Establishes mechanism by which CSOs can access domestic funding through the Social Contracting (Swakelola Type 3) channel and implement interventions at national, provincial and/or district levels. 2. March 2020. Solicitation of GF for new PRs/Implementing Arrangements.
	5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	The Government of Indonesia has committed to purchase all ARVs for PLHIV in Indonesia. The GOI has contributed roughly 75-80% of the national HIV/AIDS Response over the last 3 years. As the number of PLHIV on ART increases, the GOI has committed to ensure all PLHIV have access to treatment. 2006 Permenkes GOI commits to provide ARVs to all people living with HIV/AIDS.

	6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	All facilities in Jakarta are currently utilizing the PEPFAR-developed ARK 6.0 (national cohort platform) to monitor and report on PLHIV morbidity and mortality outcomes. PEPFAR will be assisting the MOH to introduce a more sophisticated patient records system (SIHA NIK) to improve these monitoring and reporting functions over the ROP19 and ROP20 periods. 1. 2019. MOH ARK 6.0 (national cohort platform) – developed by PEPFAR – allows facilities to monitor and report individual-level morbidity and mortality outcomes. 2. 2020. SIHA NIK moves the current HIV HMIS system (SIHA) to a patient records system whereby the national program can monitor individual morbidity and mortality outcomes across facilities, districts and provinces.
	7. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	<u>*Sub national level:*</u> All facilities in Jakarta are currently utilizing the PEPFAR-developed ARK 6.0 (national cohort platform) to operatize case-based surveillance across sites over the 2020 period. <u>*National level:*</u> PEPFAR will support the MOH and Jakarta PHO to introduce the SIHA NIK patient records system which will utilize a patient's national ID code to support and track an individual's treatment coverage across facilities, districts and provinces. *National level – policy:* 1. 2019. MOH ARK 6.0 (national cohort platform) – developed by PEPFAR – utilized facility patient identification codes to track patients within and between sites in Jakarta. 2. 2020. SIHA NIK will utilize patient national ID codes as key identifiers across all sites within and beyond Jakarta.

Site Level MPRs	Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	*Sub national level:* With support from PEPFAR, Jakarta has intensified efforts to institutionalize Test and Start following the signing of the July 2018 MOH circular that established Test All guidance and parameters for rapid ART. As of quarter 1 FY20/ROP19, all sub-district facilities (puskesmas and direct service delivery clinics) across 5 districts in Jakarta were implementing Test and Start, with 83% of enrolled PLHIV receiving ART between 0 – 7 days, and 73% of diagnosed PLHIV receiving ART between 0 – 7 days. More than 90% of PLHIV have availed ART within each program reporting period. To ensure systematic application of Test and Start across all facilities – including high burden hospitals – the Jakarta provincial Health Office introduced Surat Edaran No. 141/SE/2019 - Acceleration of ART in 2019 – 2020 (Jakarta in December 2019 which institutionalized Test and Start in Jakarta for AIDS acceleration goals.
	Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.	*Sub national:* With PEPFAR support, the National AIDS Program (NAP) has placed 1st order of TLD through the Global Fund with the qty 100,000 bottles to arrive in March 2020. This first order will be used for all new patients in Jakarta Province. New patients in Jakarta will begin to receive TLD in April 2020, with priority for PEPFAR sites in Jakarta. *National level:* PEPFAR assists Indonesia's national health goals by facilitating the national transition to tenofovir-lamivudine-dolutegravir (TLD) as the first-line regimen for HIV patients. PEPFAR supports the Jakarta Provincial Health Office (PHO) in its transition to TLD and to coordinate with the Indonesian Ministry of Health, USAID, GF, and other key stakeholders to accelerate the phasing out of all TLE600 as well as nevirapine-based regimens, ensuring a reliable supply of TLD and other essential ARVs at all sites in Jakarta.
	Elimination of all formal and informal user fees affecting access to HIV testing and treatment and prevention in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, Cotrimoxazole, cervical cancer, PrEP and routine clinical services.	*Sub national:* With the existence of the national social health insurance (JKN), most user-related fees can be covered by the national health insurance. PWID PLHIV. 1,138 out of 1,288 PWID PLHIV reached in HIV case management interventions (88.3) reported having a Jakarta-based ID number, while 23 had Jabodetabek-based ID number (1.7%) and 4 had an ID number with residence outside of Jabodetabek (0.3%). 123 PWID PLHIV (9.5%) stated that they did not have an ID number. 1,025 PWID PLHIV stated that they had JKN (79.5%), 169 had KJS (13.1%), 94 had other insurance (7.2%) and 0 (0%) said that they did not have insurance.)

	Adoption and implementation of differentiated service delivery models for clinically stable clients that ensures choice between facility and community ART refill pick-up location and individual or group ART refill models. All models should offer patients the opportunity to get 6 months of medication at a time without requiring repeat appointments or visits.	*Sub national:* In Jakarta, multi-month ARV dispensing increased by 39.6% in Q1/FY20/ROP19 from Q4/FY19 totals to cover approximately 1,427 out of 8,112 eligible PLHIV (or 17.5% of total eligible persons), noting that facilities were not systematically distinguishing two- and 3-month dispensing options in the ART registers. *National level:* Challenges for MMD rollout remain, particularly with regards to concerns about the timeliness of ARV replenishments at site levels and the MOH definition of MMD, which emphasizes two-month dispensing options. The USAID/PSM project is now working with the MOH to strengthen supply chain reliability through the systematic use of the e-catalogue for ordering and tracking ARV supplies, and USAID/LINKAGES is working with the WHO, MOH and the Jakarta PHO to move the program towards normative 3-month MMD. Notwithstanding, comprehensive MMD scale up will be constrained until the health system can reliably guard against ARV stockouts, and the MOH provides clear guidance on MMD parameters to provincial and district health offices, which will come following the dissemination of the National Clinical Guidelines.

