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

Asia Region Operational Plan

ROP 2021 Update to ROP 2020

Strategic Direction Summary

Final

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PREFACE

On February 9, 2021, S/GAC announced a temporary pause in COP/ROP 21 planning and development due to surging COVID-19. At the time of the announcement, no further development of strategies, required tools, or consultations with stakeholders specific to COP/ROP 21 development occurred. When the planning process resumed on April 1, the compressed timeline required adjustments and streamlining for certain tools and processes. As such, OUs were requested to update their existing COP/ROP20 SDS documents rather than use the guidance previously shared as a new ROP21 template. This document provides update sections additional to the approved ROP20 SDS document, which is not altered; rather, the blue update boxes in each section highlight any new decisions, agreements, and shifts planned for ROP21. Other text (with white background) is the approved ROP20 text. For example, in the ROP20 narrative, we referred to 11 countries; moving forward in the ROP21 narratives (in blue), we refer to 12 countries (with the addition of the Philippines to the region). There may be other technical or strategic approaches that were included and approved in the ROP20 narrative that became irrelevant as the impact of COVID-19 began to affect countries, but no changes were made to the approved ROP20 document. Section 1.0, the Goal Statement, is the only section that is replaced completely from the ROP20 SDS. This document indicates which tables were updated for ROP21.

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
BTC	Back to care
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
CLM	Community led monitoring
COP	Country Operational Plan
COVID-19	Coronavirus Disease 2019
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
HRSA	Health Resources and Services Administration
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
POCT	Point of care testing
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
SNM	Social Network Model
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—Updated for ROP21

The ROP21 **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 (PNG), 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) will coordinate and 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), targeted testing including index, self, and social network strategies, harm reduction programming, gender-affirming service delivery, differentiated service delivery models, reducing stigma and discrimination, improving data use, and initiating community-led monitoring (CLM). Two years following regional consolidation, ARP has successfully completed one year of regional program implementation (ROP19, implemented in FY20) and two ROP planning cycles (ROP19 and ROP20). In November 2020, the ARP held a retreat to assess if internal structures and processes put into place based on assumptions made prior to regionalization remained salient. A small working group is refining recommendations from USG regional retreat participants, which will result in a proposal to make some structural shifts to better address the needs of the region as expressed in the retreat. Staffing recommendations for the PEPFAR Coordination Office are reflected in the PARCU ROP21 budget.

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 ROP21 technical directives as described below. These activities will be carried out in a new policy environment: on January 28, 2021, President Biden rescinded the Mexico City Policy. In rescinding the policy, President Biden required agencies involved in foreign assistance to immediately end the imposition of the policy in future awards, waive the policy's application in existing awards, and notify recipients as soon as possible that the policy conditions have been waived.

ARP was one of the first regions impacted by COVID-19 and moved quickly to address numerous issues associated with this new disease. Immediate widespread disturbance of international travel and shortages of medical supplies necessitated an unprecedented regional and multilateral collaboration to unblock commodities and make them available in countries facing shortages. Meetings were quickly switched to virtual platforms, starting with the ROP20 process. Countries reprogrammed funds and adopted innovative approaches to address COVID-19 challenges and support host country government responses to the pandemic. Staff members—including those personally touched by COVID-19--are challenged daily to go well beyond their usual roles to participate in coordination activities and urgent responses that have become the norm during this ongoing global crisis. In ROP21, the U.S. Congress and the Biden administration, through the American Rescue Plan Act (ARPA), designated $250,000,000 to the Department of State "to support programs for the prevention, treatment, and control of HIV/AIDS in order to prevent, prepare for, and respond to coronavirus, including to mitigate the impact on such programs from coronavirus and support recovery from

the impacts of the coronavirus." PEPFAR will use these funds to: (1) address urgent ARV commodities needs due to COVID; (2) prevent, prepare for, and respond to coronavirus (including prevention of COVID-19 infection, illness, and death among PEPFAR-supported beneficiaries and health workforce); and (3) mitigate COVID-19 impact on PEPFAR programs and beneficiaries and support program recovery from the impacts of coronavirus. PEPFAR efforts will align to the broader USG global COVID-19 response and recovery strategy, objectives, lines of efforts, and associated metrics. The 12 ARP countries submitted ARPA proposals for a total sum of $5,220,000. Please refer to Appendix E for more information on the ARPA country proposals.

In ROP21, $2.9 million in PEPFAR funding will support **unifying collaborations** in the region that enhance sharing of knowledge, resources, best practices, and tools. USAID and CDC submitted proposals identifying and addressing common challenges across the region and/or enhancing collaboration and knowledge sharing between two or more countries in the region.

CDC will support three proposals and the objectives listed below:

1) **Establishment and Implementation of a Laboratory Community of Practice (COOP) for ARP**
    - Develop a laboratory COOP and consortium among the 12 ARP countries and other stakeholders and partners for achieving unmet MPRs and reaching UNAIDS 95-95-95 goals
2) **Building a Community of Practice for Border Programming**
    - Improve access to HIV/TB services among migrant PLHIV through client center border program in India
3) **Capacity Building for CLM**
    - Build the capacity of ARP CSOs to support and monitor PLHIV and KP services

Common inputs shared across the three CDC regional proposals include: (1) convening and knowledge sharing; (2) tool and guidance development; and (3) training and capacity building. The lab proposal takes advantage of staff and partners in country to establish a COOP. While the border activities will center around the border between India and Burma, the tools developed and activities implemented can and will be extrapolated to support migrant populations in other border countries, such as Tajikistan and Kyrgyz Republic. Lastly, the CLM proposal addresses many of the challenges that have been identified in ARP countries, such as limited number of civil society and other organizations that have skill/expertise in CLM in each country.

CDC envisions its regional proposal activities will primarily supplement the work being conducted in the ARP countries. To prevent any potential duplication and ensure coordination with country-level activities--especially where there are existing activities already occurring (e.g., CLM)--CDC will assess with the interagency PEPFAR team whether and how the supplemental regional support can be complementary and how to translate lessons learned from country-level activities and teams for regional advancement.

USAID will partner with UNAIDS and with regional KP networks and KP CSOs to **catalyze a regional effort to reach epidemic control, addressing specific program areas identified by KP networks and KP CSOs as urgent: scaling proven HIV KP innovations and supporting KP CSO sustainability**. USAID will dedicate $1M to working with these KP networks and regional KP CSOs through EpiC, with 70 percent of funding going to subawards to enhance regional KP TA and KP CSO capacity. This major portion of the work will focus on capacity building to support technical innovation and exchange and scaling high-impact interventions for community-based KP-led health services, building on efforts already underway, and adding a specific component for Central Asia. TA will scale these services and ensure that KP networks and regional KP CSOs have the support they need to play a key role in providing TA moving forward.

Another $400k will support KP CSO sustainability, focusing on moving countries forward on domestic and private financing opportunities in a variety of areas, depending on country readiness. This activity will include developing metrics that will support policy movement for social contracting and expanding social health insurance reimbursement menus. The proposal builds on existing models in the region for social enterprises, and, through establishing a sustainability forum, it will build momentum for peer-to-peer knowledge sharing and innovation.

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 ROP20. In ROP21, they will focus on closing the remaining gaps, sustaining epidemic control, distilling lessons learned, and taking on leadership roles in the region.**

Burma, at 85%-90%-94% (94% VL suppression among those tested [2019; pre-coup]), is committed to continuing HIV services after the February 1, 2021, military coup, to mitigate the uncertainty resulting from the political situation and civil disobedience movement which has crippled the public health system, exacerbated by the COVID-19 pandemic. PEPFAR sites are adapting services to cover additional patients from the national antiretroviral therapy (ART) cohort, and the PEPFAR team is coordinating with major donors and NGO/CSO partners to fill HIV service gaps after the closure of a number of National AIDS Program (NAP) sites. Burma hopes to preserve the gains from the last decade and minimize disruption of ART, prevention, harm reduction, and lab services in collaboration with strong leadership from CSOs and multilaterals. Continued program innovations include index testing, PrEP, differentiated KP services for PWID, MSM, TGW, FSW, and KP partners, and working with multilaterals to ensure continued SI and lab activities and commodity supply. PEPFAR will formalize and strengthen the role of CSOs beyond advocacy, to include service delivery and CLM.

Cambodia, at 84-99-97, will intensify its efforts to ensure program sustainability and country ownership. Cambodia will transition to a country-owned HIV response that increases local partner engagement and domestic resources for the HIV/AIDS program. The program will use real-time recency data to detect and respond to outbreaks, scale up micro-targeted PrEP to all high burden areas, implement the Master Patient Index nationwide, and aggressively scale up international policies: ART initiation (within 7 days of HIV diagnosis) from 80% to 95%, multi-month dispensing (MMD) scale up from +3MMD (45%) to 6MMD nationwide, > 90% of all PLHIV on tenofovir/ lamivudine/dolutegravir (TLD), TPT completion from 28% to 60%, and viral load (VL) coverage of >95% with a VL turnaround time of <10 days.

Kyrgyz Republic, currently at 72-63-90, will continue implementing key client-centered policies and practices through aggressive roll-out of MPRs, including differentiated service delivery, finalizing TLD transition, 6MMD, PrEP, and antiretroviral (ARV) dispensing strategies--including community-based ART in 4 oblasts. The country will scale up case finding, including index and self-testing, ensuring adherence to the "5Cs."

Nepal, at 83-79-49, experienced challenges to VL scale up and results with diversion of lab/HR capacity to address COVID-19 testing. PEPFAR will focus on removing barriers to close remaining gaps, sustaining epidemic control once reached, gleaning lessons learned, implementing continuous quality improvement monitoring for treatment adherence and continuity, and developing a leadership role in responding to HIV in the region. Nepal will continue to work with UNAIDS and GF to develop a sustainability plan; scale up recency testing and case-based surveillance (CBS) to ensure strategic case finding; expand PrEP; support CSOs, as social enterprises to deliver quality KP-friendly HIV/AIDS services and implement new KP-led CSO sustainability activities; and develop into a regional TA provider.

Tajikistan, at 62-84-92, will identify undiagnosed PLHIV, integrate community-based ART and HIV self-testing into HIV services to achieve higher ART coverage in three PEPFAR-supported areas, and expand VL suppression approaches nationally. Heavier focus will be placed on reaching young men, as this group has lower rates of ART coverage. PEPFAR will support national expansion of recency testing and scale up high-impact prevention interventions, including PrEP and MAT. Collaboration with GF will continue to strengthen supply chain systems to improve quantification and forecasting to prevent ARV and other commodity stock outs, including HIV diagnostics and VL tests. To obtain more precise KP epidemiological data for better decision-making, Tajikistan plans to strengthen CBS, and implement a BBS and integrated PSE among PWID and FSWs.

Thailand, at 97-75-85, will continue to expand index and recency testing, integrate HIV-self testing into current strategies, and increase uptake of same-day ART (SDART), 6MMD and VL testing, including community-based DSD options. PEPFAR will promote integration of coaching and quality improvement activities into the national quality system to sustain key HIV interventions. Facility and community-based settings will accelerate the institutionalization of PrEP and KP-led health services. PEPFAR and its partners will continue to provide targeted technical assistance (TA) and support at the provincial level to increase national impact. PEPFAR will further sustainability of community-based organizations (CBOs) through social contracting and social enterprise models developed in partnership with key stakeholders, including the National Health Security Office (NHSO) and private sector. Thailand CSO partners also will serve as regional TA partners working to build south-to-south exchanges with CSOs in other countries in the region to share experience and learning.

Tier 2: Accelerate and Achieve

Three countries—**India, Lao PDR,** and the **Philippines**--are not yet at epidemic control but have identified opportunities in ROP21 to accelerate country progress.

India, currently at 76-84-84, will focus on accessing unreached KPs in PEPFAR-supported areas through a variety of targeted efficient case finding strategies such as index testing, social networking models, and self-testing (in collaboration with UNITAID and PATH). Working with GOI and GF partners, PEPFAR will increase an integrated service delivery approach across the prevention to treatment continuum, including single window services and KP peer navigation. In response to and in partnership with communities, focus will continue on testing, partner notification, and comprehensive prevention including finding and linking KPs. India will build on successful strategies to decrease linkage loss and increase ART access. In partnership with communities, the GOI and GF, PEPFAR will continue to address treatment interruption, closing ART gaps and improving VL access and suppression through a client-centered approach targeting SDART, test and treat strategies, TLD scale-up, community ART distribution scale-up, aggressive implementation of differentiated service delivery, and MMD in 40 districts in 6 states. VL coverage will expand to achieve 90% coverage in ROP21.

Lao PDR, currently at 71-74-76, will advance self, index, and recency testing policy and implementation in three high-burden areas. PEPFAR will address gaps in linkage and treatment continuity through enhanced case management, SDART, MMD, and TLD transition. PrEP will be implemented in three provinces among targeted high-risk MSM and TG.

Philippines, at 70-61-16, will scale up key HIV prevention and treatment service gaps in public, community, and select military facilities in 5 areas (National Capital Region, Central Luzon, CALABARZON, Western and Central Visayas). Above-site efforts will focus on quality improvement, supply chain and procurement, data, laboratory systems, sustainability, and policy and guideline development to further MPRs. Strategies to

increase SDART, TLD transition, TPT provision, DSDM, and MMD expansion will support the second 95, in addition to PEPFAR support for return to care and ART adherence through client-centered differentiated services, advanced HIV disease management, and KP-specific case management strategies. To increase VL testing coverage, PEPFAR will conduct a diagnostic network optimization (DNO) assessment, expand point of care (POC) and near-to-POC VL testing, and increase patient treatment literacy and U=U messaging. PEPFAR will strengthen collaboration with multilateral and donor partners, including the GF and UNAIDS, to leverage additional resources and funds to improve program results. Lastly, PEPFAR will promote quality improvement, health system accountability, and responsiveness through strengthening independent and local community groups and CSO CLM activities. Innovations such as recency testing and the use of alternative sampling strategies to complement the biobehavioral surveys conducted by the DOH will be included.

Tier 3: Protect the Investment

Despite substantial PEPFAR and other donor investments, **Indonesia**, **Kazakhstan,** and **PNG** have experienced historical challenges in achieving UNAIDS 90-90-90 benchmarks. To address these challenges, these countries will focus on the following activities.

Indonesia, at 66-40-23, will focus on two areas: (1) to optimize systems, policies, and practices to ensure ART beneficiaries achieve and maintain VLS, with phased transition to a data-informed, equal partnership among key stakeholders in country, sustainable government- and civil society-led response; and (2) to accelerate the ability of the Government of Indonesia, KP CSOs, and the private sector to more effectively plan, deliver, and optimize comprehensive, scaled HIV and AIDS prevention, care, and treatment services in 13 districts across Jakarta and Greater Jakarta.

Kazakhstan, at 76-73-81, will continue to provide site-level services in 2 geographic areas to maintain those PLHIV currently on ART and will introduce new targeted prevention, care, and treatment services targeted toward MSM. Building on community efforts with PWID and those who use drugs, PEPFAR will expand targeted services and partnership with CSOs to MSM, given the increasing epidemiology and needs in this group. PEPFAR will continue to shift 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 SDART, ensure uninterrupted supply of ARVs, and prioritize social contracting for KP HIV services. Health facilities and CBOs will continue to focus on treatment interruption and self-testing, and PEPFAR will work with the MOH to develop self-testing and PrEP guidelines and standard operating procedures (SOPs).

PNG, at 76-89-91, will continue activities to ensure saturation along the HIV care continuum including index testing, expanding Test and Start, addressing ART continuity and interruption, and increasing VL coverage in the National Capital District (NCD). TA support and collaboration with the National Department of Health (NDoH) will ensure quality and continuity of care and treatment services for PLHIV. Increased VL testing coverage will be achieved through DNO and VL testing decentralization. PNG will begin supporting the design and implementation of an independent civil society-driven CLM activity. Above site activities include surveillance, monitoring, and reporting of pediatric cases and early infant diagnosis (EID). PNG will work closely with local stakeholders to advocate for the introduction of PrEP, supporting PrEP policy and guideline development for national adoption. With PNG's success transitioning over 90% of eligible PLHIV in NCD to TLD, PEPFAR will monitor the national transition and commodity supplies to ensure sustained roll out nationally. PNG will also continue to integrate sexual and gender-based violence (SGBV) screening, counseling, and referral activities into HIV services and support the scale up of the new SGBV guidelines nationally.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden, and regional profile

ROP21 UPDATES

With a combined population of almost 2 billion, there are an estimated 3.5 million people living with HIV (PLHIV) across the 12 countries--ranging from 9,800 in **Kyrgyz Republic** to 2,349,000 in **India**. Philippines data have been added for ROP21. 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. The Philippines has the fastest growing HIV epidemic in the Asia-Pacific region; the number of new HIV infections in the Philippines increased 203% in just eight years (from 4,400 in 2010 to over 13,000 per year in 2018) and is still increasing, while most countries in the Asia-Pacific region have seen plateaus or declines. Countries demonstrate varied progress toward UNAIDS 95-95-95 goals, and in ROP20 these gaps have been exacerbated by the COVID-19 pandemic. *Country specific epidemic figures are available in Appendix 1.*

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 (updated for ROP21 for all countries)

	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	204,000	184,624	90%	94%	492,836	38,881	30,063
	Cambodia	15,552,211	0.54	74,918	62,239	62,164	99%	97%	43,215	3,848	3,779
	India	1,300,000,000	0.22%	2,349,000	1,774,867	1,485,895	84%	84%	25,940,000	96,260	87,242
	Indonesia	269,603,400	0.26%	543,705	359,457	142,906	40%	23%	4,199,992	52,638	40,062
	Kazakhstan (15+)	18, 631,779	0.19%	36,000	27,485	20,176	73%	81%	3,052,697	3,442	2,780
	Kyrgyz Republic (15+)	6,389,500	0.13%	9,800	7,050	4, 442	63%	90%	398,650	636	493
	Lao PDR	7,265,625	0.2%	15,073	10,691	7,955	74%	76%	91,467	1,580	1,246
	Nepal	29,219,318	0.13%	30,301	25,214	19,827	79 %	49%	213,179	2,313	2,070
	PNG	8,970,000	0.87%	55,670	41,752	37,160	89%	91%	175,075	3,987	3,670
	Philippines	108,116,622	0.20%	111,400	78,291	47,977	61%	16.3%		8,058	5,072
	Tajikistan (15+)	9,313,800	0.20%	13,000	8,117	6,791	84%	92%	836,487	999	906
	Thailand	69,587,096	0.66%	501,105	488,168	367,052	75%	85%	1,250,788	27,061	27,693

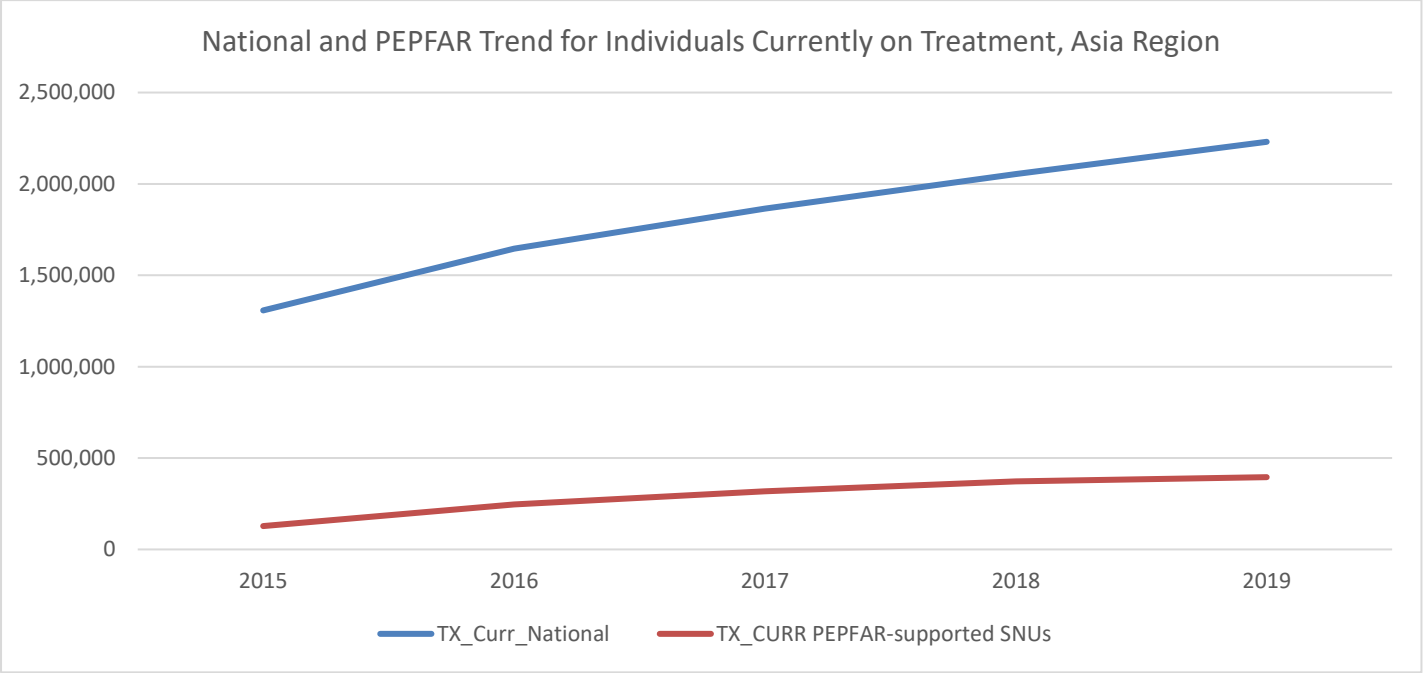
	Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression (updated for ROP21 for all countries)										
	Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Country	Total Pop. Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Population <15 years	Burma	14,825,000	-	10,860	-	7,927	-	-	-	-	1,076
	Cambodia	-	-	2,775	1,986	1,978	99.6%	50%			74
	India	400,000,000	.02%	78,807	70,926	56,464	80%	-	-	-	-
	Indonesia	66,039,900	.03%	17,550	-	-	-	N/A	46,824	954	788
	Kazakhstan	-	-	-	-	-	-	-	-	-	-
	Kyrgyz Republic	-	-	-	-	-	-	-	-	-	-
	Lao PDR	2,302,369	0.01%	542	448	303	68%	75%	658	33	30
	Nepal	8,373,745-	-	1,268	1,251	1,221	98%	-	2,761	83	-
	Philippines	35,392,757	-	<500	-	-	-	-	-	-	-
	PNG	3,160,000	N/A	5,100	3,825	1247	33%	N/A	N/A	N/A	N/A
	Tajikistan	-	-	-	-	-	-	-	-	-	-
	Thailand	11,353,065	0.02%	2,406	2,950	1,720	58%	75%	20,641	109	153
Men 15-24 years	Burma	4,821,000	0.76%	142,000 (>15)	-	99,690 (>15)	-	-	-	-	18,313 (>15)
	Cambodia	-	-	3,517	3,012	3,003	99.7%	62%			661
	India (>15)	450,000,000	0.24%	1,276,051	869,010	729,010	84%	-	-	-	-
	Indonesia	22,260,700	0.18%	39,424	-	-	-	N/A			
	Kazakhstan	1,910,339	<0,04%	717	547	483	88%	86%	-	176	151
	Kyrgyz Republic	526,880	<0.04%	<200	172	125	73%	94%	-	48	36
	Lao PDR	708,576	0.13%	906	567	439	77%	69%	6,084	222	168
	Nepal	-	0.02%	537	-	-	-	-	-	-	-
	Philippines	10,680,325	0.2%	23,000	74% (15+)	46% (15+)					
	PNG	914,340	N/A	1,730	1,298	803	62%	N/A	N/A	N/A	N/A
	Tajikistan	64,400	<0,116%	<1,000	227	212	93%	94%	-	52	45
	Thailand	4,634,091	0.27%	16,849	20,529	13,625	66%	70%	159,367	4,370	3,952
Men 25+ years	Burma	13,702,000	-	-	-	-	-	-	-	-	-
	Cambodia	-	-	30,557	26,170	26,143	99.9%	73%			1,960
	India	*Combined with stats above*									
	Indonesia	21,837,100	0.13%	290,903	-	-	-	N/A	663,417	27,256	21,161
	Kazakhstan	4,484,527	0.5%	20,786	15,876	11,007	69%	83%	-	2,110	1639
	Kyrgyz Republic	1,574,790	0.34%	5,400	3,253	1,833	56%	88%	-	425	318
	Lao PDR	1,799,473	0.44%	7,589	5,141	3,899	76%	78%	13,841	764	600
	Nepal	-	-	15,135	-	-	-	-	-	-	-
	Philippines	26,050,066	0.2%	68,000		41,449 (15+)					
	PNG	2,035,660	N/A	19,850	14,888	**11,452**	61%	N/A	N/A	N/A	N/A
	Tajikistan	2,195,600	0.39%	8,600	4,416	3,459	78%	90%	-	540	483
	Thailand	23,235,764	1.05%	265,269	274,611	191,101	70%	84%	519,311	14,869	15,289
Women 15-24 years	Burma	4,825,000	88,000 (>15)	-	-	-	-	-	-	-	10,674 (>15)
	Cambodia	-	-	2,754	2,248	2,243	99.8%	62%			165
	India* (>15)	450,000,000	0.20 %	994,000	834,931	700,421	84%	-	-	-	-
	Indonesia	79,484,800	0.37%	29,401	-	-	-				
	Kazakhstan	1,829,544	<0.03%	537	410	348	85%	89%	-	91	82

	Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression (updated for ROP21 for all countries)										
	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 (#)
	Kyrgyz Republic	506,386	<0.04%	<200	161	132	82%	87%	-	31	25
	Lao PDR	692,443	0.10%	745	465	299	64%	61%	31,298	182	*134*
	Nepal	-	0.02%	624	-	-	-	-	-	-	-
	Philippines	10,243,047	0.1%	1,800	73% (15+)	23% (15+)					
	PNG	860,280	N/A	2,840	2,230	1295	73%	N/A	N/A	N/A	N/A
	Tajikistan	829,700	<0.060%	<500	225	212	94%	90%	-	59	53
	Thailand	4,420,996	0.18%	8,338	11,229	7,193	64%	69%	119,431	1,392	1,287
Women 25+ years	Burma	16,147,000	-	-	-	-	-	-	-	-	-
	Cambodia	-	-	35,315	28,823	28,797	99.9%	74%			919
	India	*Combined with stats above*									
	Indonesia	79,980,900	*0.21%*	*165,797*	-	-	-	*N/A*			
	Kazakhstan	*5,033,844*	*0.26%*	*13,542*	*10,332*	*8,031*	*78%*	*86%*	-	1029	*862*
	Kyrgyz Republic	1,696,028	0.16%	2,700	2,207	1,577	71%	94%	-	314	252
	Lao PDR	1,762,764	0.31%	5,291	4,070	3,015	74%	82%	39,576	374	*314*
	Nepal	-	-	12,744	-	-	-	-	-	-	-
	Philippines	26,814,620	0.1% (15+)	4,000		1,339 (15+)					
	PNG	1,999,720	N/A	26,150	19,613	**17,222**	88%	N/A	N/A	N/A	N/A
	Tajikistan	2,233,000	0.13%	2,800	3,249	2,908	90%	93%	-	349	325
	Thailand	25,615,314	0.75%	208,246	196,087	153,413	78%	87%	432,038	6,321	7,012
MSM	Burma	268,000	8.8%	22,517	-	-	-	-	64,870	4,652	-
	Cambodia	88,000	4.0%	3,520					22,875	655	655
	India	357,000	2.69%	*9,603*	*6223*	*5,176*	83%	-	213,986	599	520
	Indonesia	502,986	17.9%	90,117				*N/A*	138,350	8,819	
	Kazakhstan	5,033,844	0.26%	13,542	10,332	8,031	78%	86%	-	1029	862
	Kyrgyz Republic	1,696,028	0.16%	2,700	2,207	1,577	71%	94%	-	314	252
	Lao PDR	57,825	5.09%	2,903	1,647	1,331	81%	47%	*1,710*	373	332
	Nepal	60,333	5.0	3,511	-	317	-	-	5,841	289	*216*
	Philippines	830,000	5.0%	41,500	28.40%				16% (2015)		
	PNG	-	-	-	-	-	-	-	-	-	-
	Tajikistan	13,400	2.3%	308	132	114	86%	92%	4,841	23	22
	Thailand	600,419	8.77%	65,502	32615	23040	71%	75%	95431	7238	6750
FSW	Burma	75,000	8.3%	8,892	-	-	-	-	55,759	2,679	-
	Cambodia	50,600	3.2%	1,619					30,127	74	74
	India	868,000	1.69%	13,541	*9,289*	6,547	70%	-	596,576	656	609
	Indonesia	277,624	2.1%	6,446 (high risk) 5,623 (low risk)					*64,863*	*1,454*	
	Kazakhstan	20,250	1.4%	284	350	188	54%	75%	2,923	14	9
	Kyrgyz Republic	7,100	2.0%	156	82	32	39%	80%	25	6	4
	Lao PDR	15,886	0.89%	144	180	91	51%	74%	11,070	79	23
	Nepal	49,018	2.2%	470	-	173	-	-	7,333	152	*173*
	Philippines	210,000	0.6%	12,600	36.30%						

	Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression (updated for ROP21 for all countries)										
	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 (#)
	PNG	-	-	-	-	-	-	-	-	-	-
	Tajikistan	17,500	2.9%	508	372	320	86%	89%	12,459	40	38
	Thailand	117,632	1.33%	800	876	483	55%	70%	24539	299	206
PWID	Burma	93,000	34.9% (2017)	21,212	-	-	-	-	47,900	11,680	-
	Cambodia	3,200	15.2%	487					320	1	1
	India	177,000	6.26%	*11,080*	5,496	*5,712*	103.9%*	-	108,324	*1,202*	1,039
	Indonesia	34,517	13.6%	4,294					8,532	193	
	Kazakhstan	94,600	8.3%	7,851	10,113	6, 786	67%	73%	15,942	333	255
	Kyrgyz Republic	25,000	14.3%	3,100	1,971	840	27%	89%	796	92	56
	Lao PDR	*1,694*	7.40%	124	-	-	-	-	-	-	-
	Nepal	30,867	2.8%	798	-	-	-	-	-	-	-
	Philippines	7,400	29%	2,146	26.90%						
	PNG	-	-	-	-	-	-	-	-	-	-
	Tajikistan	22,200	12.1%	26,868	1,831	1,216	66%	89%	18,017	81	63
	Thailand	25,620	15.1%	3,950	2377	1716	72%	*80%*	8,869	199	209
Priority Pop	Cambodia	TG: 6,500	9.6%	624					4,709	270	268
	India	TG: 70,000	3.14%	*2,198*	*1,486*	*1,358*	91.4%	-	49,000	289	214
	Indonesia	TG: 34,695	11.9%	3,633					15,558	503	
	Nepal	TG: 21,460	12%	*NA (TG combined with MSM)*	-	-	-	-	171	124	127
		MSW: 18,287	7.4%	784	-	-	-	-	94	95	101
		Clients of FSW: NA	0.3%	2,318	-	-	-	-	5,556	371	461
		Migrants: NA	0.4%	9,804	-		-	-	119	35	50
	Philippines	TG: 190,000	3.9%	7,410							
	Thailand	*TGSW:* 20,343	9.45%	2,381	-	-	-	-	-	-	-
		MSW: 18,785	7.67%	2,671	-	-	-	-	-	-	-

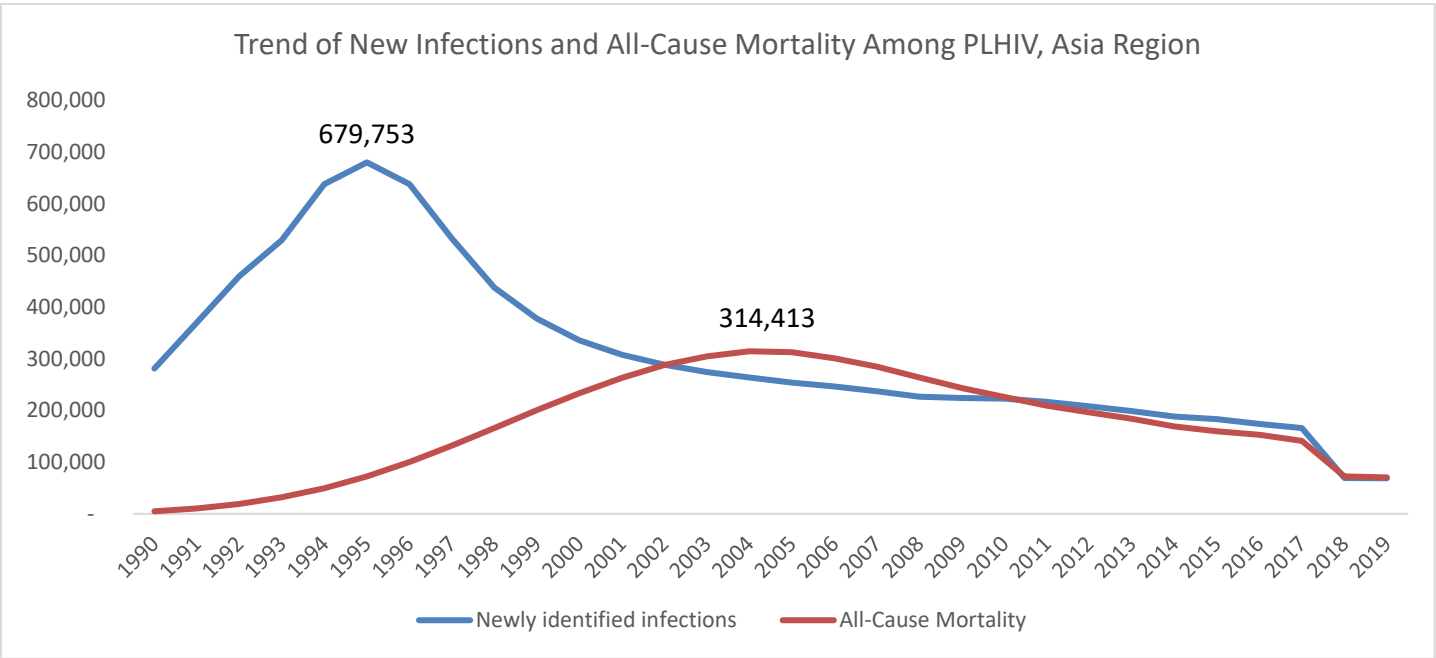
	Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression (updated for ROP21 for all countries)										
	Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Country	Total Pop. Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Sources & Notes	***Burma***: Updated for all populations except men and women 25+; 2019 national estimates by AEM; National Strategic Plan on HIV and AIDS (2021-2025); Annual Progress Report, NAP (2019) ***Cambodia:*** Updated for all populations; the required Age and Sex distributions were calculated by using proportions of age and sex retrieved from national ART database 2020 for PLHIV, PHIV diagnosed, PLHIV on ART. EAM 2020 used for total population ART coverage and viral load suppression. Key population testing, positives identified and initiated on ART data based off prevention database. ***India***: Updated for all populations; UNAIDS Data Hub 2020; National AIDS Control Organization (2019-20). Annual Report; ; National AIDS Control Organization (2017, 2020).Total population, FSW, MSM, HIV testing and linkage to ART within the last year calculated for April-September 2020. Sankalak: Status of National AIDS Response; Integrated Bio Behavioural Survey (IBBS) 2014-15; HIV Estimates Report 2019 Note: ART coverage among PWID 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***: Updated for all populations; HIV Quarterly Report of HIV and STIs Program, MoH (Dec 2020); What's the difference? Understanding measures of progress towards 90–90–90, UNAIDS, 2017. ***Kazakhstan***: Updated for all populations; National Statistics Agency, as of Jan 01,2020; EHCMS; Spectrum 2021 draft ***Kyrgyz Republic:*** *Updated for total population and population < 15 yrs only.* National Statistics Agency, Spectrum/AIM (2021) outputs EHCMS; IBBS RAC Report 2016. ***Lao PDR***: Updated for all populations; HIVCAM database 2020, Center for HIV/STI, Laos MOH. ***Nepal:*** Updated for all populations; National HIV estimates 2020; Routine program data reported for Nepal Country Progress Report 2020 (Global AIDS Monitoring, HIV Epidemic Update of Nepal, FACT SHEET, 2020); EpiC Nepal Routine Program Report 2020 ***Philippines:*** Updated. www.aidsinfo.unaids.org, 2019 data; HARP report, December 2020; 2018 for total population HIV testing and linkage to ART https://www.indexmundi.com/philippines/demographics_profile.html; PEPFAR Epi-Aid, 2020; GF Grant Application, 2020. ***PNG:*** Updated for all populations, except PWID. Spectrum Estimations, HIV Patient Database (HPDB), and HIV Surveillance Database. ***Tajikistan:*** Updated for total population and population < 15 years only. National Statistics Agency, As of Jan 01, 2020; EHCMS; PSE 2015 (MSM) and 2018 (PWID and SWs); IBBS 2017 (MSM) and 2018 (PWID and SWs). ***Thailand***: Updated for all populations. AIDS Epidemic Model (AEM, April 2020) and National AIDS Program Report (NAP, October 2020, HIV tested, HIV, positive and ART initiation in year 2020); All newly initiated ART included prior diagnosed in past years and newly positive diagnoses in year 2020 who initiated ART in 2020.										

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), updated for ROP21.



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, updated for ROP21 (with the exception of India, Kazakhstan, Kyrgyz Republic, Philippines, and Tajikistan)
(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 Treatment Continuity

ROP21 UPDATES

Tier 1: Sustain the Gains

Burma, Cambodia, Kyrgyz Republic, Nepal, Tajikistan, and **Thailand** will scale up best practices, including client-centered approaches implementing and expanding MMD, TLD transition, TPT, differentiated service delivery, and high yield KP case finding strategies, including index testing, SNS, enhanced peer outreach, and HIV self-testing**. Kyrgyz Republic, Nepal, Cambodia,** and **Thailand** will improve quality of HIV services through strengthening of CSOs and CLM and support to community HIV self-testing **(Thailand, Nepal). Burma, Nepal,** and **Kyrgyz Republic** will scale up and institutionalize PrEP.

In **Thailand**, new ROP21 activities will focus on the use of new lab technology for TB case finding, development of digital health solutions to reduce lab workload, use of community monitoring data for quality improvement, expansion of S&D e-learning among health care providers, and further expansion of Bangkok's telehealth system to ensure ART continuity in the context of COVID-19. Support to CBOs will focus on assisted HIV self-testing, Online2Offline booking for health services, telehealth, community-based DSD (e.g., PrEP, ART, and VL testing), and development of social enterprises. Advocacy with the NHSO for expansion of HIV services qualifying for CBO reimbursement will continue**.**

Nepal will scale up DSD, including same-day and point of diagnosis ART initiation and community-based ART; increase adherence and returning known positives to ART; implement an advanced HIV disease package; strengthen the one national health information system; expand recency testing; increase VL coverage in PEPFAR districts; and expand e-LMIS for forecasting, quantification and supply of HIV commodities**.**

Kyrgyz Republic will expand DSD and HIVST involving pharmacies, diversified financing solutions to support CBO sustainability efforts, and introduce CLM in four PEPFAR regions. The program will improve provider capacity to respond to emerging health needs, e.g., online/virtual services during the pandemic, or reach new subgroups. **Kyrgyz Republic** will expand mixed method case finding approaches, granular data analysis and risk/case profiling, as well as expansion of online/virtual services.

Given the current political situation, **Burma** will shift its strategy to identify 50% of new PLHIV through index testing and share best practices for Index Testing with GF and other CSO partners who are leading DSD in the changing landscape. **Burma** will ensure the continuity of HIV services by adapting services at PEPFAR sites, providing care for patients from the national ART cohort at PEPFAR sites and coordinating with major donors and their NGO and CSO partners to fill gaps in the HIV services cascade.

Tier 2: Accelerate and Achieve

In Philippines, 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. Countries will increase efforts for case finding of hard-to-reach KPs through index testing and other modalities and improve client experience and treatment outcomes to increase treatment continuity rates and reduce treatment interruption. Working in concert with host governments and stakeholders such as GF, WHO, UNAIDS, civil society**, Philippines, India,** and **Lao PDR** will scale up quality, client-centered treatment options to impact adherence and treatment continuity, which comprise facility and community-based strategies for service delivery, including MMD, SDART and TLD transition**. Philippines** is adapting HIV services to online platforms, including demand generation and counseling, and will scale up these activities in ROP21. **India** will build on its success in MMD and client-centered decentralized ART delivery and emphasize an integrated strategy approach including SDART/rapid ART, single window prevention, testing and treatment services for KPs and PLHIV to impact linkage loss and treatment interruption. Lessons learned

under PEPFAR from integrated community-led transgender clinics in Manipur and Telangana on linkage and continuity will be shared and scaled. **Lao PDR** will scale up and institutionalize PrEP, integrate surveillance of recent infections into national HMIS, establish HIV serology EQA program at all ART sites and provincial hospitals, and establish a local VL EQA program to strengthen VL decentralization. **Philippines** and **India** will improve quality of services through institutionalizing CQI approaches and strengthening CSOs and CLM**. India** will continue to scale up demonstrated efforts to maintain TX_CURR despite COVID interruptions, through multiple strategies, such as granular analysis of site-level data, spatial data representation, client centered ART distribution using telehealth and active follow up of treatment interruption.

Tier 3: Maintenance/Protect the Investment:

Indonesia, Kazakhstan, and **PNG** will continue to focus on activities that support PLHIV on ART and ensure ART beneficiaries achieve and maintain VL suppression. All countries will continue to strengthen and expand safe and ethical index testing. **Indonesia** will prioritize targeted HIV testing --specifically PITC for TB and STI clients and VCT for key and priority populations, and support the national program to disaggregate, record and report PITC modalities by population type in an effort to illustrate the impact of more targeted approaches. The program will introduce up to three HIV community-based screening/HIV self-testing (HIVST) intervention models, in partnership with the UNITAID STAR-III initiative in Jakarta and Greater Jakarta. In **Indonesia** and **PNG**, PEPFAR teams will accelerate ART coverage in PEPFAR priority SNUs by scaling up quality, client-centered treatment options to impact adherence and treatment continuity, which comprise facility and community-based strategies, including MMD, SDART and TLD transition. To increase ART initiation and continuity among PLHIV, **PNG** and **Indonesia** will use active case management to support PLHIV on ART, provide TA and monitor HIV commodities including ARVs, testing and VL supplies. VL testing will continue to be amplified in Indonesia through dedicated specimen transport systems; improved testing turns around times; strategic partnerships with the private sector; and comprehensive U=U communications through a variety of channels. **Indonesia** will also introduce an advanced HIV disease TA package at high-burden hospitals, strengthen TB screening for PLHIV, and support the finalization of PrEP guidelines. **Indonesia** and **PNG** will improve quality of services through strengthening of CSOs and CLM. **Kazakhstan** will work in several new areas, including MSM case finding, introduction of DDD, and granular site management. **PNG** will implement a back to care (BTC) campaign to bring back those who have experienced treatment interruption. **PNG** will also scale up the use of data to track those who have or are at risk of missed appointments to ensure increased adherence and continuity of treatment. Additional activities include case profiling to identify factors that contribute to adherence and treatment continuity challenges, as well as scale up DSDM for increased uptake and coverage of HIV service provision.

The following section describes 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[1] 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

[1] 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.

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; the Community Action Approach supports adherence and improve retention, community volunteers and community engagement on quality improvement of ARV services 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 treatment interruption. 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.

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

ROP21 UPDATES

In ROP21, the ARP's annual investment profile is unclear since many countries do not have updated data.

Updates regarding procurement of key commodities: In 2020, the Government of **Nepal** procured 100% of ARVs and HIV Test Kits as compared to 2019 when GF procured 100% of ARVs; PEPFAR and GF only supported emergency supplies of ARVs, including for the TLD transition. The Government of the **Philippines** (GOP) currently funds all ARV procurement apart from the current stock of TLD, procured by the GF for ART-naïve clients for 2021-2022 (currently a total of 197,260 bottles/30 bottles/30 tabs for ~15,000 clients/1 year). No comprehensive assessment of HIV investments has been done in recent years, and there are significant knowledge gaps, particularly in subnational public investment.

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, updated for ROP21

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	$37,853,196	5%	55%	40%	1%
	Cambodia	$12,379,018	1%	54%	40%	5%
	India	$500,000,000* (Not disaggregated by Program Area)	3%	10%	87%	-
	Indonesia	$32,394,219	18.3%	18.4%	63.3%	$32,394,219
	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	$3,566,237	18%	10%	72%	0.3%
	Philippines	-	-	-	-	-
	PNG	$6,253,012	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	$13,218,195	59%	41%	-	-
	Cambodia	$3,138,085	-	96%	-	4%
	Indonesia	$6,789,157	3.3%	96.7%	-	-
	Kazakhstan	$3,680,797	11.1%	1.2%	87.7%	-
	Kyrgyz Republic	$4,477,226	50.6%	49.4%	-	-
	Lao PDR	-	-	-	-	-
	Nepal	$2,710,870	30%	70%	0.3	-
	Philippines	-	-	-	-	-

	PNG	-	-	-	-	-
	Tajikistan	$1,060,624	81.1%	17%	1.9%	-
	Thailand	-	-	-	-	-
PMTCT	Burma	$0	0%	0%	0%	0%
	Thailand	$3,218,723	0.11%	-	99.69%	0.19%
	Nepal	$58,596	-	92%	8%	
HTS	Burma	$7,324,889	20%	80%	0%	0%
	Cambodia	$2,172,275	58%	27%	2%	12%
	Indonesia	$13,537,162	2%	8%	90%	-
	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)	$2,762,822	51%	0%	27%	22%
	Philippines	-	-	-	-	-
	PNG	$895,500	-	16%	74%	10%
	Tajikistan	$1,914,110	56.9%	43.1%	0%	0%
	Thailand					
Priority Populations	Burma	$-	0%	0%	0%	0%
	Cambodia	-	-	-	-	-
	Indonesia	-	-	-	-	-
	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	1,340,857	-	82%	18%	-
	Philippines	-	-	-	-	-
	PNG	-	-	-	-	-
	Tajikistan	$487,027		53.5%	46.5%	
	Thailand	$20,583,728	1.95%	4.18%	93.64%	0.24%
Key population prevention	Burma	$23,834,529	16%	56%	4%	23%
	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	2,665,568	23%	69%	8%	-
	Philippines	-	-	-	-	-
	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	Burma	$1,865,715	-	100%	-	-
	Cambodia	$233,117	-	-	-	-
	Kazakhstan	$752,488	-	-	100%	-
	Nepal	212,952	-	100%	-	-
	Tajikistan	$8,680	-	91%	9%	-

Laboratory	Burma	$1,289,292	98%	2%	0%	0%
	Cambodia	$1,771,042	21%	77%	-	2%
	Indonesia	$1,201,993	10%	90%	-	-
	Kazakhstan	$1,269,331	3.4%	-	96.6%	-
	Kyrgyz Republic	$871,225.00	38.4%	60.5%	1.1%	-
	Lao PDR	-	-	-	-	-
	Nepal	$918,990	76%	14%	8%	2%
	Philippines	-	-	-	-	-
	PNG	$485,500	9%	15%	76%	-
	Tajikistan	$354,924	100%	-	-	-
	Thailand	-	-	-	-	-
SI, Surveys and Surveillance	Burma	$3,173,518	38%	59%	1%	2%
	Cambodia	$2,838,271	36%	16%	41%	6%
	Indonesia	$5,859,816	36%	17%	47%	-
	Kazakhstan	$2,408,768	5.8%	-	94.2%	-
	Kyrgyz Republic	$476,946	50.2%	13.1%	7.2%	29.6%
	Lao PDR	-	-	-	-	-
	Nepal	$195,472	72%	0%	9%	19%
	Philippines	-	-	-	-	-
	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	$7,618,755	52%	46%	1%	2%
	Cambodia	$6,450,900	29%	1%	53%	17%
	Indonesia	$9,281,745	30%	1.5%	68.5%	-
	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	$1,617,562	11%	58%	27%	4%
	Philippines	-	-	-	-	-
	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 World Bank (WB).
***Indonesia*:** 2016 NASA, in consultation with UNAIDS; GF confirmation from country team; PEPFAR 2019 Expenditure Reporting.
Kazakhstan: GFATM Funding Request 2020; KSCDID 2020; UN agencies allocation and expenditures table 2020
***Kyrgyz Republic*:** National AIDS Center consolidated expenditure report 2018 with updated numbers for 2019.
Lao PDR: Consolidated expenditure report 2018.
***Nepal*:** Expenditure data reported to GAM 2020, all amounts in USD.
Philippines: Expenditure data not available to country team.
***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	$26,403,895	-	43%	57%	-
	Cambodia	$6,775,691	-	78%	22%	-
	India*	Unknown	-	50%	50%	-
	Indonesia	$44,076,760	-	2%	98%	-
	Kazakhstan	$15,099,000	-	-	100%	-
	Kyrgyz Republic	$941,403.00	-	54.3%	46.0%	-
	Lao PDR	$919,074	0%	100%	0%	0%
	Nepal	$2,576,461	6%	14%	80%	-
	Philippines	-	-	-	-	-
	PNG	$465,668	0%	100%	0%	0%
	Tajikistan	$673,145	-	100%	-	-
	Thailand	$118,525,734	0.42%	0.86%	98.71%	-
Rapid test kits	Burma	$572,289	-	100%	-	
	Cambodia	$1,528,683	-	100%	-	-
	India	Unknown	-	100%	-	-
	Indonesia	Unknown	-	-	100%	-
	Kazakhstan	$157,000	-	-	100%	-
	Kyrgyz Republic	$683,756	6.9%	29.8%	63.4%	-
	Lao PDR	$185,392	14%	86%	0%	0%
	Nepal	$1,261,594	11%	32%	56%	3%
	Philippines	-	-	-	-	-
	PNG	$1,693,329	0%	100%	0%	0%
	Tajikistan	$270,765	-	100%	-	-
	Thailand	$6,011,778	26.9%	3.36%	69.63%	0.11%
Other drugs	Burma	$2,871,435	-	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	$197,037	0.4%	99.6%	-	66%
	Philippines	-	-	-	-	-

	PNG	$1,250,030	0%	100%	0%	0%
	Tajikistan	$165,595	-	49.7%	50.3%	-
	Thailand	$2,127,189	0.15%	-	99.85%	-
Lab reagents	Burma	$1,333,022	-	100%	-	-
	Cambodia	$210,991	-	100%	-	-
	Indonesia	Unknown	-	-	100%	-
	Kazakhstan	$4,678,000	1%	-	99%	-
	Kyrgyz Republic	-	-	-	-	-
	Lao PDR	-	-	-	-	-
	Philippines	-	-	-	-	-
	PNG	$612,744	0%	100%	0%	0%
	Tajikistan	$40,471	-	100%	-	-
	Thailand	$47,121,711	1.42%	-	98.58%	-
Condoms	Burma	$549,177	0%	100%	-	-
	Cambodia	$163,719	-	100%	-	-
	India	Unknown	-	100%	-	-
	Indonesia	$464,483	-	100%	-	-
	Kazakhstan	$631,000	-	-	100%	-
	Kyrgyz Republic	$490,633	-	95.9%	-	4.1%
	Lao PDR	-	-	-	-	-
	Nepal	$69,121	68%	32%		
	Philippines	-	-	-	-	-
	PNG	$2,423,803	0%	100%	0%	0%
	Thailand	$1,084,654	-	10.45%	89.55%	-
VL commodities	Burma	$1,124,365	-	100%	-	-
	Cambodia	$2,157,600	3%	97%	-	-
	Indonesia	Unknown	-	-	-	-
	Kazakhstan	$659,000	-	-	100%	-
	Kyrgyz Republic	$597,023.00	-	100.0%	-	-
	Lao PDR	-	-	-	-	-
	Nepal	$372,112	62.4%	34.2%	0.4%	3.2%
	Philippines	-	-	-	-	-
	PNG	Unknown	-	-	-	-
	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	-	-	-	-	-
	Philippines	-	-	-	-	-
	Thailand	$982,301	-	-	100%	-
Other commodities	Burma (Health Equip.)	$4,036,250	-	100%	-	-
	Cambodia	$26,864	100%	-	-	-
	India	Unknown	-	100%	-	-
	Indonesia	Unknown	-	-	100%	-

	Kazakhstan	$633,000	2%	-	98%	-
	Nepal	$2,799	100%			
	Philippines	-	-	-	-	-
	PNG	$82,079	0%	100%	0%	0%
	Tajikistan	$33,815	0%	100%	0%	0%
	Thailand	$78,776	-	100%	-	-
Total	All Countries	$308,151,209	-	-	-	-

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.
***Indonesia*:** 2016 NASA, in consultation with UNAIDS.
Kazakhstan: GFATM Funding Request 2020; KSCDID 2020; UN agencies allocation and expenditures table 2020.
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*:* Commodities report submitted to GAM 2020, all amounts in USD.
Philippines: No expenditure data available to country team.
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

ROP21 UPDATES

Only one country, **Nepal**, conducted a Sustainability Index Dashboard (SID) in 2020-2021. Results will be shared once the findings have been validated with stakeholders.