Kazakhstan

	Minimum Program Requirement	Status
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[1]	Adopted; challenges but improving
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[2]	Adopted; rollout in process
	3. Adoption and implementation of differentiated service delivery models, including 6-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3]	Adopted; challenges but improving
	4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of ROP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4]	Nationally scaled with fidelity
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual VL testing and results delivered to caregiver within 4 weeks.	Improving and scaling up
Case Finding	1. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	Improving and scaling up
Prevention and OVC	1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[6]	Adopted; preparing rollout
	2. *Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents*	

	living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	
Policy & Public Health Systems Support	1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[7]	Nationally scaled with fidelity
	2. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[8]	Implemented with fidelity
	3. Evidence of treatment and VL literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	Adopted; challenges but improving
	4. Clear evidence of agency progress toward local, indigenous partner direct funding.	Transition underway
	5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	GoK fund 90% of HIV response
	6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Adopted and implemented
	7. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	National scale-up underway

Site Level MPRs	Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	Linkage to care among PLHIV is 66% nationally and 68% in PEPFAR SNUs. Although linkage has improved over time, in PEPFAR SNUs, wait time for ART initiation was reduced from 204 days (2017) to 13 days in FY19 Q4 + FY20 Q1 . PEPFAR will advocate with MOH for an update to the testing algorithm and pilot of community based confirmatory testing. In addition, ART initiation and retention challenges remain are fueled in part by interruptions in ART within the country. PEPFAR will support supply chain strengthening activities to ensure appropriate procurement and distribution of ART.
	Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.	As an upper middle-income country, Kazakhstan does not have access to low cost TLD. In the new Clinical protocol (to be approved in March 2020), TLD is the first line regimen, or alternatively, regimens containing 3TC (or FTC), TDF (or TAF), and DTG. After the Clinical Protocol approval, the country will put all adult PLHIV on ART on one of the alternative first line regimens. The country will also remove all nevirapine-based regimens in FY 21.
	Elimination of all formal and informal user fees affecting access to HIV testing and treatment and prevention in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, Cotrimoxazole, cervical cancer, PrEP and routine clinical services.	All user fees are paid by the Mandatory Health Insurance Fund (MHIF). All clinical services are free for PLHIV. PrEP will start in 2021 and will be free for individuals at risk for HIV. During the initial rollout, GoK will procure PrEP for approximately 200 people, and the GF will procure PrEP for 100 people in Almaty, Karaganda, and Nur-Sultan.
	Adoption and implementation of differentiated service delivery models for clinically stable clients that ensures choice between facility and community ART refill pick-up location and individual or group ART refill models. All models should offer patients the opportunity to get 6 months of medication at a time without requiring repeat appointments or visits.	Approximately 93% of ART clients currently receive MMD of between 3 and 5 months. MMD for up to 12 months has been authorized in September 2019 for stable PLHIV. Kazakhstan will implement 6MMD in ROP20. PEPFAR will support MOH train providers and generate demand. PEPFAR will also support supply chain strengthening activities to ensure consistent access to ART as providers implement MMD.

Kyrgyz Republic

	Minimum Program Requirement	Status
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[1]	Adopted; challenges but improving
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[2]	Adopted; transition underway
	3. Adoption and implementation of differentiated service delivery models, including 6-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3]	Adopted; roll out underway
	4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of ROP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4]	Nationally scaled with fidelity
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual VL testing and results delivered to caregiver within 4 weeks.	Implemented with fidelity (PEPFAR)
Case Finding	1. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	Implemented with fidelity (PEPFAR)
Prevention and OVC	1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[6]	Adopted; rollout underway
	2. *Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden*	

	areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	
Policy & Public Health Systems Support	1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[7]	Nationally scaled with fidelity
	2. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[8]	Nationally scaled with fidelity
	3. Evidence of treatment and VL literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	Adopted; challenges but improving
	4. Clear evidence of agency progress toward local, indigenous partner direct funding.	Transition underway
	5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	Govt. funds 30% of HIV response
	6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Nationally scaled with fidelity
	7. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	Nationally scaled with fidelity
Site Level MPRs	Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	This is one the main areas for strengthening and consolidating the efforts of PEPFAR team in ROP20. PEPFAR will advocate reducing the turn-around time for diagnosis confirmation through the revision of testing algorithm and ART initiation on the POC that makes all services accessible to clients. Strengthening U=U message on both community and facility levels. Continue the sensitization of health care providers on importance of sDART.

	Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.	The Kyrgyz Republic launched TLD transition in FY19. PEPFAR has supported the development of TLD transitional plan country-wide that is under the implementation. Almost 40% of PLHIV on ART are on DTG regimen, among them 92% are on TLD. By Q4 FY20 80% of ART patients are on TLD. The Kyrgyz Republic is phasing out all nevirapine-based regimens by June 2020.
	Elimination of all formal and informal user fees affecting access to HIV testing and treatment and prevention in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, Cotrimoxazole, cervical cancer, PrEP and routine clinical services.	No user fees for service provision at public and NGOs sectors.
	Adoption and implementation of differentiated service delivery models for clinically stable clients that ensures choice between facility and community ART refill pick-up location and individual or group ART refill models. All models should offer patients the opportunity to get 6 months of medication at a time without requiring repeat appointments or visits.	MMD for 3 months is already included in the National HIV Clinical Protocols (CP) since 2017. Currently HIV CP is being revised for 6-month MMD and should be approved in Apr 2020. Community based ART has been launched in 2 SNUs and will be scaled up in ROP20. PEPFAR will conduct social behavior change communication activities targeted to clients and healthcare providers to increase demand for MMD. PEPFAR will support supply-chain management and forecasting to ensure at least 6-month supply of drugs in ROP20.

Lao PDR

	Minimum Program Requirement	Status
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[1]	**Policy status**: Test and start (Treat all policy) adopted in the national guidelines 2016. **Current Update:** All 11 ART facilities in Lao PDR have implemented test and start across all age, sex, and risk groups. Linkage from testing to treatment was 90%. **ROP20 Plan**: Test & treat policy adopted and implemented nationwide since 2017 and is part of routine treatment service.
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[2]	**Policy status**: National guidelines 2017 recommend TLD as the first line drug regimen for adult and children including women of childbearing age and children weight >35 years. **Current Update:** All 11 ART facilities in Lao PDR have administered TLD regimen to all newly diagnosed PLHIV and rapidly transition those PLHIV on current TLE ART regimen to TLD; Fully transition PLHIV to TLD by end of 2020.
	3. Adoption and implementation of differentiated service delivery models, including 6-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3]	**Policy status**: MMS 3-6 months included in the national guidelines 2017 **Current Update:** All 11 ART facilities in Lao PDR show steep increasing trend for MMS 3-4 months during 2016-2019, resolutions through national QI forum will improve implementation of MMD-6 in FY20. Dialogue with CHAS, Lao PDR MOH and GF and its SR (CHAI) dealing supply chain was conducted to ensure continuation of ARV supplies once MMD-6 started rolling out. **ROP20 Plan**: National Quality Improvement Mechanism and Forums to be strengthened to advance and monitor implementation of MMD3-6 months while support MoH and partners decentralizing ART POC sites for stable PLHIV All existing 11 ART facilities and new ART POC sites implement MMD 3-6.
	4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of ROP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4]	**Policy status**: MOPH guidelines 2020 recommended 1HP/3HP as preferred TPT regimen for PLHIV. **Current Update:** Uptake of TPT among newly diagnosed PLHIV was low GF will provide 3HP supply to 2000 cases in 2020 (start in April) Rifapentine is not included in the national essential drug list and cost is very expensive. **ROP20 Plan**: Monitor the national implementation of TPT for PLHIV Support MOPH to submit rifapentine in the national essential drug list.
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual VL testing and results delivered to caregiver within 4 weeks.	**Policy status**: The national guidelines recommended VL testing 6 months after ART initiation and annually. for stable PLHIV. **Current Update:** GF fully support VL testing. VL testing and suppression are in the national QI indicator list that all ART sites closely monitor and improve.