In ROP21, PEPFAR **Cambodia** will work with UNAIDS, WHO, and CHAI to ensure that the current GF grant (2021-2023) funds will address the low score areas of the SID by transitioning commodity security and supply chain to the national program. PEPFAR/**Nepal** participated in the development of the GF's sustainability plan by its principal recipient, Save the Children.

Continued severe government shortfalls in income in **PNG,** compounded by the COVID-19 pandemic response, have again reduced the NDoH budget. PEPFAR **PNG** is working closely with all stakeholders in sustaining the COVID-19 response and taking necessary steps to mitigate impacts on PLHIV accessing care and treatment services.

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

ROP21 UPDATES
In all 12 ARP countries, PEPFAR investments are aligned to the disease burden geographically. Six countries have updates to ROP20 as either geographic areas changed or new epidemiologic data are presented. In addition, please refer to Figures 2.5.1 in Appendix 1, which present maps by country program (Burma, Indonesia, and Philippines have been updated for ROP21; others remain unchanged from ROP20).

In **Cambodia**, PEPFAR expanded its focus from four to eight provinces (Phnom Penh, Battambang, Banteay Meanchey, Siem Reap, Kandal, Kampong Cham, Kampong Speu and Sihanouk Ville), accounting for more than 80% of PLHIV in the country.

In **India**, PEPFAR will develop and implement life-saving interventions focusing on key and vulnerable populations in the 42 highest priority districts of 6 states (Maharashtra, Telangana, Andhra Pradesh, and the North East [NE] states of Mizoram, Manipur, and Nagaland) with the highest HIV burden, prevalence, or HIV incidence. Interventions will focus on community informed prevention among KPs, and ART, treatment continuity, and VLS among all PLHIV.

Indonesia will provide TA at above site and site levels in 13 districts in Jakarta and Greater Jakarta. Eight districts in Greater Jakarta were ASAP districts that will become part of ROP21. The 13 districts account for 19% of the national estimated number of PLHIV. In close collaboration with the GF, UNAIDS, and WHO, Indonesia will develop and operationalize community-based screening in the priority sites, improve treatment continuity, and accelerate VLS.

Nepal will support a total of 37 districts, with DSD (26 districts with a full package of HIV prevention, care, treatment, and VL testing services) or TA-SDI (11 districts) support. The program will focus on increasing VL testing coverage, reducing IIT, and increasing treatment continuity across the cascade as part of efforts to accelerate the number of PLHIV on treatment

In the **Philippines**, HIV cases from five regional areas (National Capital Region [NCR], CALABARZON, Central Luzon, Central Visayas, and Western Visayas) make up over 80% of all reported cases in the country. In the 2018 BBS, HIV prevalence was estimated to be 5.9% among MSM and transgender women (TGW) who ever had anal sex across 13 sites. Estimated HIV prevalence among PWID was reported to be 25.2% among women and 42.3% among men (data only available from Cebu City and Mandaue City in Central Visayas, 2015 BBS). Lastly, the HIV prevalence among FSW ranged from 0.02% to 0.3%.

In coordination with RTG and GF, PEPFAR **Thailand** continues to focus its investment in 13 high-burden provinces, in which 56% of all new HIV-infections occur, and where 57.8% of new MSM and TG infections will occur. Targeted interventions include PrEP expansion among most-at-risk MSM and TG in 11 provinces.

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 present 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

ROP21 UPDATES
Across the 12 ARP countries, the development of ROP21 was a participatory process which included consultation with all the key stakeholders of the HIV national response. Between January and May 2021, each country held events attended by a range of key stakeholders, including MOH, CSOs, GF, UNAIDS, WHO, WB, and the private sector. Teams introduced the priorities for the next year and provided the opportunity for all participants to inform ROP21 development. A particular area of discussion during many of these meetings was community-led monitoring, which participants strongly supported as a real demonstration of PEPFAR's commitment to empowering communities. In January-February 2021, and again in April 2021, PEPFAR ARP hosted several separate regional stakeholder meetings that brought together CSOs, to discuss their unique needs across the region. These important stakeholders recognized the significant movements that were made to ensure that KP communities are able to meaningfully engage with the PEPFAR processes to design and support services to address their health and human rights needs and made specific recommendations for KPs and PLHIV, including building capacity for KP-focused differentiated services for prevention, care, and treatment, and sustainable organizational development through south-to-south CSO exchanges and targeted regional TA. Please refer to Appendix D for the CSO recommendations and regional responses. PEPFAR teams continued to be engaged in completing the next round of GF applications and coordinating with UNAIDS, as well as participating in discussions on GF COVID-19 mitigation plans.

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.

GF 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.

ROP21 UPDATES

2.7 Stigma and Discrimination

The Philippines has a complex legal framework that creates potential barriers to access to services based on stigma and discrimination for key populations, including punitive drug policies that can inhibit risk disclosure. The HIV/AIDS Act of 2018 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. Alternative case finding and testing strategies, such as self-testing and social network strategies, will be pursued to increase access for key populations. Safe and ethical index testing training will include provider screenings for intimate partner violence and will ensure appropriate elicitation of contact information. Additionally, cultural and religious taboos and stigma have worked against creating normative use of condoms outside of sex work. PEPFAR will provide client-centered care and KP-friendly services to reduce stigma and discrimination. For example, providers will be trained on U=U messaging to decrease stigma associated with sero-discordant sexual relationships. PEPFAR will engage KP groups and civil society organizations in the implementation of community-led monitoring activities to improve service quality and reduce provider stigma and discrimination. PEPFAR will also support facilitation of a multi-level stigma and discrimination training of trainer with military leadership, military healthcare workforce, troops, and military PLHIV using evidence-based materials. The program will also work closely with military leadership to establish a working-group/committee comprised of Ministry of Defense, military services (e.g., Army, Navy, Air Force), and military health care providers to review current military policies related to HIV and to steer a draft Code of Conduct and Action Plan through an appropriate review and approval process to final launch.

In collaboration with UNAIDS, **Kazakhstan** will develop a new stigma and discrimination reduction plan that will incorporate findings of the Stigma Index survey of 2021.

Community-led monitoring will be a key strategy for PEPFAR **PNG** to mitigate stigma and discrimination. Additionally, PEPFAR will implement new measures in supported facilities to reduce stigma and discrimination through client education and counseling on patients' rights to respectful high quality care, the introduction of codes of conduct prohibiting discrimination by facility staff, and continued training and monitoring in sites. **PNG** will also identify well-performing sites and develop mentorship opportunities for lower-performing sites to improve HIV service provision quality and decrease stigma and discrimination.

3.0 Geographic and Population Prioritization

ROP21 UPDATES

Across the 12 countries, PEPFAR Asia Region will support 171 SNUs, of which 2 are "attained"; 13 are "scale up to saturation"; 106 are "aggressive scale up"; 2 are "sustained"; and 25 are "central support". The Asia

Region added 4 SNUs for ROP21. Six countries (**Cambodia, Kazakhstan, Tajikistan, the Kyrgyz Republic, Lao PDR**, and **PNG**) will maintain support to the same prioritization and number of SNUs as in ROP20. **Thailand** will maintain 2 "attained" SNUs, transition 5 "sustained" and 2 "scale-up aggressive" SNUs to "scale-up saturation" and target 2 SNUs for "scale-up aggressive." Burma will target 25 SNUs for "scale up aggressive." **India** will support 40 districts; of these, 3 are "scale up to saturation" and 37 are "aggressive scale up." Based on 2019 Spectrum estimates, PLHIV estimates for the 4 ROP20 "attained" districts were revised and increased resulting in their change to "saturation/aggressive" prioritization in ROP21. Indonesia will expand from 5 "sustained" SNUs to 13 "scale-up aggressive" SNUs, and Nepal from 35 to 37 "scale-up aggressive" SNUs. The Philippines will support 5 SNUs with aggressive scale-up.

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 (Updated for ROP 21)

	Table 3.1.1 Current Status of ART saturation updated for ROP21				
Prioritization Area	**Country**	**Total PLHIV/% of all PLHIV for ROP21**	**# Current on ART (FY20)**	**# of SNU ROP20 (FY21)**	**# of SNU ROP21 (FY22)**
Attained	India	-	-	4	-
	Thailand	21,015	18,945	2	2
Scale-up Saturation	India	43,171	26,302	2	3
	PNG	6,412	5,047	1	1
	Thailand	108,710	92,241	2	9
Scale-up Aggressive	Burma	N/A*	9,594	36	25
	India	584,576	319,155	32	37
	Indonesia	103,125	34,155	0	13
	Kyrgyz Republic	7, 631	3,172	4	4
	Lao PDR	10,691	7,772	5	5
	Nepal	30,301	19,827**	35	37
	Philippines	86,000	35,409+++	0	5
	Tajikistan	8,670	4,780	3	3
	Thailand	91,069	56,139	4	2
Sustained	Indonesia	-	-	5	0
	Kazakhstan	6,158	3,699	2	2
	Thailand	-	-	5	0
Central Support	Cambodia	74,918	62,110	25	25
Total		1,174,816	634,365	167	171

**No Township (prioritized SNU) level data are available.*
***Includes national contribution.*
++2 SNUs that only provide HTS services are excluded.
+++ HARP, April - June 2020 (Manila, Regions 4A, 3, and 7 total 56,215; Region 6 was estimated to be ~4,000)

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

ROP21 UPDATES

All 12 countries will continue emphasis on differentiated case finding strategies for KPs, primarily through the scale up of index client and partner testing and HIV self-testing, 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. Given the devolving security

situation, civil disobedience movement, and closure of many government clinics, **Burma** will shift its strategy to identify 50% of new PLHIV through index testing. The other 50% of testing will focus on other high-yield mobile testing where possible, facility based testing, and HIV screening at 10 high volume private sector sites. **Cambodia** has been implementing HIV Index case testing through the Partner Notification Testing and Tracing (PNTT) program, with a yield of 51% among partners who were tested. The Peer Driven Initiative testing (PDI+) for MSM and TG has resulted in a yield of 6%. **Cambodia** has a linkage to treatment rate of 94%. In **India,** ROP21 will build on routine granular analysis and innovative strategies to reach young KP, adolescents, and children (including through family-based programming). Continued coordination between prevention, treatment and OVC partners will be emphasized and teams will also leverage support from GF partners. Where client elicitation has been challenging among KP (MSM, FSW, and TG women), India will continue to train counselors and communities on social network models/enhanced peer outreach approach (EPOA)-focused strategies, and how the SNM and index testing strategies may be blended to increase case finding that is targeted and efficient. In the **Kyrgyz Republic**, PEPFAR case finding contributed to 369 of the new HIV cases found in FY20 in the 4 PEPFAR SNUs.

HIVST continues to expand within the region (**Philippines, Cambodia, Indonesia, India, Kazakhstan, Kyrgyz Republic, Thailand,** and **Nepal**) using facilities, peer outreach, online approaches and other client distribution services (e.g., pharmacies). Following a HIVST pilot in **Cambodia**, PEPFAR will work with NCHADS to scale up HIVST from Phnom Penh to an additional three high KP burden provinces in ROP20 and nationwide in ROP21. India will scale up assisted HIVST and virtual outreach for clients seeking anonymity, partnering with preferred providers among KP. The learnings of this model will lead to the development of the National HIVST policy. Linkage strategies for assisted and unassisted self testing, as well as virtual support for clients using self testing, will be emphasized in ROP21. In partnership with the UNITAID STAR-III initiative, **Indonesia** will introduce up to three HIV community-based screening/HIV self-testing (HIVST) intervention models which will provide 25,000 HIVST kits for PEPFAR implementing partners in Jakarta and Greater Jakarta. **Kyrgyz Republic** will expand HIVST strategies including integration of HIVST into facilities and other client distribution services (e.g., pharmacies, online, and via index testing. **Nepal** has proposed a target of 12,000 for HIV self testing in ROP21, which is a 100% increase from the ROP20 target. **Thailand** will continue to enroll participants in the first assisted HIVST pharmacy-delivered model, analyze data, disseminate results, and support HIV ST guideline development.

SDART and other approaches to enrolling PLHIV on ART and identifying those at risk for treatment interruption continue to be strengthened. The Government of **India** has adopted s-DART/rapid ART as national policy and the implementation of integrated models and decentralized ART initiation is striving to bridge the linkage loss among PLHIV. With rapid or SDART now being implemented across Jakarta, **Indonesia** will direct TA efforts to systematizing this practice across Greater Jakarta and expanding its utilization across the national program. TA will emphasize the adaptation and operationalization of standard operating procedures, district-level clinical mentoring, and the systematic use of the national cohort system (ARK 6.0) for rapid ART tracking and continual quality improvement. **PNG** will increase the use of data to track those who experienced treatment interruption to bring them back into care. For those who are newly diagnosed, increased focus will be on Test and Start to address barriers to same-day ART. Additionally, **PNG** will monitor under-performing clinics to provide additional TA. Client-centered approached will be scaled up, including increasing the amount of counseling time between providers and patients, encouraging health care workers to walk with patients to pick up medication, and mentorship among high-performing sites to lower-performing sites.

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 14 days (2020). 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

ROP21 UPDATES
Across the 12 countries of ARP, PEPFAR will continue to support existing activities to retain clients on ART and ensure VLS through identifying those at risk for treatment interruption, utilizing peer educators, navigators, health care workers, and case managers—including those working virtually in the COVID-19 context--to assist and track PLHIV through the clinical cascade and re-engage those treatment

interruptions in care, and scale-up and expand progress toward MPRs including SDART, DSD, MMD, TLD, TPT, and promotion of viral load literacy activities including U=U.

In **Cambodia,** NCHADS incorporated the intensive chart review activities (CamBlitz) into the national continuous quality improvement (CQI) program, and the SOP for re-engagement of patients who miss an appointment to re-engage within 28 days was developed, disseminated and is now being implemented. **Burma** will emphasize DSD through CSOs, NGO partners, private sector, a peer-led case management model, and introduction of the Johns Hopkins Common elements treatment approach (CETA) in peer-led mental health. **Indonesia** will emphasize decentralized drug distribution through the PEPFAR-developed Jak Anter initiative, using ride-based apps to transport antiretroviral medicines directly to PLHIV; this approach will be intensified across Jakarta and Greater Jakarta to ensure treatment continuity within the context of COVID-19. Indonesia also plans to strengthen enhanced and virtual case management to help PLHIV clients overcome structural and social barriers to partner notification, ensure timely links to treatment, and assist newly diagnosed or reengaged ART clients to establish and maintain long-term treatment compliance. **India** will build on routine granular analysis and innovative strategies to reach young KP, adolescents, and children (including through family-based programming). Continued coordination between prevention, treatment and OVC partners will be emphasized, and teams will also leverage support from GF partners. Virtual outreach using locally targeted strategies will continue to provide additional outreach to persons living with, at risk, or affected by HIV.

In the **Philippines**, PEPFAR will promote return to care strategies and support treatment adherence through case management. Additionally, **Philippines** plans to implement client-centered interventions including motivational counseling, differentiated ART delivery, CQI, and provide TA to manage advanced HIV disease. The promotion of U=U messaging, as well as POC and near-POC VL monitoring will contribute to increasing VL testing coverage for clients to reach and maintain VL suppression. In ROP21, **PNG** will utilize a highly effective three-tier system for active case management, expanding new data-driven track and trace activities, and initiating DSDM models for ART dispensing. **PNG** also will utilize evidence-based IIT prevention and BTC strategies, including utilizing case profiling and risk modeling, to alert providers of those at high-risk to IIT, providing differentiated approaches to retain patients on treatment (e.g., social support groups, mother groups, and others), increasing counseling time between providers and patients, and expanding DSDM and community models for ART provision.

PNG will implement VL surge campaigns, as well as routine and mobile VL testing modalities to increase testing coverage for eligible PLHIV. Surge campaigns are planned for quarterly implementation with activities to support laboratory and supply assessments, microplanning, U=U messaging, and sample collection. Additionally, through collaboration with the GF, PNG plans to support diagnostic lab optimization activities to determine VL testing capacity for HIV for increased coverage.

India will focus on (1) continued transition to TLD (including pediatric cohorts, (2) coordination with GF partners on systematic tracking and tracing of treatment interruption to re-engage PLHIV in care, (3) implementation of advanced disease management (ADM) packages (including improved TB diagnosis), (4) integration of TB TPT into DSD models and applying lessons learned from COVID, and (5) decentralized drug distribution through community-based sites and use of peripheral health systems for drug delivery. **India** will also engage and leverage faith-based organizations to disseminate messages around HIV prevention and ART services in the NE states of Mizoram, Manipur, and Nagaland. **India** will increase emphasis on family-centered pediatric services and decentralized models to specifically address challenges around service delivery and uptake. Adolescent- and youth-specific services, including integration with national adolescent program (CDC-UNICEF) will be prioritized. COVID mitigation is further informing CQI efforts, and **India** will coordinate IPC efforts to leverage the work of TB partners around airborne infection control. Large ART centers will be the target of site safety and CQI, and support will be provided to improve administrative, environmental, and structural approaches to IPC. In addition, while the TG persons bill has passed, more needs to be done to realize full care. Understanding the importance of TG

integrated strategies, lessons learned under PEPFAR from integrated community-led transgender clinics in Manipur and Telangana on linkage and continuity will be shared and scaled.

Access to VL testing and subsequent viral suppression will be improved through identification of those at risk, DNO activities, including participation in HIV VL EQA/PT programs (**Kyrgyz Republic**) demand creation with U=U messaging, and enhanced adherence counseling. The **Kyrgyz Republic, Kazakhstan**, and **Tajikistan** have identified viral non-suppression was among documented KPs and younger men, and in ROP 21 **Kyrgyz Republic** will support rapid situational analysis and mapping to better understand and respond to structural barriers for KPs for viral load monitoring and 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 verify reported numbers and to validate documentation practices and their management practices at service delivery sites providing ART and other HIV services. 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. 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 to 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

ROP21 UPDATES

The 12 countries in the Asia Region will continue to tailor and scale up KP programs, specifically targeting MSM, TG, FSW, and PWID, depending on the country-specific epidemiology. This includes investments in interventions that identify newly diagnosed and recent infections (index testing, recency) and prevention of HIV acquisition among at risk populations (PrEP).

Thailand will transition site-level index training support to above site support at PEPFAR-supported (n=13) and GF-funded provinces (n=18). All site and above-site level index testing services will report results in the national database. PEPFAR will work closely with the MoPH and the National Health Security Office to promote monitoring of index testing as part of routine data monitoring. In the **Philippines**, PEPFAR will support safe and ethical index testing, enhanced peer outreach and social networking approaches, and self-testing.

India will strengthen strategies for comprehensive KP prevention including scale up of MAT programs. PEPFAR will expand integrated KP models for single window services by scaling up decentralized community dispensation based on positive experience from co-located ART-MAT Centers and Community ART Refill Groups, and TG wellness clinics. These will serve as the one-stop access point for 'holistic health care'--providing a continuum of essential services including prevention, testing, linkage, treatment, and treatment continuity.

Recency will continue to expand in ARP. In **Cambodia**, HIV recency has been implemented in 66/69 sites, and the SOP to use recency results to detect outbreak and improve programs is being developed. In **Thailand,** implementation is ongoing at 15 Bangkok sites with plans to expand to 19 additional sites in eight provinces in FY22. **Nepal** implemented recency in all sites in ROP20 and will continue in ROP21. **Lao PDR** will scale up recency testing at ART sites in ROP21. Three countries--**Kyrgyz Republic, Tajikistan,** and the **Philippines**--will initiate recency testing; Philippines plans to conduct recency testing on 25% of new positives in 2 SNUs (Regions VI and VII).

PrEP activity expansion is planned for **the Kyrgyz Republic, Lao PDR,** the **Philippines,** and **India.** In the **Kyrgyz Republic,** activities consist of 1) PrEP integration into existing prevention and ART services (including MAT); 2) continued roll-out of PrEP, including DSD model implementation for PrEP delivery with PrEP dispensation at the community level, 3) implementation and integration of e-PrEP into EHCMS, 4) initiation of national discussions on injectable long-acting PrEP with special focus on PWID, and 5) development of a national PrEP training curriculum and plan as well as CBO and HCW trainings with close coordination and collaboration between facility and community level providers. PrEP implementation expansion from one PEPFAR SNU (Vientiane Capital) to two additional SNUs (Savannakhet and Champasak) among MSM and TG at highest risk for HIV in **Lao PDR**. In the **Philippines**, PrEP guidelines were approved in early January 2021. With PEPFAR-procured ARVs augmenting the pool of drugs for the Joint PEPFAR-GF PrEP Distribution Plan, free PrEP will be scaled up by the national PrEP program and stimulate local demand for commercial PrEP. In addition, PEPFAR will support demand creation campaigns for PrEP among MSM, including the use of social media, and advocate for scale up and promotion to other high-risk individuals beside MSM. PEPFAR, in collaboration with GF, will scale up PrEP distribution and demand generation in priority regions. In **India**, the national program has developed draft PrEP technical guidelines, and they are currently under review for finalization by the competent authority.

In ROP21, the India PEPFAR program will demonstrate models of PrEP service delivery and quality assurance both in the private and public sectors.

India will continue to work with children of KPs and linking all children living with HIV (CLHIV) and adolescents living with HIV (ALHIV) in all 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. 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, 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

ROP21 UPDATES
The planning level letter provided some specific directives for ROP21. Selected countries provided comments on these priorities in additions to Table 4.4.1 in Appendix 1.

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

ROP21 UPDATES
HIV-related commodity procurement varies by country. Nepal will procure ARVs for PrEP, syphilis tests and treatment drugs, VL reagents and supplies, HIV self-testing and recency testing test kits, and

laboratory test kits and drugs for AHD not covered by the GF. **Lao PDR** and **Thailand** will purchase VL tests for recency confirmation. **Tajikistan**, **Kazakhstan**, and the **Kyrgyz Republic** will procure HIVST test kits. **Burma** will not purchase any commodities in ROP21. **The Philippines** will procure ARVs for PrEP and provide technical assistance in collaboration with multilateral partners (GF) to strengthen logistic mechanisms to prevent stock outs of critical commodities. **Indonesia** will work closely with WHO and the GF for commodity monitoring at national and sub national level, as well as work closely with CSOs to update commodities data.

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

ROP21 UPDATES

Strengthening cross-technical collaborations and implementation across agencies and with external stakeholders, including UNAIDS and the GF: PEPFAR and GF work closely in **Burma** and **Indonesia** on the implementation and coordination of various strategic activities (i.e., PrEP, index testing, U=U, and HIV/TB co-located services). In **Kyrgyz Republic**, PEPFAR and GF work closely on the implementation and coordination of various strategic activities, i.e., recency testing and index testing, PrEP (UNAIDS is also included), social contracting, financial sustainability (costing analysis, NASA, and results-based financing), HIV strategy evaluation and development of new HIV strategy (GIZ and UNAIDS included). In **Kazakhstan**, PEPFAR and GF worked collaboratively on development and adoption of the Sustainability Roadmap for HIV service delivery. In ROP21, PEPFAR will support several activities to support implementation of the Roadmap, including fiscal space analysis and social contracting for KP-focused HIV services.

Case-based surveillance: In **Kyrgyz Republic,** the EMR roll-out will continue as well as the expanded utilization of EHCMS to serve as a more holistic CBS. This support will include routine data reviews and client follow-up at the sub-national levels as well as granular and real data analysis and response to data trends at the national level.

Ensuring above service delivery activities are mapped to key barriers and measurable outcomes related to reaching epidemic control: In the **Philippines**, regulatory processes required for TLD and PrEP to be included into the national formulary are expected to delay national TLD procurement to 2024. PEPFAR will provide above-site support for the health technology assessment (HTA) required for both PrEP and TLD; patient-centered pharmaceutical services and pharmacovigilance of HIV commodities; and assistance to the Philippine Food and Drug Administration in streamlining a supportive regulatory system and environment for HIV/AIDS medicines. To prepare for the scale up of HIV self-testing, PEPFAR will begin to explore private partnerships with pharmacies (i.e., mClinica). Initial work will focus on developing a model to market self-test kits and referral to services for key populations and PLHIV for follow-up care.

Collaborating with multilateral and donor agencies to improve results across the cascade: PNG will partner with UNAIDS and the GF to support CLM and improve the quality of HIV service provision in NCD, as well as DNO activities to increase VL testing coverage.

Use of unique identifiers across sites and programs in clinical settings: 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 Master Patient Index roadmap for scale up.

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).

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. 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 to establish a national-level UIC with key stakeholders.

4.7 Targets by population

Table 4.7.1 ART Targets by Prioritization for Epidemic Control (updated for ROP21, with the exception of Cambodia and PNG)							
Prioritization Area	Country	Total PLHIV	Expected current on ART (APR FY21)	**Additional patients required for**	**Target current on ART (APR FY22) *TX_CURR***	Newly initiated (APR FY22)	ART Coverage (APR 22)

				80% ART coverage		*TX_NEW*	
Attained	Thailand	21,015	18,945	90%	--	----	99%
Scale-Up Saturation	India	43,171	27,721	6,816	29,914	3,389	69%
	PNG	6,412	5,977	0	6,097	419	83%
	Thailand	108,710	92,241	84%	26,830	1,865	90%
Scale-Up Aggressive	Burma*	-	11,080	-	11,677	900	
	India	584,576	344,446	123,690	450,881	44,459	77%
	Indonesia	103,101	33,281	49,200	40,605	5,588	39%
	Kyrgyz Republic	7,631	3,536	2,569	5,208	1,596	68%
	Lao PDR	10,691	7,772	781	7,375	1,045	74%
	Nepal	30,301	22,387**	6,060	25,084**	2,800	82%**
	Philippines	86,000+	35,409	33,540	38,847***	3,438	45%
	Tajikistan	8,670	5,329	1,607	7,287	1,895	84%
	Thailand	91,069	56,139	16,716	20,869	1,997	69%
Sustained	Kazakhstan	6,158	4,250	676	5,380	1,177	80%
Total							

*: No Township (prioritized SNU) level data are available.
**Includes national contribution. Target for Nepal used from Draft National HIV Strategic Plan 2021-26.
***Includes national contribution.
+ HIV/AIDS & ART Registry of the Philippines, December 2020. Spectrum-AIDS Epidemic Model (AEM), April 2020.

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 (updated for ROP21, with the exception of Cambodia and PNG)				
Country	**Target Populations**	**Population Size Estimate (SNUs) and disease burden**	**Coverage Goal (in FY22)**	**FY22 Target**
Burma	FSW MSM/TG PWID	23,205 47,203 58,158	7% 7% 4%	1,562 3,083 2,195
India	FSW (KP Prev) MSM (KP Prev) TG (KP Prev) PWID (KP Prev)	213,538 54,684 10,575 45,817	14% 16% 14% 30%	29,089 8,920 1,464 14,016
Indonesia	MSM FSW PWID TG People in prisons and other enclosed settings	48,775 40,298 10,575 45,817		18,460 5,154 836 2,508 112
Kazakhstan*	PWID	23,900 Est Size; 12% Prev	-	-
Kyrgyz Republic*	PWID	25,000 Est. Size, 14.3% Prev	-	
Lao PDR	MSM/TG (high risk)	23,523	17%	3,980
Nepal	FSW (KP Prev) MSM/TG (KP Prev) Clients of FSWs, high risk male and female, migrants and prisoners (PP_Prev)	45,957 94,582 N/A	25% 19% N/A	4,572 6,859
Philippines	MSM TG FSW	221,590 57,449 11,277	13% 16%	14,193 342

	PWID	45,817		
PNG*	MSM FSW	-	-	-
Tajikistan*	PWID	22,200 Est Size; 12.1% Prev	-	
Thailand	MSM/TGW (high risk)	112,195	18%	20,491
Total	**FSW** **MSM/TG** **PWID** **Clients of FSWs, prisoners, migrants**			**137,836**

Sources & Notes:
Burma: Draft PSE of 5 PSNU from National Strategic Plan of HIV/AIDS (2021-2025)
Kazakhstan: UNAIDS 2018.
Indonesia: KP Size Estimation Report, MoH 2020
** Kazakhstan, Tajikistan, Kyrgyz Republic, and PNG do not have KP-Prev or PP_Prev targets.*
Kyrgyz Republic: UNAIDS KP Atlas. https://kpatlas.unaids.org/dashboard.
Lao PDR SPECTRUM-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

ROP21 UPDATES

In **Burma**, national revitalization of the four public sector and four private sector high throughput HIV VL PCR sites is planned, and a DNO exercise initially planned for ROP20 will be undertaken. These activities will ensure greater coverage with a combination of enhanced support for transportation networks, expanding POC VL capacity, supply chain TA, and laboratory TA to ensure availability of testing reagents, and improved turnaround time to enable appropriate clinical decisions based on VL results by clinicians and clients The DNO exercise was not feasible in ROP20 given the current situation in Burma. **Cambodia** renewed its contract with the Abbott company under the new GF grant 2021-2023, and in March 2021, the newest VL platform machine, Alinity m, was installed at the NCHADS lab. Alinity m can detect and quantitate HIV-1 RNA using plasma, serum, and DBS, and ensure differences in viral loads are true differences and an undetectable result is truly un-transmittable. In collaboration with the National Public Health Lab (NPHL), GF, and other stakeholders, **Nepal** will provide support for review, revision, and implementation of a VL optimization plan developed in ROP20, specifically taking into account the impact of COVID-19 and addressing bottlenecks to scale up, including use of COVID-19 PCR machines for HIV VL testing. **Nepa**l has obtained additional PCR machines for COVID-19 diagnosis and will assess their use for HIV VL testing in ROP21.

The Philippines will support a DNO exercise in ROP21 and expansion of viral load testing access and coverage via POC or near-to-POC testing platforms to PLHIV in all PEPFAR-supported regions. In 2020, the **Philippines** national stakeholders developed a VL optimization plan to address bottlenecks to VL scale up; however, due the impact of COVID-19, the country will revisit and update the original plan.

In **India**, PEPFAR will demonstrate and scale up integrated laboratory services with KP focus for early detection and comprehensive management of HIV/STI, routine VL, opportunistic infections and monitoring of adverse drug reactions. **India** will also build lab capacities and lab network for monitoring of HIV DR with a focus on patients failing TLD or other dolutegravir-based regimens for improved clinical management. In ROP21, **PNG** and GF will partner to support DNO activities in NCD and nationally to identify barriers and opportunities to increase VL testing coverage for PEPFAR supported clients in ROP21.

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.

4.9 Viral Load and Early Infant Diagnosis Optimization

ROP21 UPDATES
In ROP 21, PEPFAR **PNG** will leverage resources from the GF and other stakeholders and support NDoH to conduct DNO. This analysis will contribute to guiding the HIV/TB diagnostic network integration to better analyze the current capacity for VLC scale up and to optimize existing VLSM to streamline national level VL and EID testing data reporting. Under the national program to reduce the long turnaround for the results to caregivers, **India** will support validation/verification and strategic placement of near point of care testing (POCT) NAT platforms for EID.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

ROP21 UPDATES
In ROP21, ARP countries were not asked to provide key systems gaps or barriers to achieving sustained epidemic control or complete the Table 6 tool. We will report here progress on the activities to address identified ROP20 key barriers. Client-centered services: In ROP21, PrEP scale up will continue in **Burma, Cambodia, India, Nepal, Thailand, Kyrgyz Republic**, and **Tajikistan,** accompanied by above-site support for PrEP roll-out through the public and private sectors. This support will include 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, Indonesia, Nepal, Thailand**). In K**azakhstan,** a toolkit of community-based medical (testing, treatment support) and social services (with M&E and CQI components) will be developed to

address the issues with capacity to deliver client-centered HIV services. The toolkit will also be supported by an e-learning platform to ensure CBOs have access to standard description of the services. **Kyrgyz Republic** will implement Granular Site Management in high volume PEPFAR supported sites that will result in evidence-based quality-improvement efforts at the level of service delivery; support a robust system of QI/QA at community level to ensure development of tools and further expansion of online client feedback platform; implement CLM to address concerns and needs of beneficiaries of services at PEPFAR sites with subsequent correction and advocacy actions; introduce Buprenorphine; and expand and improve the quality of low-threshold, integrated MAT/ART program nationwide. In ROP21, the country will also waive formal registration requirements for PWID to enroll in MAT, develop a communication strategy and demand creation for MAT, and implement a computer-based cognitive behavior change therapy program aimed to improve adherence and treatment continuity of patients in MAT. In **the Philippines**, PEPFAR will support critical technical and operational guideline development to improve the quality of testing and treatment services for KP and PLHIV. PEPFAR will support the more aggressive rollout and implementation of the country's rapid HIV diagnostic algorithm (rHIVda) that decentralizes confirmatory testing to ensure faster ART linkage.

Limited availability of and ability to use reliable epidemiologic and programmatic data: In **Burma**, PEPFAR will continue to advance support for data use capacity building and the development and strengthening of case-based surveillance systems to inform better programming by constructing KP, demography and geography specific care cascades. In order to improve data for decision making, **Kyrgyz Republic** will work to improve client-centric monitoring and management and provide TA to HIV services to introduce LIMS in RAC. The country will support activities on HIV CBS in order to monitor trends in high-risk populations. Additional activities include: building capacity and institutionalizing data use at the national and sub-national levels through remote and on-site workshops for Republican and Oblast level staff; strengthening the capacity of RNC in management of EMR; implementing QR-code-assisted based patient registration and methadone dispensing system countrywide; and integrating recency testing into the routine case-finding processes and introduce DHIS2. In **Tajikistan**, PEPFAR will collaborate with GF and government on IBBS for PWID and FSW and will finalize and disseminate the IBBS among MSM and PWID in the **Kyrgyz Republic**. In **India**, **Kyrgyz Republic, Philippines,** and **Tajikistan**, PEPFAR will support improvement of national- and sub-national PLHIV estimations. In **India**, PEPFAR will support improvement of incidence and mortality for epidemic monitoring and continue to advance support for data QI activities improving the quality of program and surveillance data collection, mapping, and estimation of size of key populations, cascade monitoring, and data analysis and utilization to assess performance, decision making, and improving the quality of services. In **Lao PDR**, PEPFAR will assess UIC used in DHIS2 and provide TA to improve quality of unique identifier systems. **PNG** will utilize information from improved strategic information dashboards to inform program adaptations in real time. Improved information systems will enable efficient case profiling and strengthen active case management, minimizing treatment interruption. Strengthened SI systems will also enhance progress to improving viral load testing coverage. Through triangulating data, with feedback from community-led monitoring, **PNG** will strengthen quality improvement activities for HIV treatment services, particularly for key populations.

Domestic financing: In **Nepal**, activities will engage the government and the non-governmental sector to allocate budgets for HIV services. Similarly, social health insurance will be promoted among PLHIV and PEPFAR will continue to strengthen CLM. **Lao PDR** will promote the inclusion of essential HIV services in MOH national guidelines to promote local ownership and domestic financing.

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, Philippines, 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, Philippines.** 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, Philippines,** 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**.**

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

ROP21 UPDATES
The ARP distributed assets model has been difficult to achieve because of staff shortages at the country level, while country-level activities to achieve 90-90-90 and MPRs and OGAC processes and requirements have increased or become more complex. Initiatives like ASAP and KPIF, with the addition of the Philippines as the 12th country, followed by the COVID-19 situation, further stretched a thin staff. In

Kazakhstan, two vacant LES PEPFAR State positions have been discontinued in line with the regionalization goals and the establishment of PARCU.

To be responsive to the needs of the region and Washington and to operate effectively as one Operating Unit, for ROP 21, **PARCU** will hire an FTE FSN Deputy PEPFAR Coordinator. Recognizing that hiring can take time, **PARCU** has planned and budgeted for filling gaps/surge needs, including significant gaps for SI support, with agency and consultant assistance.

The PEPFAR Philippines program has been delayed in launching activities due to the COVID-19 pandemic and inability of PEPFAR implementing agencies to establish program operations on the ground. USAID is the only agency with an established presence in country, launching activity implementation in ROP20. HHS implementing agencies are still in the process of securing formal accreditation by the Government of the Philippines and initiating activities on the ground. During ROP21, PEPFAR plans to resolve these delays and accelerate program activities. Recruitment of staff is ongoing and there are no plans to request additional staff in ROP21.

In **PNG**, USAID is now the only USG agency supporting PEPFAR. Three CDC PEPFAR-funded staff were retained under USAID after the departure of CDC. In ROP21, PNG will continue funding three full-time PEPFAR HIV positions (one being a vacancy from ROP20) and two PEPFAR-funded staff members at 50%, which were approved in a previous ROP. No new positions are expected in ROP21. Three non-PEPFAR funded staff based in Manila, Philippines, also support the management of the PEPFAR PNG program at 50% LOE or less. The new U.S. Embassy compound costs—specifically ICASS--are estimated to increase slightly.

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 (Updated for ROP21)

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 projections[2]
HIV Prevalence (%)		0.57		ND		ND		0.3		0.4		ND		ND	AEM estimates Apr 2019; UNAIDS 2019 estimates
AIDS Deaths (per year)	7,700		ND		ND		ND		ND		ND		ND		UNAIDS Databook Myanmar 2020
# PLHIV	240,000		ND		ND		ND		ND		ND		ND		UNAIDS Databook Myanmar 2020
Incidence Rate (Yr)		0.19		ND		ND		ND		ND		ND		ND	UNAIDS Factsheet Myanmar 2019
New Infections (Yr)	10,000														UNAIDS Databook Myanmar 2020
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	5,000	2													UNAIDS Factsheet Myanmar 2019
Notified TB cases (2019)	137,325		ND		ND		ND		ND		ND		ND		WHO: TB Country Profile 2020
% of TB cases that are HIV infected (2019)	9,798	7.8	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	WHO: TB Country Profile 2020
Estimated Population Size of MSM*	268,000	1.3													MSM BBS 2019
MSM HIV Prevalence	NA	8.6													MSM BBS 2019
Estimated Population Size of FSW	75,000	0.3													FSW BBS 2019
FSW HIV Prevalence	NA	8.3					NA	3.1			NA	6.8			FSW BBS 2019 and HHS 2020
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															

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

Cambodia

Table 2.1.1 Host Country Government Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	15,552,211 M=7,571,837 F=7,980374		2,226,524	27.9	2,347,269	31.0	1,348,683	16.9	1,325,071	17.5	4,405,166	55.2	3,899,496	51.5	General Population Census of the Kingdom of Cambodia 2019
HIV Prevalence (%)		0.54													AEM, 2020
AIDS Deaths (per year)	1200		N/A		N/A		N/A		N/A		N/A		N/A		AEM, 2020
# PLHIV	74,918		N/A		N/A		N/A		N/A		N/A		N/A		AEM, 2020
Incidence Rate (Yr)		0.007													AEM, 2020
New Infections (Yr)	1133		N/A		N/A		N/A		N/A						AEM, 2020
Annual births (2019)	217731	1.4%													General Population Census of the Kingdom of Cambodia 2019
% of Pregnant Women with at least one ANC visit	415333	100													National PMTCT report 2020
Pregnant women needing ARVs	694	85%													AEM, 2020
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 (2020)	29261		N/A		N/A		N/A		N/A		N/A		N/A		CENAT Report, 2020
% of TB cases that are HIV infected	570	1.9%													CENAT Report, 2020
% of Males Circumcised	N/A														
Estimated Population Size of MSM*	88,000														AEM, 2020
MSM HIV Prevalence		4.0%													NCHADS MSM and TG IBBS, 2019
Estimated Population Size of FSW	50,600														AEM, 2020

FSW HIV Prevalence		3.2%													FSW IBBS 2016
Estimated Population Size of PWID	6,500														AEM, 2020
PWID HIV Prevalence		15.2%													PWID IBBS 2017
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Estimated Size of Priority Populations (Transgender)	3,200														AEM, 2019
Estimated Size of Priority Populations Prevalence (Transgender)		9.6%													NCHADS MSM and TG IBBS 2019
	**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table. Cite sources*														

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 2019 report, NACO, 2019
AIDS Deaths (per year)	69,110		NA		NA		NA		NA		NA		NA		India HIV Estimation 2019 report, NACO, 2019
# PLHIV	2,349,000		NA		NA		NA		NA		NA		NA		India HIV Estimation 2019 report, NACO, 2019
Incidence Rate (Yr.)		.05/1000		NA		NA		NA		NA		NA		NA	India HIV Estimation 2019 report, NACO, 2019
New Infections (Yr.)	69,220														India HIV Estimation 2019 report, NACO, 2019

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**	**%**	
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	20,520														India HIV Estimation 2019 report, NACO, 2019
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)
MSM HIV Prevalence		4.3													IBBS, 2015 (although HSS 2016 shows a prevalence of 2.69, we have used IBBS since it is a population-based prevalence, while HSS is carried out among KPs registered in facilities)
Estimated Population Size of FSW	868,000														NACO Annual Report 2018-19
FSW HIV Prevalence		2.2													IBBS, 2015 (although HSS 2016 shows a prevalence of 1.56, we have used IBBS since it is a population-based prevalence, while HSS is carried out among KPs registered in facilities)

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**	**%**	
Estimated Population Size of PWID	177,000														NACO Annual Report 2018-19
PWID HIV Prevalence		9.9													IBBS, 2015 (although HSS 2016 shows a prevalence of 6.26, we have used IBBS since it is a population-based prevalence, while HSS is carried out among KPs registered in facilities)
Estimated Size of Priority Populations of TG	70,000														NACO Annual Report 2018-19
Estimated Size of Priority Populations Prevalence of TG		7.5													IBBS, 2015 (although HSS 2016 shows a prevalence of 3.14, we have used IBBS since it is a population-based prevalence, while HSS is carried out among KPs registered in facilities)

Indonesia

Table 2.1.1 Host Country Government Results															
	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	269,603,400	100.0	32,448,400	12.0	33,591,500	12.5	21,837,100	8.1	22,260,700	8.3	79,980,900	29.7	79,484,800	29.5	Indonesia Population Projection for Year 2020, Result of SUPAS 2015, Indonesia Bureau of Statistics
HIV Prevalence (%)		0.20		0.03		0.03		0.13		0.18		0.21		0.37	Spectrum, Ministry of Health
AIDS Deaths (per year)	30,137		1,092		1,148		568		647		9,875		16,807		Spectrum, Ministry of Health
# PLHIV	543,075		8,573		8,977		29,401		39,424		165,797		290,903		Spectrum, Ministry of Health
Incidence Rate (Yr)		0.01		0.004		0.004		0.03		0.04		0.01		0.01	Spectrum, Ministry of Health
New Infections (Yr)	29,557														Spectrum, Ministry of Health
Annual births	4,432,800	2.1													Indonesia Population Projection for Year 2020, Result of SUPAS 2015, Indonesia Bureau of Statistics
% of Pregnant Women with at least one ANC visit	5,068,082	96.4													Indonesia Health Profile 2019, MoH (https://www.kemkes.go.id/resources/download/pusdatin/profil-kesehatan-indonesia/Profil-Kesehatan-Indonesia-2019.pdf)
Pregnant women needing ARVs	10,461														Spectrum, Ministry of Health
Orphans (maternal, paternal, double)															
Notified TB cases (Yr)															
% of TB cases that are HIV infected															
% of Males Circumcised	N/A														
Estimated Population Size of MSM*	502,986														Technical Report "Size Estimates of Population at Risk of HIV Infection in Indonesia 2020", Minisrty of Health
MSM HIV Prevalence	N/A	17.9													Integrated Biological and Behavioral Survey 2018-2019, Ministry of Health
Estimated Population Size of FSW	277,624														Technical Report "Size Estimates of Population at Risk of HIV Infection in Indonesia 2020", Minisrty of Health
FSW HIV Prevalence	N/A	2.1						1.2				2.5			Integrated Biological and Behavioral Survey 2018-2019, Ministry of Health
Estimated Population Size of PWID	34,517														Technical Report "Size Estimates of Population at Risk of HIV Infection in Indonesia 2020", Minisrty of Health
PWID HIV Prevalence	N/A	13.6													Integrated Biological and Behavioral Survey 2018-2019, Ministry of Health
Estimated Size of Priority Populations (specify) - Transgender	34,695														Technical Report "Size Estimates of Population at Risk of HIV Infection in Indonesia 2020", Minisrty of Health
Estimated Size of Priority Populations Prevalence (specify) - Transgender	N/A	11.9													Integrated Biological and Behavioral Survey 2018-2019, Ministry of Health

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, 631,779	100.0	2,607,748	14	2,765,088	15	1,143,013	6	1,195,956	6	5,846,884	31	5,073,090	27	National Statistical Committee of the Republic of Kazakhstan (January 01, 2020; https://stat.gov.kz/api/getFile/?docId=ESTAT379486)
HIV Prevalence (%)	-	0.19		0.01		0.01	-	0.05	-	0.06	-	0.23	-	0.41	Estimated # PLHIV (Spectrum 2021 data)/Total population
AIDS Death (per year)	<200		<100				<100		<100		<100		<200		Spectrum 2021 draft
Estimated # PLHIV	36,000		216		200		537		717		13,544e		20,786		Spectrum 2021 draft
Incidence Rate per 1000 population (Yr)	-	0.18													Spectrum 2021 draft
New Infections (Yr)	3,500		<100				108		247		942		2103		Spectrum 2021 draft
Pregnant Women Needing (ARVs)	<500														Spectrum 2021 draft
Notified TB Cases (Yr)	5,832														TB program statistics, 2021
% of TB cases that are HIV infected	615	10.5													EHCMS, As of Jan 31, 2021; calculated % = TB that are HIV infected/ TB registered cases.
Estimated Population Size of PWID	94,600														HIV program statistics, 2020
PWID HIV Prev.		8.3%													HIV program statistics, 2020
Estimated Population size of MSM	62,000														HIV program statistics, 2019
MSM HIV Prev.		6.6%													HIV program statistics, 2019
Estimated Population Size of FSW	20,250														HIV program statistics, 2019
FSW HIV Prev.		1.4%													HIV program statistics, 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	6,636803	100	1,069,181	16.1	1,122886	16.9	500,291	7.5	520,163	7.8	1,773,197	26.7	1,651,085	24.8	National Statistical Committee of the Kyrgyz Republic As of January 01, 2021 (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				<200		<200		<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														https://kpatlas.unaids.org/dashboard
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/f

			iles/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	29,219,318	100	4,135,375	14	4,238,370	15	3,271,502	11	3,217,470	*11*	8,359,428	29	5,997,173	21	UN Population Projection 2020
HIV Prevalence (%)		0.13		0.01		0.01		0.02		0.02		0.14		0.26	National HIV Estimates 2020
AIDS Deaths (per year)	674		9		10		3		3		208		384		National HIV Estimates 2020
# PLHIV	30,301		626		642		623		537		12,744		15,135		National HIV Estimates 2020
Incidence Rate (Yr.)		0.03		0.03		0.03		0.03		0.04		0.01		0.05	National HIV Estimates 2020
New Infections (Yr.)	636														National HIV Estimates 2020
Annual births	581,600														World Population Prospects 2017
% of Pregnant Women with at least one ANC visit	85%														NDHS2016
Pregnant women needing ARVs															National HIV Estimates 2020
Orphans (maternal, paternal, double)															National HIV Estimates 2020
Notified TB cases (Yr.)	27,745 (2019/20)														Tuberculosis Profile FY 2076/77
% 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 2.8		IBBS, Kathmandu valley, 2017 IBBS, Pokhara valley, 2017 IBBS, Eastern Terai highway districts, 2017 IBBS, Western to Far-western Terai highway districts, 2017 Nationwide IBBS among PWIDs, 2020
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
National estimates indicate that **Nepal** had 30,301 PLHIV in 2020 with an adult HIV prevalence of 0.13%. An estimated 80% new HIV infections occur through heterosexual transmission (NCASC, 2020). Nepal's treatment cascade currently is at 83-79-49. Nepal is lagging behind in reaching its target for the third 90. Nepal's HIV response benefits from strong political will and commitment from the Government of Nepal as well as robust collaboration between PEPFAR, the GF, and the government and has been heavily impacted by the COVID-19 pandemic. The National HIV Strategic Plan (NHSP) 2016-21 currently drives Nepal's HIV response. The NHSP 2021-26 has been drafted and is in the process of being endorsed.				

Papua New Guinea

Table 2.1.1 Host Country Government Results (PNG)			
	Total		***Source, Year***
	N	%	
Total Population	8,970,000		Spectrum Estimates (2021)
HIV Prevalence (%)		0.87	Spectrum Estimates (2021)
AIDS Deaths (per year)	540		Spectrum Estimates (2021)
# PLHIV	55,670		Spectrum Estimates (2021)
Incidence Rate (per year)		0.34	Spectrum Estimates (2021)
New Infections (per year)	2,995		Spectrum Estimates (2021)
Annual births	238,171		Spectrum Estimates (2021)
% of Pregnant Women with at least one ANC visit		54	Annual HIV Program Report (2018)
Pregnant women needing ARVs	1,612	0.64	Spectrum Estimates (2020)
Orphans (maternal, paternal, double)	9,192		Spectrum Estimates (2021)
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*			IBBS Report (2017)
MSM HIV Prevalence*	7,500		IBBS Report (2017)
Estimated Population Size of FSW*		8.5	IBBS Report (2017)
FSW HIV Prevalence*	16,100		IBBS Report (2017)
Estimated Population Size of PWID		14.9	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*			

Philippines

Table 2..1.1 Host Country Government Results (Philippines)															
	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	108,116,622														
HIV Prevalence (%)		0.1 (15+)													
AIDS Deaths (per year)	1,600		<100		<100		<100		<500		<200		1,400		AIDSinfo | UNAIDS
# PLHIV	83,755														HARP Jan 2021
Incidence Rate		.14%													AIDSinfo | UNAIDS
New Infections (Yr)	16,000														AIDSinfo | UNAIDS
Annual Births	1,673,923														https://psa.gov.ph/vital-statistics/id/163858
% Pregnant Women with at least One ANC visit		94%													https://data.unicef.org/topic/maternal-health/antenatal-care/
Pregnant Women Needing ARV	9														HARP Jan 2021
Notified TB Cases															
% of TB cases that are HIV infected (2019)	11.000														AIDSinfo | UNAIDS (BBS, 2015)
Estimated Population Size of MSM	830,000														AIDSinfo | UNAIDS (BBS, 2015)
MSM HIV Prevalence		5%													AIDSinfo | UNAIDS (BBS, 2015)
Estimated Population Size of FSW	210,000														AIDSinfo | UNAIDS (BBS, 2015)
FSW HIV Prevalence		0.6%													AIDSinfo | UNAIDS (BBS, 2015)

Estimated Population Size of PWID	7,400			AIDSinfo | UNAIDS (BBS,2015) - just for Cebu
PWID HIV Prevalence		29%		AIDSinfo | UNAIDS (BBS,2015) - just for Cebu
Estimated Population Size of TG	190,000			AIDSinfo | UNAIDS (BBS, 2018)
TG HIV Prevalence		4%		

The **Philippines** has the fastest growing HIV epidemic in the Asia-Pacific region; the number of new HIV infections in the Philippines increased 203% in just eight years (from 4,400 in 2010 to over 13,000 per year in 2018) and is still increasing, while most countries in the Asia-Pacific region have seen plateaus or declines. VL testing coverage remains a challenge nationally; however, VL suppression among those who have been tested are at 94%. The epidemic in the country is mainly concentrated among KPs including MSM/TGs, and as of December 2020 there is an average of 47 new HIV infections a day. VL testing coverage remains low with significant gaps along the HIV care continuum.

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	9,313,800	100.0	1,527,000	16.4	1,664,100	17.9	829,700	8.9	864,400	9.3	2,233,000	24.0	2,195,600	23.6	National Statistics Agency, As of January 01, 2020 www.stat.tj/ru/
HIV Prevalence (%)		0.2	<0.031					<0.06		<0.116		0.13		0.39	UNAIDS data, 2019, https://aidsinfo.unaids.org
AIDS Death (per year)	<500		<200				<100		<100						UNAIDS data, 2019, https://aidsinfo.unaids.org
Estimated # PLHIV	14,000		<1000				<500		<1,000		2,800		8,600		UNAIDS data, 2019, https://aidsinfo.unaids.org
Incidence Rate per 1000 population (Yr)		0.17													UNAIDS data, 2019, https://aidsinfo.unaids.org
New Infections (Yr)	<1,600		<500				<100		<200						UNAIDS data, 2019, https://aidsinfo.unaids.org
Pregnant Women Needing (ARVs)															EHCMS, As of Jan 31, 2020
Notified TB Cases (Yr)															2019 WHO Global TB report, data from 2018

% of TB cases that are HIV infected				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/

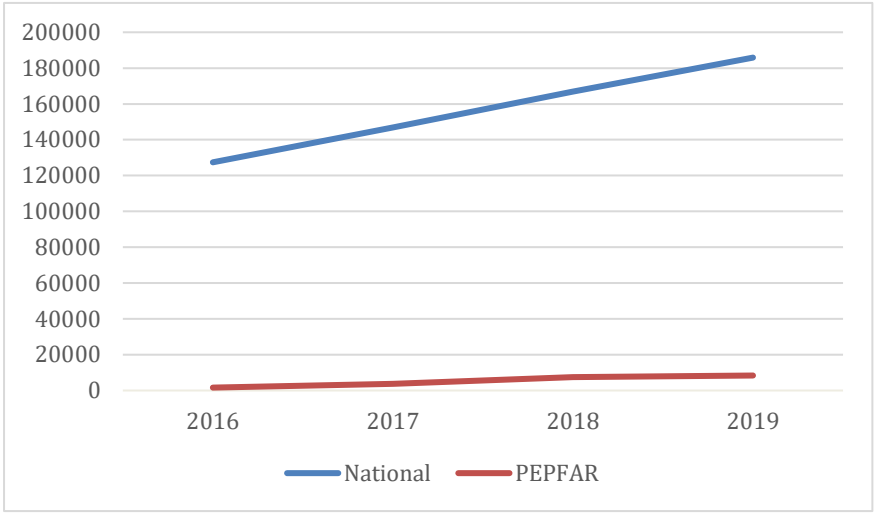
Thailand

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 Pop. 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

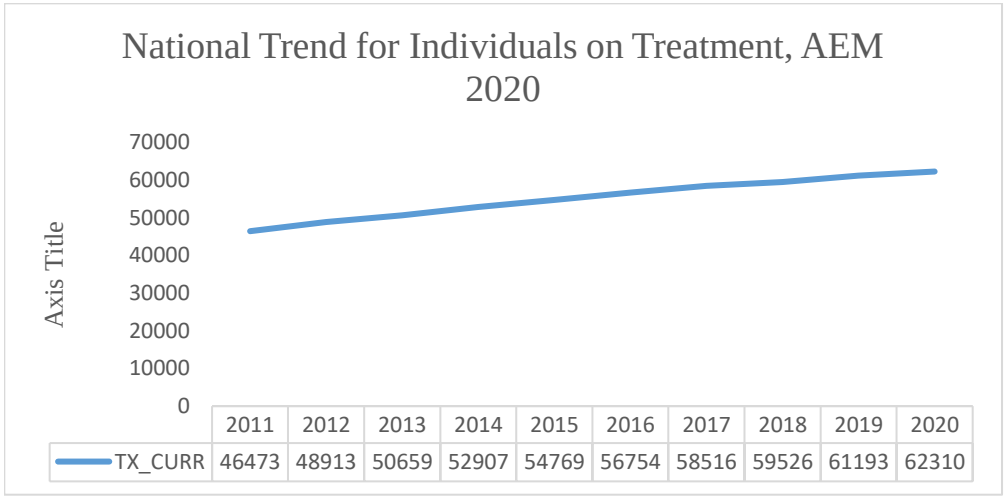
MSW HIV Prevalence		3.8		8	2.81		15	4.59	IBBS 2018
Sources: AEM, SPECTRUM-AEM, IBBS led by Division of Epidemiology, Thailand MOPH									

Figure 2.1.3 National Trend for Individuals currently on Treatment, AEM 2020, Updated for ROP21

Burma

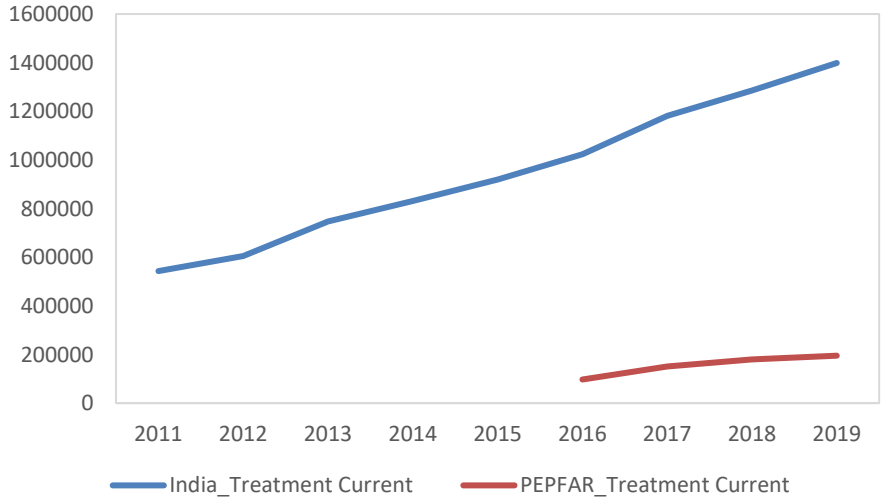


Cambodia



PEPFAR does not support site-level activities in Cambodia. The trend line reflects national data.

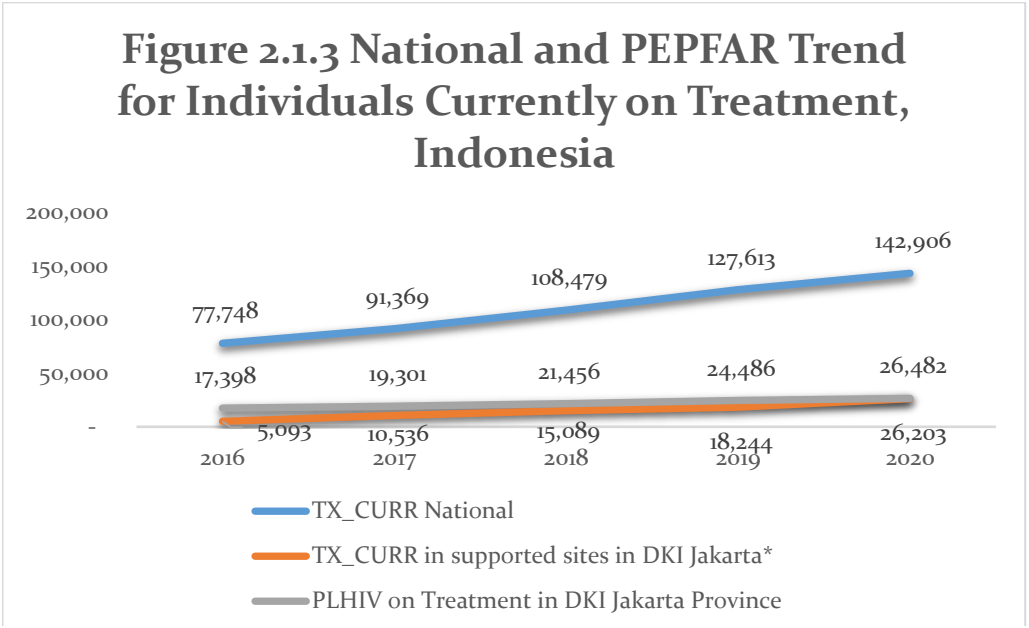
India



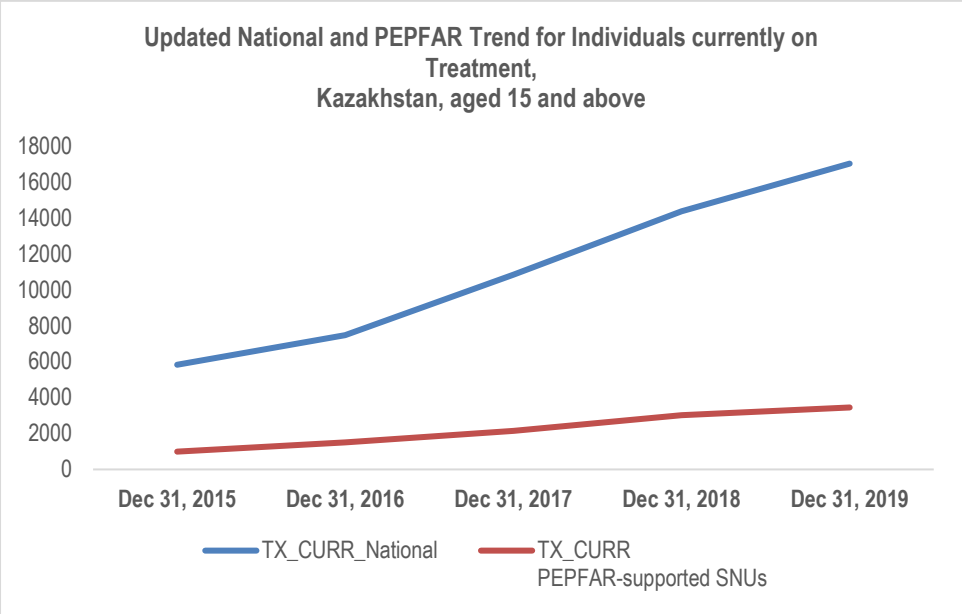
*India Treatment figure from March 2020, UNAIDS Data Hub 2020, CDC India Treatment figure from DATIM (September 2020)

JNC

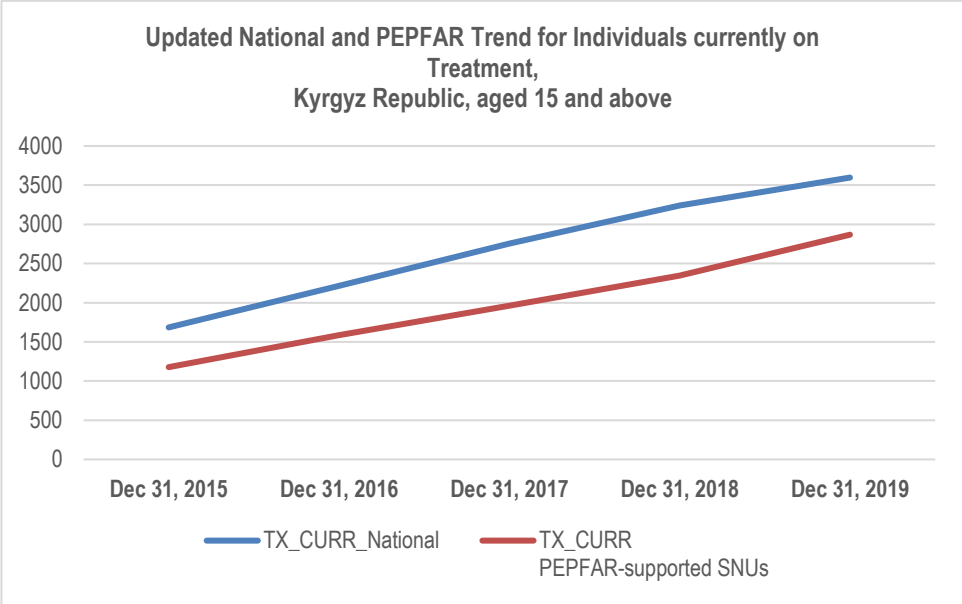
Indonesia



Kazakhstan

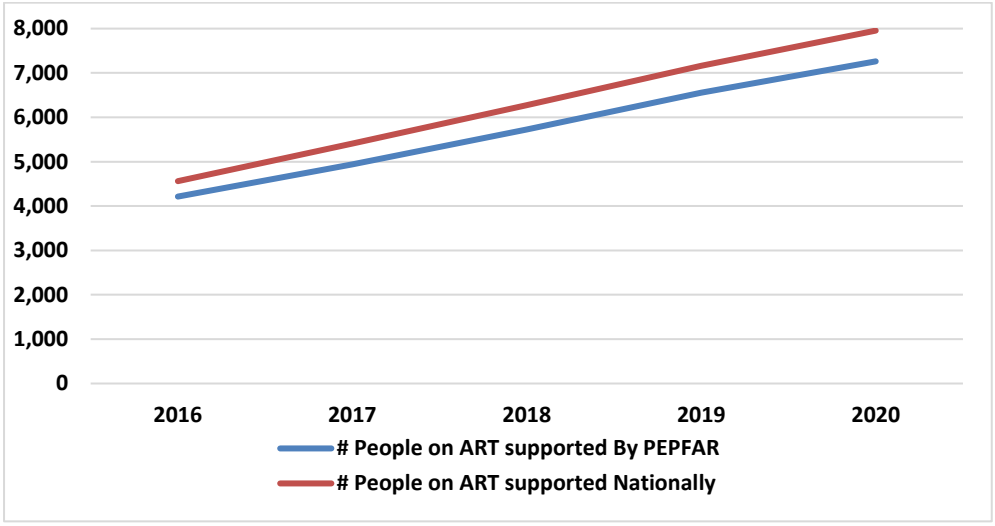


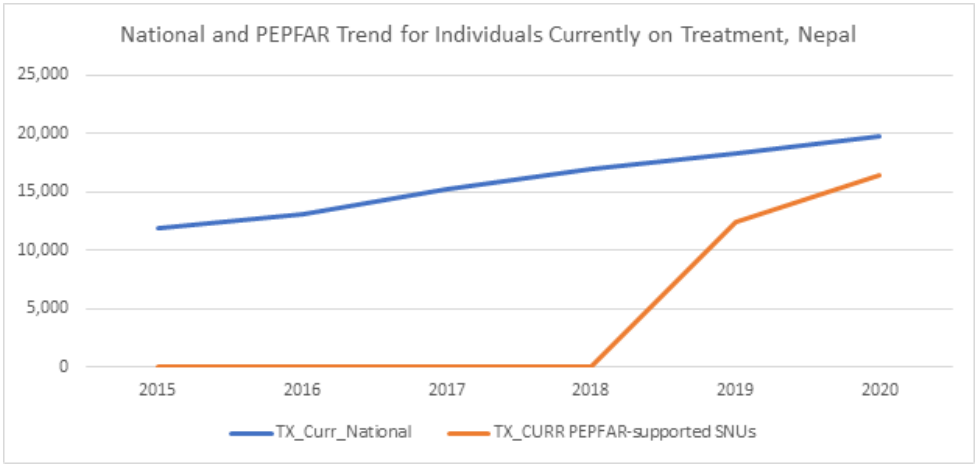
Kyrgyz Republic



Lao PDR

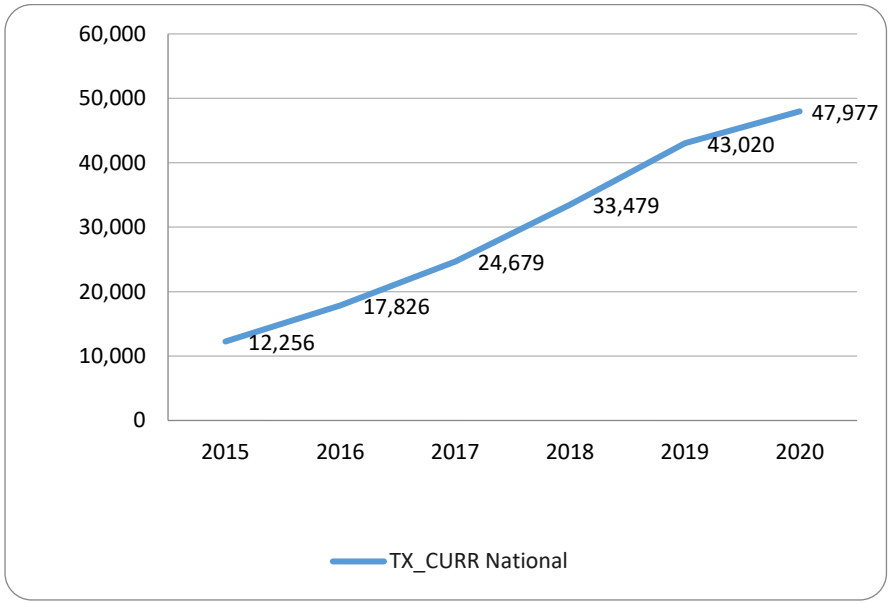
Nepal



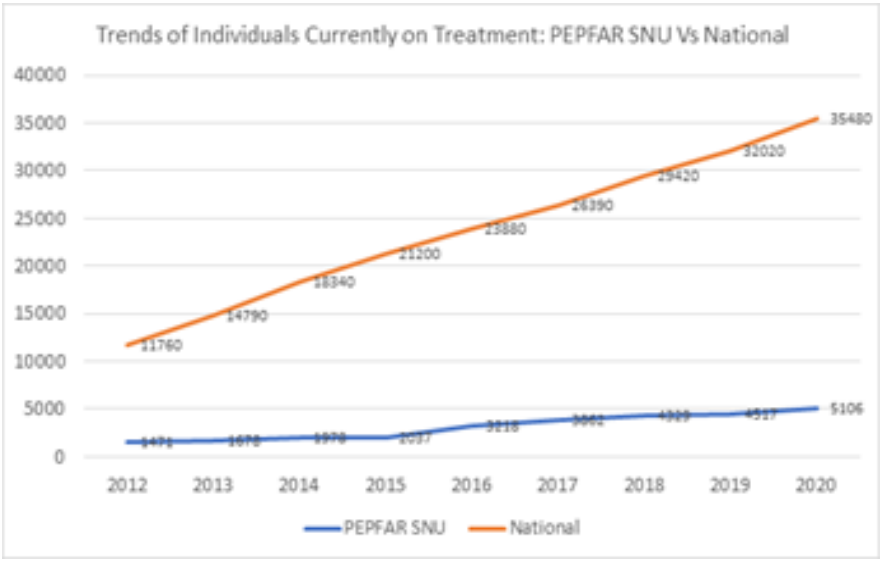


Note: Nepal just started reporting PEPFAR data in 2019

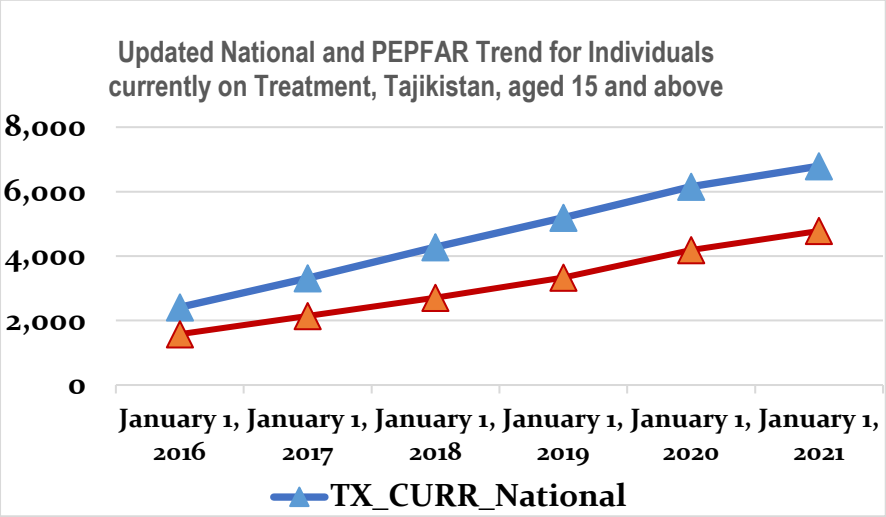
Philippines



Papua New Guinea



Tajikistan



Thailand

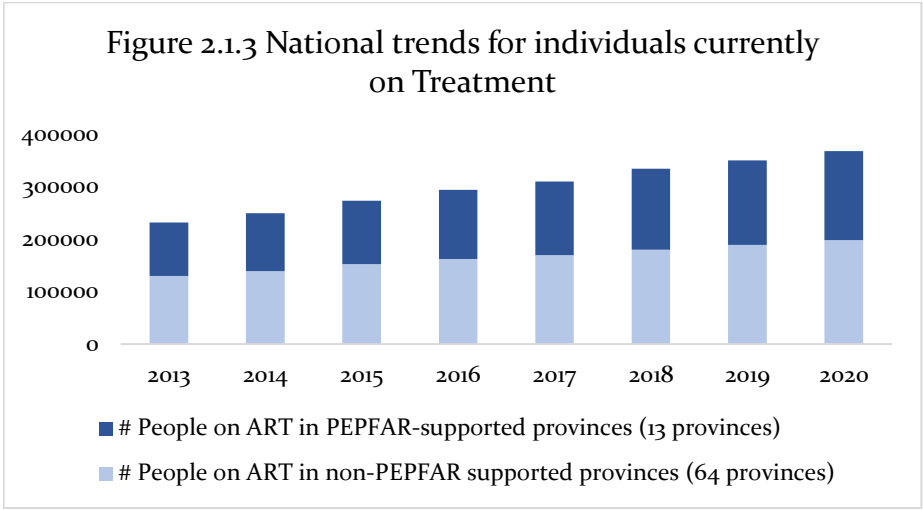
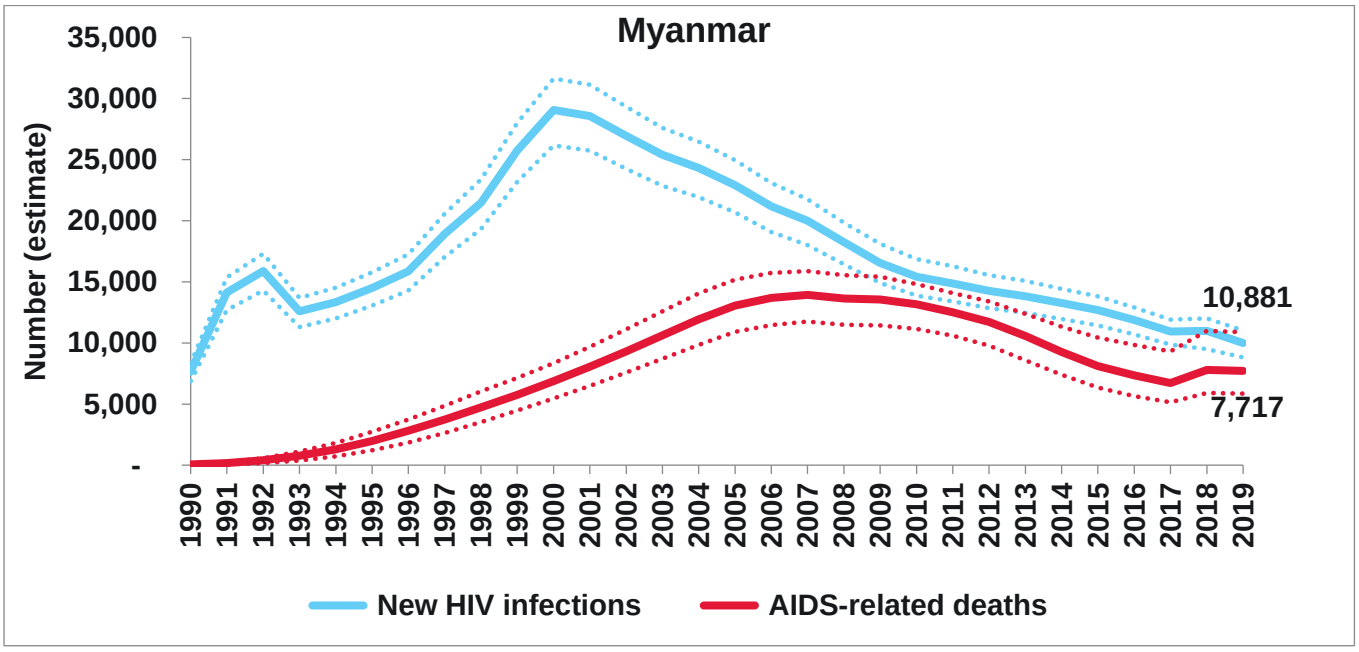


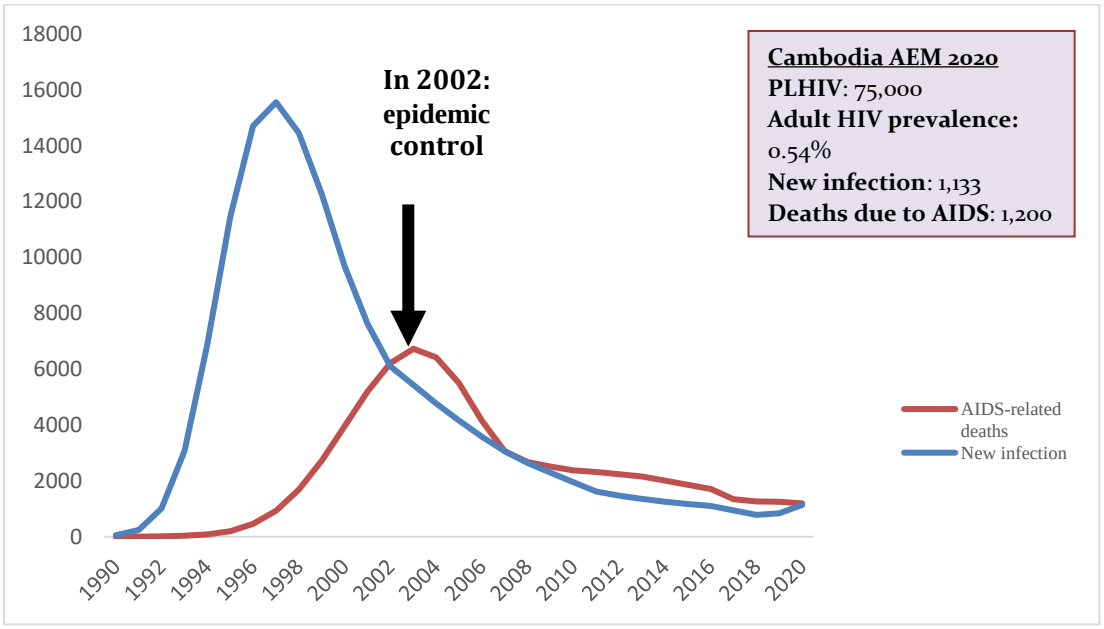
Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality Among PLHIV, by Country, updated for ROP21, with the exception of India, Philippines, and Tajikistan

Burma

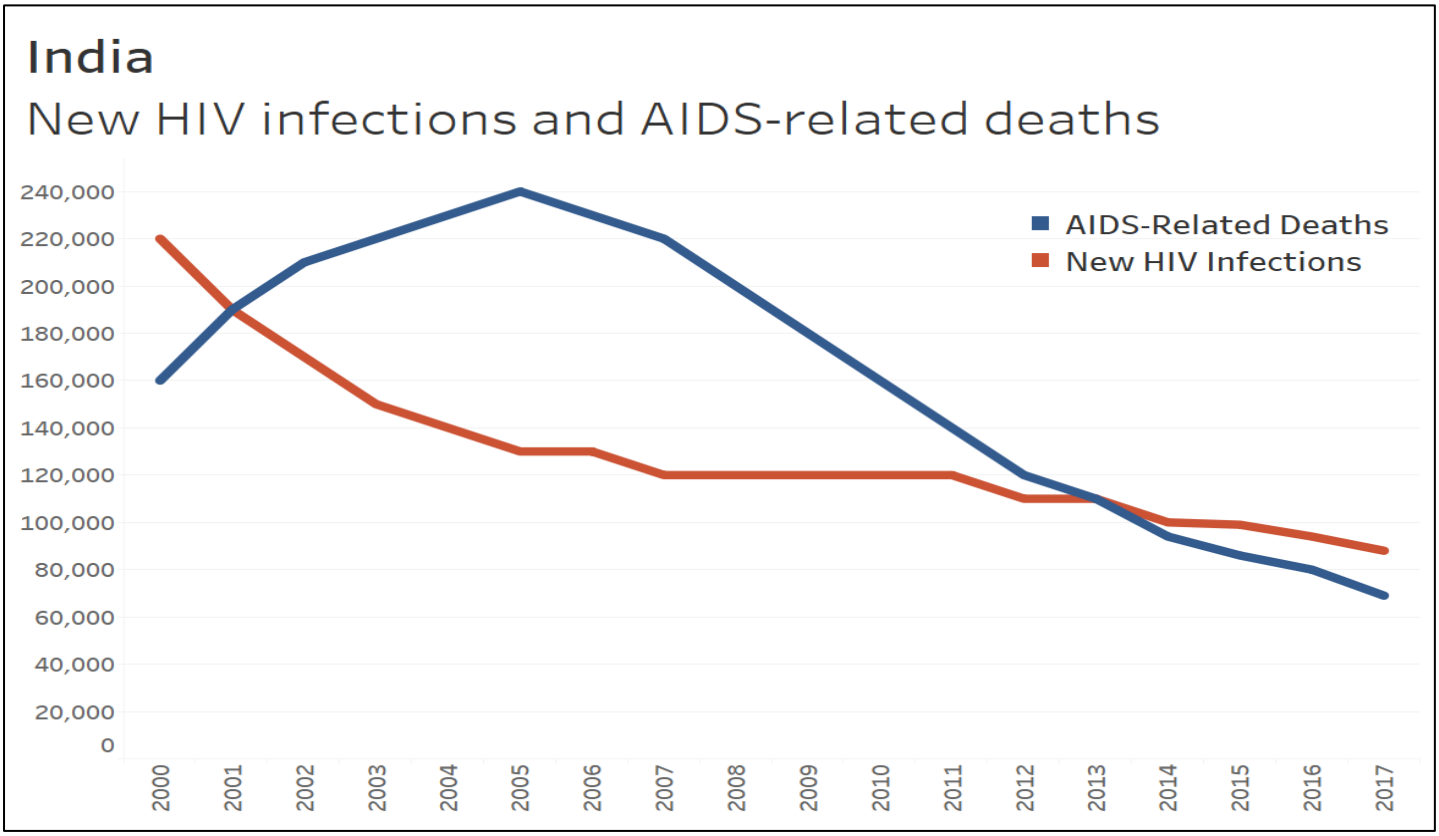


Source: Prepared by www.aidsdatahub.org based on UNAIDS 2019 HIV Estimates and UNAIDS Data 2020.

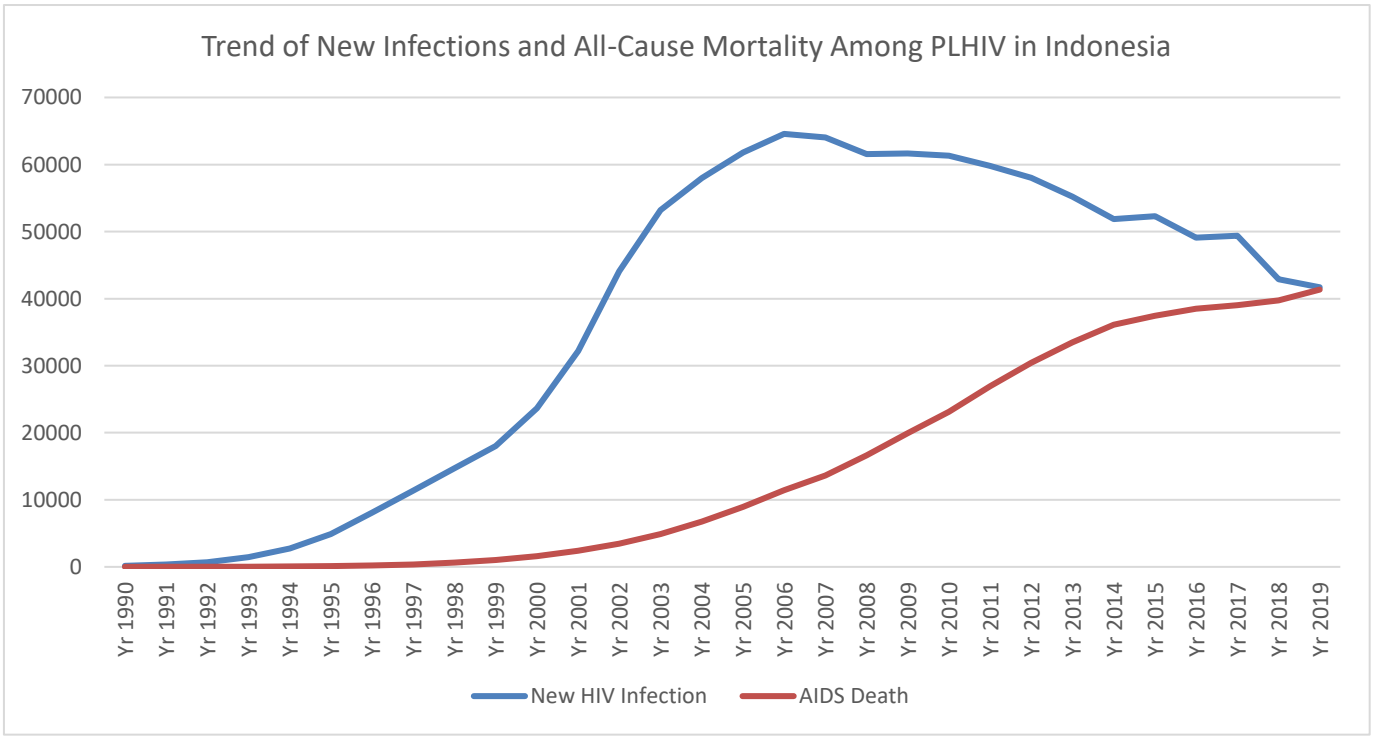
Cambodia



India



Indonesia



Source: Spectrum 2019 using 2018 program data

Kazakhstan

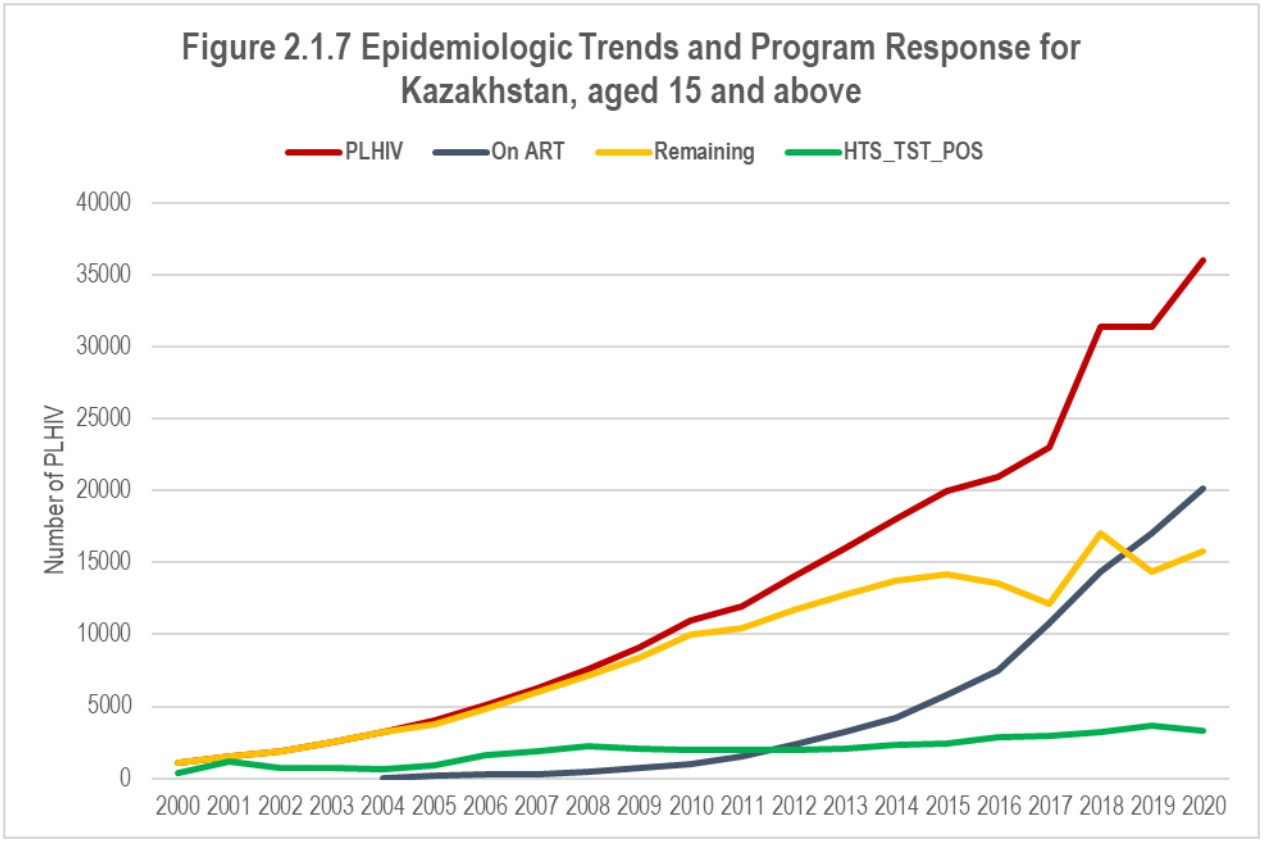
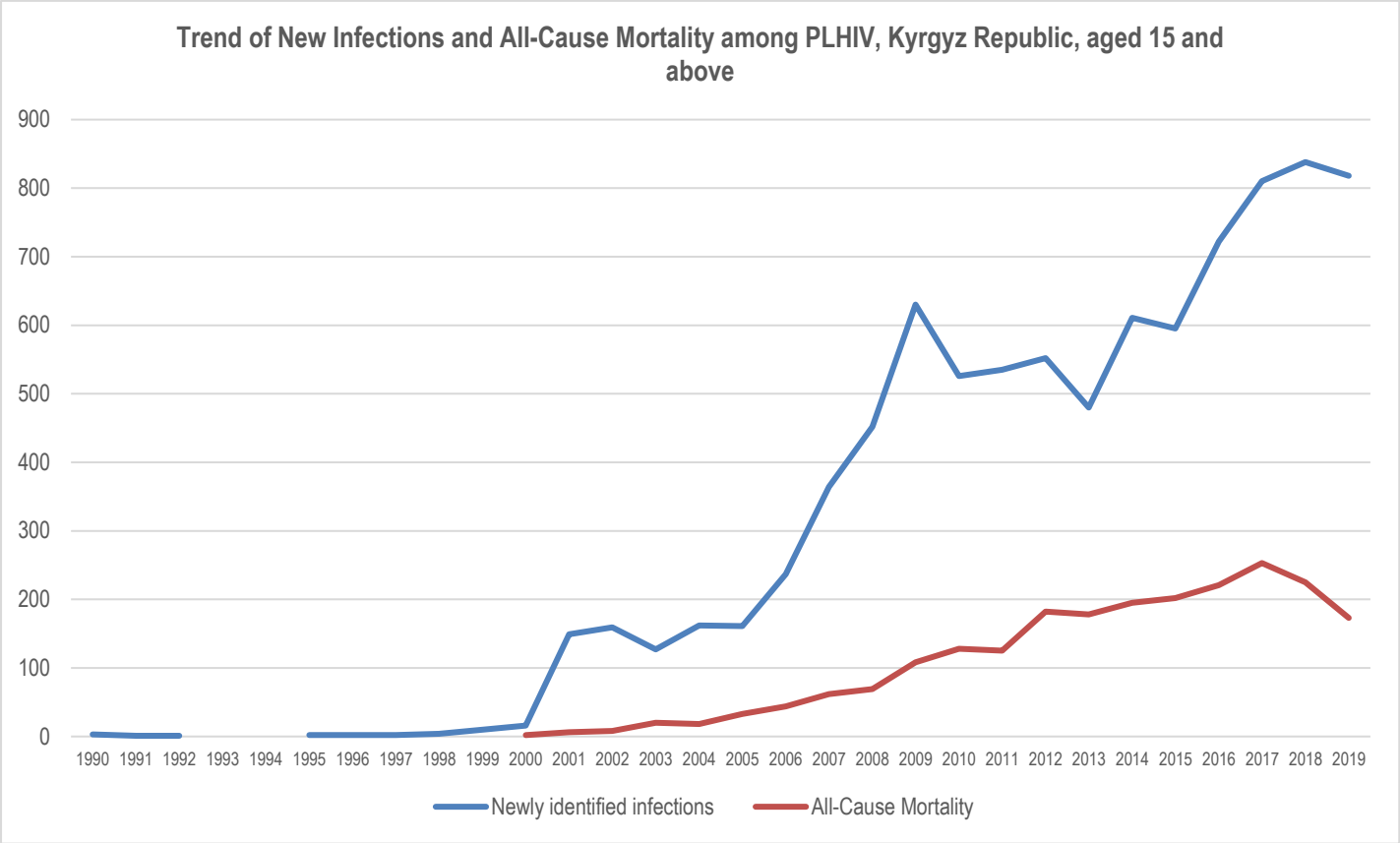
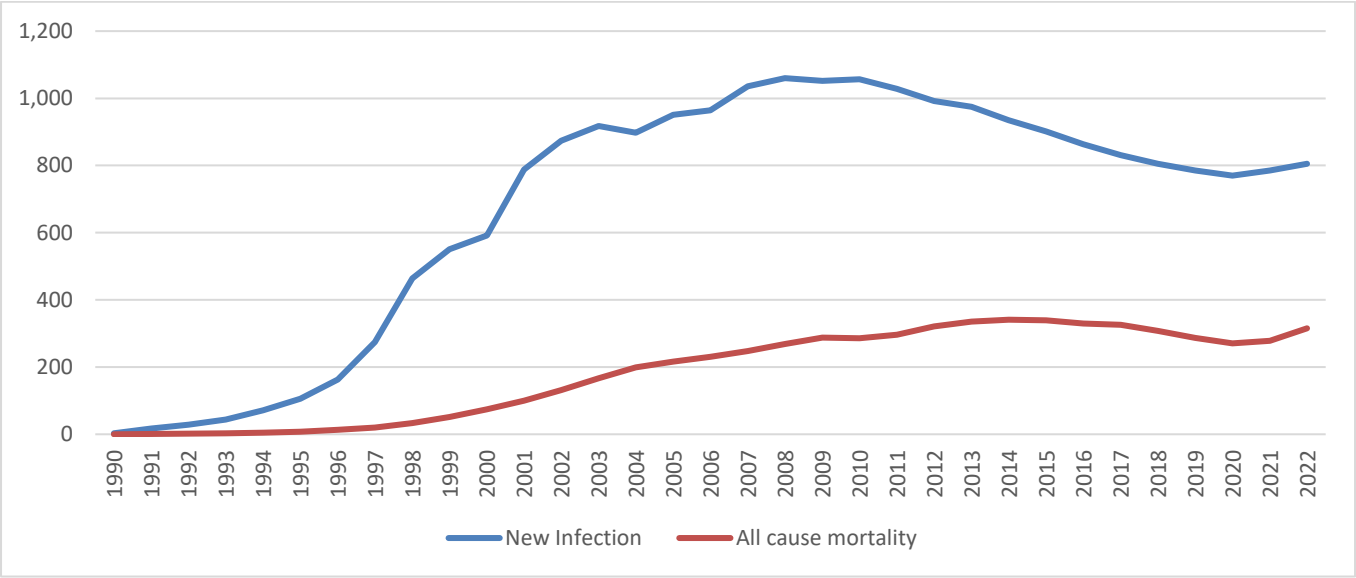