		ROP20 Plan: VL testing and suppression will be one of the focuses of the national QI indicator to be further improved.by all ART sites
Case Finding	1. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	**Policy status**: Self-testing & Index testing have been adopted in the national ART guidelines 2017 **Current Update:** After regional index testing workshop in BKK, Lao program adopts and implement passive index testing/partner and risk network referral testing among MSM/TG through LINKAGES in Vientiane Capital Through CDC TA, Index testing SOP is under the development and to be finalized by the end of FY20. The SOP encompasses 5 Cs principles and IPV screening tools to ensure that no harms to clients. Self-testing is one of the testing strategies being used among MSM/TG in PEPFAR supported province. **ROP20 Plan**: Scaling up Index Testing services with Strengthen coaching/supportive supervision, monitor site performance and identify lessons to improve targeted HIV case finding nationwide (USAID) EpiC, with its expanded geographical coverage, will scale up testing targets with CHAS/MOH's procuring test kits for index testing targets including self-testing kits. ??? PEFAR continues mobilizing CHAS, MOH and Global Fund to procure Oral Quick test kits to sustainably strengthen self-testing.
Prevention and OVC	1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[6]	**Policy status**: PrEP is adopted in the National ART Guidelines **Current Update:** (USAID) PrEP pre-implementation among MSM/TG will be conducted by Q3-4. **ROP20 Plan**: (USAID) with CHAS procurement mechanism and funding, PrEP will be implemented among MSM/TG in Vientiane Capital with technical support from EpiC???
	2. *Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.*	*Not applicable to the Lao PDR context*
Policy & Public	1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[7]	**Policy status**: Testing and ARV including ANC and TB services are free of charge; however, since the GF decreased funding, some OI drugs are covered by patients because of not covered by NHI **ROP20 Plan**: advocate for grater domestic resources

	2. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[8]	**Policy status**: Lao pDR MOH in progress implementing quality of health care policy "Five Good One Satisfaction" in which ART service CQI is incorporated and supported at all ART sites. **Current Update:** All ART sites implemented QI activities as part of the activities; National ART QI list of indicators has been established and monitored at both central and site levels. **ROP20 Plan**: Improve QI system capacity, coaching tools and interventions at sites; Conduct national QI workshops to monitor and share good practices on key QI priority topics included SD/rapid ART, MMD, TPT, LTFU, VL monitoring & suppression, Index Testing and S&D
	3. Evidence of treatment and VL literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	**Policy status**: Lao PDR MOH is developing and rolling out enhanced adherence counseling package and flip chart by ROP20 **Current Update:** Enhance adherence counseling package being developed and trainings will be conducted for 7 sites in 5 provinces by end 2020; U=U adopted in the HIV prevention roadmap; health care providers have been educated on U=U **ROP20 Plan**: Enhance adherence counseling package trainings will be conducted for all ART sites, including new ART POC; U=U message will be re-enforced both among health care providers and communities through CSOs
	4. Clear evidence of agency progress toward local, indigenous partner direct funding.	**Policy status**: Based on Prime Minister Decree 238, 2017, all NPA/CSO are limited to funding lower than 50,000 USD for which a number of NPAs receive funding from international donor through sub-granting **Current Update:** LaoPHA, a CSO, receives funding through LINKAGES because of the Decree 238 as a sub grantee **ROP20 Plan**: Because of limited numbers of CSOs in Lao PDR, LaoPHA will be continued for EpiC by being a sub-grantee.
	5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	**Policy status**: CHAS co-finances with the GF worth 10% of total ARV drugs nationwide **Current Update:** (USAID) Data generated by LINKAGES with high yield of HIV positive among MSM/TG demonstrated that such model is worth investing. **ROP20 Plan**: (USAID) CHAS commits to procure Index testing kits, self-testing kits and PrEP for EpiC implementation while scaling up EPM/CBS models to other partners and provinces.
	6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	**Policy status**: Lao PDR MoH mandates to transitioning all vertical HIS to DHIS2 **Current Update:** Current HIV service data system (HIVCAM) with UIC built in is in progress migrating to DHIS2 **ROP20 Plan**: in collaboration with GF, MoH and partners, capacity and infrastructure for application of DHIS2 as HIV CBS will be strengthened and rolled out in all ART sites.

	7. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	**Policy status**: Lao PDR MoH mandates to transitioning all vertical HIS to DHIS2 **Current Update:** Current HIV service data system (HIVCAM) with UIC built in is in progress migrating to DHIS2 **ROP20 Plan**: Capacity and infrastructure for application of DHIS2 as HIV CBS will built and rolled out in all ART sites.
Site Level MPRs	Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	**Policy status:** Test and start (Treat all policy) adopted in the national guidelines 2017 **Current Update:** All 11 ART facilities in Lao PDR have implemented test and start across all age, sex, and risk groups. Linkage from test positive to treatment was 92% according to national cascade and 91% for MSM/TG (LINKAGES) **ROP20 Plan:** Test & treat policy adopted and implemented nationwide since 2017 and is part of routine HIV testing and ART services in all 11 ART facilities and newly established ART POC sites; PEPFAR will work with GF and other partners' PLHIV peer network complementing to MSM/TG enhanced peer mobilizer (EPM) model supporting community based supporters (CBS) to reach, test, and refer to treatment and retain; In addition, we will further improve linkage in PEPFAR-supported sites through case managers, coaching, and supervision, including SIMS visits by PEPFAR team and implementing partners and Lao PDR MoH. During site visits PEPFAR will consult and improve service flow and client centered options for better linkage.
	Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.	**Policy status**: National guidelines 2017 recommend TLD as the first line drug regimen for adult and children including women of childbearing age and children weight >35 years **Current Update:** All 11 ART facilities in Lao PDR have administered TLD regimen to all newly diagnosed PLHIV and rapidly transition those PLHIV on current TLE ART regimen to TLD - Fully transition PLHIV to TLD by end of 2020 **ROP20 Plan**: National Quality Improvement Mechanism and Forums to help monitor the completion of TLD transition and address any potential issues; the further transition to TLD at PEPFAR-supported sites will be intensified through, case managers, coaching and supervision including SIMS visits by PEPFAR team and implementing partners and Lao PDR MoH.

	Elimination of all formal and informal user fees affecting access to HIV testing and treatment and prevention in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, Cotrimoxazole, cervical cancer, PrEP and routine clinical services.	**Policy status**: Testing and ARV including ANC and TB services are free of charge; however, since the GF decreased funding, some OI drugs are covered by patients because of not covered by NHI **Current Update:** Testing and ARV including ANC and TB services are free of charge; however, since the GF decreased funding, some OI drugs are covered by patients because of not covered by NHI **ROP20 Plan**: advocate for grater domestic resources; the implementation at PEPFAR supported sites will be intensified through, case managers, coaching and supervision including SIMS visits by PEPFAR team and implementing partners and Lao PDR MoH. During site visits PEPFAR will advocate mobilizing PLHIV access to the membership of National Health Insurance (NHI) scheme.
	Adoption and implementation of differentiated service delivery models for clinically stable clients that ensures choice between facility and community ART refill pick-up location and individual or group ART refill models. All models should offer patients the opportunity to get 6 months of medication at a time without requiring repeat appointments or visits.	**Policy status**: MMS 3-6 months included in the national guidelines 2017 **Current Update:** All 11 ART facilities in Lao PDR show steep increasing trend for MMS 3-4 months during 2016-2019, resolutions through national QI forum will improve implementation of MMD-6 in FY20 **ROP20 Plan**: National Quality Improvement Mechanism and Forums to be strengthened to advance and monitor implementation of MMD3-6 months while support MoH and partners decentralizing ART POC sites for stable PLHIV ; all existing 11 ART facilities and new ART POC sites implement MMS-6; the implementation at PEPFAR supported sites will be intensified through, case managers, coaching and supervision including SIMS visits by PEPFAR team and implementing partners and Lao PDR MoH.

Nepal

	Minimum Program Requirements	Update
Care and Treatment	1. **Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.**[3]	Test and start strategy are being implemented nationally and PEPFAR is monitoring ways to improve it. The current revision (2020) of the National HIV Testing and Treatment Guidelines makes direct and immediate linkage to treatment compulsory.
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[4]	Transition to TLD agreed upon nationally and will be implemented from April 2020 onwards. Dolutegravir based regimen kept as 1st line ARV in National HIV Testing and Treatment Guidelines being revised.
	3. **Adoption and implementation of differentiated service delivery models, including 6-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.**[5]	DSD including MMD for 3 to 6 months is already included in the National HIV Testing and Treatment Guidelines, which is currently being revised and awaiting endorsement from the GON. MMD will be implemented nationally beginning April 2020.
	4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of ROP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[6]	TPT is in place and is being provided as per national guidelines to all PLHIV. Country is planning for a transition from 6H based regimen to 3HR based regimen.
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual VL testing and results delivered to caregiver within 4 weeks.	VL optimization agreed upon among national stakeholders including National government and VL service sites.

[3] Guidelines on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015
[4] Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019
[5] Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016
[6] Latent tuberculosis infection: Updated and consolidated guidelines for programmatic management. Geneva: World Health Organization, 2018

Case Finding	1. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[7]	Index testing (on hold in PEPFAR sites) and self-testing scaled up nationally through LINKAGES and Global Fund partner agencies. Children with an HIV positive biological parent are being tested.
Prevention and OVC	1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[8]	Country agreed to roll out PrEP nationally. PrEP will be implemented beginning April 2020 and will target highest risk groups.
	2. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	*Not applicable to the Nepal context*
Policy & Public Health Systems Support	1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[9]	HIV testing and treatment is free from government hospitals and through PEPFAR implementing partner.
	2. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and	Country is committed to improving the quality of HIV services and already has periodic QA monitoring at the site level. The PEPFAR program will institute CQI

[7] Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016 https://www.who.int/hiv/pub/self-testing/hiv-self-testing-guidelines/en/

[8] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015 (http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en).

[9] The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005

	program management. CQI is supported by IP work plans, Agency agreements, and national policy.[10]	methodologies to drive HIV service improvements at PEPFAR sites and will also advocate for the adoption of CQI at nationally.
	3. Evidence of treatment and VL literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	Country has a national treatment literacy manual that PEPFAR/Nepal providing TA to the GON to revise. The updated manual will have more emphasis on VL testing with messages of U=U and TLD regimen. The national stigma training curriculum is also being revised.
	4. Clear evidence of agency progress toward local, indigenous partner direct funding.	PEPFAR/Nepal is conducting a capacity assessment of local partners and will develop a capacity building plan based on the assessment.
	5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	GON has assumed 100% of the funding for ARVs (including TLD); ART counselors at ART sites; and HIV test kits.
	6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	The country will launch the one national HIV information system in ROP19. The system allows for recording and reporting of morbidity and mortality outcomes. The HIV information system will track reasons for mortality.
	7. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	Host government is in process of implementing UIC across all the national sites. National HIV database is in the last phase of development, pilot and training is planned in Feb-Mar 2020 to implement from April 2020.
Site Level MPRs	Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	The country has significantly approved linkage at the site level and is currently undertaking a quantitative/qualitative assessment to better understand the causes of LTFU and death. Results will be used to improve linkage at the site level and to better target the causes of LTFU and death to raise linkage to greater than 95%. The program is also concomitantly improving same day ART initiation rates and that is also expected to improve linkage rates across all demographic groups.
	Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.	Nepal will complete the transition to TLD by April 2020. Per guidelines, all PLHIV weighing > 30 Kg will have access to TLD in ROP20, if not well before. The country will also remove all nevirapine-based regimens.
	Elimination of all formal and informal user fees affecting access to HIV testing and treatment and prevention in the public sector for access to all direct HIV services and	Nepal does not currently require user fees for HIV services.