Figure 2.1.7 Epidemiologic Trends and Program Response for Kazakhstan, aged 15 and above
PLHIV
On ART
Remaining
HTS_TST_POS
Number of PLHIV
40000
35000
30000
25000
20000
15000
10000
5000
0
2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020

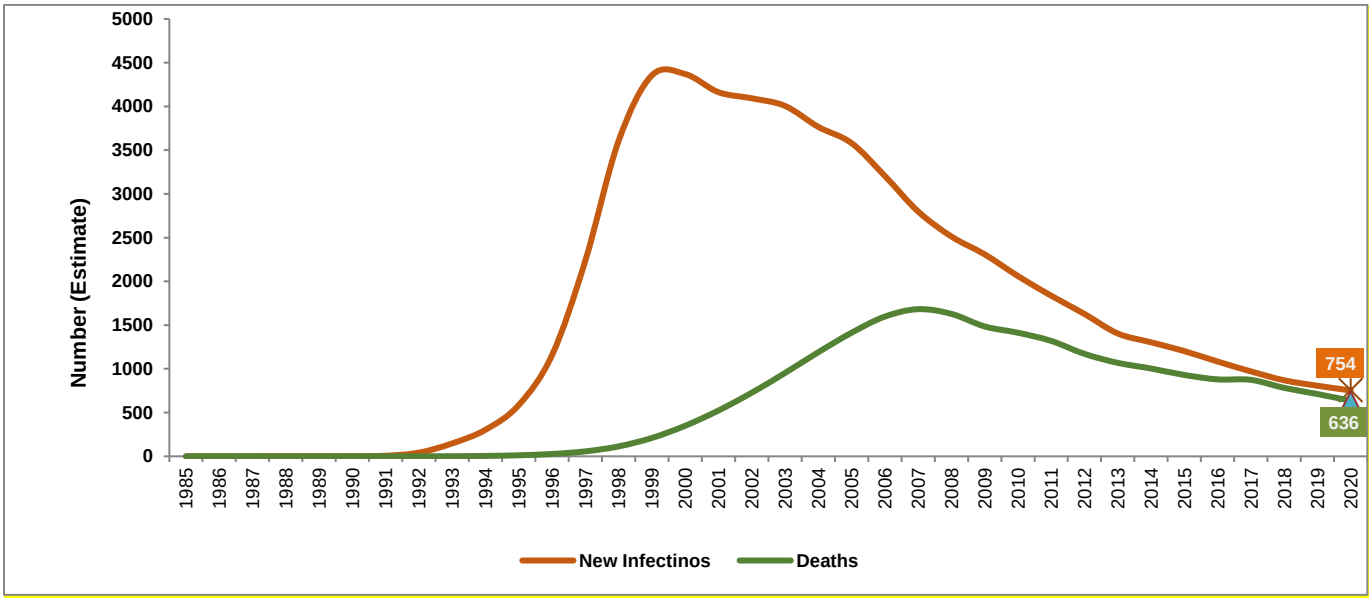
Kyrgyz Republic



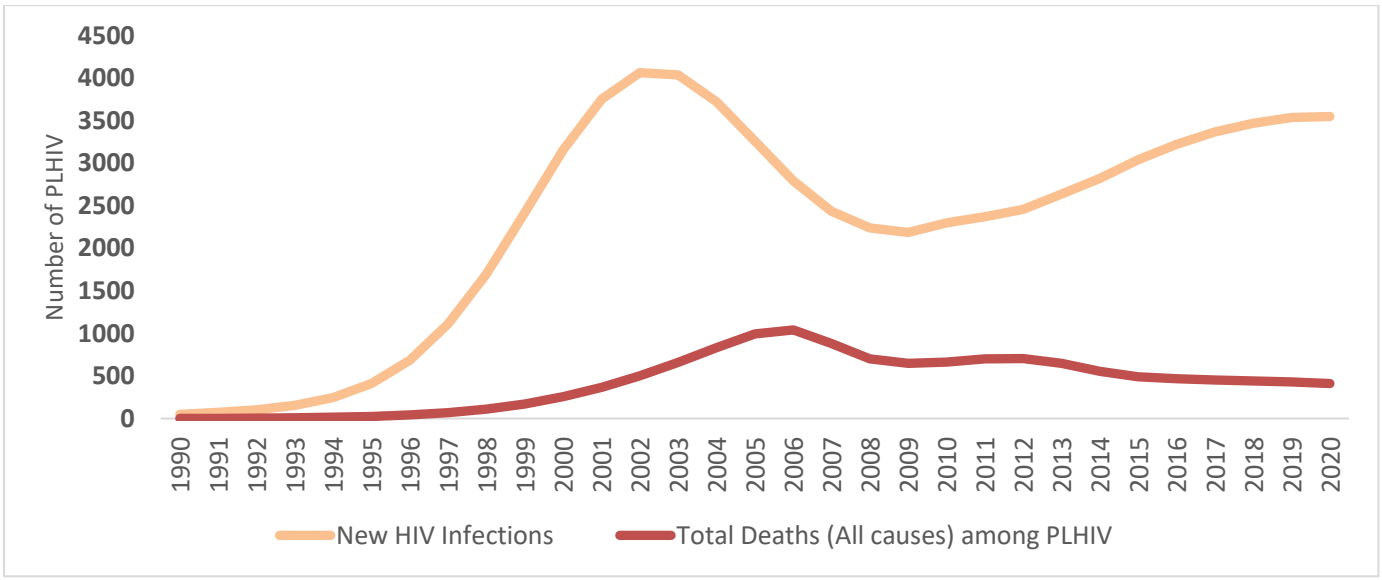
Lao PDR



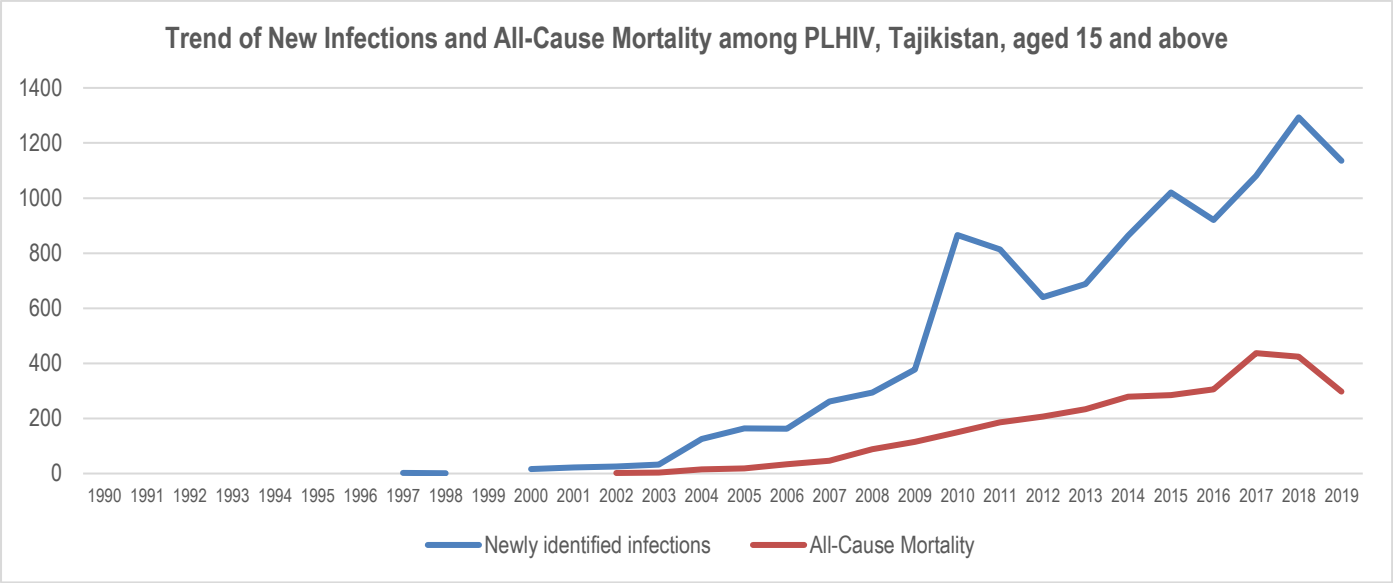
Nepal



Papua New Guinea



Tajikistan



Thailand

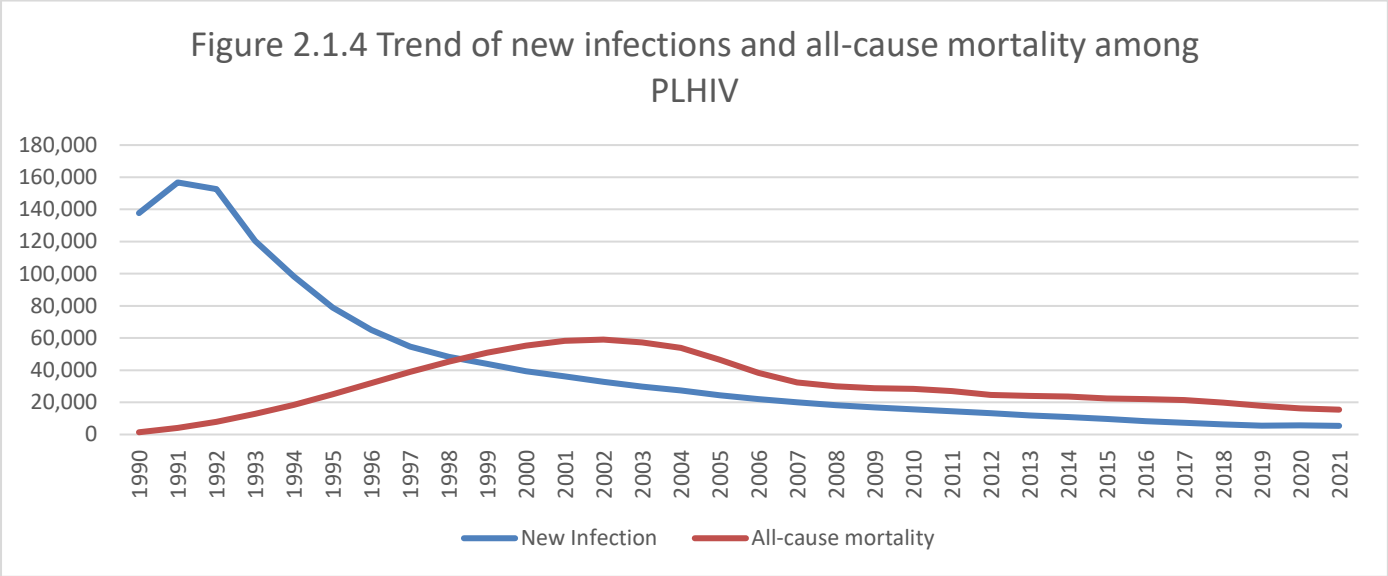
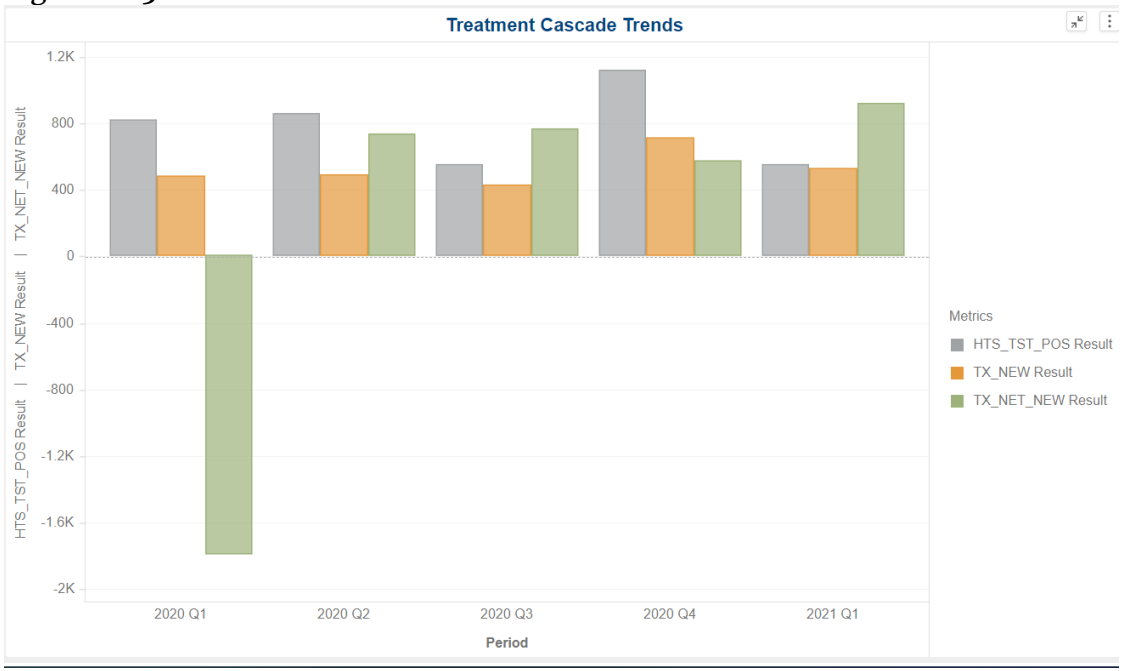
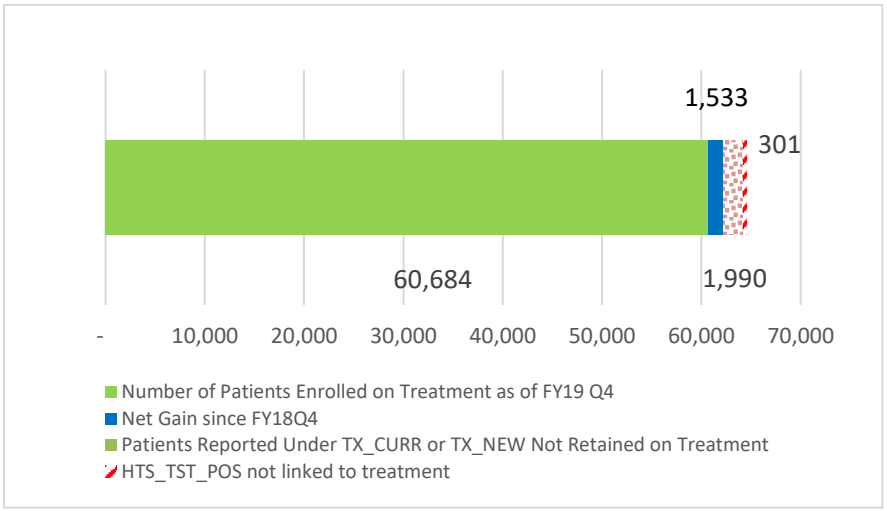


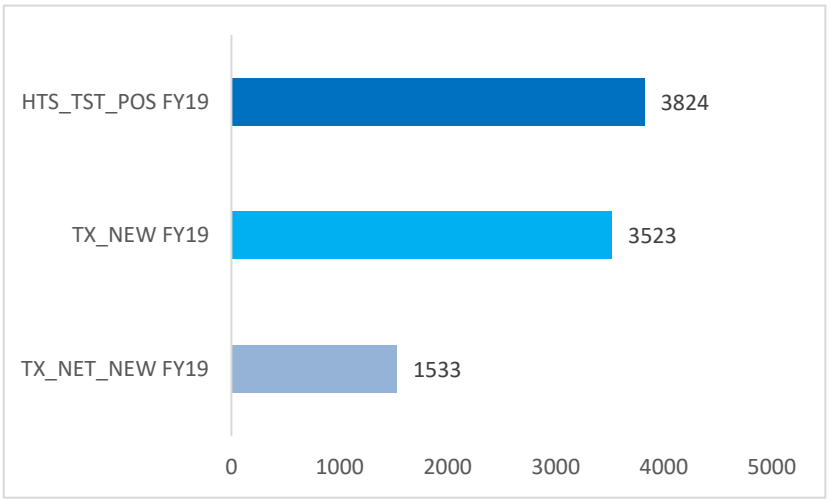
Figure 2.1.5 Progress retaining individuals in lifelong ART in FY20, by country, Updated for ROP21 with the exception of Cambodia and Kazakhstan

Burma
Figure 2.1.5

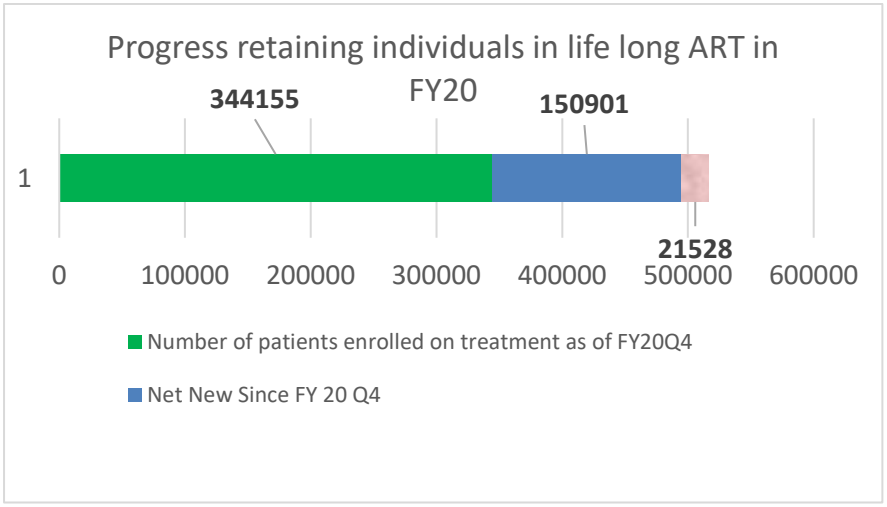


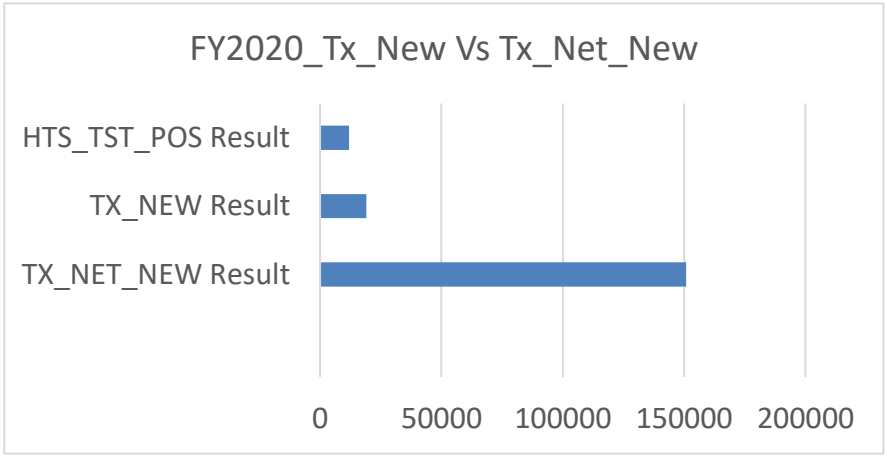
Cambodia





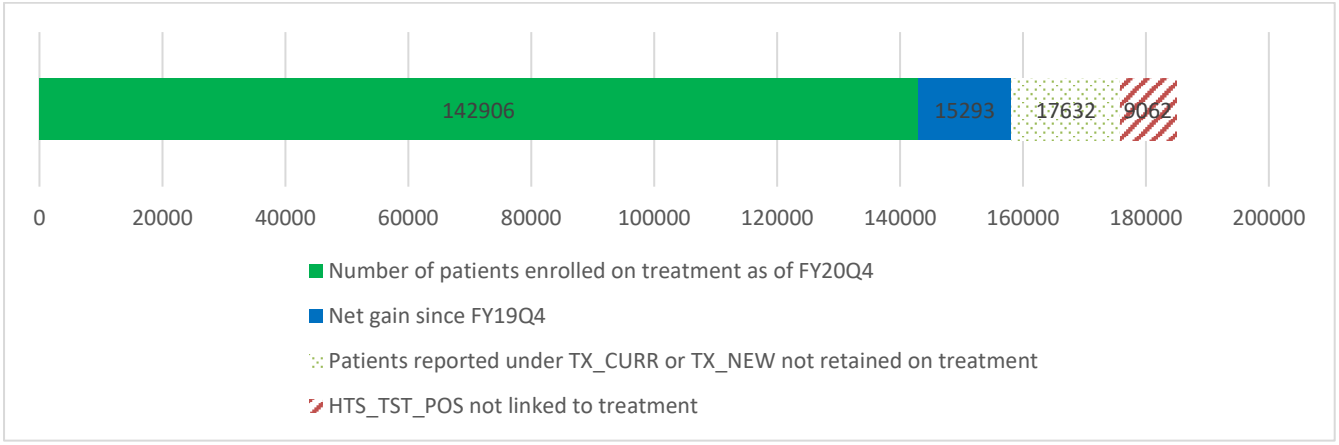
India

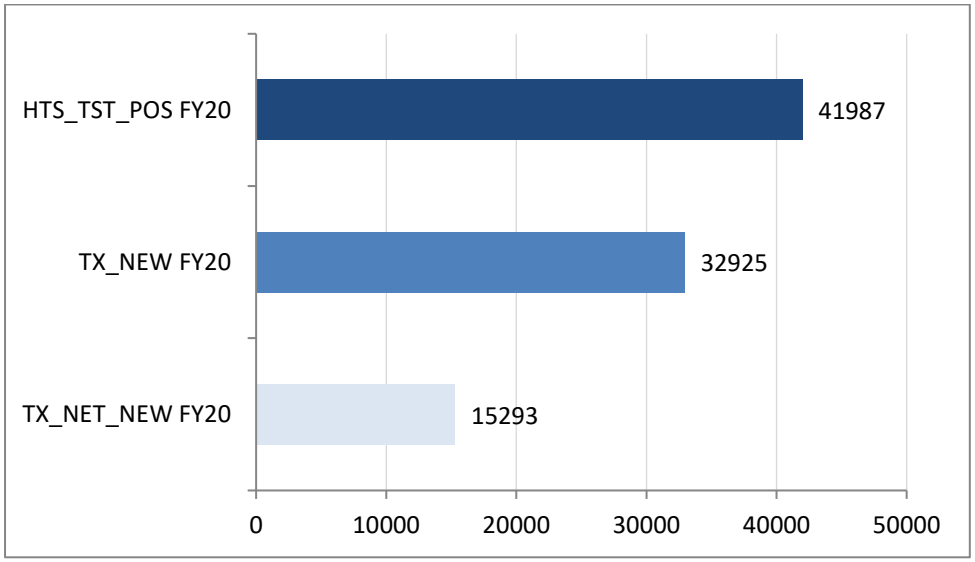




Note: Since HTS_POS KPs is from a subset of KPs trained whereas Tx_CURR is for all populations, the HTS_TST_POS not linked was not possible to present.

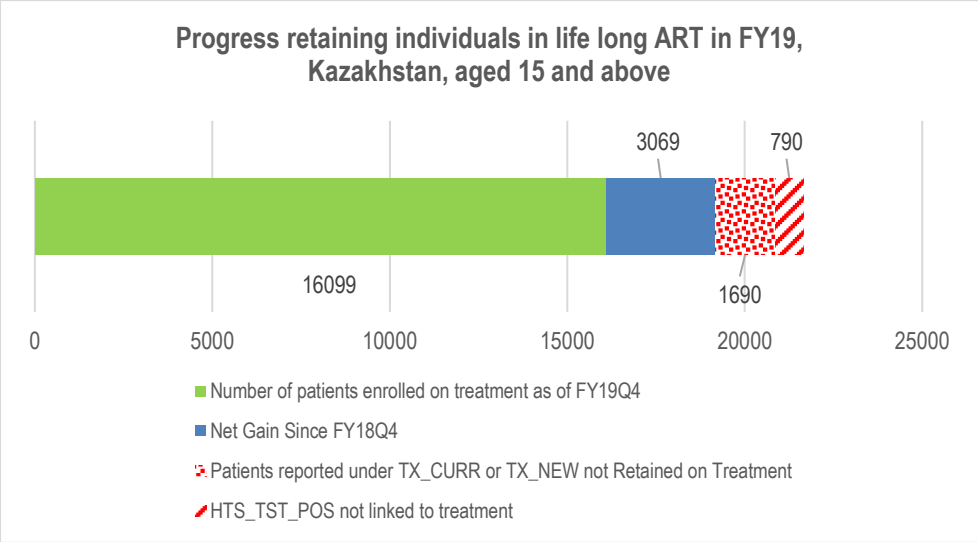
Indonesia

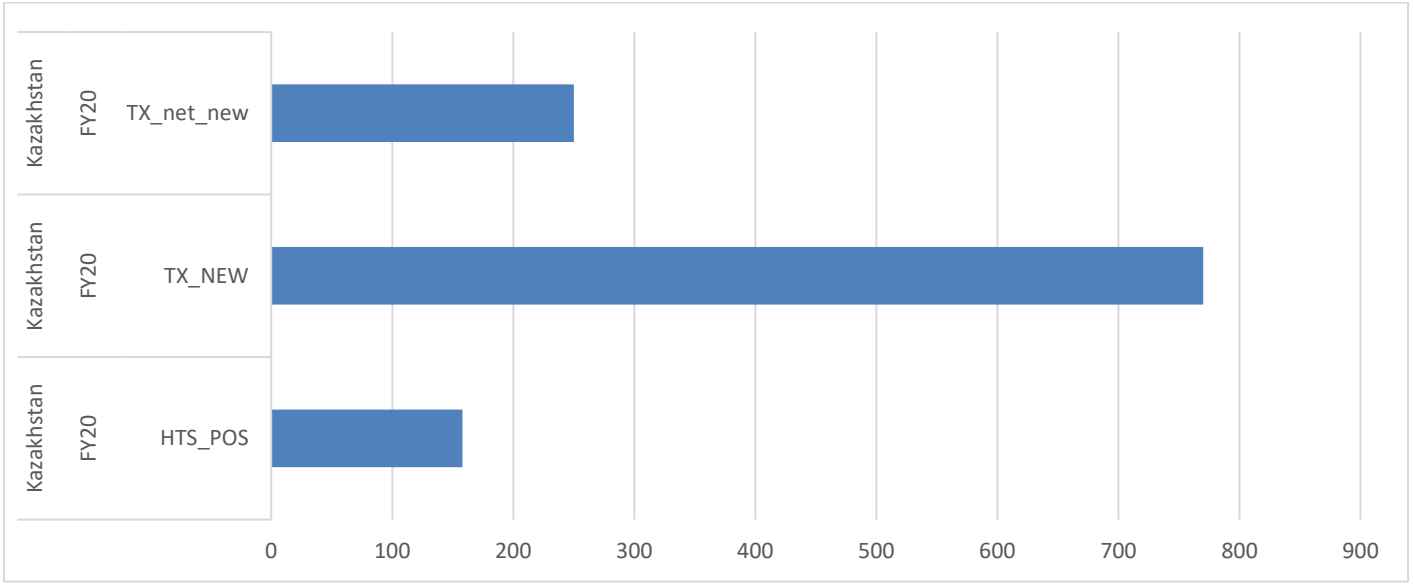

142906
15293
17632
9062
0
20000
40000
60000
80000
100000
120000
140000
160000
180000
200000
Number of patients enrolled on treatment as of FY20Q4
Net gain since FY19Q4
Patients reported under TX_CURR or TX_NEW not retained on treatment
HTS_TST_POS not linked to treatment


HTS_TST_POS FY20
41987
TX_NEW FY20
32925
TX_NET_NEW FY20
15293
0
10000
20000
30000
40000
50000

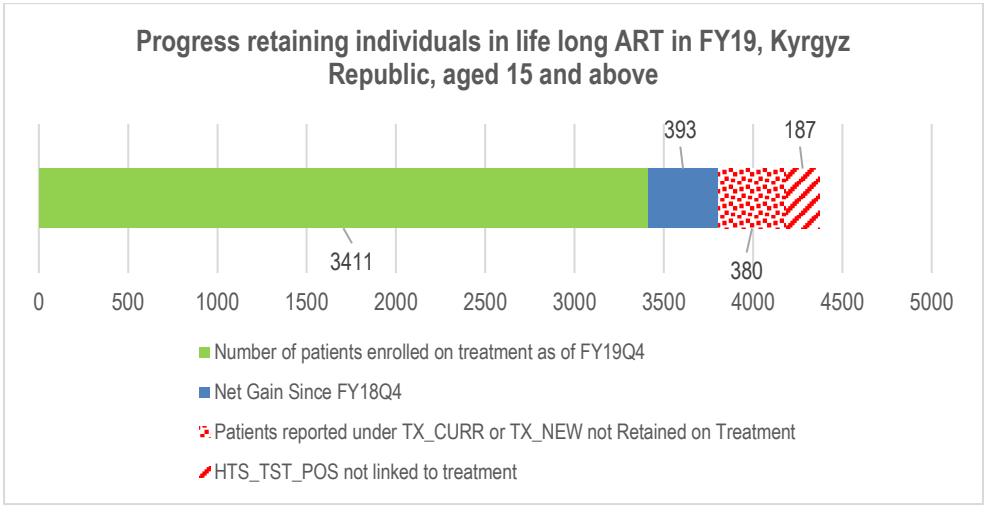
Source: MoH Quarterly Report.

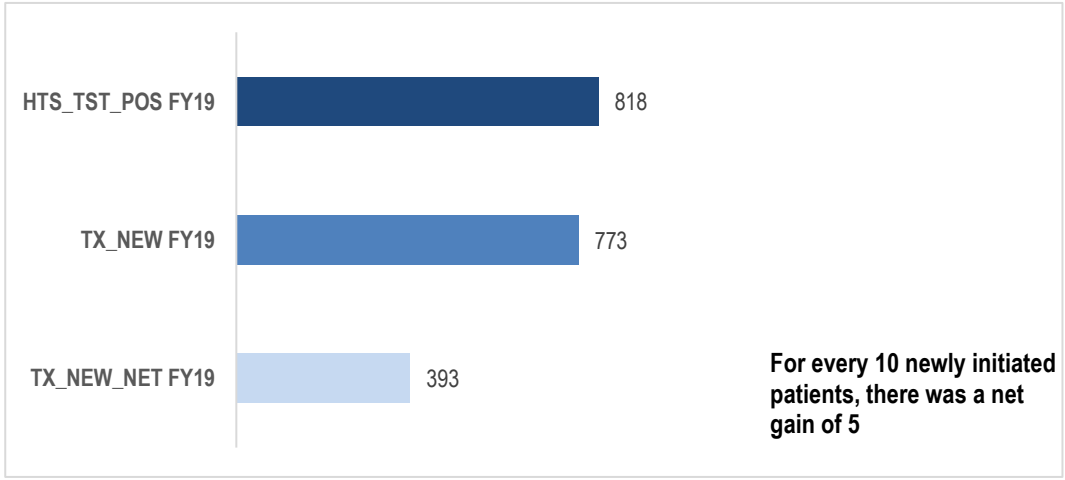
Kazakhstan





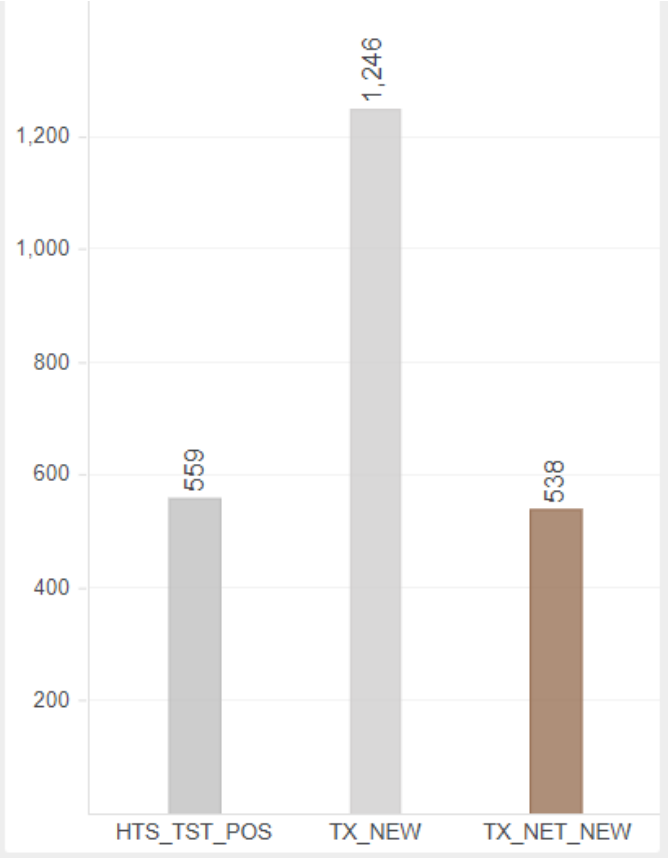
Kyrgyz Republic





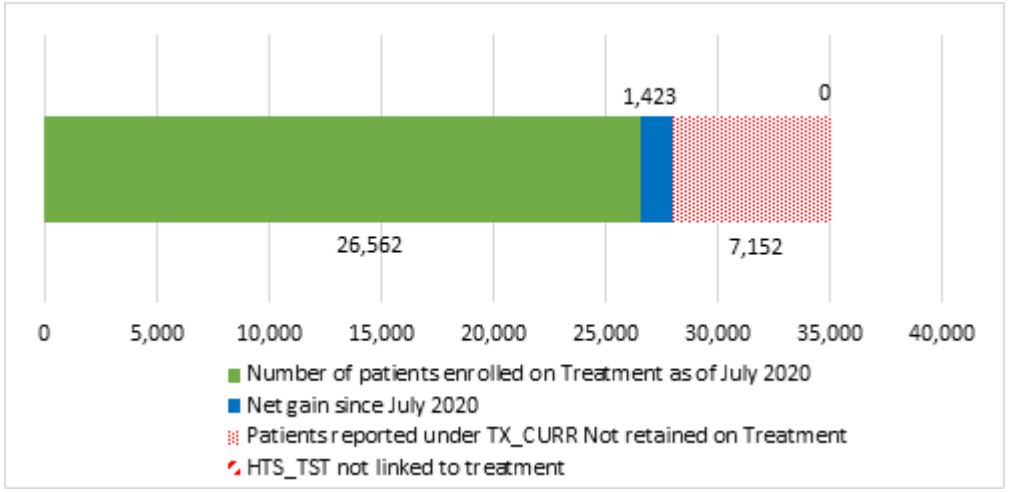
Lao PDR

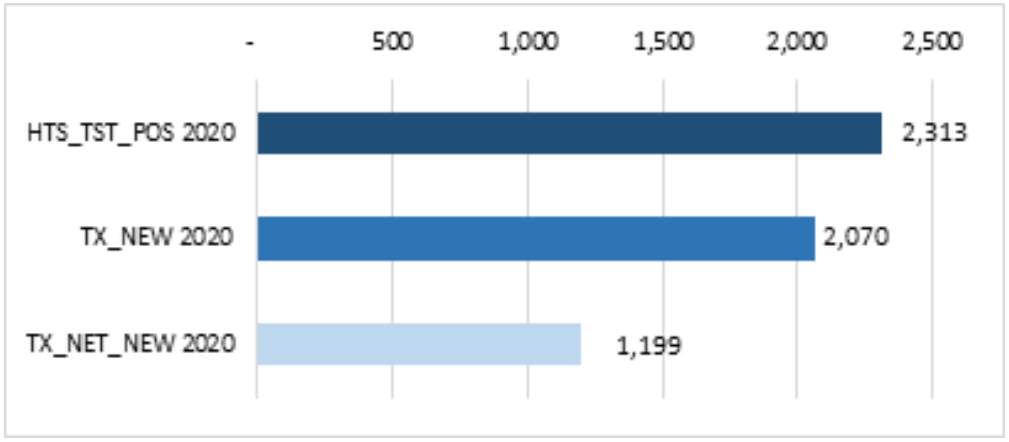
Figure 2.1.5 Progress retaining individuals in lifelong ART in FY20, by country



Nepal

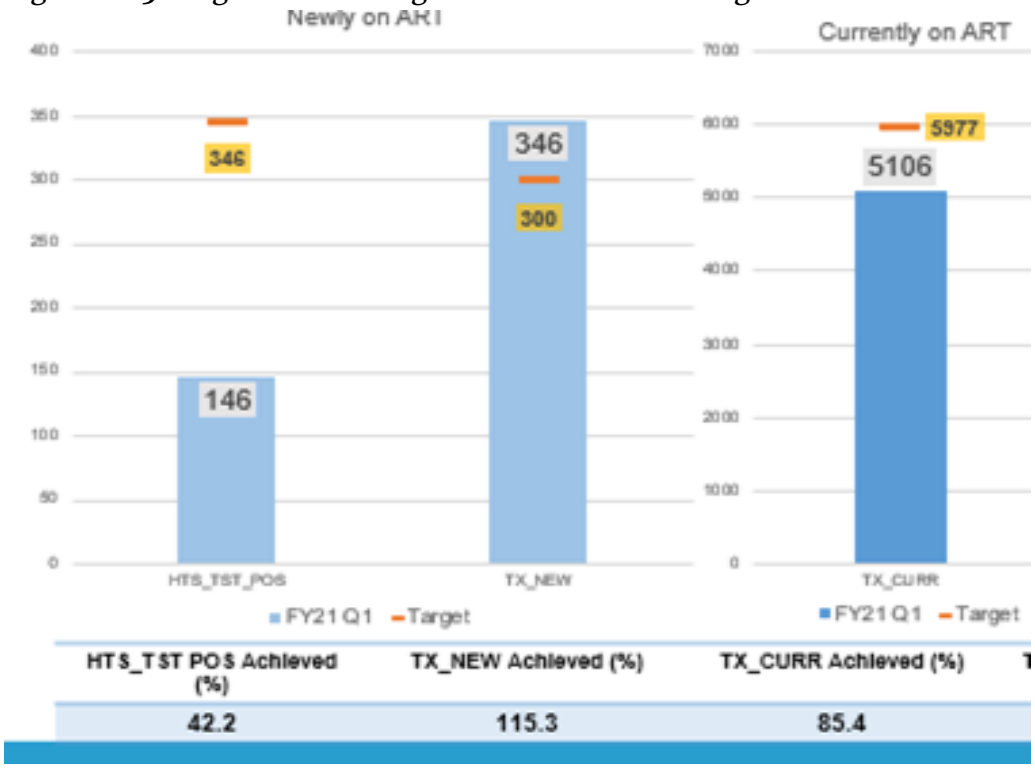
Figure 2.1.5 Progress retaining individuals in lifelong ART in FY20, by country





Papua New Guinea

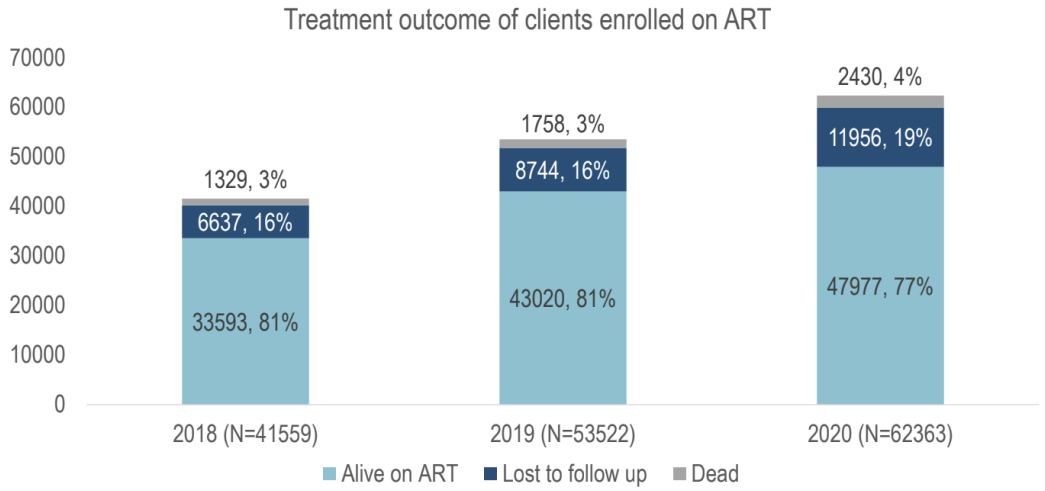
Figure 2.1.5 Progress Retaining Individuals in Lifelong ART in FY20



Philippines

ENROLLMENT AND ADHERENCE

Proportion of clients lost to follow up increased from 16% (2019) to 19% (2020)



Source: National HIV/AIDS and ART Registry of the Philippines, December 2020

Tajikistan

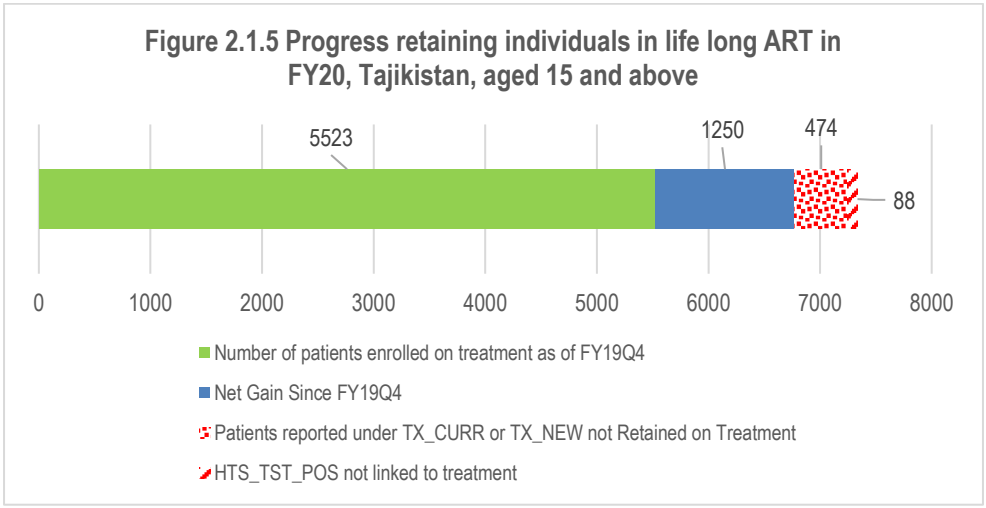
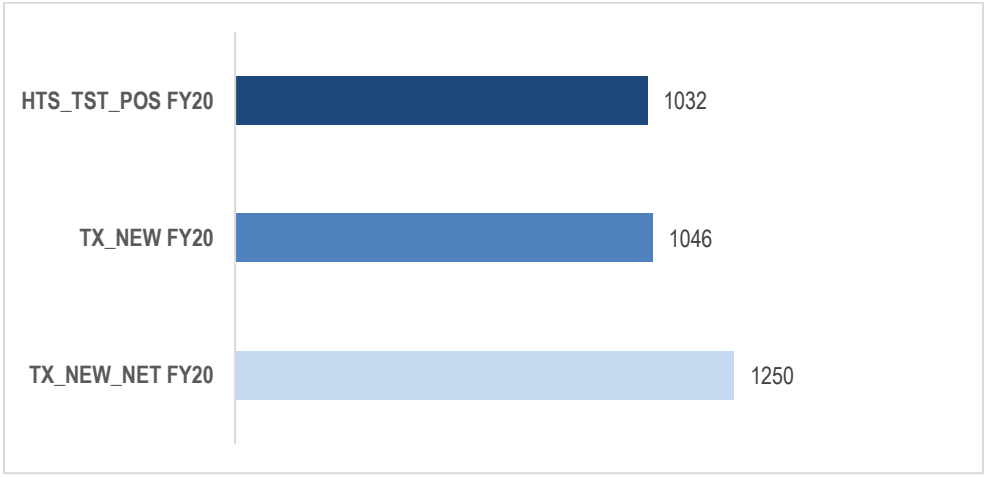


Figure 2.1.5 Progress retaining individuals in life long ART in FY20, Tajikistan, aged 15 and above
5523
1250
474
88
0
1000
2000
3000
4000
5000
6000
7000
8000
Number of patients enrolled on treatment as of FY19Q4
Net Gain Since FY19Q4
Patients reported under TX_CURR or TX_NEW not Retained on Treatment
HTS_TST_POS not linked to treatment


HTS_TST_POS FY20
1032
TX_NEW FY20
1046
TX_NEW_NET FY20
1250

Thailand

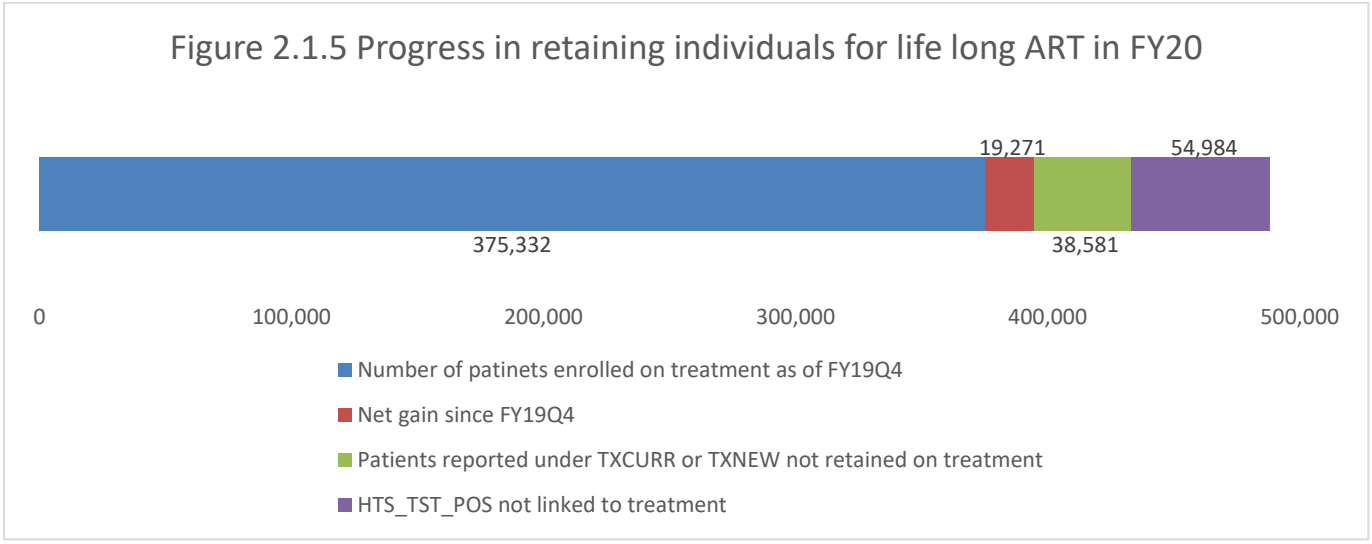


Figure 2.1.5 Progress in retaining individuals for life long ART in FY20
19,271
54,984
375,332
38,581
0
100,000
200,000
300,000
400,000
500,000
Number of patinets enrolled on treatment as of FY19Q4
Net gain since FY19Q4
Patients reported under TXCURR or TXNEW not retained on treatment
HTS_TST_POS not linked to treatment