[10] Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019

	medications, and related services, such as ANC, TB, Cotrimoxazole, cervical cancer, PrEP and routine clinical services.	
	Adoption and implementation of differentiated service delivery models for clinically stable clients that ensures choice between facility and community ART refill pick-up location and individual or group ART refill models. All models should offer patients the opportunity to get 6 months of medication at a time without requiring repeat appointments or visits.	As noted above, MMD for 3 to 6 months is already included in the National HIV Testing and Treatment Guidelines, which is currently being revised and awaiting endorsement from the GON. MMD will be implemented nationally beginning April 2020. One site is currently providing CB-ART to better address client needs and the Nepal program plans to expand this model to 12 sites by the end of ROP 19.

Papua New Guinea

	Minimum Program Requirement	Status
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[1]	Test and Start policy adopted and implemented across all age, sex, and risk groups nationally, with direct and immediate linkage of clients from testing to treatment across age, sex, and risk groups in PEPFAR SNU at 93 percent.
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[2]	HIV Care and Treatment guidelines updated September 2019 to include TLD as first line ART to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential). Children >20kg to use single DTG based regimen as first line, NVP based regimens removed. TLD transition commenced October 2019, projected to be completed Q3FY2020 in PEPFAR SNU and nationally by Q4FY2020.
	3. Adoption and implementation of differentiated service delivery models, including 6-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3]	Differentiated service delivery models, including 6-month multi-month dispensing (MMD) policy adopted into care and treatment guidelines. Implementation hampered by low ART stock levels and TLD transition. By June 2020 (Q3FY2020) adequate ART stocks will be in country and TLD transition completed hence DSDM including MMD implementation feasible, targeting 75% of PLHIV on ART in PEPFAR SNU.
	4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of ROP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4]	TB preventative treatment a national policy. PEPFAR SNU coverage is 40% for TPT, with availability of Isoniazid the main factor for low coverage. Cotrimoxazole is available to patients at no cost.
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual VL testing and results delivered to caregiver within 4 weeks.	VL management system (VLSM) deployed to facilitate optimization of VL testing, reporting and management of patients. Recently VLSM upgraded to have functionality to include Early Infant Diagnosis Testing.
Case Finding	1. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	Index testing policy adapted, and phased role out commenced in PEPFAR SNU with careful emphasis on ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established appropriately.
Prevention and OVC	1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[6]	

	2. *Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.*	
Policy & Public Health Systems Support	1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[7]	All PLHIV access ART and primary health care at no cost.
	2. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[8]	National HIV Quality Improvement is part of MOH HIV program after the launching of HIV Quality Improvement framework. Increased focus on involvement of CSOs in CQI is part of ROP19 with 3 CSO sub grants with plans for 3 more, bringing total to 6 CSOs.
	3. Evidence of treatment and VL literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	Evidence of treatment and VL literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.
	4. Clear evidence of agency progress toward local, indigenous partner direct funding.	Indigenous CSOs who have been awarded sub grants will also have capacity building preparation for direct funding.
	5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	MOH is responsible for procurement of ART. Timely adequate funding is a challenge.
	6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity. Ongoing work to integrate HIV data systems with national health information systems through a standard national unique identifier to allow for linking of HIV patient data with vital statistics.
	7. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	Revisions of HIV reporting tools have included the national unique identifiers (NID) and work is underway to integrate all HIV data systems into the national health information system to allow for true longitudinal tracking and case-based reporting.

Site Level MPRs	Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	Overall, linkage rate for the PNG PEPFAR Program is over 95% due to the interventions we have intensified (e.g. rapid initiation of ART, same-day ART, escorted referrals, and active case management).
	Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.	TLD adopted as first (>30kg) and DTG based regimen in children >20kg in 2019 Care and Treatment Guideline review. TLD transition has commenced in NCD and expected to be completed by Q3.
	Elimination of all formal and informal user fees affecting access to HIV testing and treatment and prevention in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, Cotrimoxazole, cervical cancer, PrEP and routine clinical services.	There are no user fees for all PLHIV in the public health system.
	Adoption and implementation of differentiated service delivery models for clinically stable clients that ensures choice between facility and community ART refill pick-up location and individual or group ART refill models. All models should offer patients the opportunity to get 6 months of medication at a time without requiring repeat appointments or visits.	By June 2020, ART stock in county should be replenished and MMD will implemented and scaled up.

Philippines

	Minimum Program Requirement	Status
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[1]	A Test-and-Start policy has been in place since 2016 dictating that clients with a reactive HIV screening test should be referred to a treatment hub before final lab confirmation from NRL-SACCL. Those with baseline CD4 count <200 cells/mL and those with WHO Stage III or IV disease should start ART before confirmed HIV diagnosis. However, most treatment sites do not adhere to this policy, waiting for final confirmation before linkage to care. Even fewer start clients on ART without HIV confirmation. Centralized HIV confirmatory testing at NRL-SACCL is a major barrier to timely ART initiation and screening test reliability is a barrier to decentralization of HIV testing.
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[2]	EFV to DTG transition has not yet started but is planned during HIV Strategic Plan 2020–2022; newly diagnosed persons will be prioritized. With support from GF, a TLD Transition Plan will be finalized in the next few months. Procurement and supply chain continue to be barriers to reliable availability of ART and may complicate efforts to transition to TLD.
	3. Adoption and implementation of differentiated service delivery models, including 6-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3]	Three-month MMD is included in national policy. Across the country, however, supply chain issues make MMD difficult, resulting in one-month or even 10-day prescriptions. Additionally, with only 11% of PLHIV undergoing viral load testing, it is difficult to assess eligibility for MMD. ART supply chain and low viral load testing capacity currently limit implementation of MMD. Six-month MMD has not been recommended or implemented.
	4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of ROP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4]	All patients are recommended to receive TPT and it is covered in the outpatient HIV/AIDS Treatment (OHAT) package without user fees. However, individual-level adherence is not captured by HARP. Cotrimoxazole is not included in current guidelines but can be prescribed at the provider's discretion. There may be user fees for patients who are prescribed cotrimoxazole. Lack of incorporation of TPT into the HIV surveillance system. Isoniazid stock outs were cited as a possible cause for the drop in TPT initiation rate from 2017 to 2018.
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual VL testing and results delivered to caregiver within 4 weeks.	Viral load testing rate was 11% among PLHIV diagnosed in 2018. PhilHealth will reimburse for only one viral load test per 12 months per client. The main barrier was a lack of testing reagents. Outside of Manila, it is believed that lack of access to viral load testing machines further reduces testing rates. Updated ART guidelines from 2018 recommend viral load testing every 12 months for stable patients. Prior guidelines recommended viral load testing largely in response to suspected treatment failure.

		There are GeneXperts deployed throughout the country, and these could be used to rapidly scale up VL testing. GF is indicating they can supply some of the cartridges.
Case Finding	1. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	Apart from passive client disclosure of contacts, index testing is not formally done in the Philippines. This is a sensitive subject due to 1) the concentrated epidemic among key populations, and MSM in particular, who often do not know the names or mobile numbers of their sexual contacts and 2) the HIV/AIDS Act of 2018, which penalizes providers in cases of involuntary disclosure of HIV status. Although this policy does not preclude eliciting contacts, it has induced extreme caution around disclosure among providers. Self-testing will soon be piloted in two cities (Manila City, Iloilo City).
Prevention and OVC	1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[6]	There has been a successful demand creation campaign and pilot for PrEP among MSM in the Philippines, including through social media. However, PrEP is registered and available commercially and is too expensive for widescale adoption. PrEP is currently not included in national policy nor covered by PhilHealth-OHAT.
	2. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	*Not applicable for the Philippines context*
Policy & Public Health Systems Support	1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[7]	Passage of HIV/AIDS Act of 2018 established that all Filipinos have the right to access HIV testing and treatment. There are no user fees for HIV screening, confirmatory testing, ART, TPT, annual viral load testing, or CD4 testing. However, this depends on client enrollment onto PhilHealth. Additionally, there is a 9-month waiting period following enrollment. Although the HIV/AIDS Act of 2018 has established right of access to HIV care for all Filipinos, national infrastructure and implementing policies must be updated to allow all persons to realize this right.
	2. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[8]	Philippines is a new PEPFAR program and will ensure CQI into site and program management plans.

	3. Evidence of treatment and VL literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	U=U has not been widely implemented in the Philippines. There has been some discussion, but there is also resistance among certain providers, out of concern for intermittent non-compliance with ART and for a potential increase in high-risk sexual behavior resulting in higher STI incidence. PEPFAR can assist drawing from successful U=U messaging campaigns in other countries in the region. U=U can create demand for viral load testing.
	4. Clear evidence of agency progress toward local, indigenous partner direct funding.	Philippines is a new PEPFAR program. Local institutions and CBOs active among KP and PLHIV in the Philippines will be strengthened.
	5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	The Philippines DOH currently funds all ART procurement and is expected to remain the primary funding source for drug procurement. Intermittent ART stockouts indicate unreliable supply chain. PEPFAR will support DOH to stabilize the supply chain and improve ordering practices.
	6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Families often prevent accurate and timely reporting of deaths among PLHIV and adverse events while PLHIV are on ART are reported only if they necessitate a change in regimen. Opportunistic infections, including TB, are reported, however, in Form B/C and entered into HARP.
	7. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	HARP is a comprehensive case-based surveillance system. Remaining gaps include reporting deaths among PLHIV (family often requests that HIV not be listed in the cause of death on death certificates), individual-level screening test data, and TPT initiation and completion data. Care should be taken not to disrupt the thorough case-based surveillance system established by the DOH when introducing PEPFAR MER indicators to the Philippines.
Site Level MPRs	Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	*Philippines will evaluate site-level MPRs during the implementation of ROP20 activities*
	Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.	
	Elimination of all formal and informal user fees affecting access to HIV testing and treatment and prevention in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, Cotrimoxazole, cervical cancer, PrEP and routine clinical services.	

	Adoption and implementation of differentiated service delivery models for clinically stable clients that ensures choice between facility and community ART refill pick-up location and individual or group ART refill models. All models should offer patients the opportunity to get 6 months of medication at a time without requiring repeat appointments or visits.	

Tajikistan

	Minimum Program Requirement	Status
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[1]	Adopted; challenges but improving
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[2]	Adopted; transition underway
	3. Adoption and implementation of differentiated service delivery models, including 6-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3]	Adopted and implemented
	4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of ROP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4]	Nationally scaled with fidelity
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual VL testing and results delivered to caregiver within 4 weeks.	Improving and scaling up
Case Finding	1. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	Improving and scaling up
Prevention and OVC	1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[6]	Adopted; preparing rollout
	2. *Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden*	

	areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	
Policy & Public Health Systems Support	1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[7]	Challenges but improving
	2. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[8]	Challenges but improving
	3. Evidence of treatment and VL literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	Challenges but improving
	4. Clear evidence of agency progress toward local, indigenous partner direct funding.	Transition underway
	5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	Challenges but improving
	6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Adopted and implemented
	7. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	Nationally scaled with fidelity
Site Level MPRs	Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	Out of 701 new HIV cases fond in PEPFAR supported SNUs in 2019 calendar year, a total of 678 (97 initiation was 8 days. Out of those initiated ART, 21% started ART in the same day or, due to the cli 20% of the patients newly found to be HIV positive and started ART in 2019, initiated treatment with period of ROP19 and in ROP20, PEPFAR will work closely with local AIDS centers and CSOs serv initiative and supporting peer counselors will work to further promote implementation of the same of population and sites. The new case identification and treatment initiation data will be con subpopulations with the delayed and poor treatment initiation.

	Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.	First batch of TLD/DTG arrived in July 2019. TLD is being offered now to all eligible treatment naïve, including women of childbearing potential, pregnant and breastfeeding women, adolescents and children with weight ≥ 30 kg. DTG 50 mg - containing regimens are offered to the children weighing ≥ 20kg. As for the ART experienced patients, those with VL≥1000 and receiving NVP-based regimens were prioritized for transitioning to TLD. As of Jan 2020, a total of 1,566 patients (364 new and the rest were transitioned from other ART regimens) were on TLD (27% of the total country ART patients). It is planned that 90% of all ART patients would be transitioned to TLD by end of 2020. The rest 10% of patients will be on other DTG or EFV400-based regimens. Nevirapine-containing regimens are not any longer in the National HIV treatment guidelines.
	Elimination of all formal and informal user fees affecting access to HIV testing and treatment and prevention in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, Cotrimoxazole, cervical cancer, PrEP and routine clinical services.	No user fees for provision services to PLHIV at public and NGOs sectors.
	Adoption and implementation of differentiated service delivery models for clinically stable clients that ensures choice between facility and community ART refill pick-up location and individual or group ART refill models. All models should offer patients the opportunity to get 6 months of medication at a time without requiring repeat appointments or visits.	MMD is a part of the country HIV Care and Treatment Guidelines. According to current national policy, MMD is recommended only for clinically stable patients and labor migrants planning to be out of the country for the prolonged period. Health workers are trained on MMD provision. MMD is evenly implemented among female and males and across PEPFAR-supported SNUs. For FY20Q1, 43% of all patients receive ARVs for ≥ 3 month. Out of them, 83% and 17% received ARVs for the periods 3-5 months and ≥6 months accordingly. MMD is equally implemented among men and women. ARVs dispensation is only allowed in the government medical facilities serving PLHIV, including AIDS centers, MAT sites, and primary health care facilities in which HIV services are integrated. AIDS center nurses deliver ARVs to those unable to visit ART clinics to refill ARVs. Patients receiving MMD mainly include stable patients and labor migrants. MMD planned to be implemented beyond stable patients. Potential challenges for scaling up MMD implementation are stock on hand and beliefs by ART providers that MMD can further reduce adherence and country practice to receive ARVs from the Central warehouse quarterly. These issues will be addressed during ROP19-20 through site-level mentorship support and supply chain above-site TA.