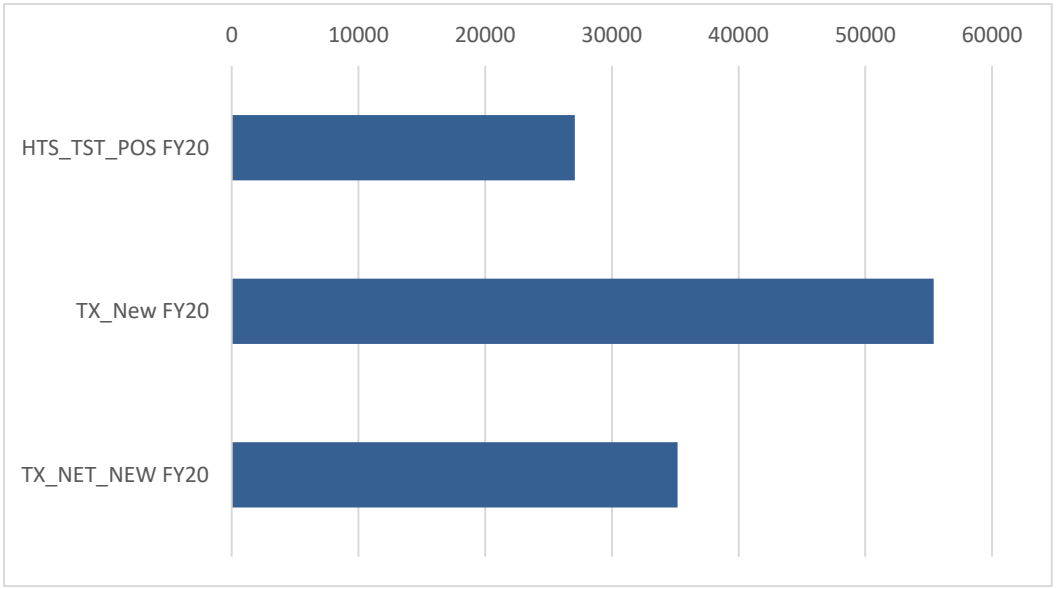
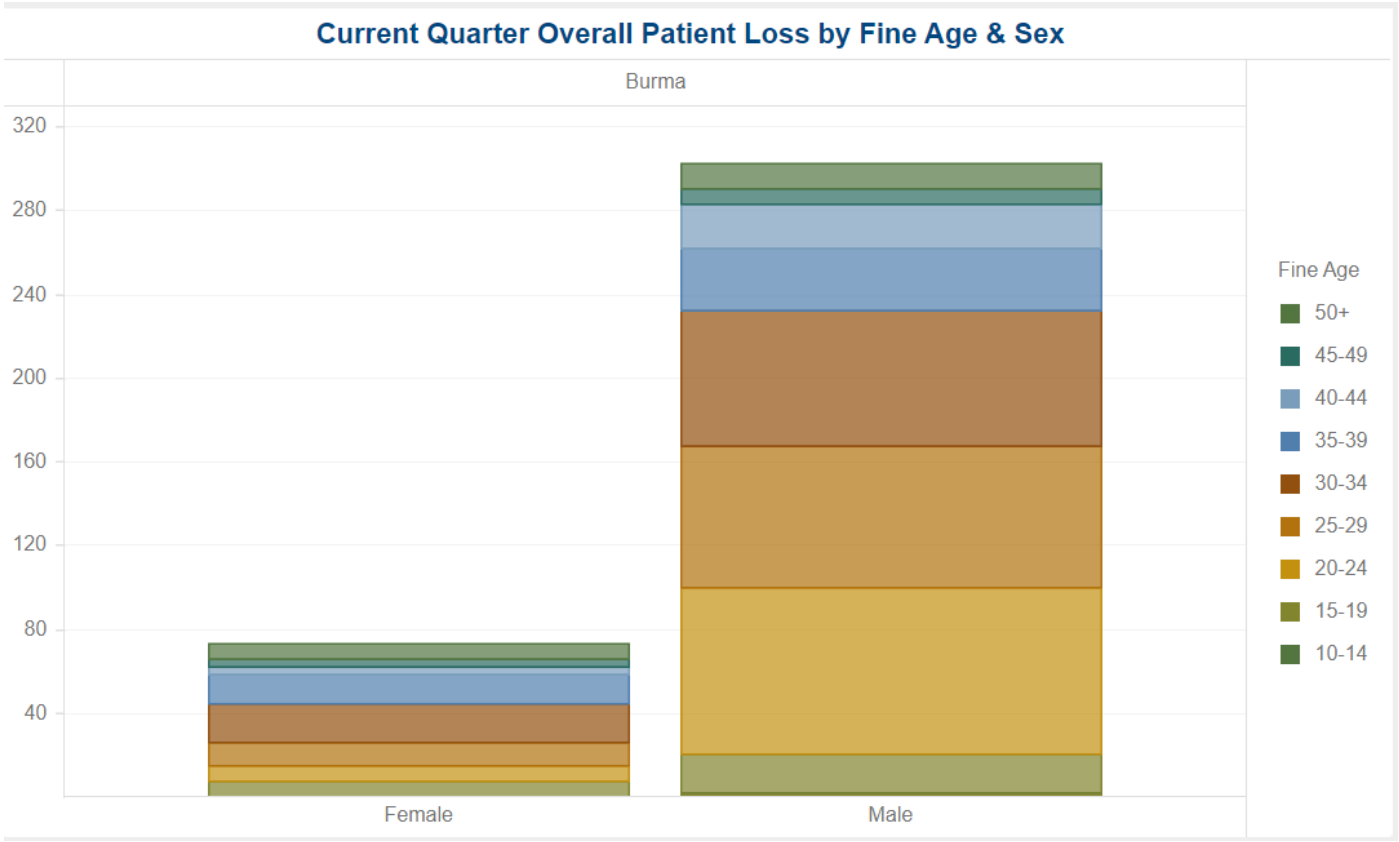

0
10000
20000
30000
40000
50000
60000
HTS_TST_POS FY20
TX_New FY20
TX_NET_NEW FY20

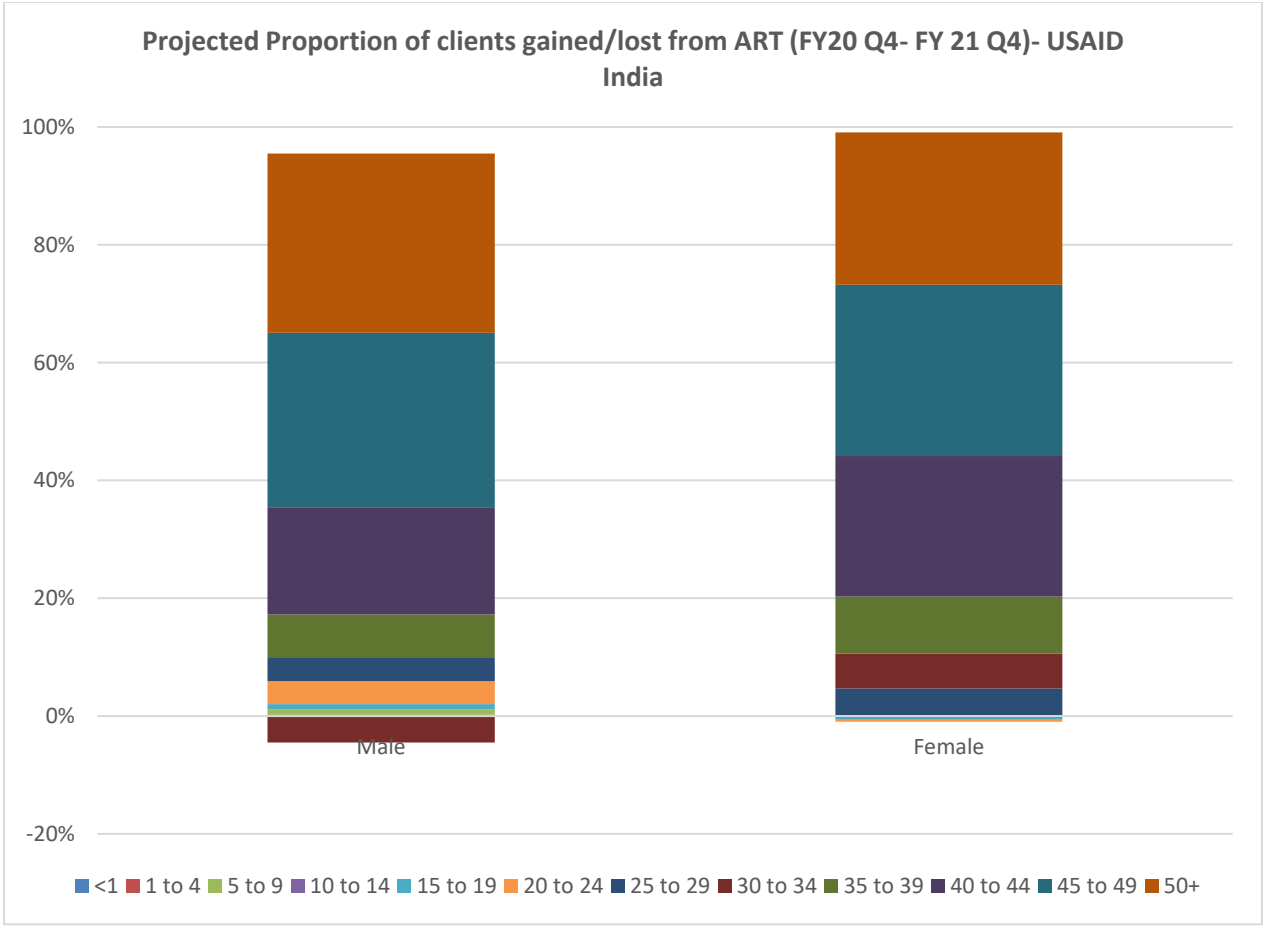
Figure 2.1.6, updated for ROP21 with exception of Cambodia

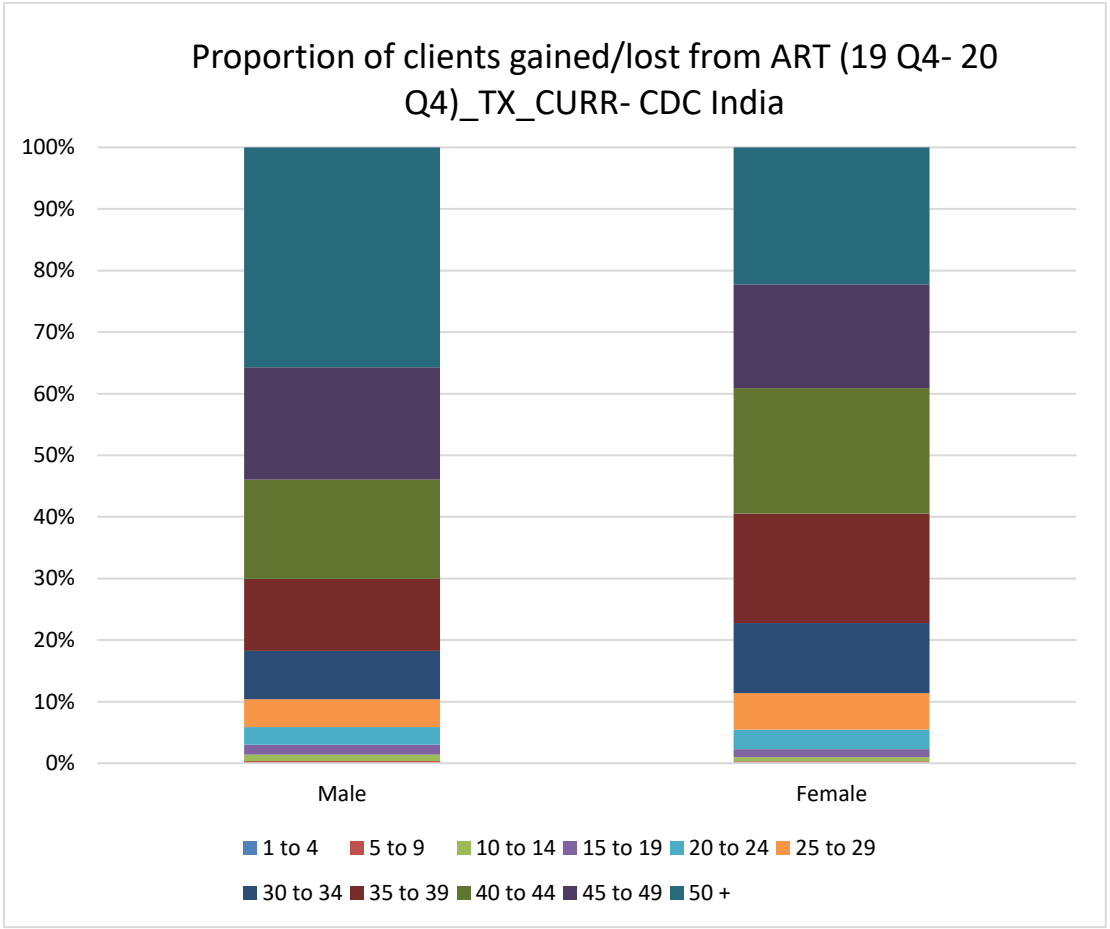
Burma

Figure 2.1.6 Proportion of clients lost from ART FY21 Q1



India
Figure 2.1.6

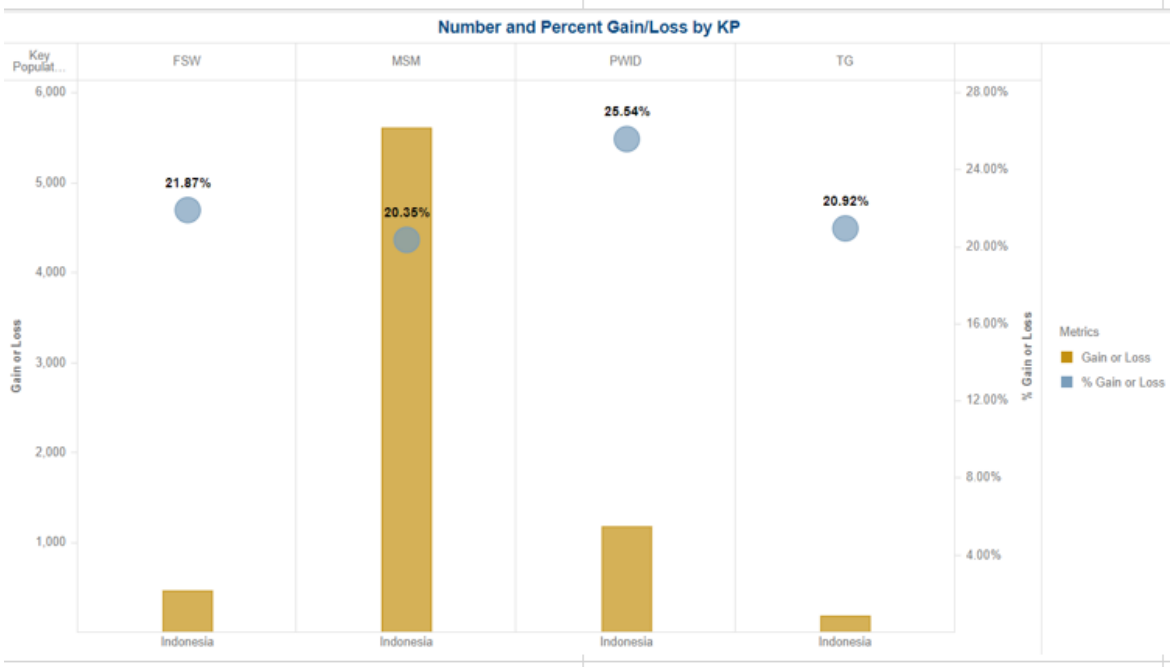



Proportion of clients gained/lost from ART (19 Q4- 20 Q4)_TX_CURR- CDC India
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Male
Female
1 to 4
5 to 9
10 to 14
15 to 19
20 to 24
25 to 29
30 to 34
35 to 39
40 to 44
45 to 49
50 +

Indonesia

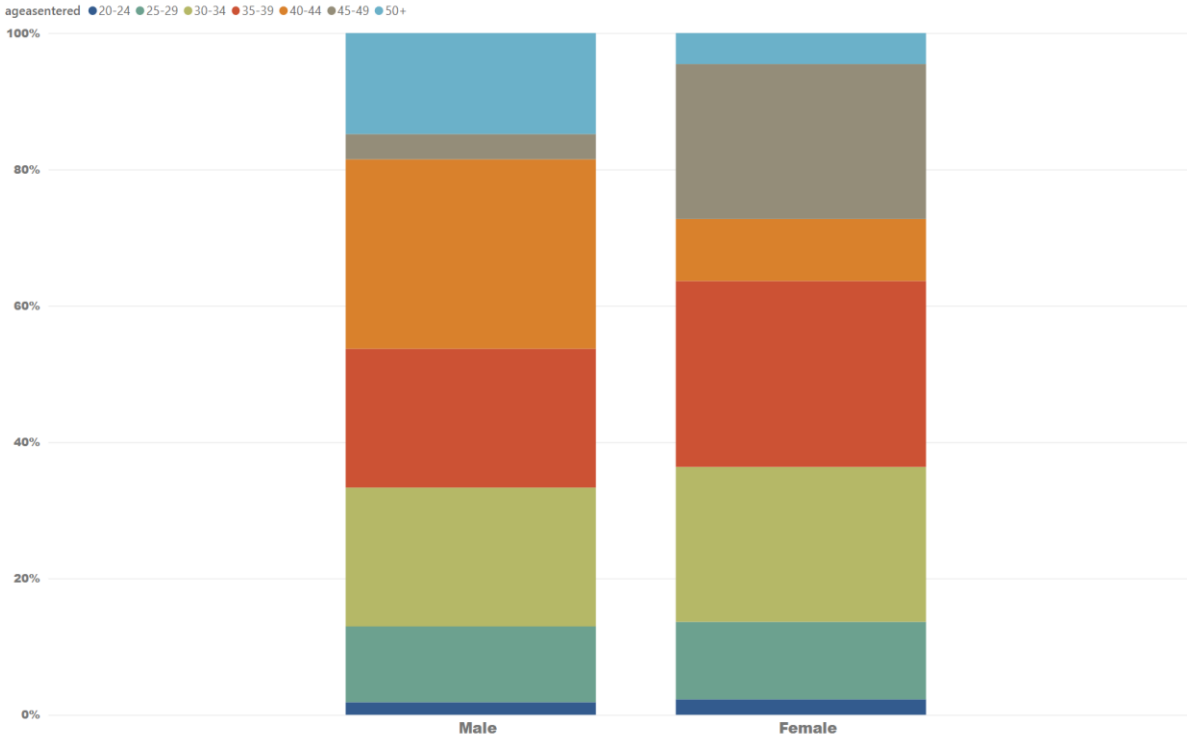
Figure 2.1.6.

OU Indonesia has only net gain/loss data disaggregated by KP

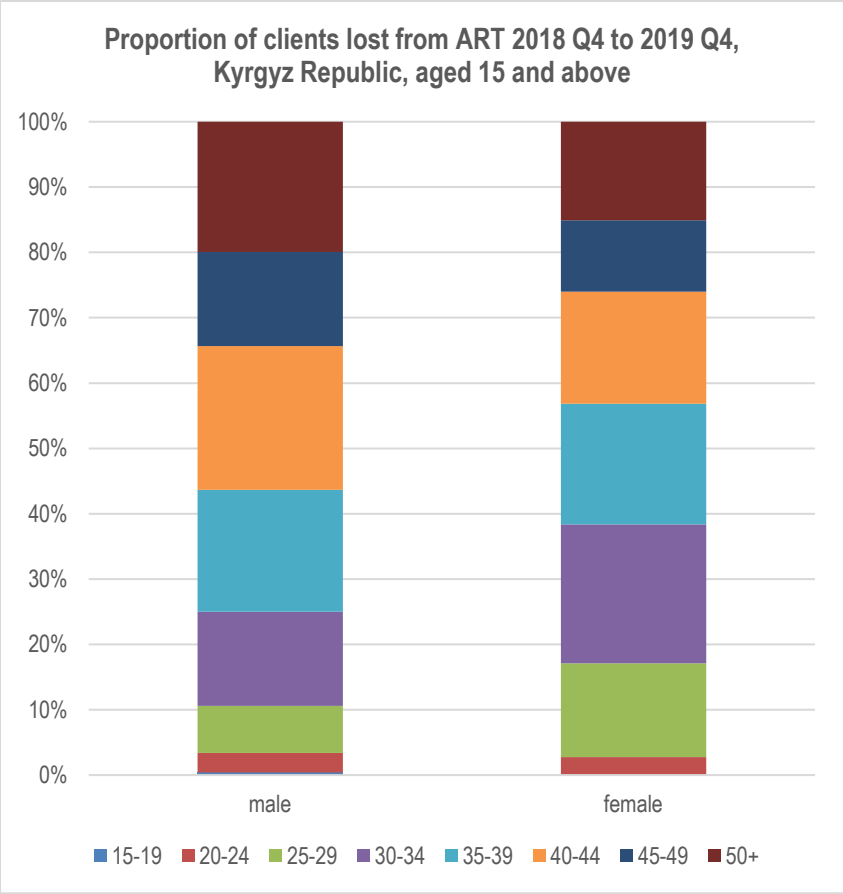


Kazakhstan

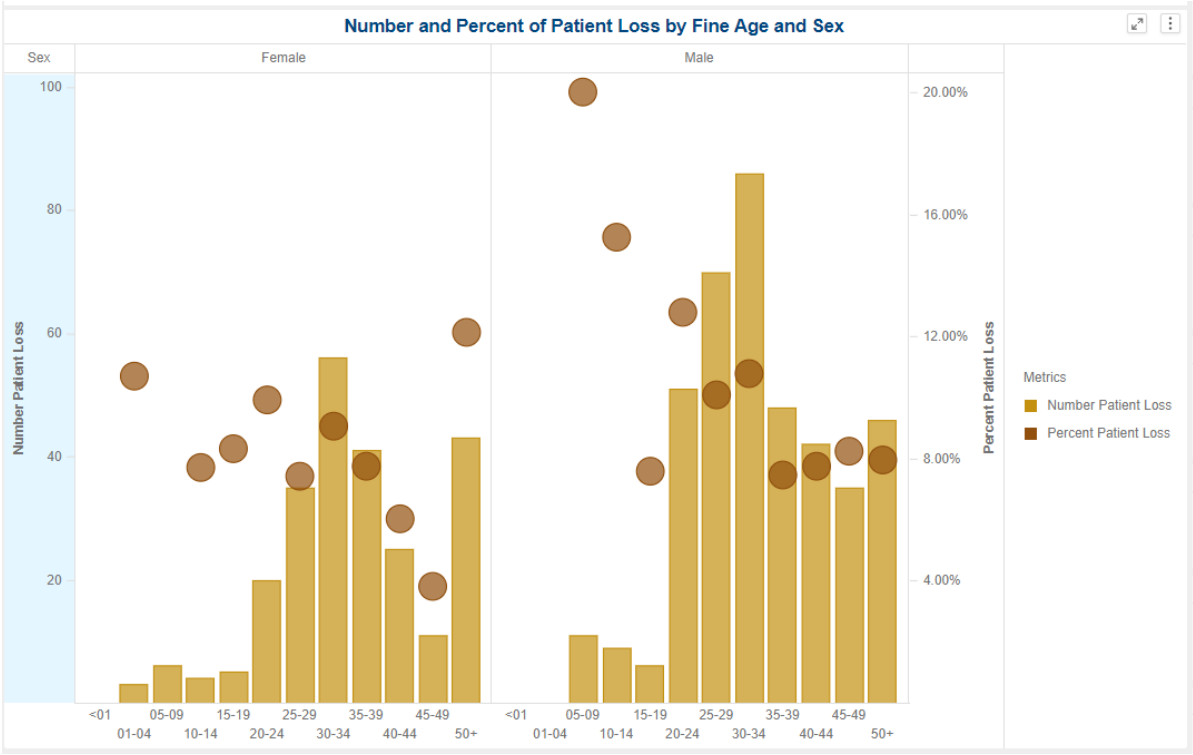
Figure 2.1.6



Kyrgyz Republic
Figure 2.1.6

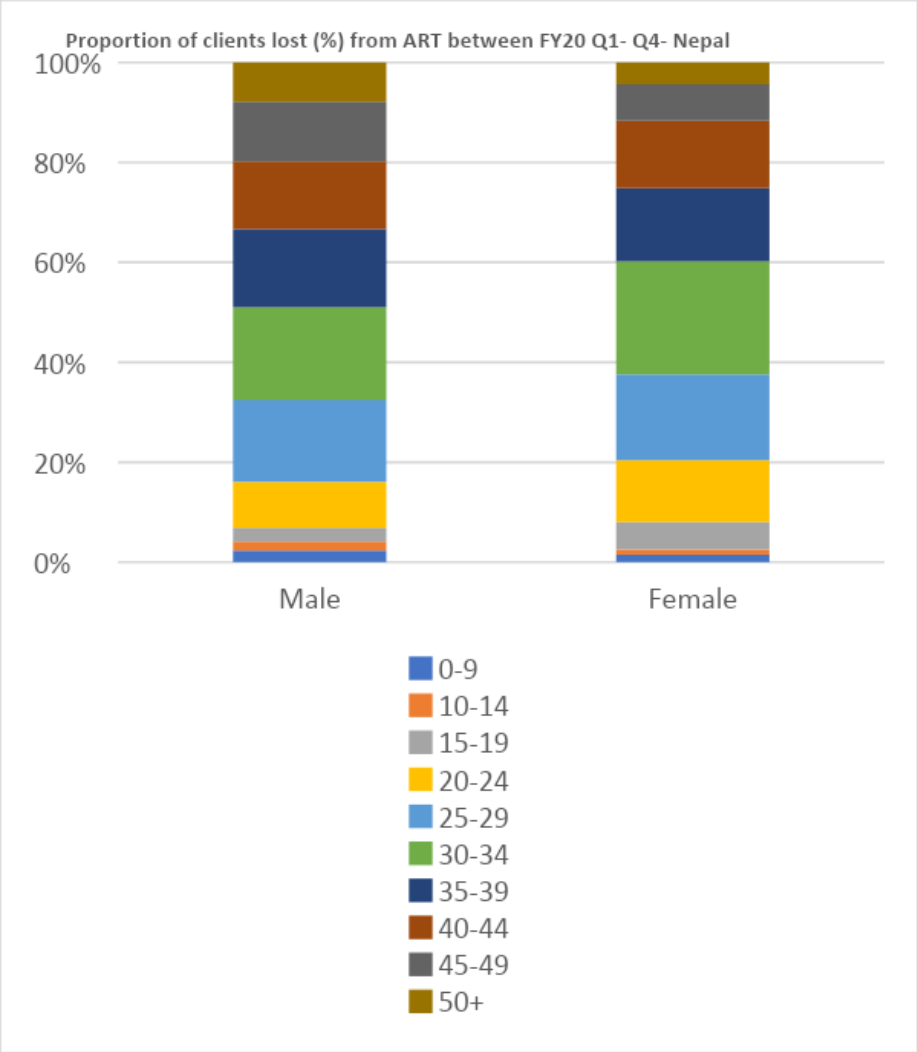

Proportion of clients lost from ART 2018 Q4 to 2019 Q4, Kyrgyz Republic, aged 15 and above
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
male
female
15-19
20-24
25-29
30-34
35-39
40-44
45-49
50+

Lao PDR
Figure 2.1.6

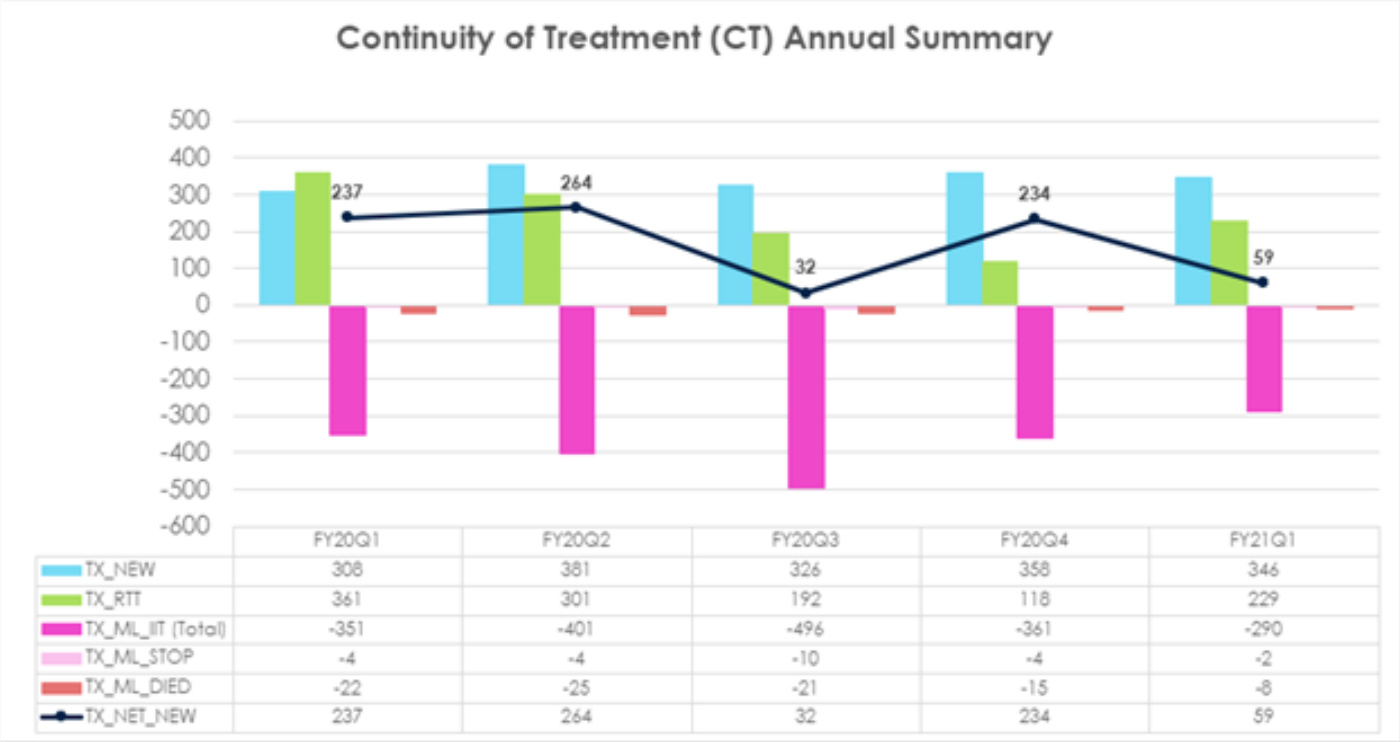


Nepal

Figure 2.1.6

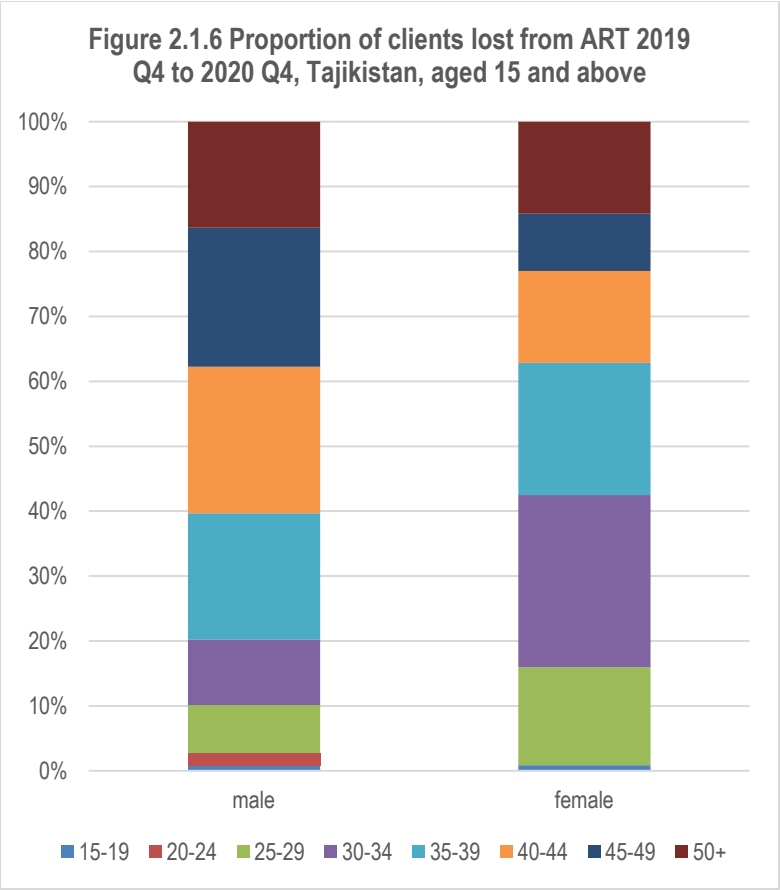


Papua New Guinea
Figure 2.1.6 Clients Gained/Lost from ART by Age/Sex, FY20 Q4



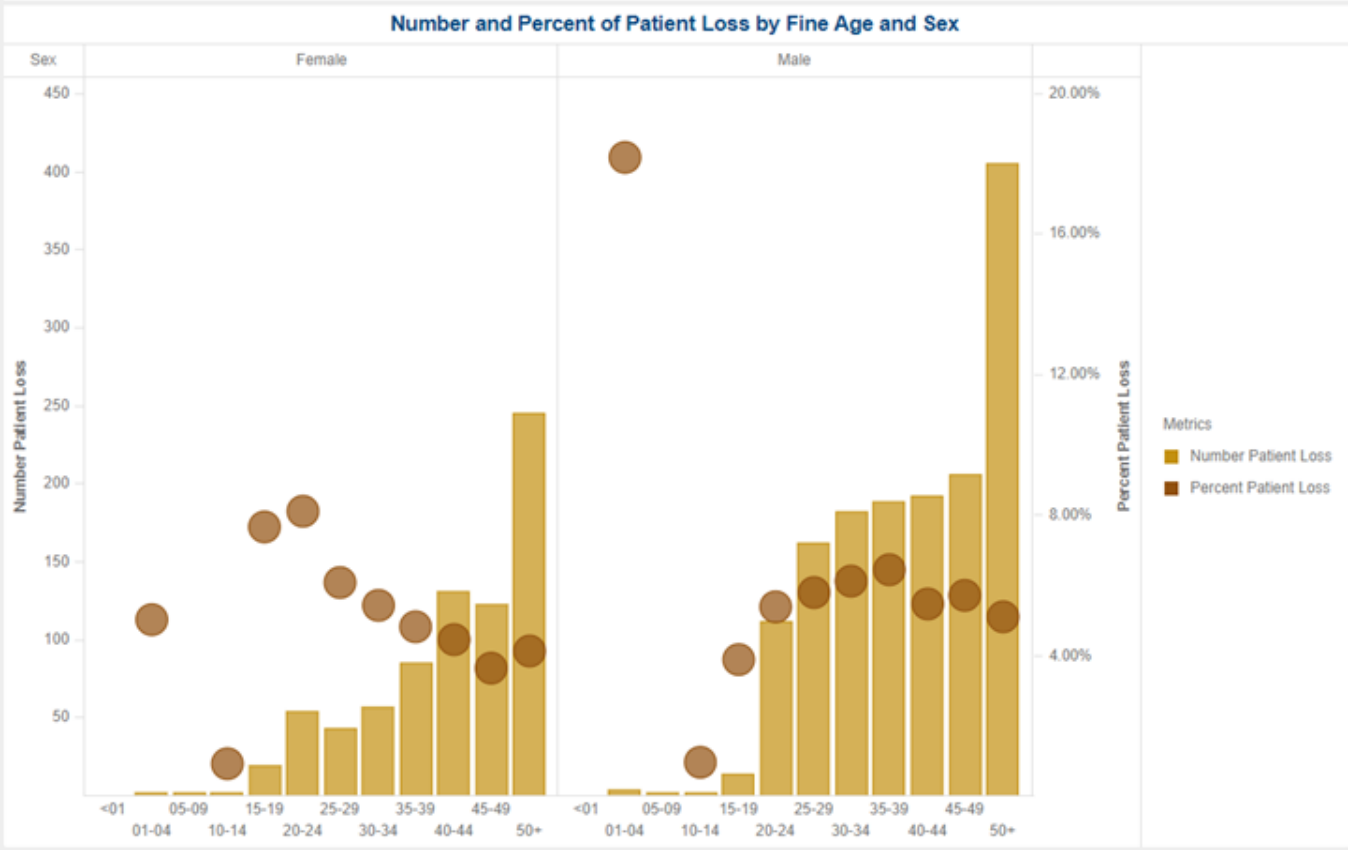
	FY20Q1	FY20Q2	FY20Q3	FY20Q4	FY21Q1
TX_NEW	308	381	326	358	346
TX_RTT	361	301	192	118	229
TX_ML_IIT (Total)	-351	-401	-496	-361	-290
TX_ML_STOP	-4	-4	-10	-4	-2
TX_ML_DIED	-22	-25	-21	-15	-8
TX_NET_NEW	237	264	32	234	59

Tajikistan
Figure 2.1.6



Thailand

Figure 2.1.6 Proportion of clients lost from ART 2020 Q4 to 2021 Q1: Thailand



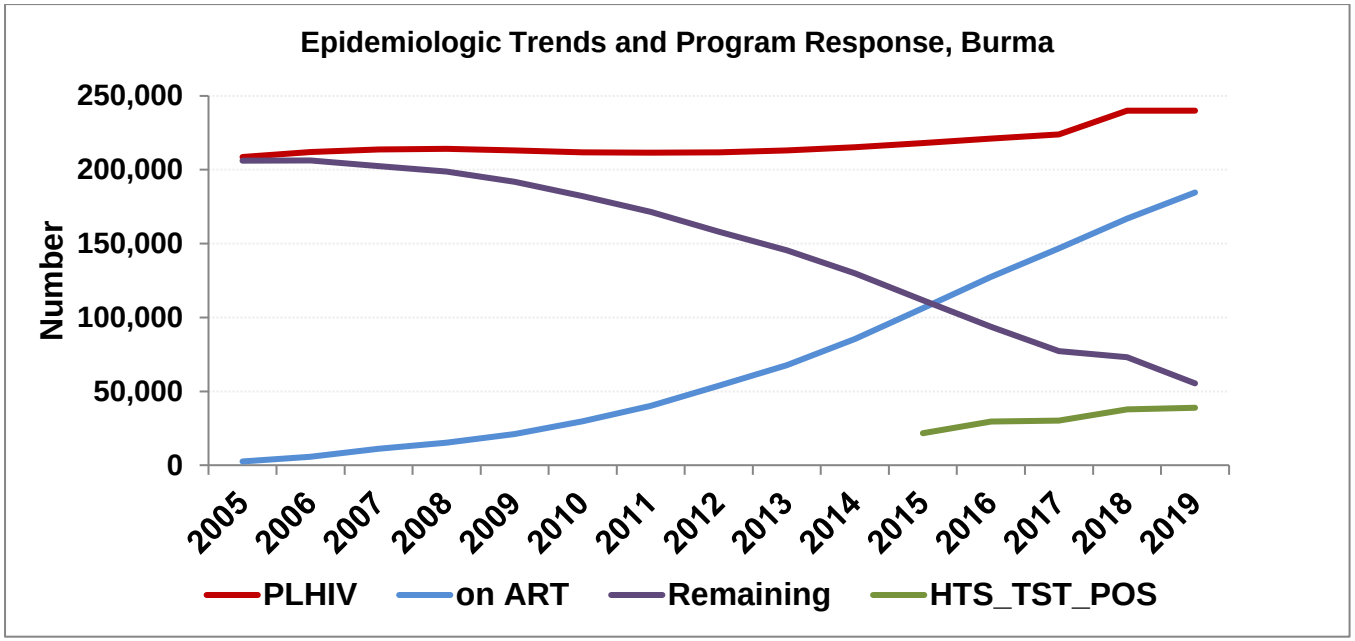
Source: Treatment: Single OU; Panorama (Retention and net gain/loss proxies, PANORAMA Q1/2021

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

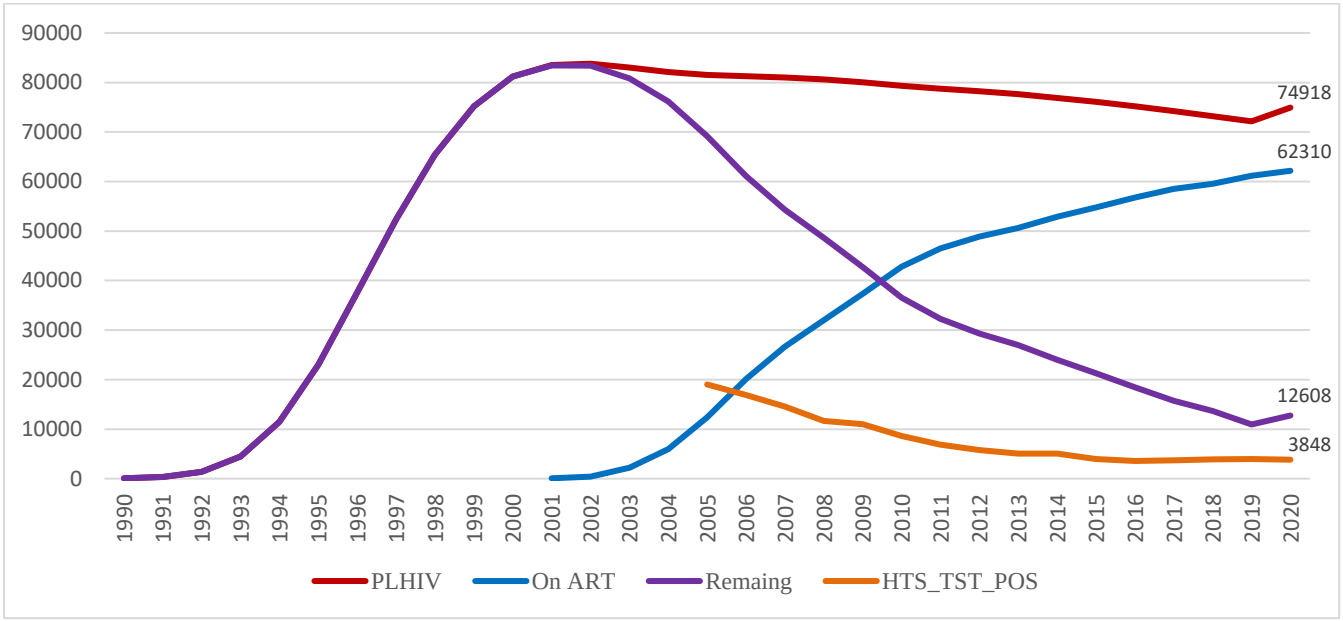
Source: *NAP web report FY2013-2020*

Figure 2.1.7 Epidemiologic Trends and Program Response, by Country, updated for ROP21, with the exception of India, Kazakhstan, Philippines, PNG, Tajikistan

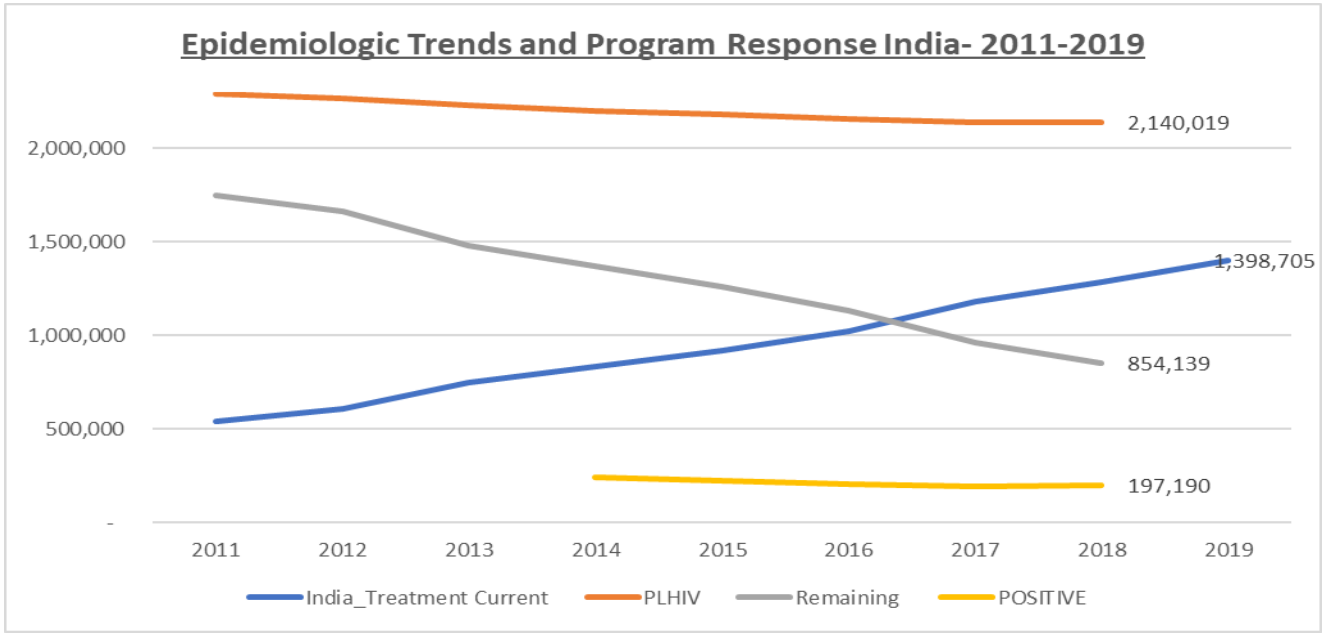
Burma



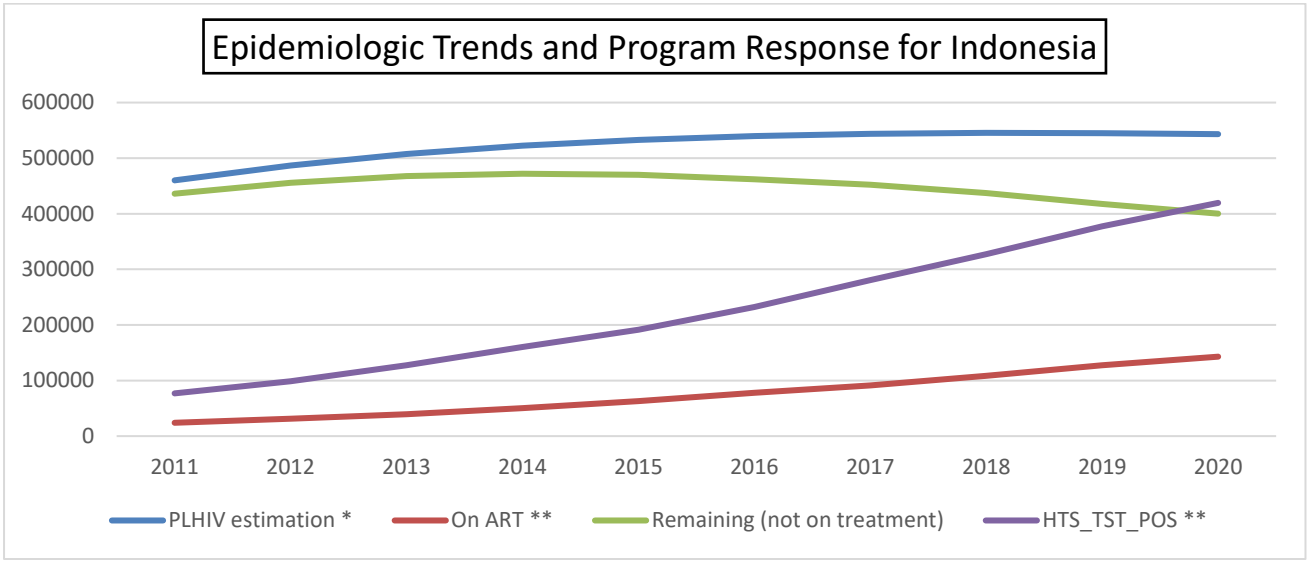
Cambodia


90000
80000
70000
60000
50000
40000
30000
20000
10000
0
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
74918
62310
12608
3848
PLHIV
On ART
Remaing
HTS_TST_POS

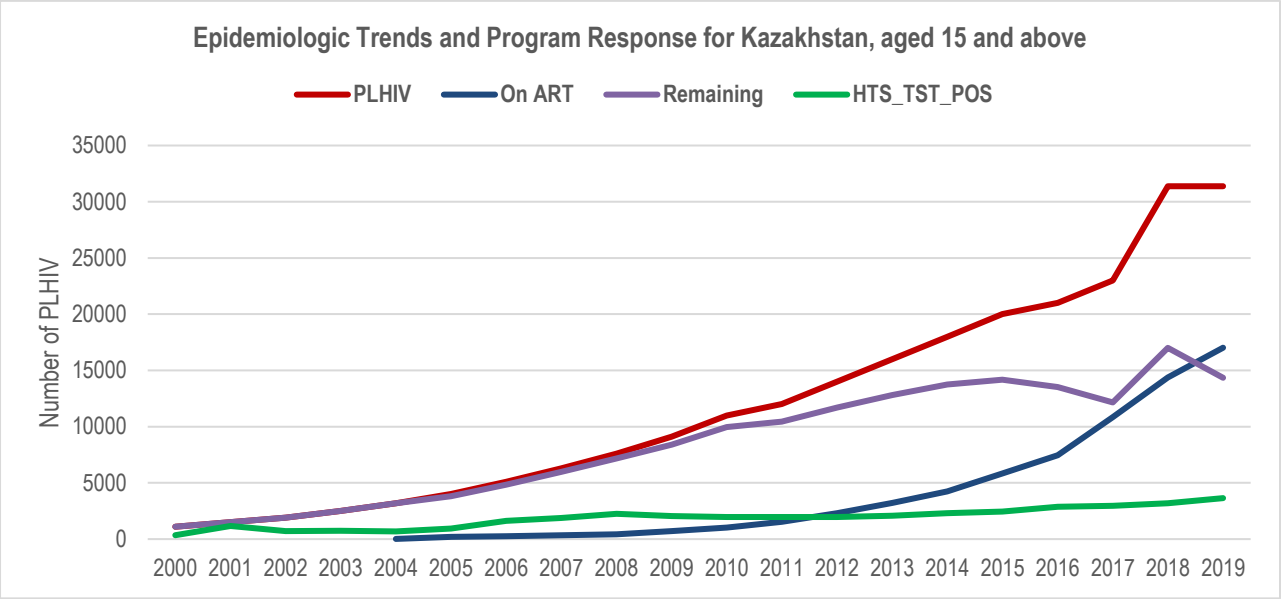
India


Epidemiologic Trends and Program Response India- 2011-2019
2,140,019
1,398,705
854,139
197,190
2,000,000
1,500,000
1,000,000
500,000
-
2011
2012
2013
2014
2015
2016
2017
2018
2019
India_Treatment Current
PLHIV
Remaining
POSITIVE