Thailand

	Minimum Program Requirement	Status
Care	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate	**Policy status:** Test and start (Treat all policy) recommended in the national guidelines 2014

	(>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[1]	**Current Update**: All PEPFAR-supported sites (CDC in 5 provinces and USAID/KPLHS model in 6 provinces) implemented test and start across all age, sex, and risk groups. Linkage from testing to treatment was 88%. **ROP20 Plan:** Test & treat policy adopted nationwide since 2015 and is part of routine treatment service
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[2]	**Policy status**: National guidelines 2020 recommend TLD as the first line drug regimen for adult and children including women of childbearing age and children weight >35 years **Current Update**: Two companies registered DTG 1 company registered for TLD Documents submitted to national essential drug list for approval **ROP20 Plan**: Fully implemented as an essential first line drug regimen
	3. Adoption and implementation of differentiated service delivery models, including 6-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3]	**Policy status**: MMS 3-6 months included in the national guidelines 2017 **Current Update:** 19/25 (76%) CDC PEPFAR-supported sites in 5 provinces started implementing MMD 6 months in FY20 National differentiated care service delivery manual developed including DSD for health facilities and community-based organization, MMD 6 months, fast-track refill, etc. **ROP20 Plan**: Full implementation in PEPFAR supported sites including community-based services (25 in 2020 and 34 sites in 13 provinces in 2021) Monitor the national implementation of MMD
	4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of ROP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4]	**Policy status**: MOPH guidelines 2020 recommended 1HP/3HP as preferred TPT regimen for PLHIV **Current Update:** Uptake of TPT among newly diagnosed PLHIV was low GF will provide 3HP supply to 2000 cases in 2020 (start in April) Rifapentine is not included in the national essential drug list and cost is very expensive **ROP20 Plan**: Monitor the national implementation of TPT for PLHIV Support MOPH to submit rifapentine in the national essential drug list
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual VL testing and results delivered to caregiver within 4 weeks.	**Policy status**: The national guidelines recommended VL testing annually. VL testing is included in the HIV benefit package of NAP. NAP also supports free EID for infants born to HIV+ mothers **Current Update:** Complete training and implement in all CDC supported sites by February 2020 Implemented VL lab link and notification in select hospitals in provinces. Initial result showed improvement in VL testing reporting system and reduced turnaround time of VL testing VL notification system notified any cases with VL>1000 for drug resistance testing and adherence counseling

		ROP20 Plan: Policy advocacy for test kit registration at the country of origin and in Thailand Expand sites of VL lab link and notification
Case Finding	1. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	**Policy status**: Self-testing policy exists Index testing is recommended in the 2020 edition of the national prevention and treatment guidelines **Current Update:** Complete training and implement in all CDC-supported sites by January 2020 Launch and implement high quality of index testing and recency testing program to integrate into routine VCT clinics in all CDC-supported sites Self-test protocol approved by Thai MOPH's EC and waiting for BMA's and TRC's Training conducted for BOOTS pharmacists Data collection program on smart phone has been developed and being tested. Preparation meetings with hotline and hospital staff planned for late March Recruitment for HIV self-testing delivery through pharmacy anticipated in April 2020 Utilizing GF's oral fluid test kit to implement at KPLHS to improve case finding **ROP20 Plan**: Develop supportive supervision, monitor site performance and identify lessons for improvement to improve targeted HIV case finding Assess program performance and identify successful elements of advocacy for nationwide implementation Anticipate self-test kits registered with/ approved by Thai FDA early FY 2021 (ROP20) Scale-up oral fluid self-testing at KPLHS sites as one of case finding strategies
Prevention and OVC	1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[6]	**Policy status**: National guidelines recommended PrEP for high risk populations including high risk MSM, serodiscordant couples, recurrent STI/PEP cases **Current Update**: PrEP actively implemented in 78 health care facilities in 30 provinces, 43 sites in 5 provinces are CDC-supported Community-based PrEP services under Princess PrEP program implemented in 6 provinces with 9 KLPHS sites **ROP20 Plan**: Maintain PrEP implementation in 43 sites nationally Train additional 5-7 large public facilities in Bangkok to provide PrEP as part of NHSO prevention support Increase PrEP user at KPLHS site by innovative approaches; online and offline strategies
	2. *Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents*	*Not applicable in the Thailand context*

	living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	
Policy & Public Health Systems Support	1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[7]	**Policy status**: All pregnant women and TB patients can access to free services of ANC, TB treatment and HIV testing and treatment at governmental facilities **Current Update**: Cervical cancer screening (pap smear) is included in prevention benefit package of universal health coverage for women aged 30-60 years old q 3 years; VIA free for women 30-45 years q 5 years; in 2020 HPV DNA screening free for 30-59 years q 5 years Demonstrated PrEP package (2,000 cases) under NHSO has implemented since FY 2020. **ROP20 Plan**: The national guidelines recommended that HIV-positive women screened cervical cancer annually. HIV-positive women can get free cervical cancer screening if they have abnormal symptom or screen abnormal at baseline. All women with cervical cancer can access to free treatment under universal health coverage scheme. PrEP implementation under NHSO reimbursement including PrEP services in facility-based/community-based organizations.
	2. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[8]	**Policy status**: CQI is supported at all level. Disease Specific Certification for HIV and STI manual available. **Current Update**: All PEPFAR-supported sites implemented QI activities as part of the activities as shown below: CDC works closely with MOPH and Health care accreditation institute (HAI) to support coaching for hospitals with poor performance on HIV treatment CDC, MOPH and HAI introduced concept of using provincial quality healthcare network certification (PNC) for ending the AIDS epidemic in each province and to sustain epidemic control. Health care providers, community health workers and provincial officers conducted a quarterly Quality Assurance and Quality Improvement at KPLHS sites to ensure quality of HIV services **ROP20 Plan**: PNC concept introduced to 4 CDC-supported provinces in 2020 and 13 provinces in 2021. Expand QI activities to cover 34 sites in 13 provinces in 2021. Key QI topics included SD/rapid ART, MMD, retention to care, improve VL coverage, enhance adherence counseling, S&D CQI etc. QA and QI provincial network comprising of health care provider, community health worker and provincial officer continue conducts a quarterly QA/QI at KPLHS sites to ensure quality of HIV services as a routine system.