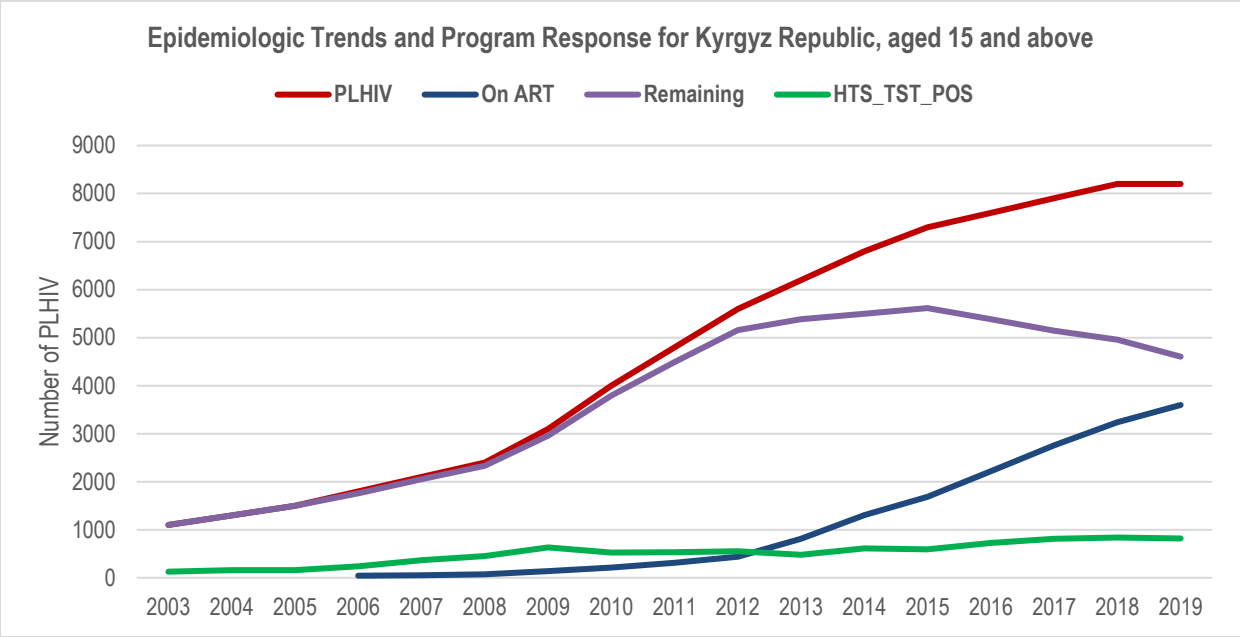
Indonesia


Epidemiologic Trends and Program Response for Indonesia
600000
500000
400000
300000
200000
100000
0
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
PLHIV estimation *
On ART **
Remaining (not on treatment)
HTS_TST_POS **

Kazakhstan


Epidemiologic Trends and Program Response for Kazakhstan, aged 15 and above
PLHIV
On ART
Remaining
HTS_TST_POS
Number of PLHIV
35000
30000
25000
20000
15000
10000
5000
0
2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019

Kyrgyz Republic



Lao PDR

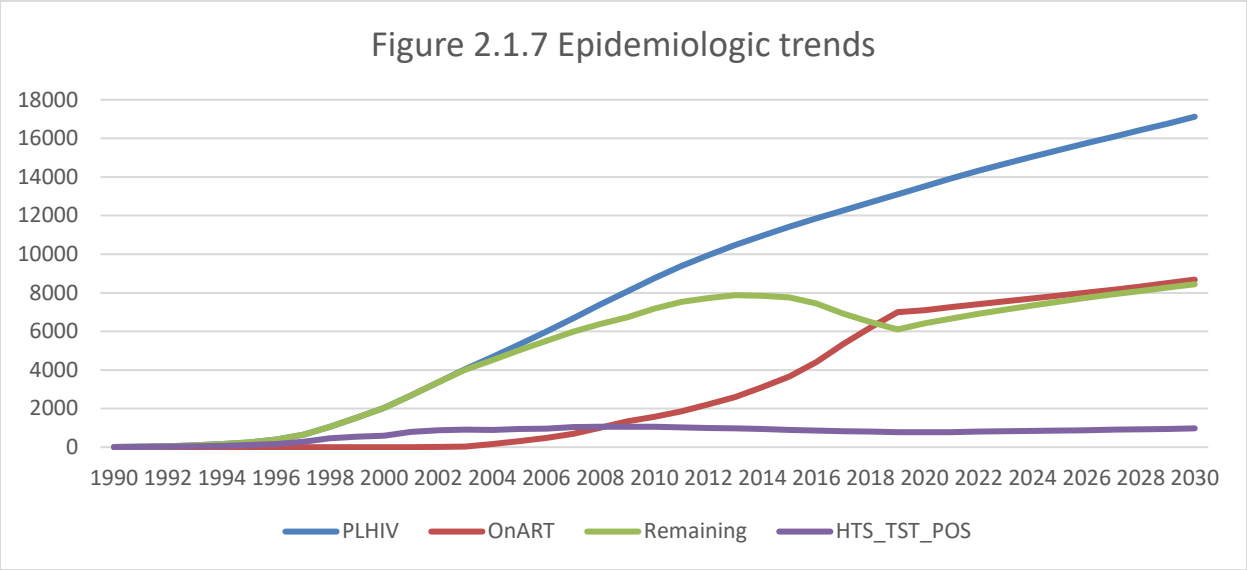
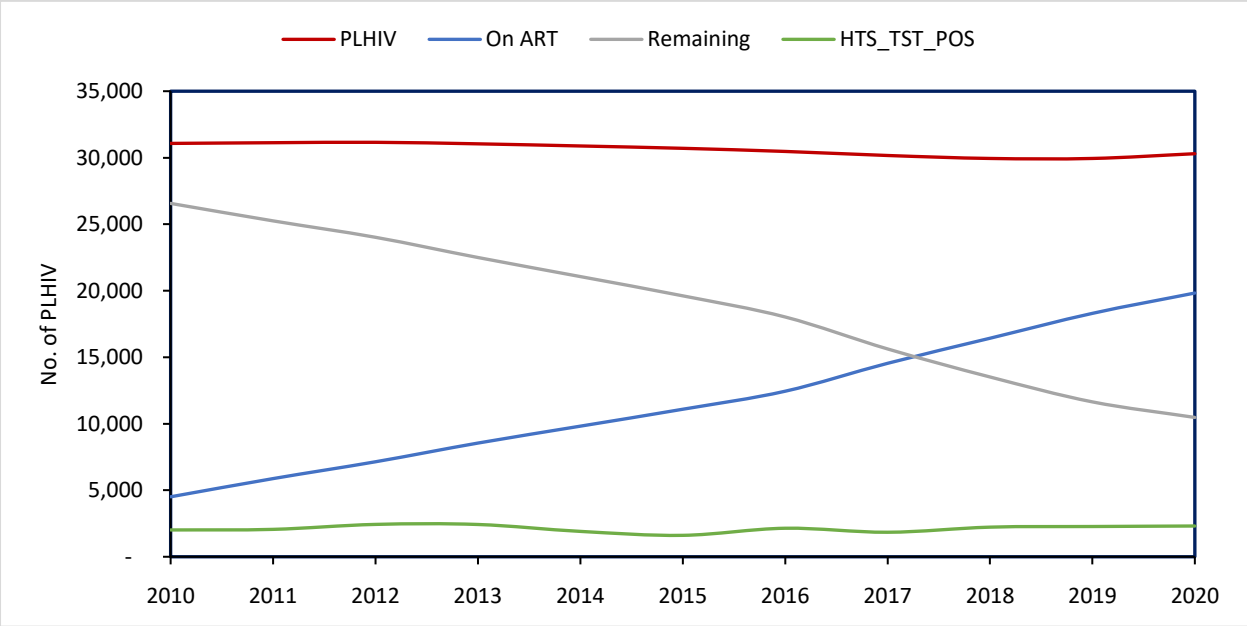
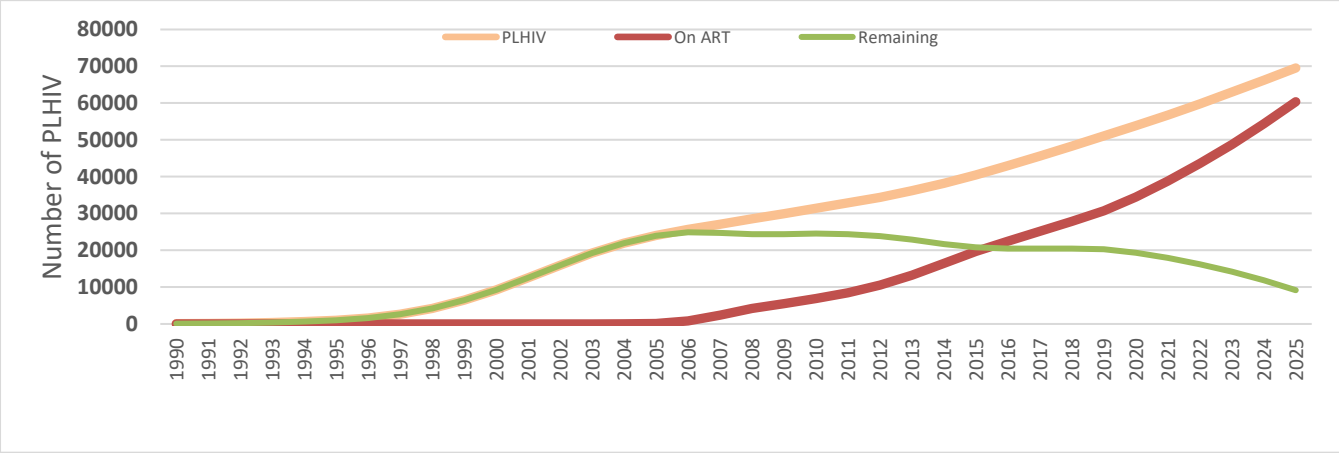


Figure 2.1.7 Epidemiologic trends
18000
16000
14000
12000
10000
8000
6000
4000
2000
0
1990 1992 1994 1996 1998 2000 2002 2004 2006 2008 2010 2012 2014 2016 2018 2020 2022 2024 2026 2028 2030
PLHIV
OnART
Remaining
HTS_TST_POS

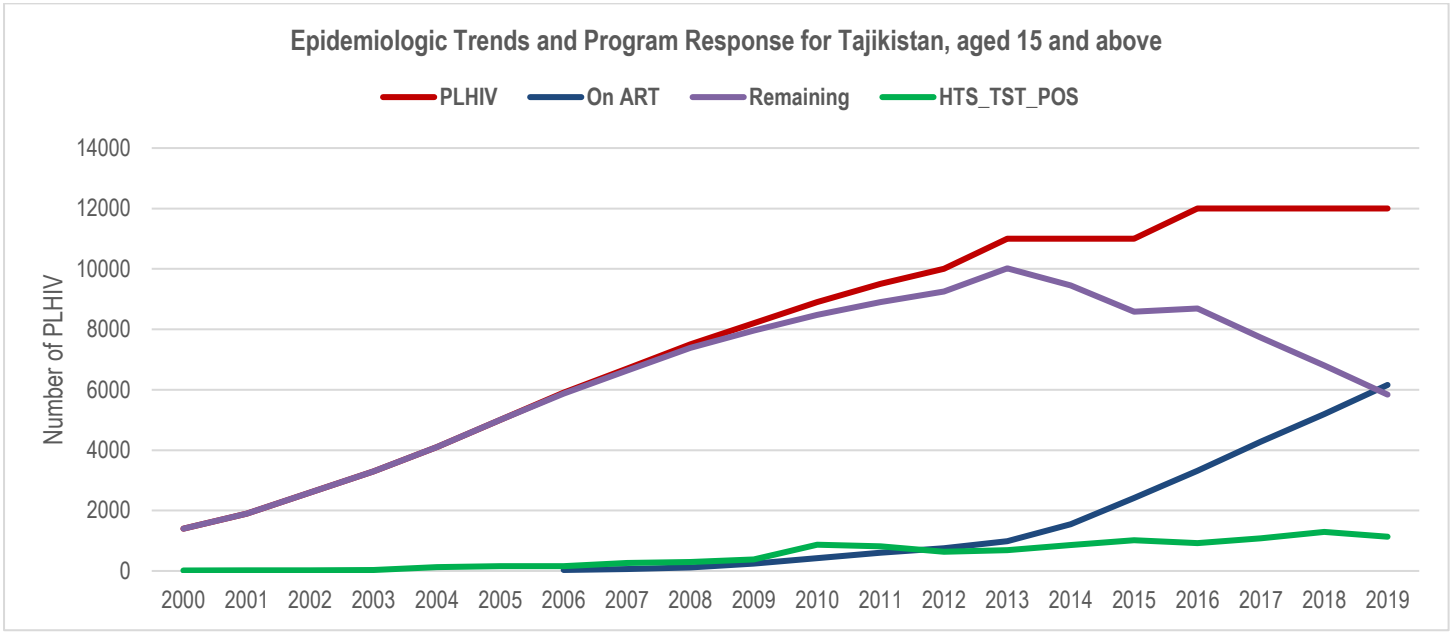
Nepal



Papua New Guinea



Tajikistan


Epidemiologic Trends and Program Response for Tajikistan, aged 15 and above
PLHIV
On ART
Remaining
HTS_TST_POS
Number of PLHIV
14000
12000
10000
8000
6000
4000
2000
0
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019

Thailand

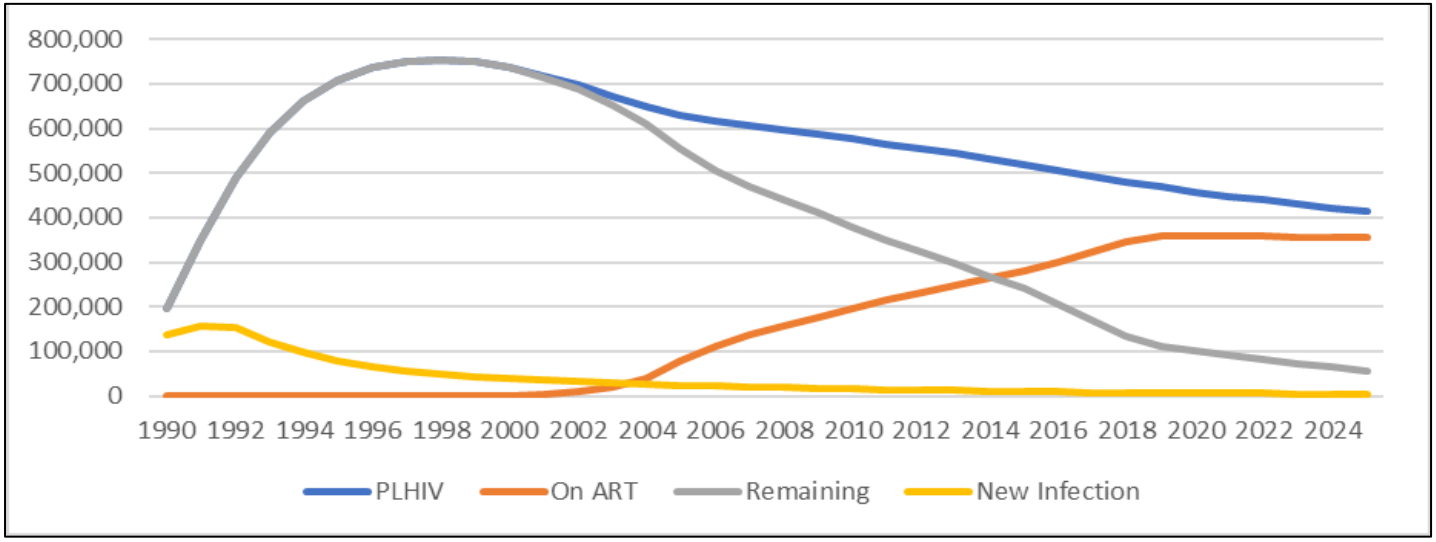
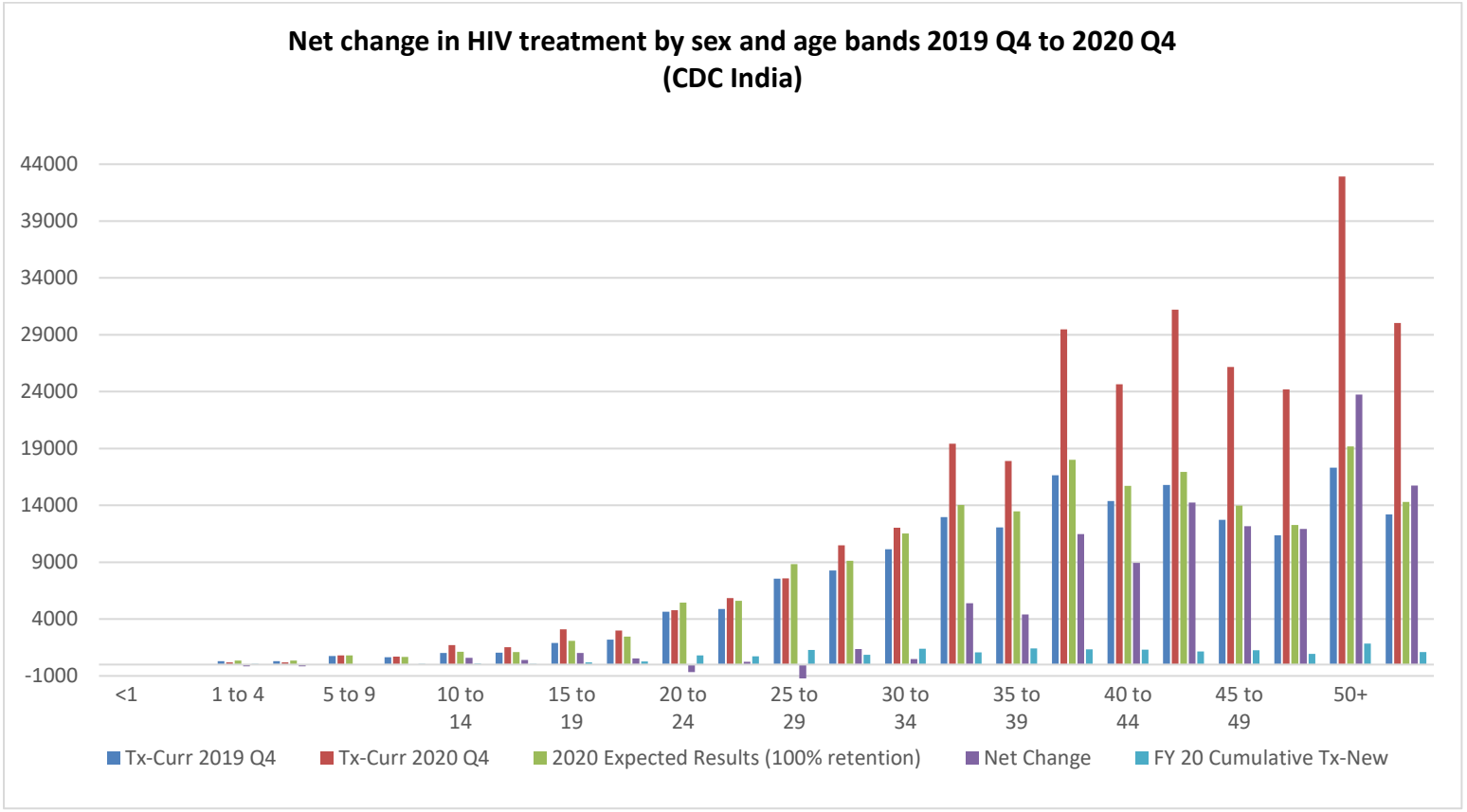
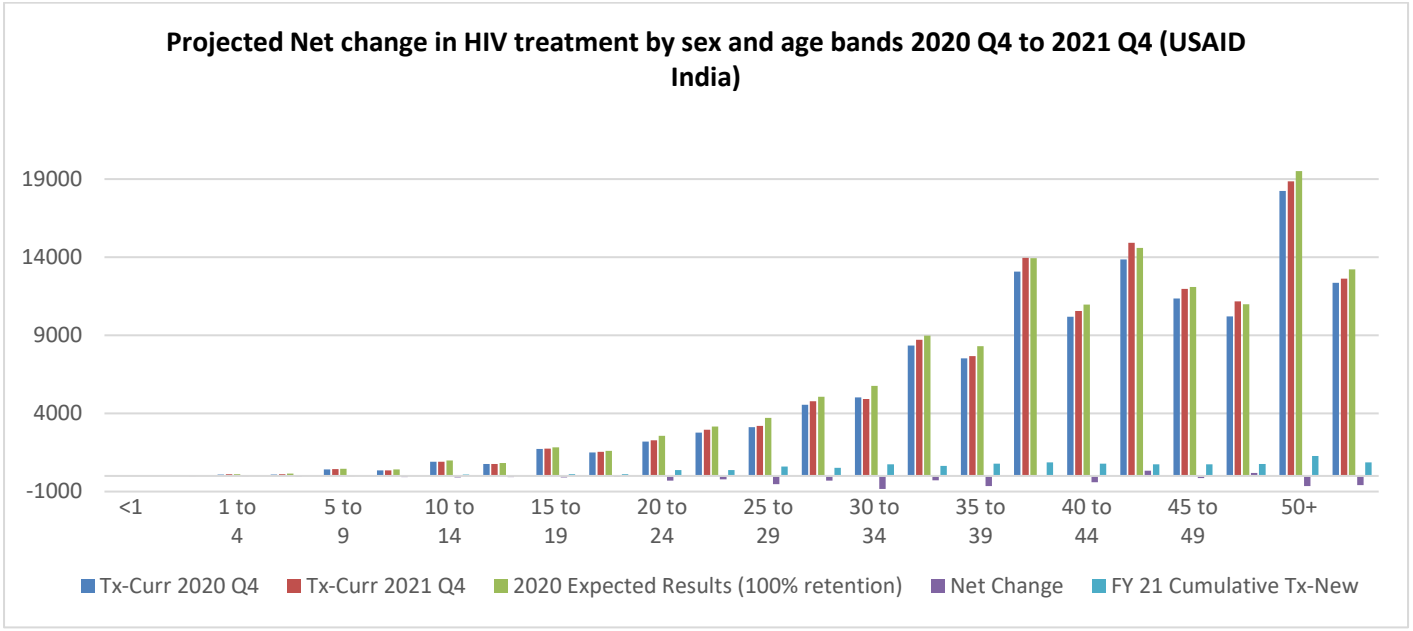

800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000
0
1990 1992 1994 1996 1998 2000 2002 2004 2006 2008 2010 2012 2014 2016 2018 2020 2022 2024
PLHIV
On ART
Remaining
New Infection

Figure 2.1.8 Net change in HIV treatment by sex and age bands 2018 Q4 to 2019 Q4 by Country, updated for ROP21, with the exception of Cambodia and the Philippines

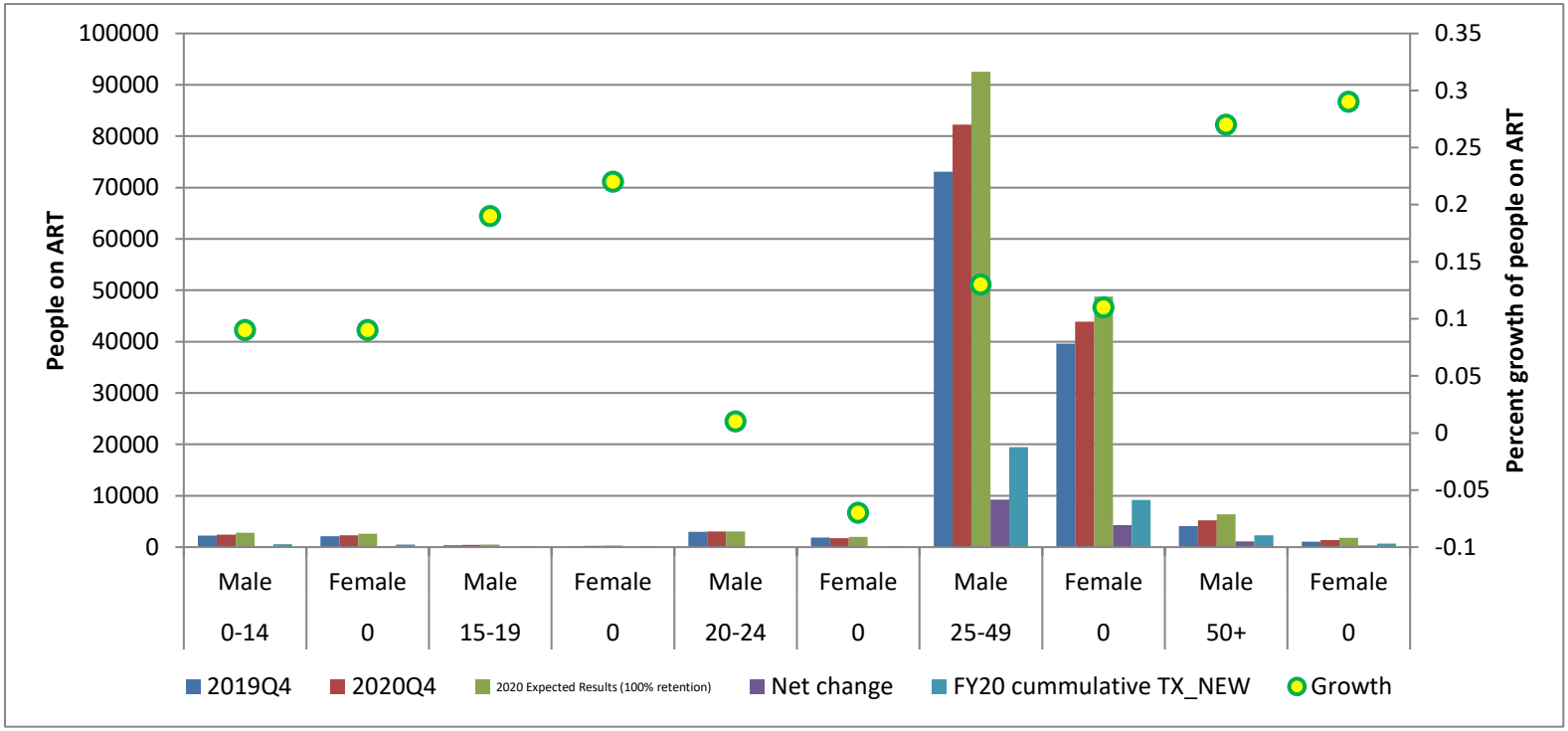
Burma

India


Net change in HIV treatment by sex and age bands 2019 Q4 to 2020 Q4
(CDC India)
44000
39000
34000
29000
24000
19000
14000
9000
4000
-1000
<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 2019 Q4
Tx-Curr 2020 Q4
2020 Expected Results (100% retention)
Net Change
FY 20 Cumulative Tx-New

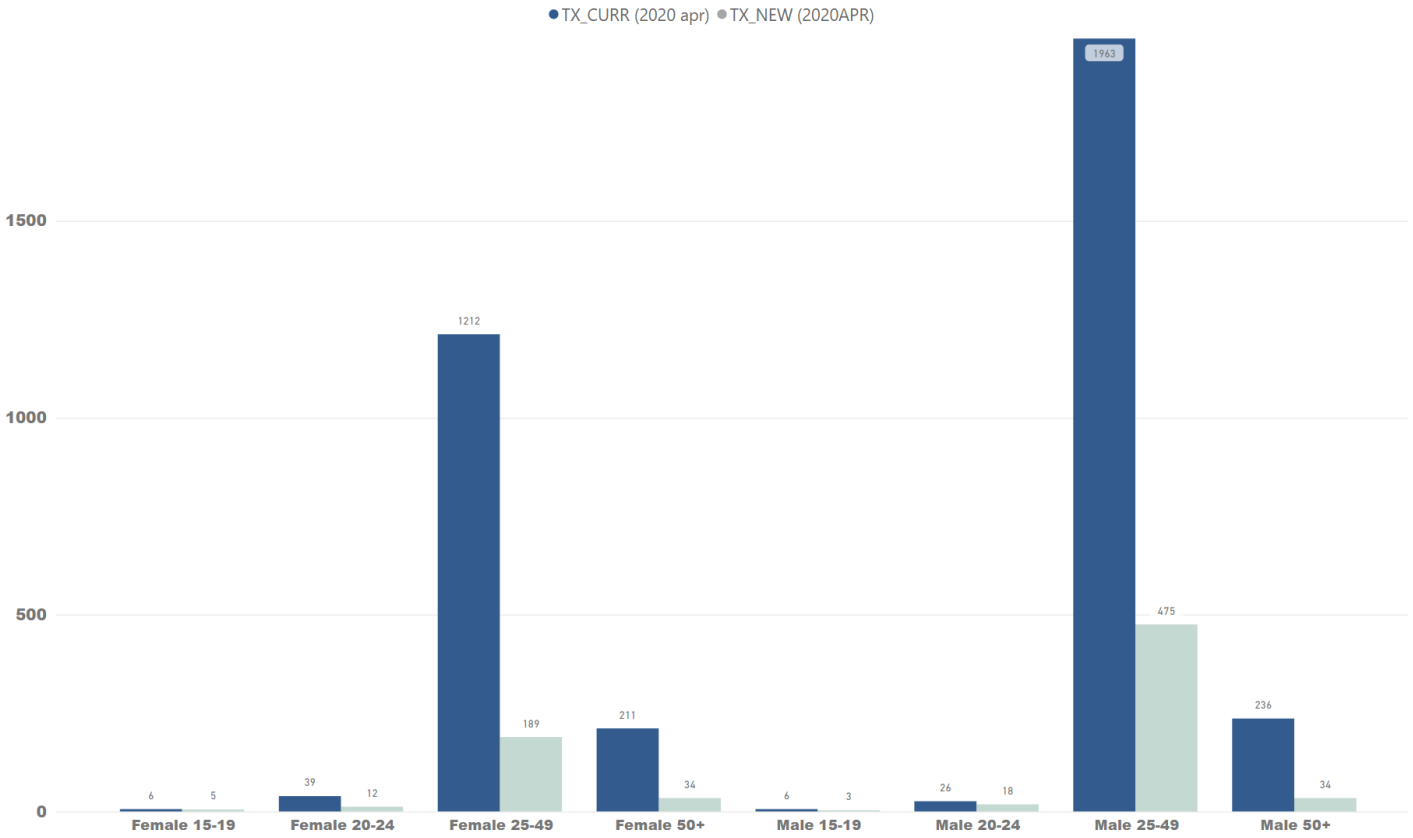

Projected Net change in HIV treatment by sex and age bands 2020 Q4 to 2021 Q4 (USAID India)
19000
14000
9000
4000
-1000
<1
1 to 4
5 to 9
10 to 14
15 to 19
20 to 24
25 to 29
30 to 34
35 to 39
40 to 44
45 to 49
50+
Tx-Curr 2020 Q4
Tx-Curr 2021 Q4
2020 Expected Results (100% retention)
Net Change
FY 21 Cumulative Tx-New

Indonesia



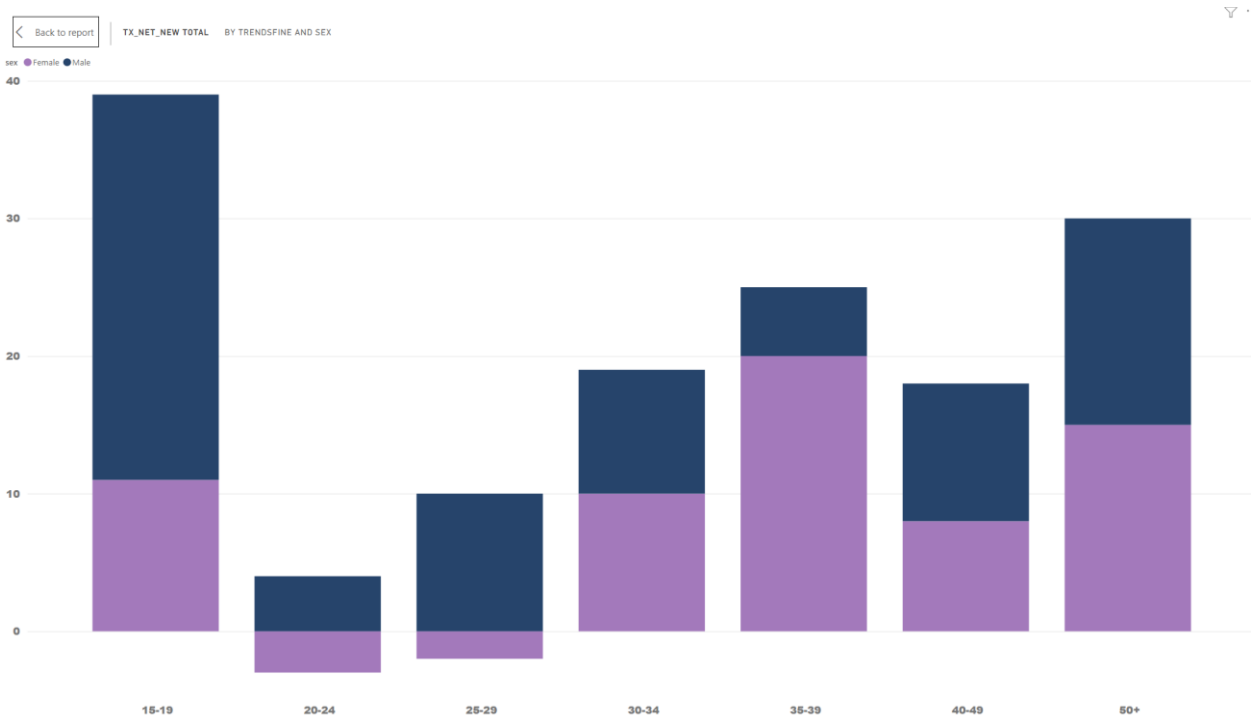
Source: MoH Quarterly Report

Kazakhstan


TX_CURR (2020 apr)
TX_NEW (2020APR)
1500
1000
500
0
6
5
39
12
1212
189
211
34
6
3
26
18
1963
475
236
34
Female 15-19
Female 20-24
Female 25-49
Female 50+
Male 15-19
Male 20-24
Male 25-49
Male 50+

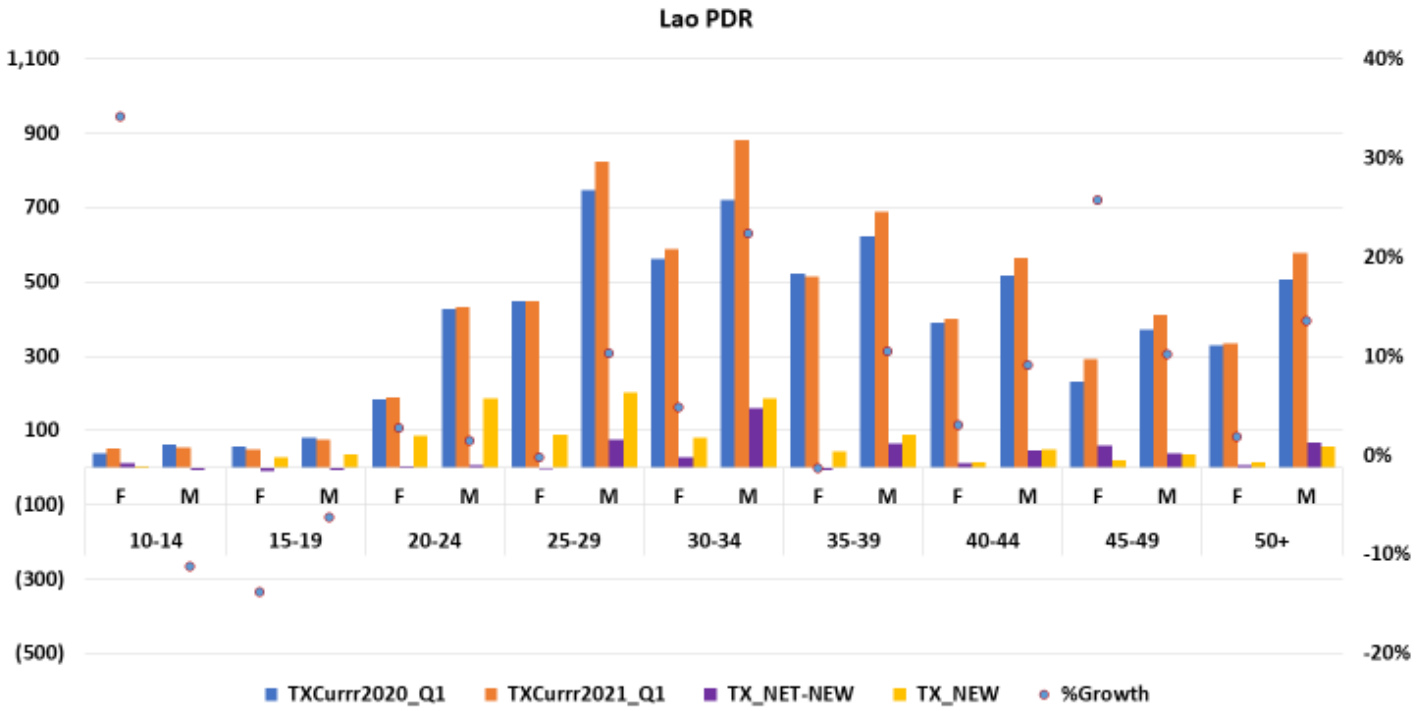
Kyrgyz Republic

Figure 2.1.8 Net change in HIV treatment by sex and age bands FY21 Q1 by Country



Lao PDR

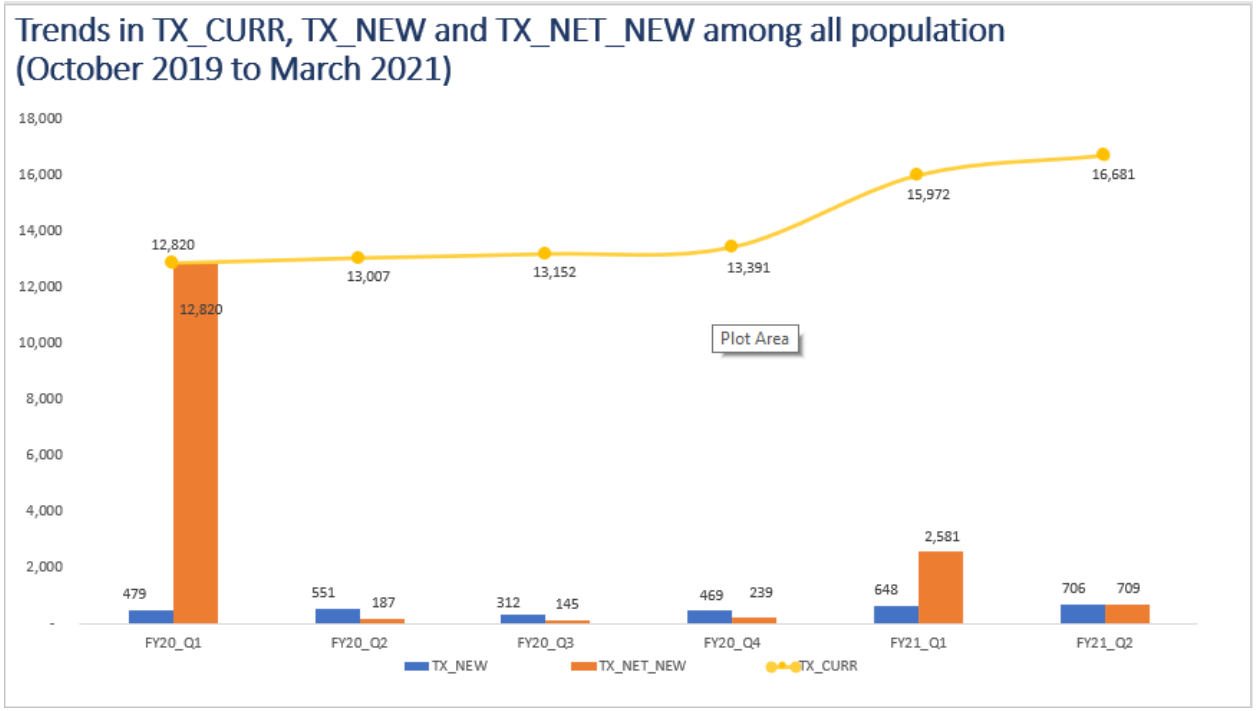
Figure 2.1.8 Net change in HIV treatment by sex and age bands 2020 Q1 to 2021 Q1 by Country



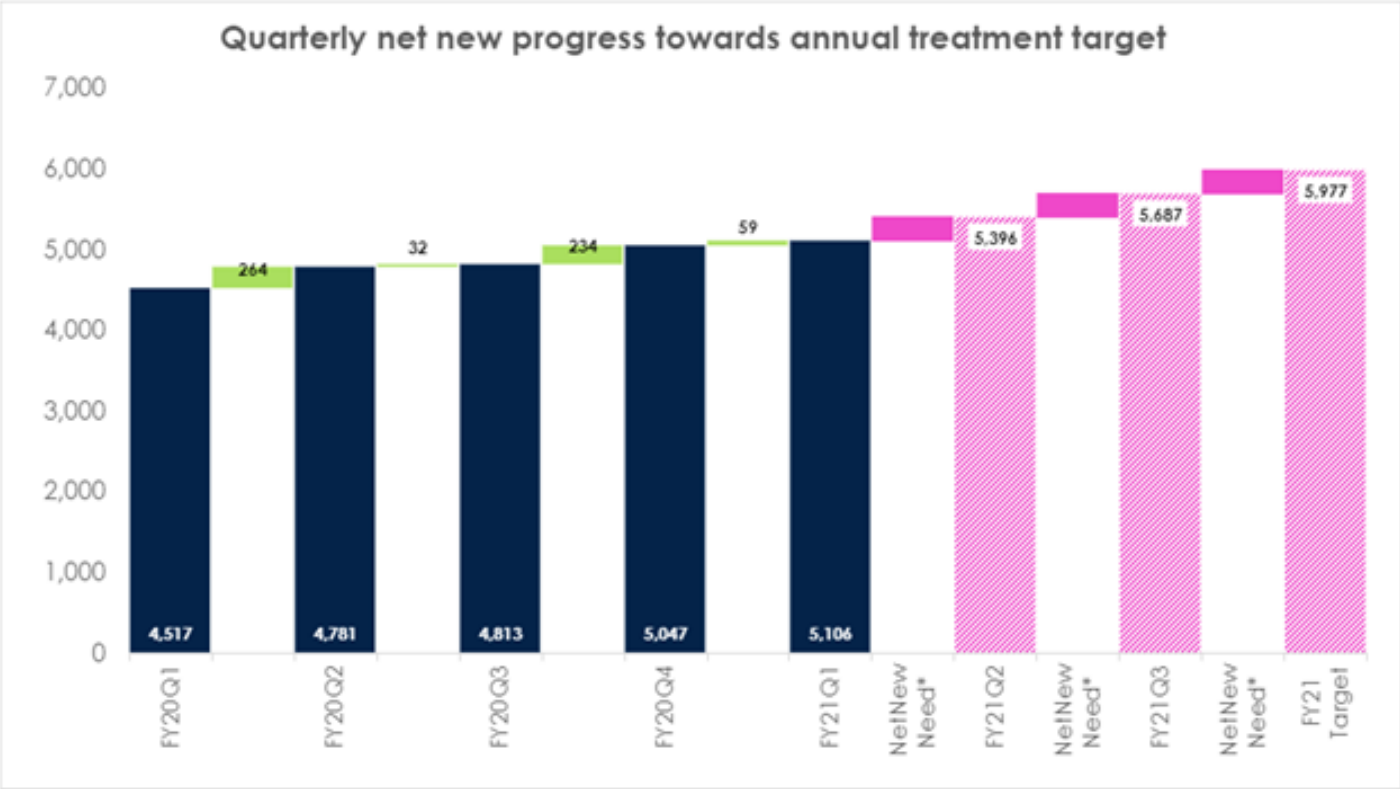
Nepal

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

Note: Nepal data is only available from October 2019.



Papua New Guinea



Tajikistan

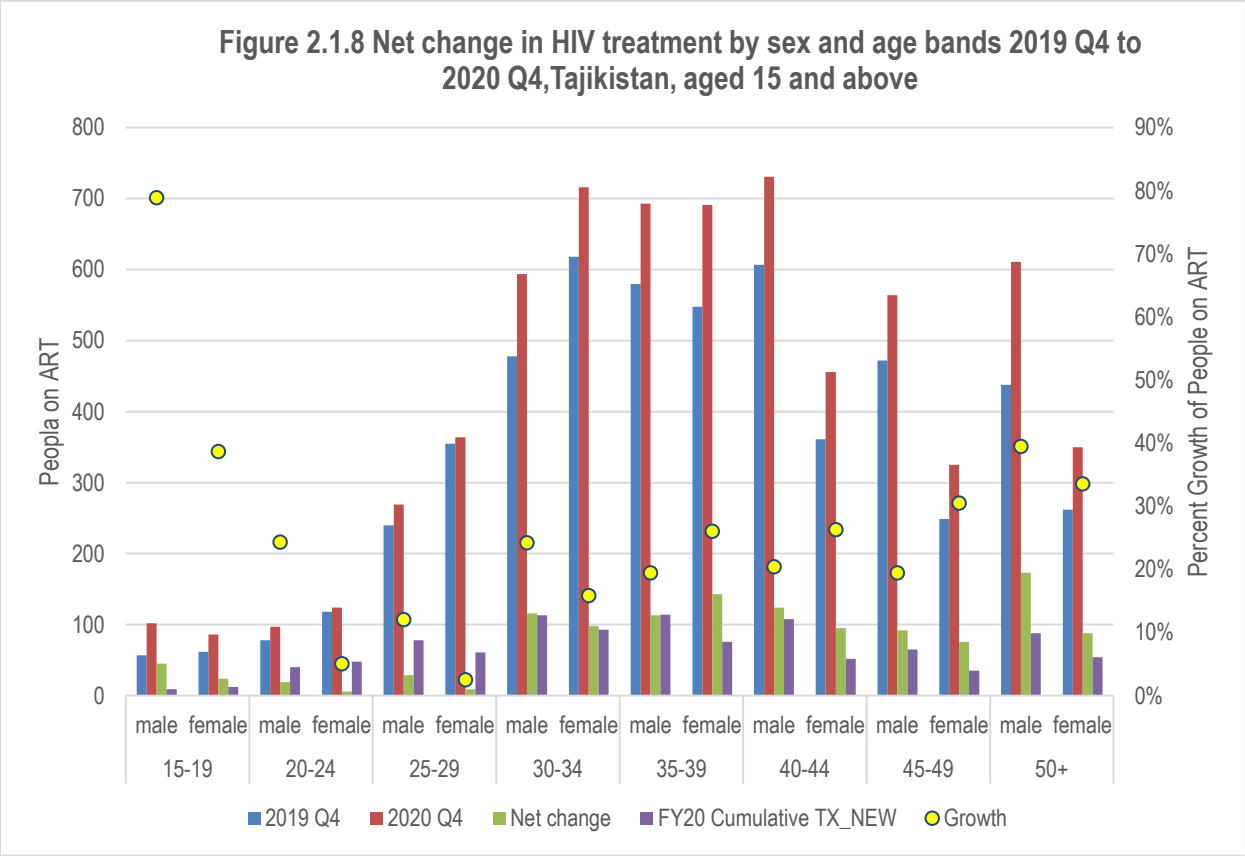
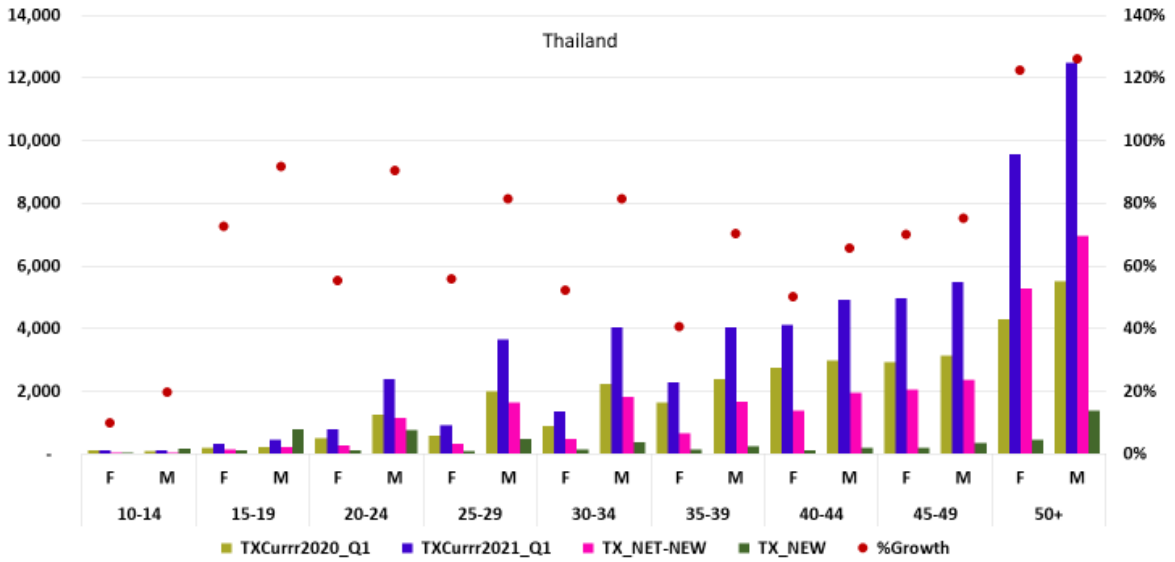


Figure 2.1.8 Net change in HIV treatment by sex and age bands 2019 Q4 to 2020 Q4,Tajikistan, aged 15 and above
Peopla on ART
Percent Growth of People on ART
800
700
600
500
400
300
200
100
0
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
male female male female male female male female male female male female male female male female
15-19
20-24
25-29
30-34
35-39
40-44
45-49
50+
2019 Q4
2020 Q4
Net change
FY20 Cumulative TX_NEW
Growth

Thailand



National AIDS Program (NAP).

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration by Country, updated for ROP21

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	$0	0	$0	
USAID TB	$10,800,000	$4,692,000	3	$4,015,876	1. End the HIV and TB epidemics 2. Community led monitoring and empower TB civil society 3. Strengthen the supply chain for key commodities
USAID Malaria	$10,000,000	$1,048,020	1	$265,500	Strengthen the supply chain for key commodities
Other (specify)	TBD	TBD			
Total	**$25,800,000**	**$5,740,020**		**$4,281,751**	

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	$5,000,000	$2,010,000	2	$1,050,000	Quality Improvement & Health Finance
USAID TB	$6,505,000	$1,200,000	2	$1,050,000	Quality Improvement & Health Finance
USAID FP/RH	$2,000,000	$2,010,000	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	$4,700,000				
USAID TB	$16,480,000				
Family Planning	$10,000,000				
CDC (Global Health Security)	$6,822,526				
Total	$38,002,526				

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	$17,000,000	$510,000	1	$720,000	To strengthen strategic information capacity at national & sub-national levels.

USAID TB	$15,000,000	$2,250,000	3	$2,081,955	To improve the capacity of national and sub national government on commodities related information, and to advocate the sub national government to increase domestic budget for HIV services.
Total	**$32,000,000**	**$2,760,000**	**4**	**$2,801,955**	

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				Address high malnutrition rates in Southern Kyrgyz Republic
USAID COVID	$4,739,977				Support COVID response and vaccine rollout
USAID TB	$6,000,000				Address high rates of TB and drug resistant TB in KR
Total	**$11,239,977**				

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	$6,180,000				This integrated nutrition, WASH, and maternal and child health activity aims to reduce child stunting in 2 southern provinces (Khammoune and Savannakhet) in Lao PDR.
USAID Malaria	$919,000				(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	**$7,099,000**				

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	$ 15,000,000	0	None	N/A	
Family Planning	$ 16,971,000	0	None	N/A	
Nutrition	$ 8,000,000	0	None	N/A	
WASH	$ 6,000, 000	0	None	N/A	
Total	**$45,971,000**	0	None	N/A	

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**
USAID TB	$300,000		1		
Total	**$300,000**				

Philippines

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					
USAID TB	$14,500,000	$1,000,000	MTAPS, ProtectHealth		
USAID Malaria					
Other FP	$13,000,000	$900,000	MTAPS, ProtectHealth		
CDC Global Immunization and Influenza Division	$539,814				National COVID-19 vaccination program
Total	**$28,039,814**	**$1,900,000**			

Tajikistan

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration

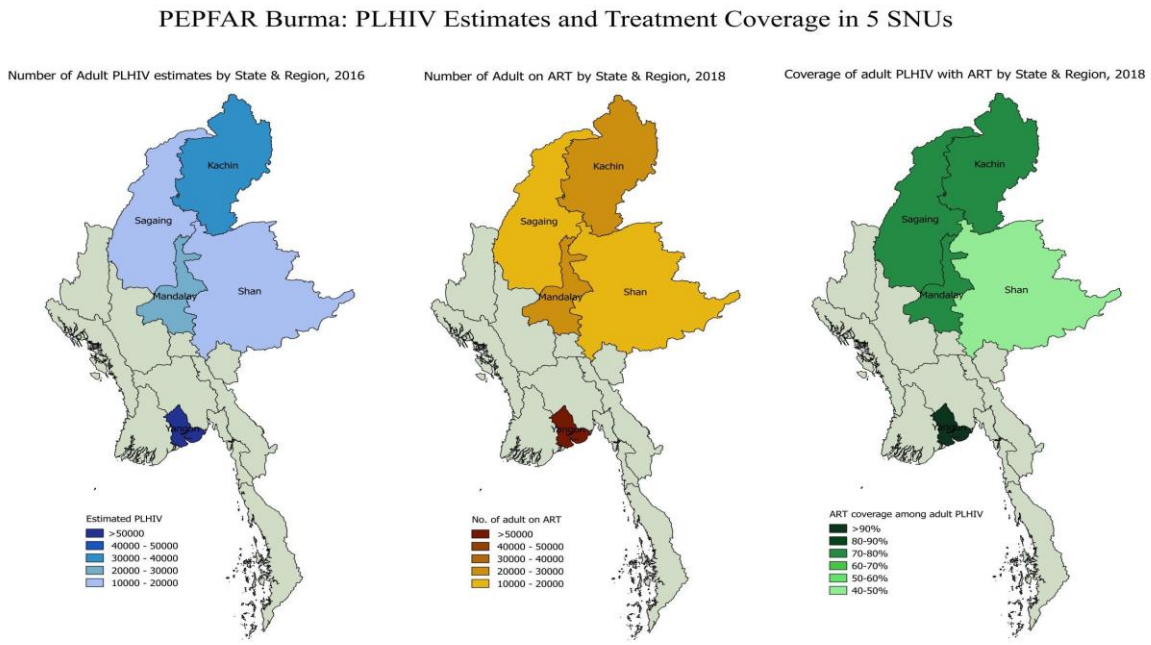
Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR ROP Co-Funding Contribution	Objectives
USAID MCH	$2,000,000				
USAID TB	$6,000,000				
NIH (nutrition)	$2,500,000				
Total	**$10,500,000**				

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

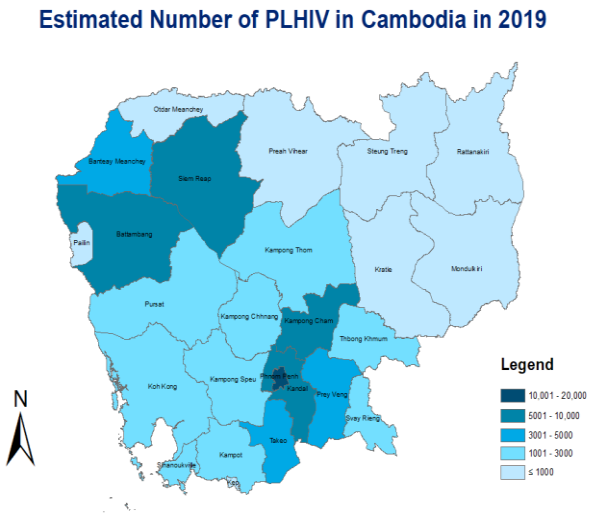
Figure 2.5.1 PEPFAR Asia Region Countries: People Living with HIV (PLHIV), Treatment Coverage, and VL Monitoring Coverage, by Country, updated for ROP21 as indicated

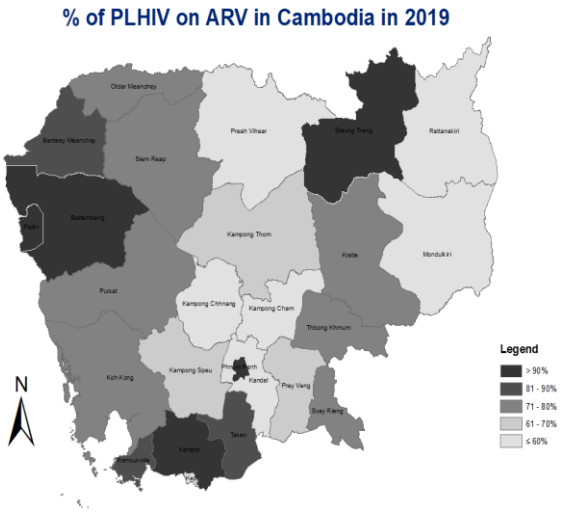
Burma (Updated for ROP21)



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%)

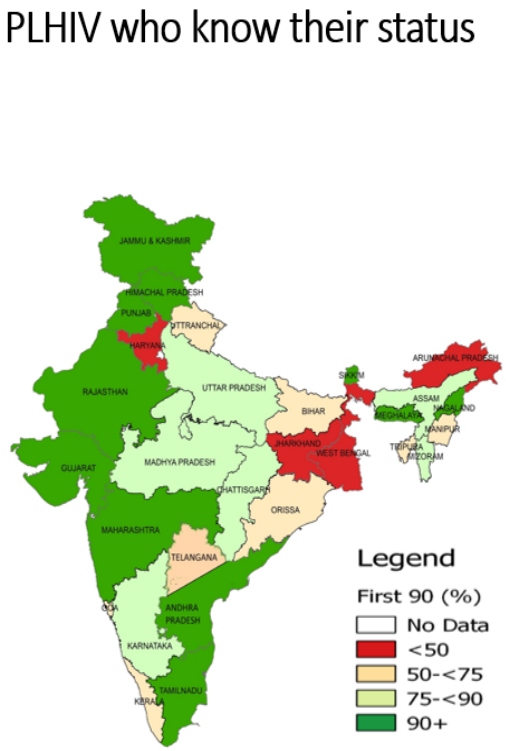
Cambodia





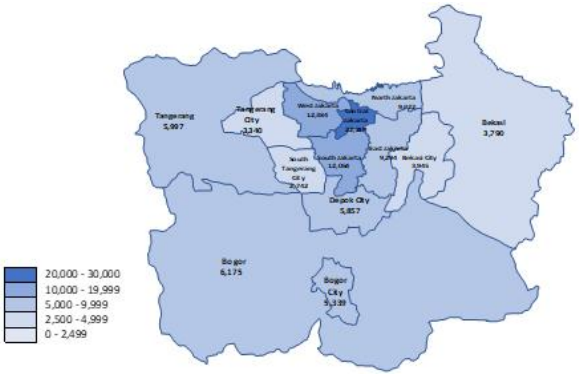
India

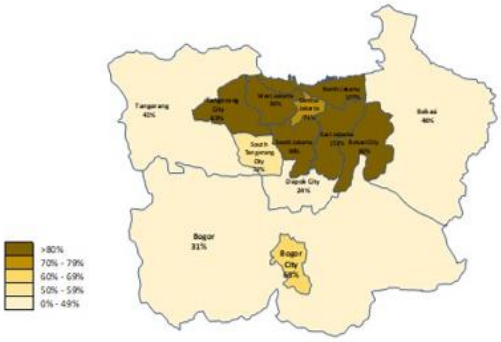
India State-Level 1st and 2nd 90, 2017 HIV Estimations



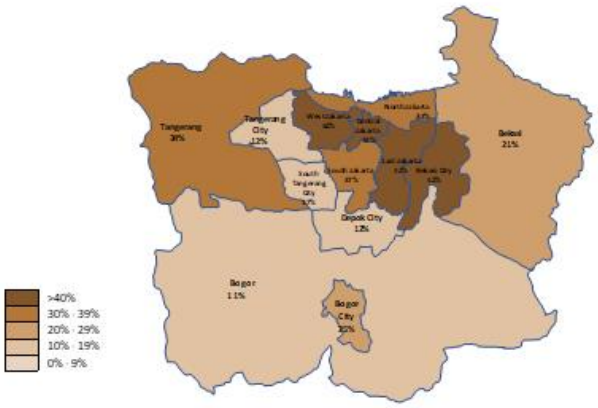
Indonesia (Updated for ROP21)

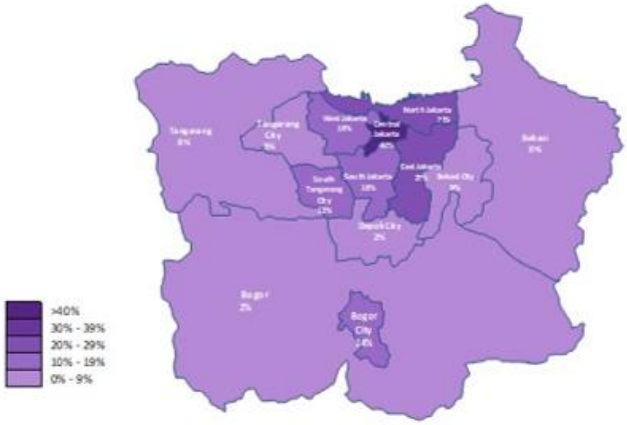
Jakarta & Greater Jakarta Estimated PLHIV and proportion diagnoses/district 2020





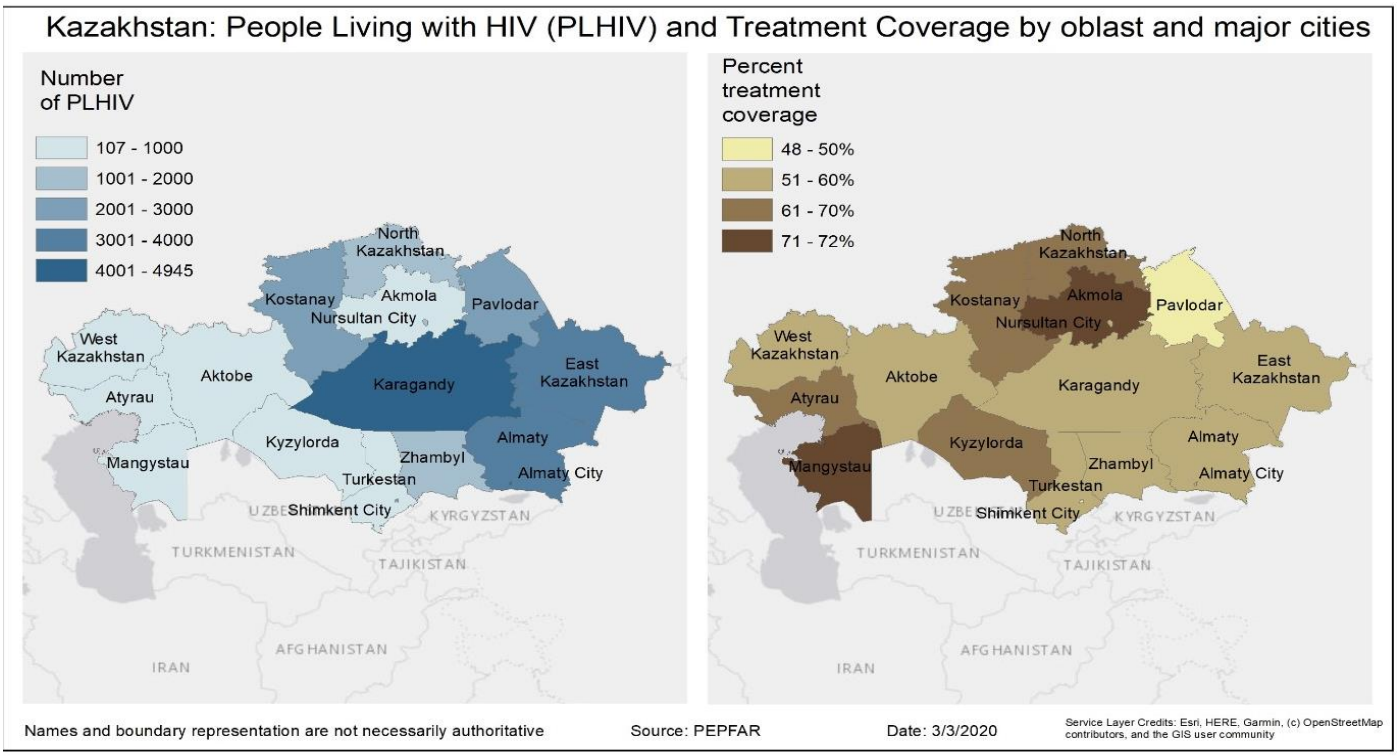
Jakarta & Greater Jakarta ART and VL testing coverage/district 2020



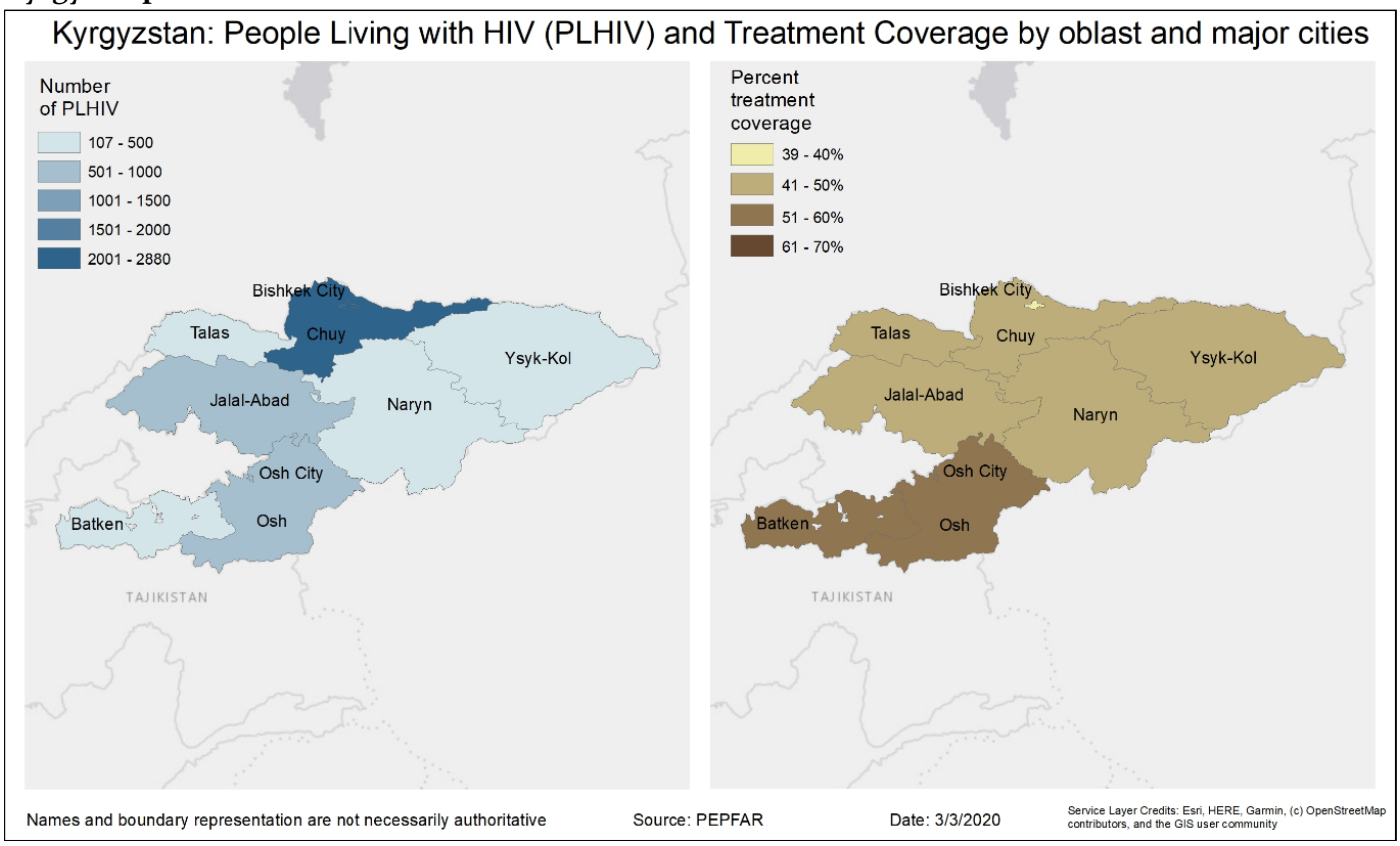


Source: 2020 PLHIV estimation

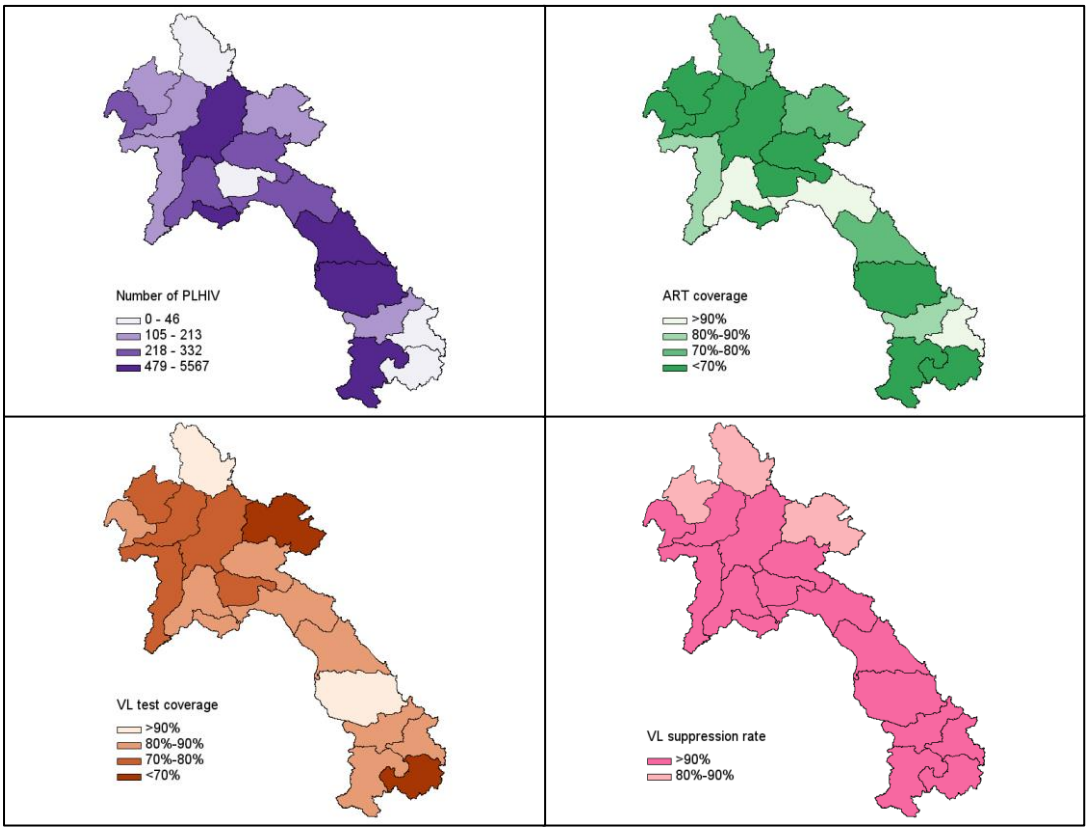
Kazakhstan



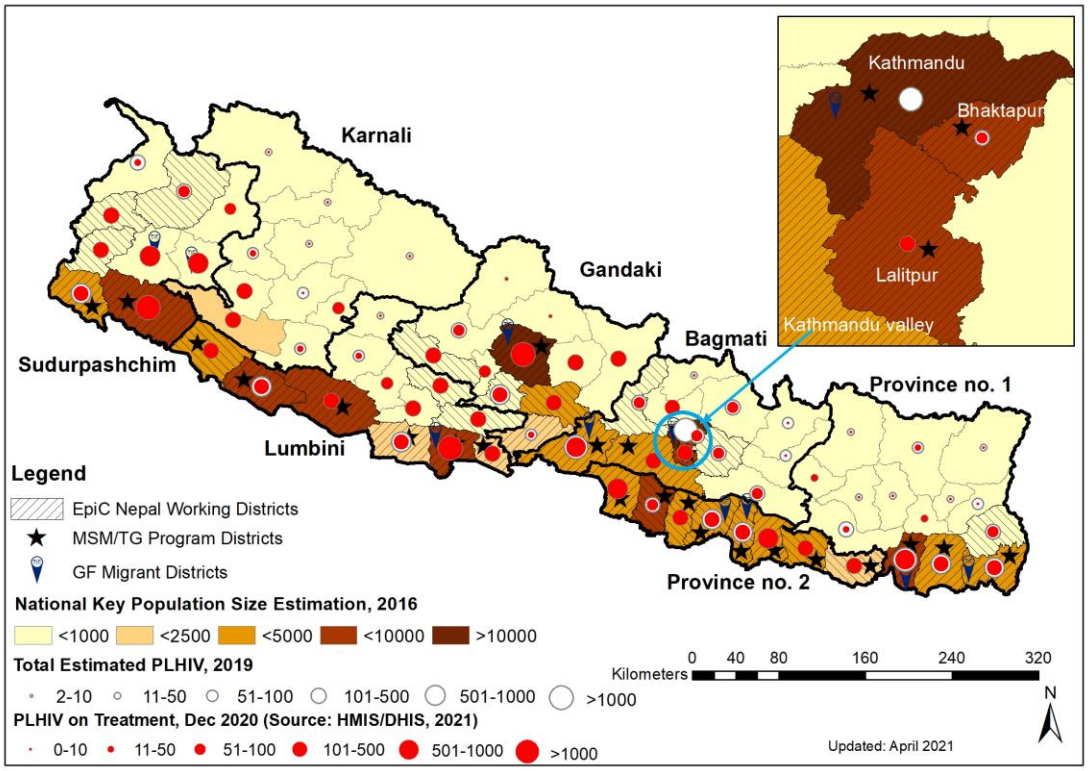
Kyrgyz Republic



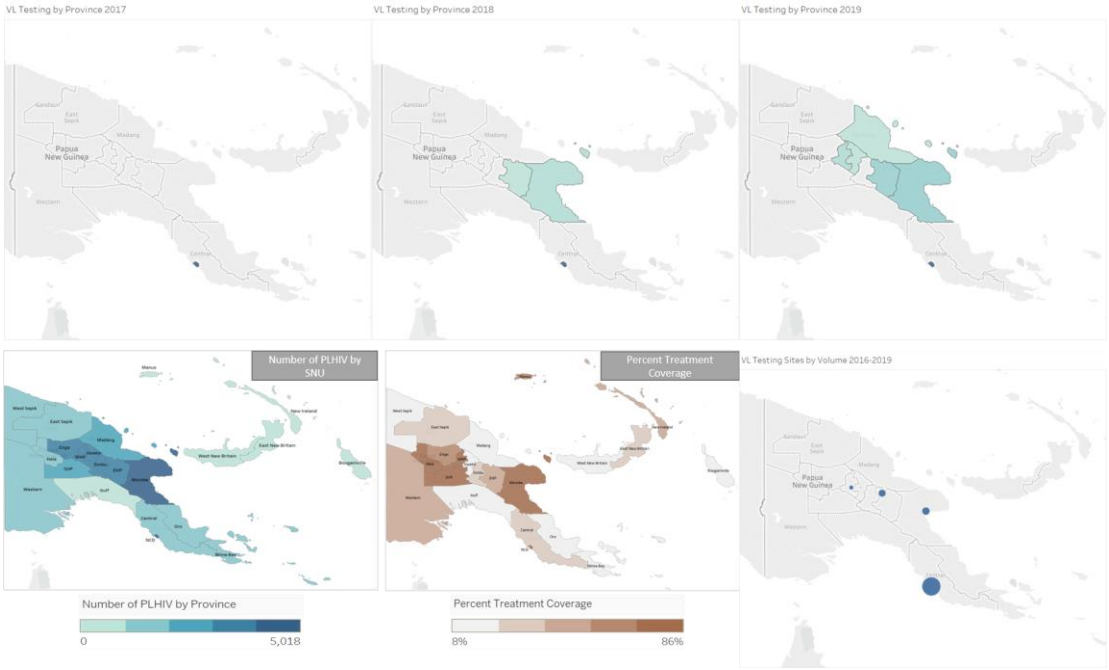
Lao PDR



Nepal

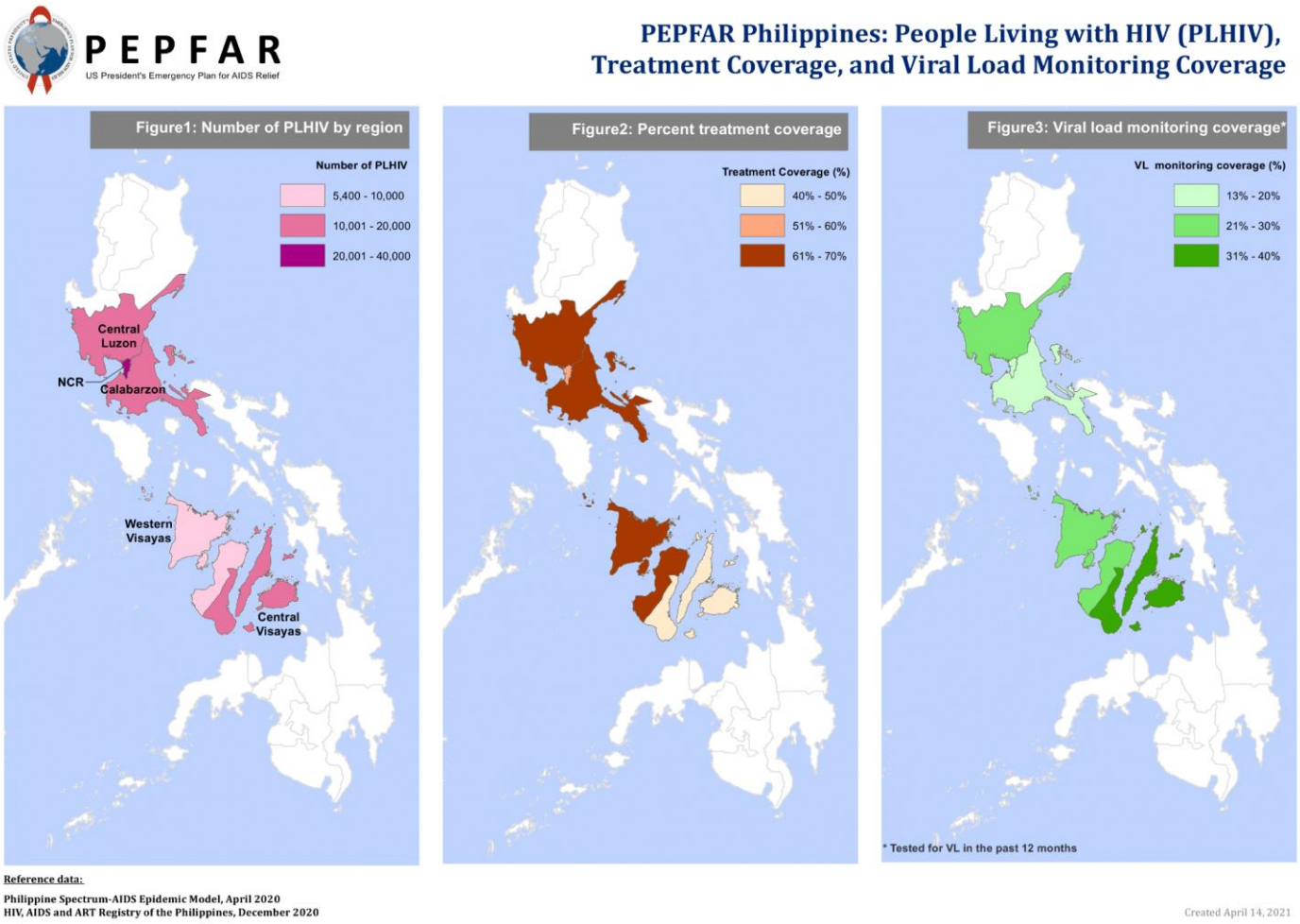


Papua New Guinea

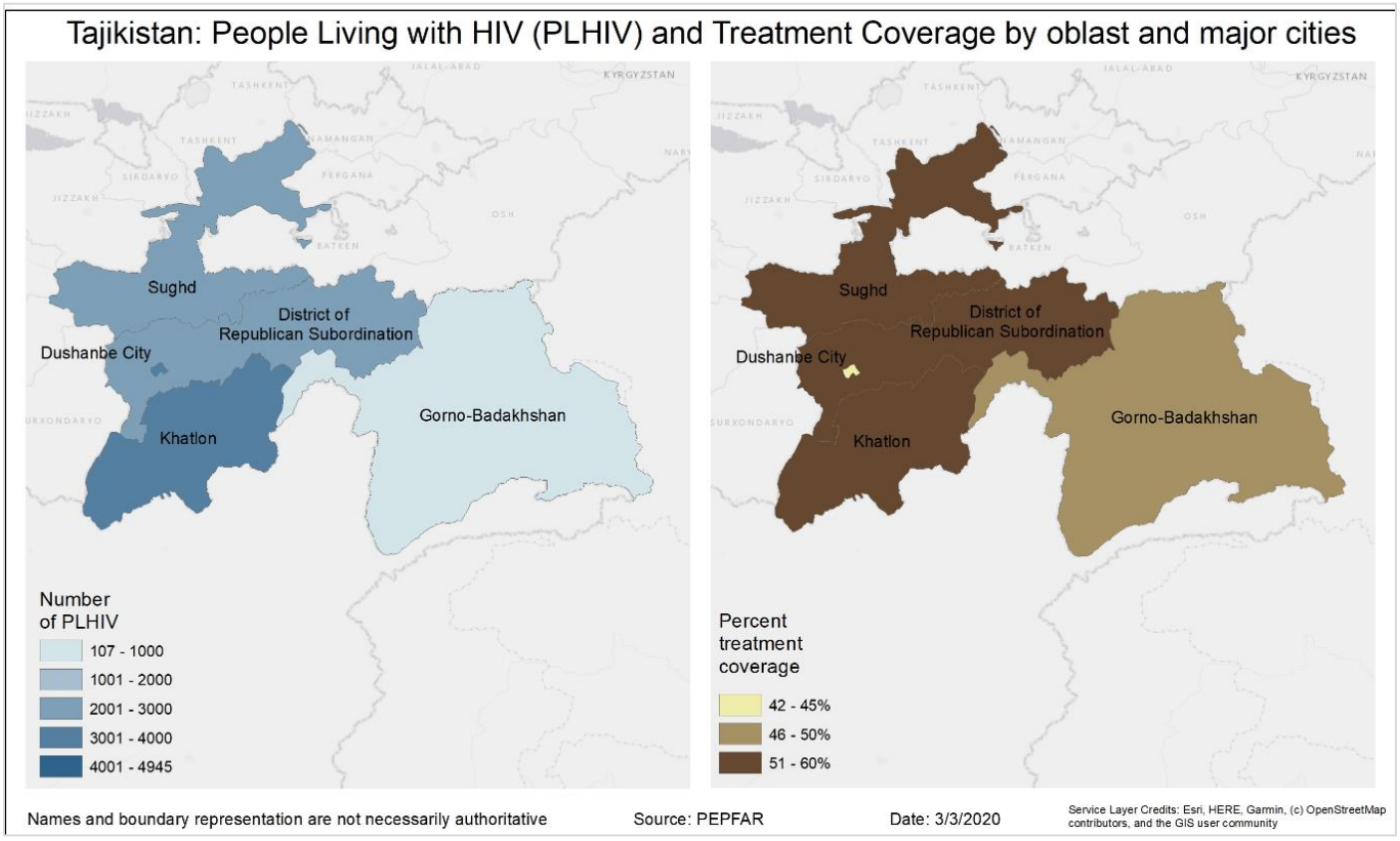


Source: National Spectrum Draft Estimates (2020) / HIV Patient Database (HPDB) / VL Sample Management System (VLSM)

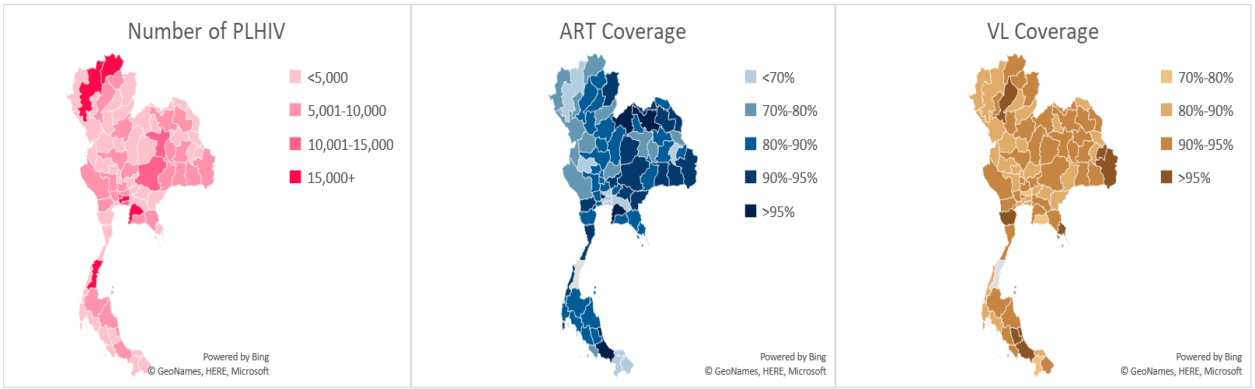
Philippines (Updated for ROP21)



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, Updated for ROP21 for countries indicated in blue box

ROP21 UPDATES
Cambodia: • Focus on micro-targeting, scale up of PrEP (including differentiated service delivery options), and addressing barriers to implementation • Utilize real-time recency data to find outbreaks of new transmission and tailor response

- Support the national program with self-testing, social network testing, and safe and ethical index testing, and needed refinements
- Rapidly scale up SDART to at least 80%, and rapid ART initiation (within 7 days of HIV diagnosis) in the absence of confirmed OI

India:

- Treatment continuity and mortality remain challenges. Scale up the implementation of Advanced Disease Package at ART sites (CDC and HRSA).

PNG:

- Treatment interruption remains a challenge; need urgent attention and a deep dive analysis to determine strategies to improve continuity of care; institutionalize QA/QI feedback loops at PEPFAR-supported sites. PEPFAR PNG conducted a Lost to Follow Up Audit in ROP20, with additional analyses from USAID HQ, to identify key information about those who experienced interruption in treatment. Strategies for treatment linkage and treatment continuity are detailed in Section 4.0. PNG will increase the use of DSDM to address barriers to treatment interruption due to the burden and cost of travel in addition to improving the quality of HIV service provision through expanding mentorship activities, promoting KP-friendly services, and CLM. COVID-19 impacted treatment continuity, and in the remaining quarters and into ROP21, PNG plans to monitor the operational status of PEPFAR-supported sites and ensure contingency plans are in place and implemented.
- TLD and 3+MMD should be scaled-up with attention to 6MMD. ○ 90% of eligible PLHIV have transitioned to TLD and uptake of 3MMD is high; will continue to support implementation of 6MMD and differentiated service delivery models. PEPFAR PNG will continue to increase 3+/6MMD in PEPFAR-supported sites, of which was scaled up as part of COVID-19 adaptation activities. In FY21-Q1 there were 81% of clients who had 3+MMD, and 4% who had 6+MMD. FY2020-Q2 to FY2021-Q1 saw an increase from 51% to 81% of PLHIV on treatment receiving 3+MMD.
- ROP 21 needs a strong focus on index testing and VLC. PNG will continue to strengthen and scale up index testing in PEPFAR-supported sites, using lessons learned to inform revision of National HIV Counseling and Testing Guidelines and NDoH scale-up of index testing nationally. Strategies for targeted case finding and index testing are incorporated into PEPFAR PNG's ROP21 activities as detailed in Section 2.2.

BURMA

PrEP scale-up has been impacted by COVID-19 restrictions and needs to be continued with expansion beyond MSM to target other key groups and differentiated service delivery (DSD) options.

In ROP21, PrEP services will continue with adjusted demand generation and service delivery interventions, adapted to the current context. PrEP services will be expanded to additional populations (MSM, PWID) and geographies (Mandalay, Sagaing and Kachin) - if possible in this environment. PEPFAR will use a gain framing approach in a KP-led grassroots movement to ensure the community is leading the PrEP response in their own communities. Demand generation will be adapted to virtual interventions due to the current context, and the possible integration of PrEP with other strategies (index testing) will be explored.

Optimize high-yield KP case finding strategies for PEPFAR and ensure technical assistance to the national program supports the same optimization: index testing requires further scale-up, though is complicated by legal environment; 75% of HTS_POS going forward should come from index; any other testing strategies need higher yields and increased targeting; ensure any PITC is risk-based; support scale of self-testing nationally through TA; ensure progress on recency testing.

PEPFAR will focus on the hardest-to-reach populations, including hidden key populations, those who are undiagnosed and outside of the healthcare system, and sero-discordant couples. 50% of HTS_TST_POS will come from index testing, and 50% of HTS_TST_POS will come from other high-yield testing strategies. In ROP20, HIV self-testing (HIVST) will be scaled up in high burden states and regions which are PEPFAR prioritized areas. PEPFAR's above site TA plans to advocate to HIV key stakeholders to endorse the use of recency infection surveillance as part of the routine surveillance system among newly diagnosed HIV cases.

ROP 19 saw improved linkage among specific KP groups, especially by Q4. However, challenges persist, especially among PWID. PEPFAR Burma should continue to address these persistent linkage challenges, especially in remote areas and among PWID and FSW, and should continue to strengthen linkage strategies and efforts at same day initiation utilizing results of "tracing the patient journey" exercise to address programmatic and policy bottlenecks. In FY21 Q1, linkage continued to improve to >95%. PEPFAR aims to improve immediate linkage to ART (toward same day ART - if possible), using a 1:1 case management model to ensure linkage to ART, building on key lessons learned.
Build on gains in MMD, both at PEPFAR supported sites and in the national program, tracking implementation at all levels to ensure 6MMD across the program. As of FY21 Q1, PEPFAR Burma had one of the highest rates of 6MMD at PEPFAR sites in the Asia Region. PEPFAR Burma is a key leader and stakeholder in the coordinated response to address ARV stock issues and ensure clients have uninterrupted access to treatment.
Burma has a high burden of TB overall, but also MDR TB and HIV-associated TB. Improved coordination between NTP and NAP is required and must be fostered with better coordination between GF grants and PEPFAR. PEPFAR Burma will focus on addressing the high burden of TB by ensuring HIV/TB co-located services, including TPT, active case finding, adapting to the new post-coup environment. PEPFAR will ensure TPT for all eligible patients including new shorted rifampicin-based regimen, and TB screenings among PLHIV and HIV screening among TB patients.
Ensure above site activities are targeted to more directly address quality of service delivery beyond PEPFAR sites; above site TA to support differentiated service delivery should also address messaging related to pre/posttest counseling, U=U, and treatment literacy. PEPFAR's above site program supports the establishment and use of Service Quality Monitoring System (SQMS) and tools at ART sites (public and private sectors) and PWID MMT sites. The SQMS system and data collection tools were endorsed in 2020, and it has been piloted in selected ART sites in 5 PSNUs. Development of an electronic dashboard with DHIS2 for Care and Treatment, SQMS for ART sites and finalization of the SQMS data collection tool for MMT sites are in progress in ROP20. Moving forward, PEPFAR will ensure full saturation of SQMS implementation in 5 PNSUs at all ART and MMT sites by coordinating with implementing partners and service providers. In ROP21, PEPFAR above site TA aims to empower KP/CSO groups by building their capacities in areas of treatment literacy including U=U, pre/post-test counselling skills as well as data use skills for managing KP-led interventions with DSD approaches.
Burma should expand viral load coverage and achieve > 95% VLC with improved turnaround time (< 7 days). Starting from ROP20, with PEPFAR support, Burma plans to complete a Diagnostic Network Optimization exercise every year to assess bottlenecks to improve HIV VL testing uptake and turnaround time. Key challenges to date are: lack of an efficient sample transportation system; delayed in result returns from clinics to clients; inefficient patient management system at the clinic level to monitor clients with high level of viremia; and poor VL literacy level among clients and service providers. Therefore, these service gaps will be addressed through PEPFAR TA on efficient operationalization of the National HIV Viral Load Monitoring Plan (2021-2025) by subnational service providers; designing a VL sample transportation network using a hub and spoke model; monitoring the implementation of VL sample management SOP and high VL case management protocol by close interaction with subnational lab and clinic workforces in 5 PSNUs; scaling up DBS implementation in remote areas and promoting VL demand generation, U=U literacy, for service providers and affected key populations.
Continue work to develop transgender-friendly and –competent services and clinics, building off ROP 20 KPIF efforts. The first transgender clinic is now operational in Yangon, providing TG-specific HIV services. PEPFAR will continue working with key partners and regional CSOs virtually to develop the transgender service package and guidelines.
Ensure momentum for case-based surveillance, building off foundational work in ROP 20; Develop and execute national surveillance plan that adopts case-based surveillance. PEPFAR will collaborate with key stakeholders to accomplish a Health Infrastructure Landscape assessment reflecting the latest evolving situations in Burma to develop appropriate case surveillance protocols. Above-site TA will be provided to support the development of UIC/ Master Patient Index and its incorporation into various components of HIV services to improve service tracking, especially for key populations. Capacity at both national and sub-national levels will be built to strengthen routine data collection systems, including HIV electronic reporting systems and data utilization.
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
Continue to increase coverage of 3+MMD: CDC demonstrated rapid/SD ART at all PEPFAR-supported treatment centers, with some sites implementing ART initiation at testing centers. Based on the learnings, sDRT/ rapid ART is a national policy and is being scaled up across the country. Over 60% of PEPFAR-supported Tx_Curr receiving 3-5 months of MMD. All PEPFAR-supported sites are dispensing 3 months ARV and/or 6 month scripting.
PrEP has moved slowly and needs concerted focus; already a focus for ROP20. ROP21 should address further scale-up: There has been significant acceleration in the private and public sector. National guidelines on PrEP developed and under approval. Training modules developed. PrEP implemented through virtual platforms in private sector.
Treatment continuity and mortality remain challenges. Scale up the implementation of Advanced Disease Package at ART sites: India is addressing treatment continuity through above site and site level work including (i) scale up of ART optimization and transition of PLHIV from NNRTI based regimen to TLD (including pediatric cohorts), (ii) coordination with GF partners on systematic tracking and tracing of LTFU to re-engage PLHIV in care, (iii) implementation of ADM packages (including improved TB diagnosis) to improve treatment continuity and reduce mortality (CDC),(iv) integration of TB TPT into DSD models and applying lessons learned from COVID-Expansion of MMD, (v) decentralized drug distribution through community based sites and use of peripheral health system for drug delivery (both adults and children), and (vi) promotion of treatment and viral load literacy activities including U=U. Teams worked on a surge dashboard. With ICPI support, CDC has developed a surge dashboard with prevention, testing, treatment and lab indicators. Tis monthly dashboard has been rolled out to partners and monthly reporting will begin from this quarter.
VLC improving but needs more focus: In ROP 20 during COVID pandemic, VLC was significantly impacted due to national lock down and treatment mitigation strategies to keep the PLHIV safe at home. Moving forward PEPFAR in collaboration with NACO, GF, CBOs, partners in these difficult times demonstrated strategies and approaches to increase access to VL testing with KP focus- community outreach and patient mobilization, hub and spoke model, network of sample transport systems within 100 km by incentivizing staff, organizing camps for priority population, integrated lab services using mobile vans, piloting DBS and near POCT. The differentiated strategies will be scaled up in ROP 21 to achieve 100% of Tx_Curr on six months of treatment.
Targeted, efficient case finding. Remedy linkage challenges and focus on translating safe and ethical index testing to national scale with fidelity. Should accelerate self-testing: Will focus on reaching unreached KPs in focus geographies through a variety of targeted efficient case finding strategies such as index testing, social networking model and self-testing (to be demonstrated through a collaboration with UNITAID and PATH). India will work with GOI and GF partners to increase an integrated service delivery approach across the prevention to treatment continuum, including single window services and peer navigation for KP. In response to and in partnership with communities, there will be a continued focus on testing, partner notification, comprehensive prevention including to find and link KPs. PEPFAR India will continue to train counselors and communities on social network models/enhanced peer outreach approach (EPOA)-focused strategies, and how SNM and index testing strategies may be blended to increase case finding that is targeted and efficient. PEPFAR will scale up assisted self-testing and virtual