	3. Evidence of treatment and VL literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	**Policy status**: MOPH will publish enhance adherence counseling package and flip chart by ROP20 **Current Update**: Enhance adherence counseling package developed and trainings were conducted to 25 sites in 5 provinces in 2019 U=U VDO is being developed CDC also support S&D assessment and training 3x4 at 110 health care facilities in 77 provinces **ROP20 Plan**: Enhance adherence counseling package developed and trainings will be conducted to 34 sites in 13 provinces in 2020 S&D e-learning including U=U messages will be developed. Treatment literacy manual will be updated and included U=U message and S&D reduction.
	4. Clear evidence of agency progress toward local, indigenous partner direct funding.	**Policy status**: CDC already worked with indigenous partner (>95%) **Current Update**: CDC works with Thai MOPH and BMA USAID supports Thai Red Cross AIDS Research Center.
	5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	**Current Update:** Thai government has strong commitment for HIV response. More than 90% of HIV budget were from the Thai government.
	6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	**Policy status**: Policy supports for monitoring HIV morbidity /mortality **Current Update:** MOPH and BMA are working on establishing morbidity and mortality reporting system Preliminary data of causes of mortality available in x hospitals in x provinces. Quality of data needed strengthened. **ROP20 Plan**: Preliminary data of causes of mortality available in x hospitals in x provinces. Quality of data needed strengthened.
	7. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	**Policy status**: National scale following Disease Control Act 2016 **Current Update**: HIV case-based surveillance was established in 2016 using MOPH centralized database. HIV-related variables obtained from 1000 hospital HIS were analyzed for morbidity and mortality reports. Data has been disseminated through Division of Epidemiology website and HIV info Hub. Start DQA in PEPFAR supported sites. **ROP20 Plan**: DQA to ensure high data quality for HIV diagnosis, ICD10 and ARV coding will be conducted in 5-10 high burden provinces. Data use for program improvement will be trained for sites and provincial program managers

Site Level MPRs	Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	**Policy status**: Test and start (Treat all policy) recommended in the national guidelines 2014 **Current Update:** All PEPFAR-supported sites (CDC in 5 provinces and USAID/KPLHS model in 6 provinces) implemented test and start across all age, sex, and risk groups. Linkage from testing to treatment was 88%. **ROP20 Plan**: PEPFAR will continue support fidelity of test to treatment (≥95%) at PEPFAR supported sites.
	Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.	**Policy status**: National guidelines 2020 recommend TLD as the preferred first line regimen for adult including women of childbearing age and children weight >35 kg; NVP-based regimen was removed from the treatment regimen in adult. NVP is still in the national guidelines for use in the following scenarios: PMTCT regimen for HIV-exposed babies with high risk of MTCT; optional regimen for children <3 years who are intolerant to LPV/r-based HAART. **Current Update:** Thai FDA approved DTG from 2 companies and TLD from 1 company. MOPH and Thai AIDS society submitted a letter to national essential drug list requesting for approval of TLD in national essential drug lists. We anticipated that TLD will be available in the national AIDS program end of ROP19. **ROP20 Plan**: PEPFAR will support the government and PEPFAR-supported sites for TLD transition and monitor TLD transition at national level.
	Elimination of all formal and informal user fees affecting access to HIV testing and treatment and prevention in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, Cotrimoxazole, cervical cancer, PrEP and routine clinical services.	**Policy status**: All pregnant women and TB patients can access to free services of ANC, TB/PJP treatment and HIV testing and treatment at governmental facilities; Thailand policy supports PrEP as part of the prevention package. However free PrEP supply is limited. This year the National Health Security Office provides budget for only 2000 PrEP users, waiting for more information on evaluation of this effort, before deciding if more budget can be allocated to free PrEP **Current Update:** Cervical cancer screening (pap smear) is included in prevention benefit package of universal health coverage for women aged 30-60 years old q 3 years; VIA free for women 30-45 years q 5 years; in 2020 HPV DNA screening free for 30-59 years q 5 years; The national guidelines recommended that HIV-positive women screened cervical cancer annually. HIV-positive women can get free cervical cancer screening if they have abnormal symptom or screen abnormal at baseline. All women with cervical cancer can access to free treatment under universal health coverage scheme.; Demonstrated PrEP package (2,000 cases) under NHSO has implemented since FY 2020 **ROP20 Plan**: PrEP implementation under NHSO reimbursement including PrEP services in facility-based/community-based organizations; USG team will work closely with UNAIDS and MoPH on national PrEP monitoring and evaluation to inform further investment, in the meanwhile leveraging PrEP commodities from GF to support those outside the NHSO PrEP funds.

	Adoption and implementation of differentiated service delivery models for clinically stable clients that ensures choice between facility and community ART refill pick-up location and individual or group ART refill models. All models should offer patients the opportunity to get 6 months of medication at a time without requiring repeat appointments or visits.	**Policy status**: The Thai national HIV treatment and care guidelines 2017 recommended MMD3-6 months for stable PLHIV receiving ART. Currently, NAP allows 6-month supply. However, social security scheme and civil servant medical benefit scheme allows for only 1-3-month supply. MOPH already discussed with social security scheme to extend period of antiretroviral drug dispensing to 3-6 months. **Current Update:** MOPH in collaboration with PEPFAR will publish national differentiated care for ART service delivery including 6-month MMD manual in ROP19. About 75% of PEPFAR-supported sites started implementing MMD 6 months. **ROP20 Plan:** Complete expansion of MMD6 months to all PEPFAR-supported sites including community sites. PEPFAR will monitor the national implementation of MMD in ROP20.