outreach for clients seeking anonymity, partnering with preferred providers among KP. The learnings of this model, will lead to the development of the National HIV self-testing policy.
Continue to improve OVC_HIVSTAT known status proxy results, ensuring HIV risk assessment for all OVC<18 years with unknown HIV status and HTS completion for all OVC<18 years with identified HIV risk factors: In ROP 21 the OVC activities will prioritize children living with HIV, children affected by HIV and children of HIV positive KP. The work will continue to support OVCs across the continuum of care, and implementation will occur in all PEPFAR SNUs, including the 3 new districts in Maharashtra with the targets for OVC included in the DataPack. 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 to 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 all 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.
INDONESIA
Targeted HIV testing modalities – particularly PITC for TB and STI clients and VCT for key and priority populations
Targeted HIV testing modalities – particularly PITC for TB and STI clients and VCT for key and priority populations – will likewise be prioritized to make the most efficient and strategic utilization of HIV testing commodities for the identification of new PLHIV. Particular focus will be placed on supporting the national program to disaggregate, record and report PITC modalities by population type in an effort to illustrate the impact of more targeted approaches. In ROP21, the program will also introduce up to three HIV community-based screening/HIV self-testing (HIVST) intervention models, in partnership with the UNITAID STAR-III initiative, which will provide 25,000 HIVST kits for PEPFAR implementing partners in Jakarta and Greater Jakarta.
Index testing
PEPFAR Indonesia will continue to strengthen safe and ethical index testing and expand index testing service delivery to 109 facilities in Jakarta; 28 facilities in Greater Jakarta; 13 CSOs; and the Update Status online platform. The program will continue to deploy stringent standards for safe and ethical index testing to ensure informed patient consent; awareness and protection of patient rights; intimate partner violence screening; and monitoring and reporting of and response to adverse events
Sustained and coordinated high-level engagement with GOI, multilaterals (GF), and USG agencies to address key barriers to HIV services in Jakarta and Greater Jakarta
PEPFAR IPs involved in Indonesia GF Funding Request, which emphasizes collaboration and joint implementation to accelerate ART coverage and address key service barriers. The Ministry of Health has asked for support for TA prevention, outreach and testing in Jakarta and Greater Jakarta whilst the GF Funding will focus ensuring treatment continuity for PLHIV. COP21 further sees the phased transition to a civil society-led response, with provision of direct funding to strengthen the engagement CSOs and sub national government in the implementation of AIDS program in the select districts. CSO organizational capacity development will continue to be emphasized throughout the COP21 programming period, with customized technical assistance provided to both PEPFAR- and GF-supported CSOs to implement effective programming at measurable technical standards and to access Government of Indonesia financing for long-term sustainability.
Provide Support to TLD Transition
ARV optimization efforts through the transition to TLD will continue in COP21, with systematic provision of TLD to new PLHIV in Jakarta and Greater Jakarta, as well as advocacy to the national program to expand TLD provision to all PLHIV on HIV treatment, in concert with WHO and UNAIDS. PEPFAR Indonesia will also support finalization and operationalization of the national treatment guidelines for ARV optimization.
Expand Clinical Strategy for advance diseases management of PLHIV
Over the COP21 period, PEPFAR Indonesia will introduce an advanced HIV disease technical assistance package at high burden hospitals across Jakarta and Greater Jakarta. Technical assistance focus will be placed on systematizing screening, treatment and/or prophylaxis for opportunistic infections; rapid ART initiation; and intensified adherence support through case management for PLHIV presenting with advanced HIV disease. The program will also strengthen TB screening for PLHIV, expand TB testing for presumptive TB PLHIV, provision of TPT for eligible PLHIV, and treatment for co-infected TB and HIV patients in Jakarta and Greater Jakarta, as part of Indonesia's TB Recovery Plan
In Collaboration with the GF to scale up MMD
MMD will be accelerated across Jakarta and Greater Jakarta through the innovative application of PEPFAR Indonesia's MMD calculator, which makes use of site-level ARV supply data to calculate and track MMD coverage, thereby mobilizing MMD efforts in challenging environments. PEPFAR Indonesia will be improving of supply chain data

visibility and the use of supply chain data for decision making. In close collaboration with key stakeholders, we will support the refinement of SIHA by collaborating with the MOH to improve the recording of PLHIV linked to the ARV treatment received. This will assist in tracking interrupted in treatment patients and reengage them into care. Strengthening SIHA will also improve real-time data processing as well as data security. With access to real-time data of ARVs stock, PHOs, DHOs and HFs will be able to calculate the stock required for the implementation of MMD.
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
Continue to expand access to PrEP, including demand creation.
Refine index testing approaches, addressing comparatively low yield; work with national program.
Scale up safe and ethical index testing with fidelity as well as self-testing.
Review and revise approach and underlying assumptions related to re-engaging previously diagnosed PLHIV in care and initiating them on treatment.
Address site specific linkage and retention challenges.
Continue support for community-based ART (CB-ART), including policy actions to institutionalize CB-ART, and explore offering other client-centered distribution services, such as HIVST distribution at pharmacies, ART distribution via lockers at community or religious sites, etc.
Continue expansion of 3+ and 6MM and TLD.
Continue efforts to address both VLC and VLS, especially those sites that have not met benchmarks for either VLC or VLS.
Strengthen case-based surveillance for public health action.
LAO PDR
Scale up PrEP implementation, including leveraging GF resources and expanding demand creation for MSM and transgender women In coordination with CHAS, GF, CSOs, and other key stakeholders, Lao PDR rolled out PrEP for the first time in FY21 Q2. Demand creation and implementation will continue to scale up in FY22, focusing on MSM and transgender women.
Expand index testing and self-testing, including outreach through virtual platforms. Index testing will be strengthened in Vientiane Capital, Savannakhet, and Champasak provinces. In FY21, PEPFAR Lao PDR is working on obtaining approval from the Government of Laos to create virtual platforms, and thus expand virtual outreach in FY22.
Continue integration of recency testing into routine HTS services 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.
Aggressively scale up SDART through provision of national policy and CQI efforts at PEPFAR-supported facilities to determine and address root cause of delay in ART initiation. SDART was approved to start in hospitals. Lao PDR will provide additional advocacy and training to expand SDART and improve reporting.
Complete TLD transition and 6-month MMD in collaboration with GF and Clinton foundation. Take dual approach to expanding 6 MMD for stable patients through high level advocacy at the country level including

policy change and TA to ensure appropriate stock forecasting and planning as well as site level QI activities to identify and address barriers to 3-6 MMD. 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.
QI for treatment continuity case management, support transportation cost and differentiated service delivery e.g., community ART services CHAS supports case manager who works closely with seven ART sites in 5 provinces to track and trace lost to follow-up cases and identify causes for lost to follow-up. CHAS also supports transportation for eligible PLHIV (poor patients, patients who live far from ART sites and have difficulty arranging transportation) to seven ART sites in five provinces. CBS provides home delivery of ARV drug for stable PLHIV in the three provinces of Laos.
Diagnostic Network Optimization is needed to ensure an efficient network and appropriate access to testing. Ensure strong VL strategy with other partners. PEPFAR Lao PDR works closely with health care providers in ART sites to check patient records and identify PLHIV who are due for their VL test, contact them for appointment arrangements and to remove any barriers for their presenting at hospitals for VL, and finally support health care providers with record keeping.
NEPAL
Support continued and aggressive implementation of PrEP. In ROP21, PEPFAR will continue to scale up PrEP services to over 4,750 clients. PEPFAR is currently supporting the National Centre for AIDS and STD Control (NCASC) to develop National Standard Operating Procedures (SOP) for PrEP implementation, which will support further national scale up and institutionalization of PrEP.
Optimize testing strategies to increase case finding, ensuring the use of higher yield and sufficiently targeted testing strategies. Strengthen/accelerate index testing, enhanced peer outreach approach (EPOA) and social network strategies. PEPFAR/Nepal will continue its targeted HTS strategy that has successfully improved yields. The program will employ HIVST and other targeted strategies including index testing, online-to-offline approaches and social network testing (EPOA and risk network referral) to try to reach the increasingly fewer remaining unidentified PLHIV and hard-to-reach KPs.
Work with stakeholders to aggressively close remaining gaps to achieving 95-95-95 goals.
PEPFAR/Nepal will continue to expand and accelerate same-day ART (SDART) and initiating treatment at the point of diagnosis, and ensure strong linkage strategies. In ROP 20. PEPFAR/Nepal initiated decentralized drug delivery of ARVs at selected KP-led sites, and will further coordinate with NCASC for expansion to other sites. This will contribute to continuation of treatment, minimizing treatment interruption and deaths. PEPFAR will coordinate with NCASC and treatment centers for implementation of an advanced disease package that will improve the quality of HIV services.
Ensure, regardless of funding source, all eligible clients have access to viral load testing and achieve viral load suppression. PEPFAR/Nepal will meet the ROP21 VL benchmark. A system of viral load sample collection, transportation, testing and sharing of results has been established. Despite COVID-19, Nepal managed to achieve its expected target for VL testing in ROP19. Nepal is conducting an assessment of viral load testing sites in ROP20 that will further identify areas for improvement and optimization. In ROP21, PEPFAR will support NCASC to ensure the country has adequate VL testing supplies and support so that all eligible PLHIV will be able to have VL testing.
Expand the country's One HIV Information System (ONHIS) to include e-LMIS for commodities, support national UIC rollout, and build a foundation for an effective HIV case-based surveillance system to maintain epidemic control, and to ensure accurate forecasting of commodity and supply chain needs. In ROP20, PEPFAR supported finalizing the ONHIS, conducting training of trainers and rolling out the training and implementation of ONHIS. In ROP21, PEPFAR will provide additional support to ensure that the system is fully functional in data collection, analysis and use. PEPFAR/Nepal will also build the foundation to adapt the system to include case based surveillance (CBS) in ROP21 . The program will also support the interoperability of eLMIS and ONHIS to ensure accurate forecasting of commodity and supply chain needs.
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.
PHILIPPINES
Ensure comprehensive update of performance and progress at ROP meeting.
Continue to work on a PrEP roadmap and rollout: partner with CBO's on KP-specific online PrEP demand creation campaigns emphasizing U=U; explore
Increased work on HTS guidelines and algorithm, inclusive of self and index testing.
Support the TLD transition operational plan and expand MMD.
Refine and develop KP case management approaches and guidelines; create KP-specific case management guidelines and provide training for case managers with technology and tools to facilitate enhanced patient-centered care for treatment and prevention.
Establish QA/QI teams at regional and local levels with clear guidance, in collaboration with HRSA
Create and facilitate a viral load scale up plan; complete DNO
Support/implement BBS for PWID and FSW.
Determine future viability of social contracting or other financial sustainability options for CBOs and an expanded HIV package as the country moves to universal health care.
TAJIKISTAN
Scale up HIVST through peer and online distribution, linked with index testing and address national policies and guidance.
Eliminate or revise PITC approach that was supposed to have been discontinued in ROP 19; address low yield through risk or symptom screening or discontinue.
Continue to scale index testing though need to address diminished case finding percentages.
Improve continuity of treatment through client-centered community services; improve community-based case management, peer support, and education; analyze treatment continuity challenges by age, sex, geography, and KP group and develop solutions (e.g., treatment interruption is highest among younger men).
Expand CB-ART, building off of the recent MoH order allowing CBOs to dispense ART and as implemented during the COVID-19 lockdown.
Support advocacy for same-day ART initiation applied consistently across stakeholders.
Accelerate progress in MMD and TLD.
THAILAND

Continue support for PrEP and including ED-PrEP for MSM; continue to push for scale to meet the needs of KP groups

PEPFAR will aim to add 5,912 new PrEP users (incl KPIF) and maintain 8,093 PrEP CURR users, contributing to 5.4 % of the national target (148,990). This will be done through demand creation and capacity building and use of evidence-based data. PrEP in the city campaign will be launched to enhance clients' literacy and increase demand on PrEP. Amplify the PrEP-Xpress service by expanding the mobile models of PrEP delivery, promoting "opt out" PrEP strategy with high-risk negatives. Intensify of online demand generation activities through online social influencers to promote the benefits of PrEP under a "Gain-Framed" message and motivate MSM and TG to start PrEP. PEPFAR will work closely with the National Health Security Office (NHSO) and the Ministry of Public Health (MoPH) to build capacity of government health care providers to bring PrEP service at scale. Best practices of PrEP differentiated service delivery model (e.g. PrEP Express) in the context of social distancing will be supported. TA for PrEP based on community-based model will be provided to GF sites to strengthen and accelerate PrEP services under GF support. PEPFAR will also work with MoPH to certify KPLHS sites for HIV services including PrEP. PEPFAR will support national PrEP M&E and provide evidence for NHSO to increase allocation of the national prevention fund to targeted free PrEP.

Expand the Online-2-Offline platform for online reservations of clients linked to the drop-in centers of CBOs with targeted segmentation strategy for sub-populations of KPs most at-risk (i.e., young MSM and trans women)

Continue online recruitment, development, and promotion of online reservations focusing on young MSM and transgender women. Support high-risk clients for linkage to PrEP and HIV-positive clients for linkage to treatment.

Continue development and implementation of recency testing, which has been delayed due to COVID 19

Continue to set up and integrate HIV recency testing into national HIV surveillance. Assess and develop a national surveillance program and dashboard for HIV recent infection. Use surveillance data to identify and characterize transmission clusters for intervention prioritization and public health actions in 3-4 high HIV burden provinces.

Accelerate, expand and institutionalize safe and ethical index testing at the national level, with a focus on fidelity to implementation guidelines/SOPs and the adoption of a supportive supervision manual; accelerate, expand and institutionalize self-testing

Work with MoPH, GF, and NHSO to expand index testing services through implementation guidelines, supportive supervision, and first line response to intimate partner violence trainings for health care providers. Support M&E at the above site level and use data to inform MoPH and NHSO policy decision to integrate index as part of the HIV testing routine and HIV testing reports. Work with MoPH to disseminate HIVST results and recommendations based on pharmacy-based delivery models. Finalize HIVST guideline incorporating information from other demonstration projects in the country (e.g. support system such as hotlines, recommended model for linkage to confirmatory HTS and ART). KPLHS models will integrate HIVST into community- based targeted HTS and distribution. Build capacity of community health workers and health care providers for KP-focused index testing (in community and facility), strengthen index testing model, monitoring, and provide supportive supervision through virtual case conferences.

Continue to build upon progress of same day initiation that is currently 56% <7 day, 6MMD (currently 38%; only 12% receiving <3M)

Work with MOPH to develop and disseminate same-day ART initiation service manual and conduct virtual online training of the service manual to health care workers working in public hospitals, prioritizing PEPFAR-supported provinces. The manual includes same-day ART flow, guidance on how to set up the system, and lessons learned from various sites. Work with MOPH and the National Health Security of Office to define key indicators for incentive-based performance to promote same-day ART initiation and monitor and improve uptake of same-day ART initiation and 6MMD. Include same-day ART initiation and 6MMD in the coaching checklist and trainings for national and provincial coach program as key priority topics for quality improvement. Support and monitor KPLHS in enhancing linkage clients to same-day ART services at referral hospitals and following up for 6MMD of KPLHS clients to reduce treatment interruption.

Support case management strategies to improve linkage of newly diagnosed KP outside of Bangkok

Support case managers at ART clinics/provincial hospitals to track and trace a) newly diagnosed PLHIV and link them to treatment, TLD initiation, same-day and rapid ART initiation, and TPT for eligible cases; b) PLHIV who were lost to follow up to return to treatment; and c) stable PLHIV for 6MMD.

Accelerate efforts to promote TLD implementation

Coordinate with MOPH, NHSO, Government Pharmaceutical Organization, and Thai AIDS Society to a) Expedite the process of TLD approval in the national essential drug list. We anticipate TLD will be included in the national essential drug list in May 2021. Single DTG and TLD will be available in the NAP system as first line ARV regimen in June 2021 and October 2021, respectively; b) Forecast TLD and DTG stock for procurement in 2022 and develop transition plan; c) Develop training package, job aids, and conduct training to health care providers including

community health workers for TLD transition once TLD is available; d) Monitor uptake of TLD transition through NAP system; e) Include TLD topic in the coaching checklist; and f) Provide TA to support PEPFAR-supported sites for transition.
Invest and expand on KP-CSO sustainability Collaborate with MOPH, NHSO, and key public hospitals to support the implementation of domestic resource mobilization and promote CSO sustainability. Work closely with the Department of Medical Sciences (DMS), MOPH, to support additional KPLHS sites to receive laboratory accreditation and be a mode of key hospital in order to reimburse HIV laboratory testing (e.g. HIV, VL, STIs testing, and counseling service) from NHSO. Coordinate with prime IP to support KPLHS in forming social enterprise for the Case Management APP, engaging with private sector, e.g. Safe Clinic, and introducing co-payment scheme at Pribta-Tangerine clinic.
Develop a national VL strategic plan Continue development and implementation of the national VL strategic plan in PEPFAR-supported sites to ensure quality of specimen referrals, logistics, turn-around-time, results reporting, and optimized data entry into the national HIV database. Scale up VL coverage for clients monitoring by drop-in center by launching the GeneXpert VL testing targeted for KPs at drop-in-centers under PEPFAR-supported sites and work closely with NHSO in VL testing reimbursement to KPLHS.

Table 4.7.4 Targets for OVC and Linkages to HIV Services in India, updated for ROP21

Table 4.7.4 Targets for OVC and Linkages to HIV Services			
SNU	**Estimated # of Orphans and Vulnerable Children[1]**	**Target # of active OVC (FY22Target) OVC_SERV**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY22 Target) OVC[2]***
Andhra Pradesh	Not Available	21,641	17,077
Maharashtra	Not Available	16,153	13,353
Manipur	Not Available	2,176	1,823
Mizoram	Not Available	2,424	1,932
Nagaland	Not Available	1,753	1,368
Telangana	Not Available	5,157	3,438
TOTAL		50,000	39,455

[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	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

				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
SNU	COP/ROP	Prioritization	Results Reported	F	M	F	M	
	COP 17		APR 18					103%
	COP 18		APR 19	126%	59%	90%	135%	120%
SNU 1	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%
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																						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	

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	
Baglung	ROP20	FEB 21	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%
Baitadi	ROP20	FEB 21	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	45%
Bajhang	ROP20	FEB 21	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	31%
Banke	ROP19	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%
	ROP20	FEB 21	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	66%
Bara	ROP20	FEB 21	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	20%
Bardiya	ROP20	FEB 21	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	45%
Bhaktapur	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%

	ROP20	FEB 21	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	42%
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%
	ROP20	FEB 21	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%
Dadeldhura	ROP20	FEB 21	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	54%
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%
	ROP20	FEB 21	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	64%
Dhading	ROP20	FEB 21	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	59%
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%
	ROP20	FEB 21	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	109%
Gulmi	ROP20	FEB 21	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	46%
Ilam	ROP20	FEB 21	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	41%
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%
	ROP20	FEB 21	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	52%
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%
	ROP20	FEB 21	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	73%
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%
	ROP20	FEB 21	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%
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%

	ROP20	FEB 21	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	93%
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%
	ROP20	FEB 21	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	69%
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%
	ROP20	FEB 21	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	94%
Kavre	ROP20	FEB 21	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%
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%
	ROP20	FEB 21	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	101%
Mahottari	ROP20	FEB 21	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	42%
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%
	ROP20	FEB 21	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	72%
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%
	ROP20	FEB 21	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	55%
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
	ROP20	FEB 21	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	71%
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%
	ROP20	FEB 21	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	66%
Palpa	ROP20	FEB 21	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	62%

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%
	ROP20	FEB 21	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	137%
Rautahat	ROP20	FEB 21	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%
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%
	ROP20	FEB 21	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%
Saptari	ROP20	FEB 21	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	50%
Sarlahi	ROP20	FEB 21	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	44%
Siraha	ROP20	FEB 21	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	110%
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%
	ROP20	FEB 21	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	68%
Syangja	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	59%
Tanahun	ROP20	FEB 21	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	59%

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
				<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	

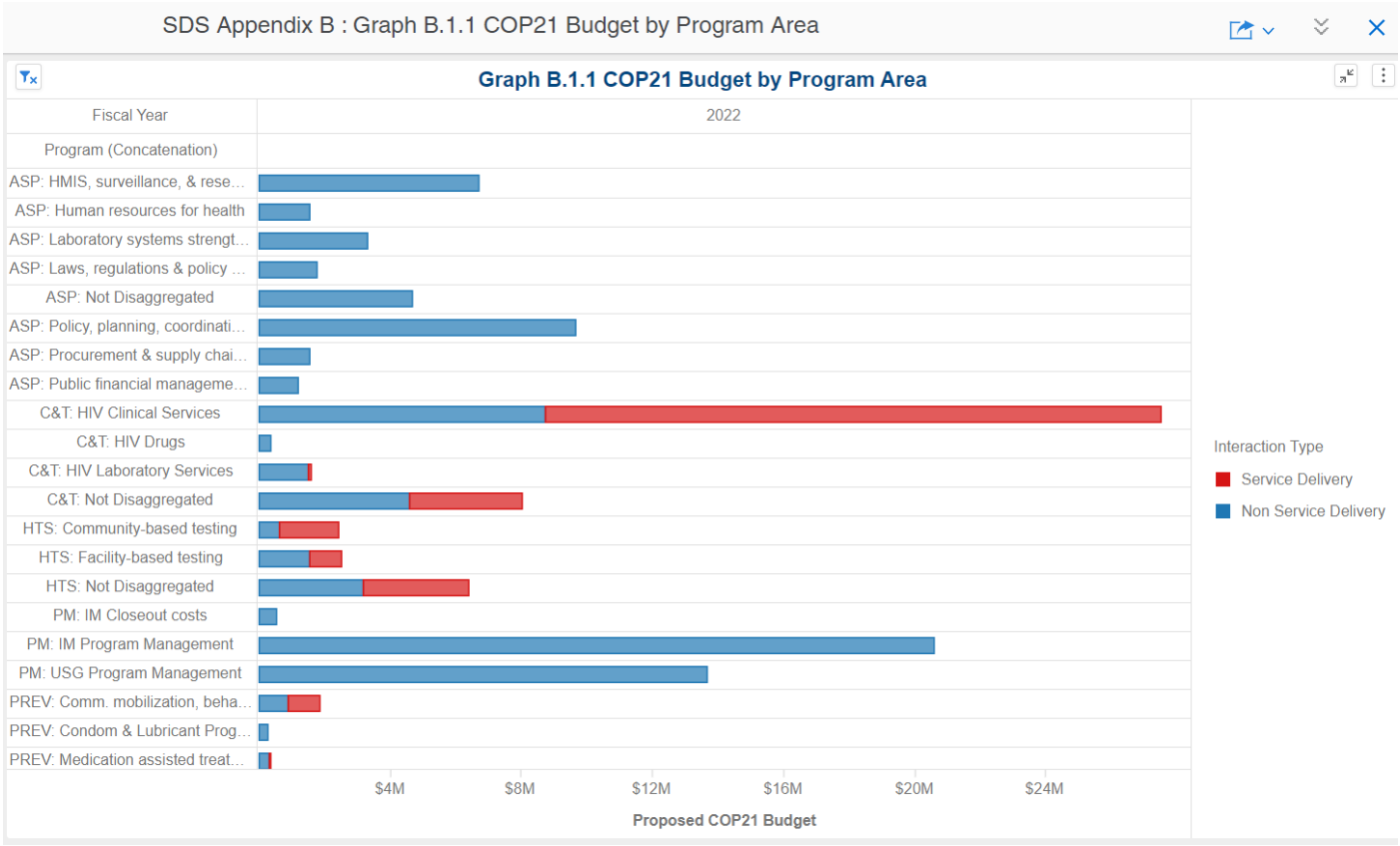
																											Coverage
Bangkok	ROP 20	Scale up aggressive	APR 21	0%	0%	63%	67%	68%	65%	67%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%	66%
Chiang Mai	ROP 20	Scale up aggressive	APR 21	0%	0%	100%	100%	80%	80%	76%	76%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%
Chiang Rai	ROP 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%
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%
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%
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%
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%
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%
Phuket	ROP 20	Attained	APR 21	0%	0%	100%	100%	100%	100%	113%	100%	108%	107%	107%	108%	107%	107%	108%	108%	107%	107%	107%	107%	108%	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%

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%
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%
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%

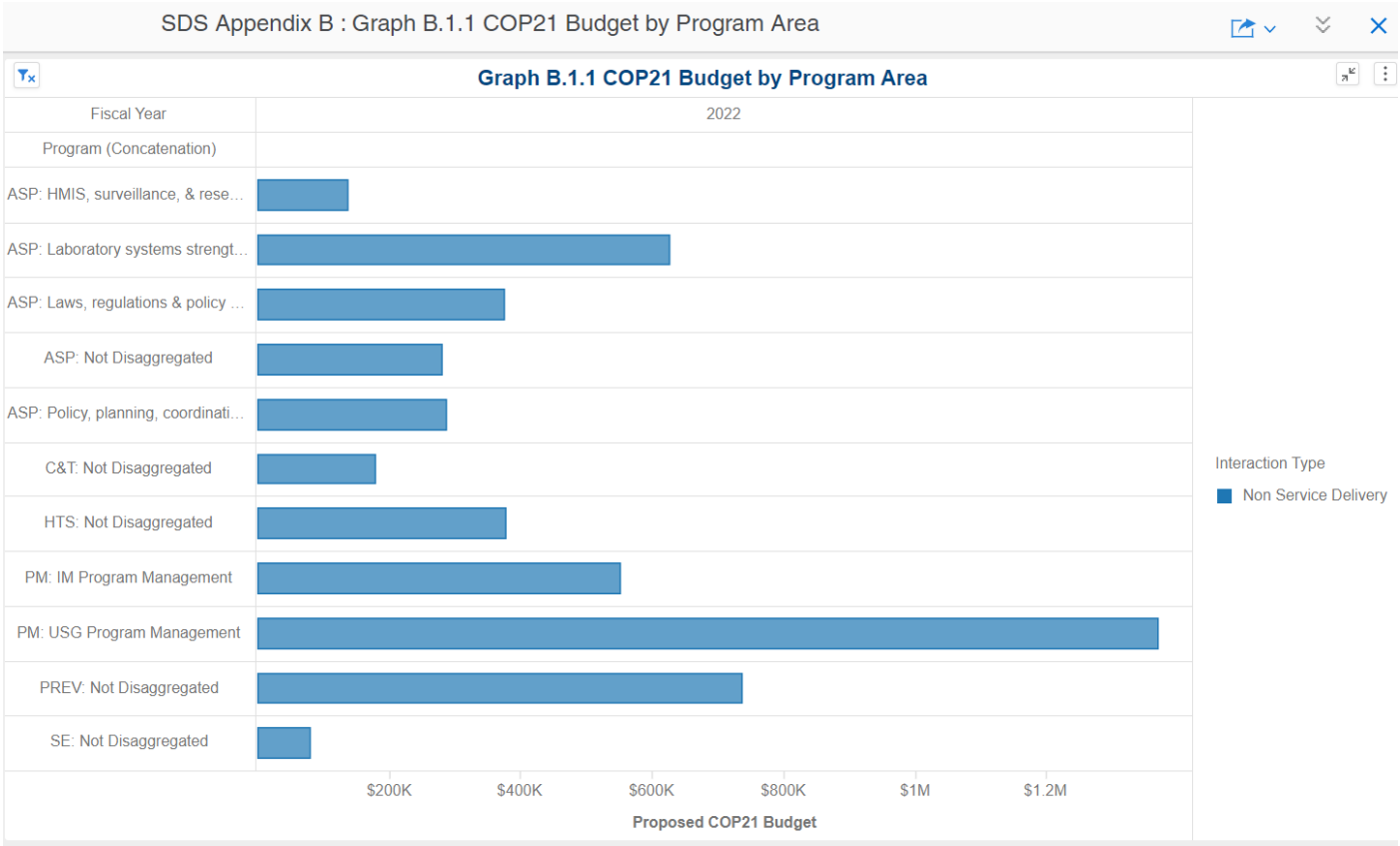
APPENDIX B: Budget Profile and Resource Projections, Asia Region and by Country (Updated June 10, 2021)

Table B.1.1 ROP21 Budget by Program Area

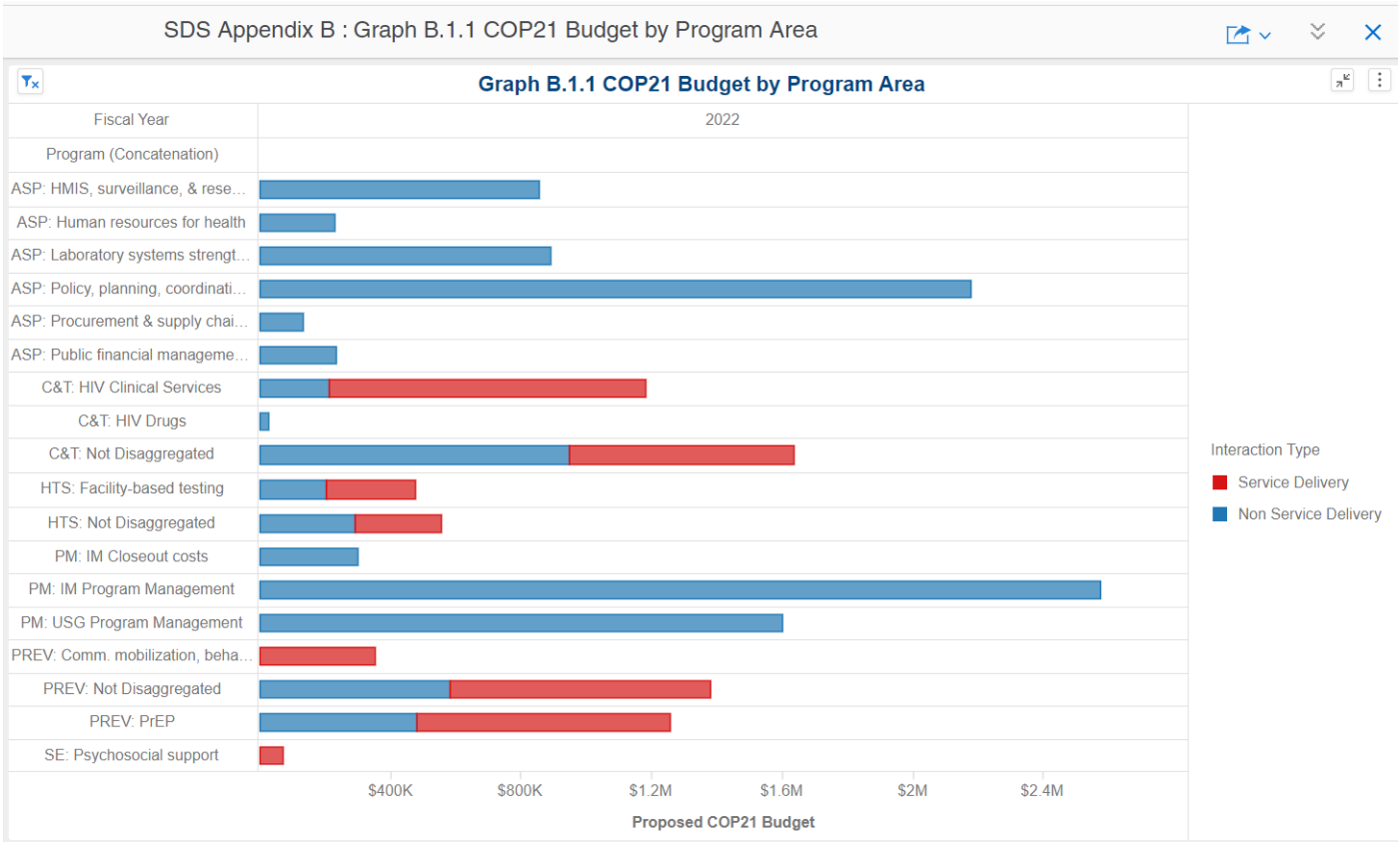
Asia Region



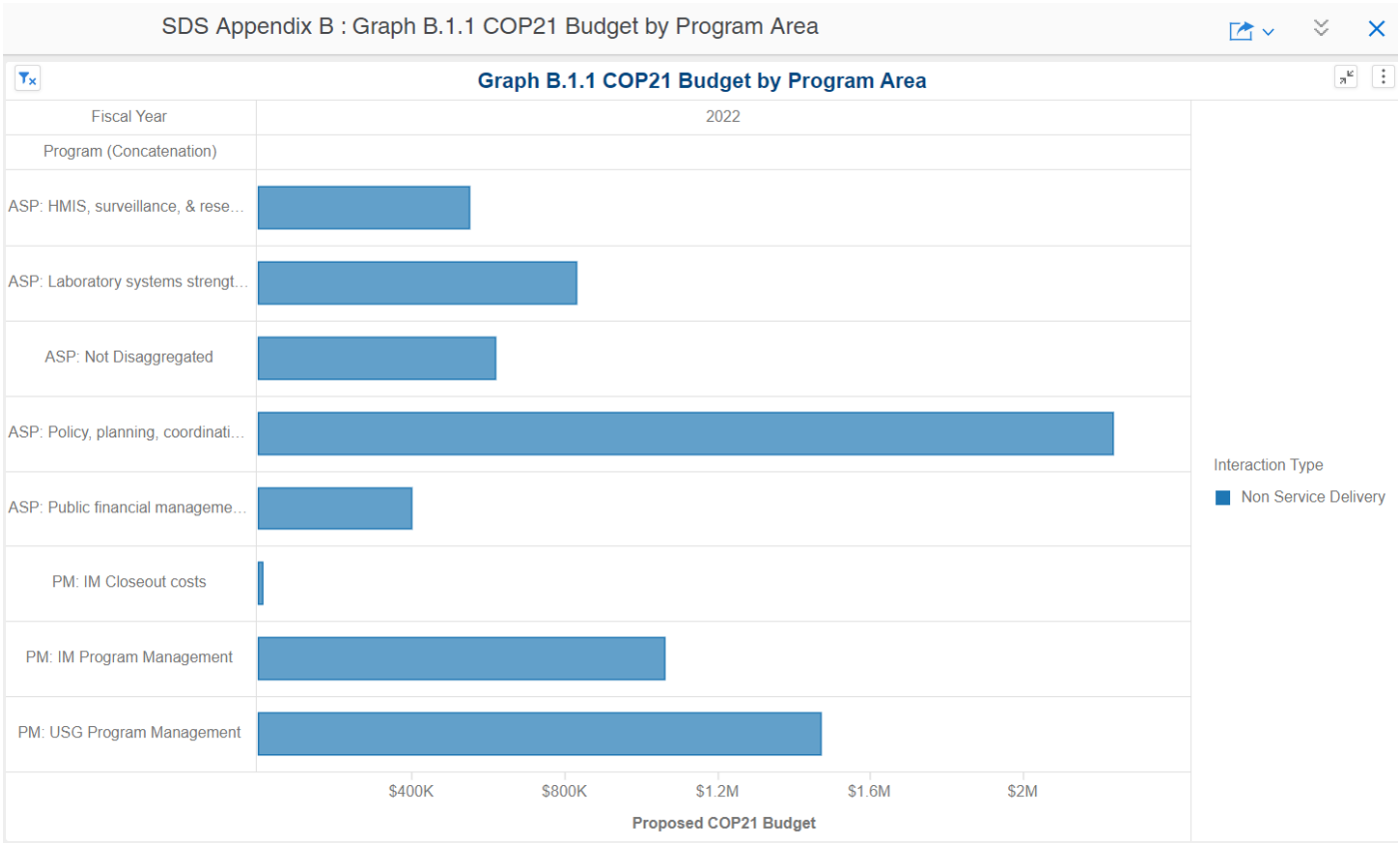
PARCU


SDS Appendix B : Graph B.1.1 COP21 Budget by Program Area
Graph B.1.1 COP21 Budget by Program Area
Fiscal Year
2022
Program (Concatenation)
ASP: HMIS, surveillance, & rese...
ASP: Laboratory systems strengt...
ASP: Laws, regulations & policy ...
ASP: Not Disaggregated
ASP: Policy, planning, coordinati...
C&T: Not Disaggregated
HTS: Not Disaggregated
PM: IM Program Management
PM: USG Program Management
PREV: Not Disaggregated
SE: Not Disaggregated
$200K
$400K
$600K
$800K
$1M
$1.2M
Proposed COP21 Budget
Interaction Type
Non Service Delivery

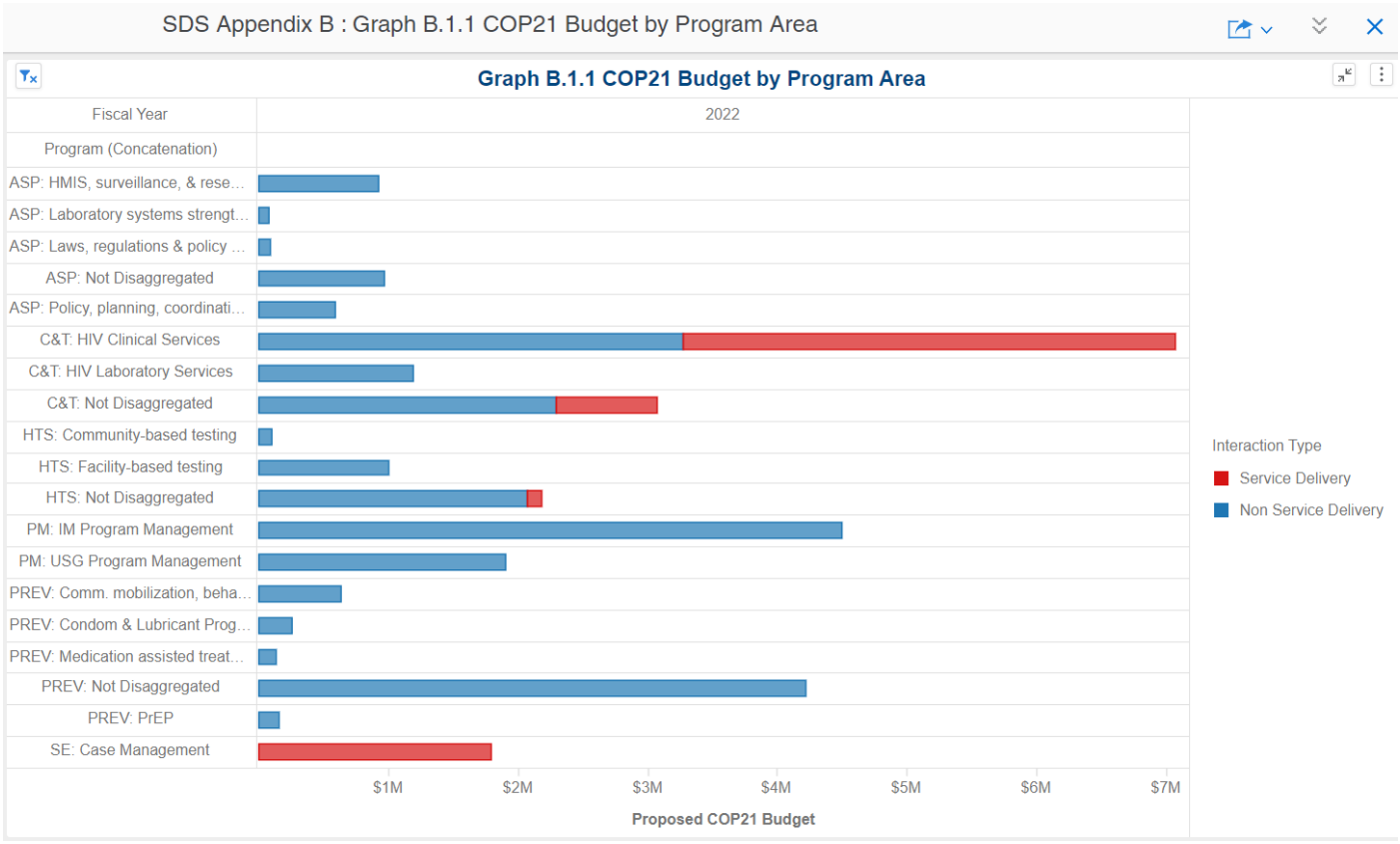
Burma


SDS Appendix B : Graph B.1.1 COP21 Budget by Program Area
Graph B.1.1 COP21 Budget by Program Area
Fiscal Year
2022
Program (Concatenation)
ASP: HMIS, surveillance, & rese...
ASP: Human resources for health
ASP: Laboratory systems strengt...
ASP: Policy, planning, coordinati...
ASP: Procurement & supply chai...
ASP: Public financial manageme...
C&T: HIV Clinical Services
C&T: HIV Drugs
C&T: Not Disaggregated
HTS: Facility-based testing
HTS: Not Disaggregated
PM: IM Closeout costs
PM: IM Program Management
PM: USG Program Management
PREV: Comm. mobilization, beha...
PREV: Not Disaggregated
PREV: PrEP
SE: Psychosocial support
$400K
$800K
$1.2M
$1.6M
$2M
$2.4M
Proposed COP21 Budget
Interaction Type
Service Delivery
Non Service Delivery

Cambodia


SDS Appendix B : Graph B.1.1 COP21 Budget by Program Area
Graph B.1.1 COP21 Budget by Program Area
Fiscal Year
2022
Program (Concatenation)
ASP: HMIS, surveillance, & rese...
ASP: Laboratory systems strengt...
ASP: Not Disaggregated
ASP: Policy, planning, coordinati...
ASP: Public financial manageme...
PM: IM Closeout costs
PM: IM Program Management
PM: USG Program Management
$400K
$800K
$1.2M
$1.6M
$2M
Proposed COP21 Budget
Interaction Type
Non Service Delivery

India


SDS Appendix B : Graph B.1.1 COP21 Budget by Program Area
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Fiscal Year
2022
Program (Concatenation)
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ASP: Laboratory systems strengt…
ASP: Laws, regulations & policy …
ASP: Not Disaggregated
ASP: Policy, planning, coordinati…
C&T: HIV Clinical Services
C&T: HIV Laboratory Services
C&T: Not Disaggregated
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HTS: Not Disaggregated
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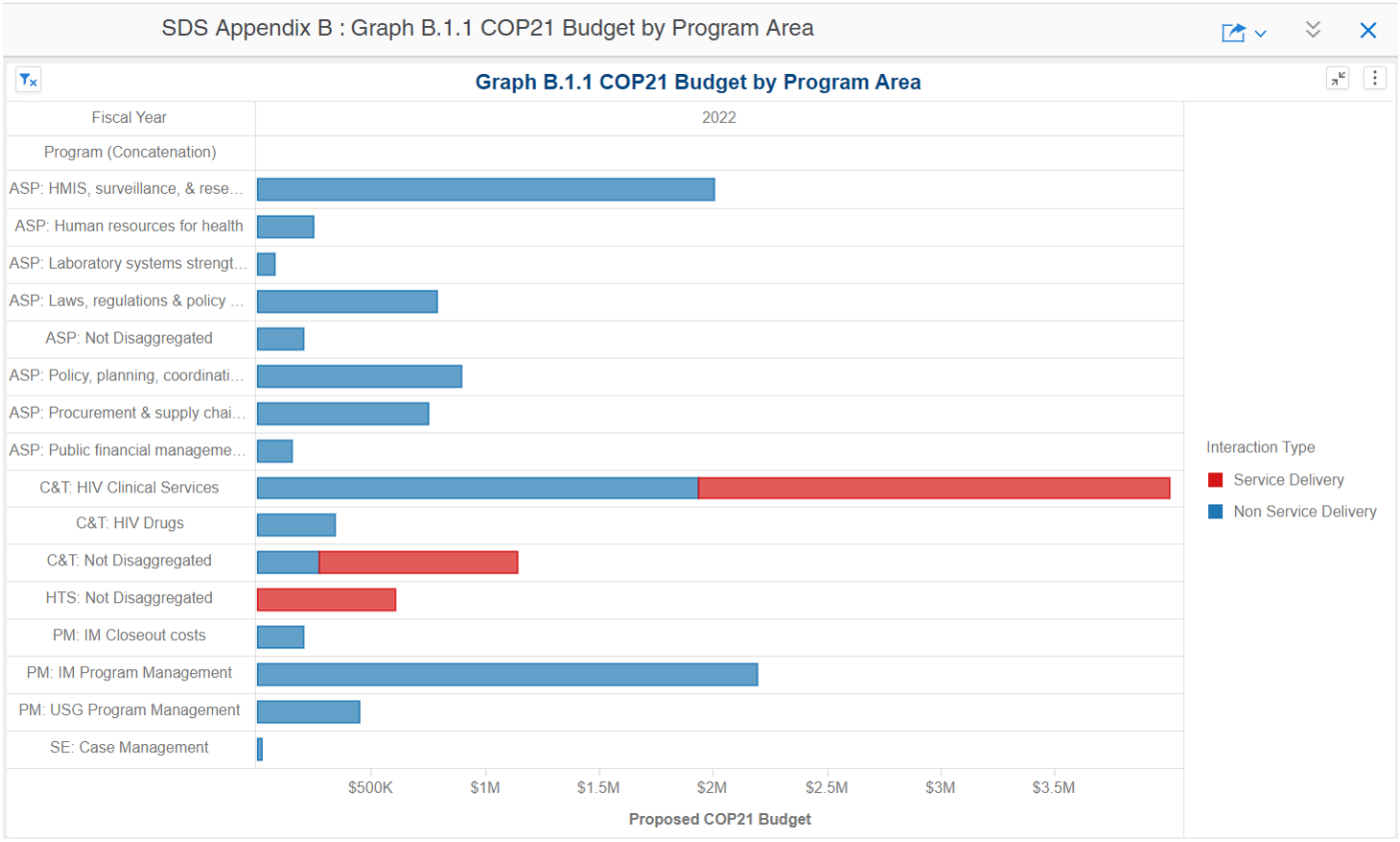
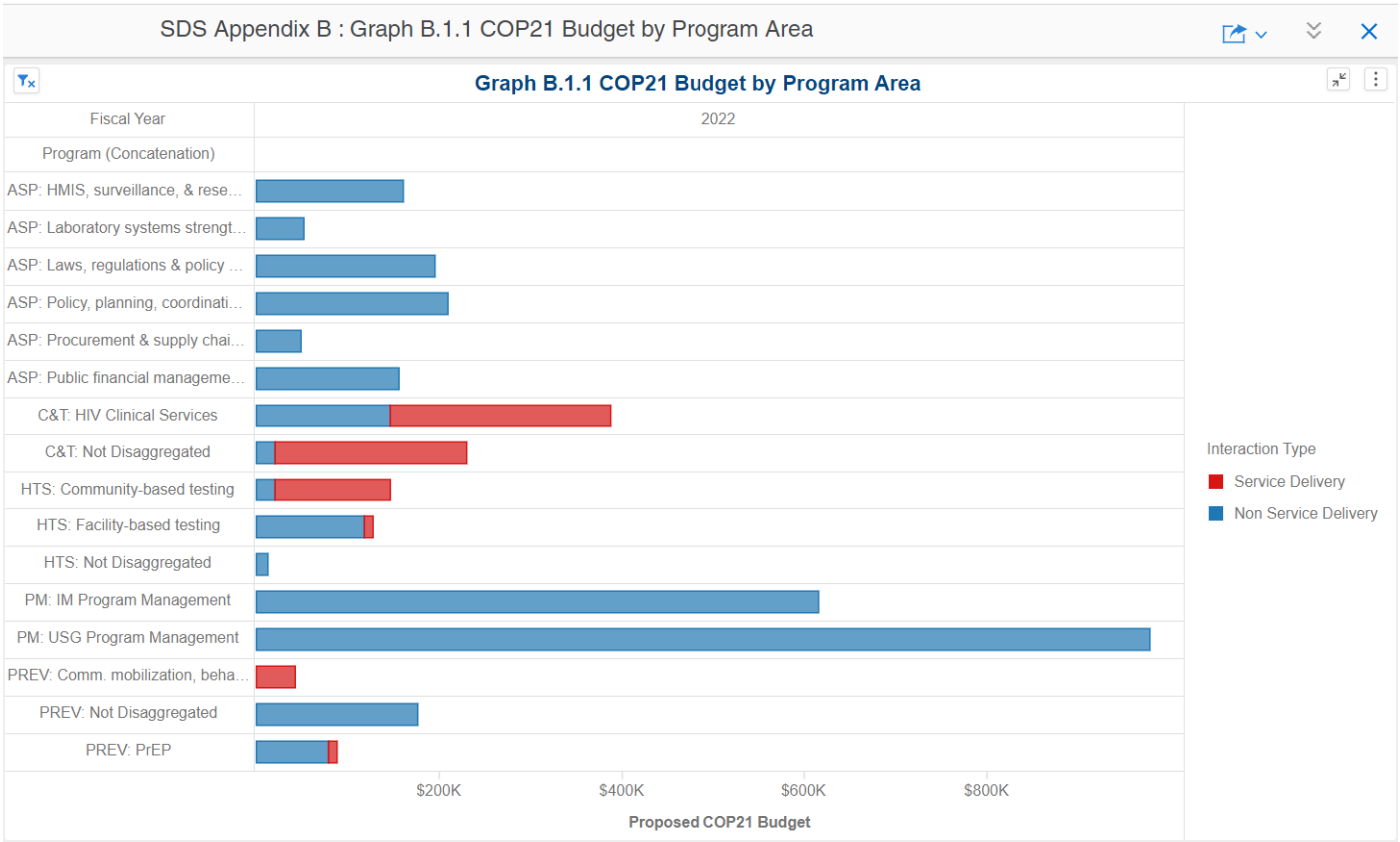
PM: USG Program Management
PREV: Comm. mobilization, beha…
PREV: Condom & Lubricant Prog…
PREV: Medication assisted treat…
PREV: Not Disaggregated
PREV: PrEP
SE: Case Management
$1M
$2M
$3M
$4M
$5M
$6M
$7M
Proposed COP21 Budget
Interaction Type
Service Delivery
Non Service Delivery

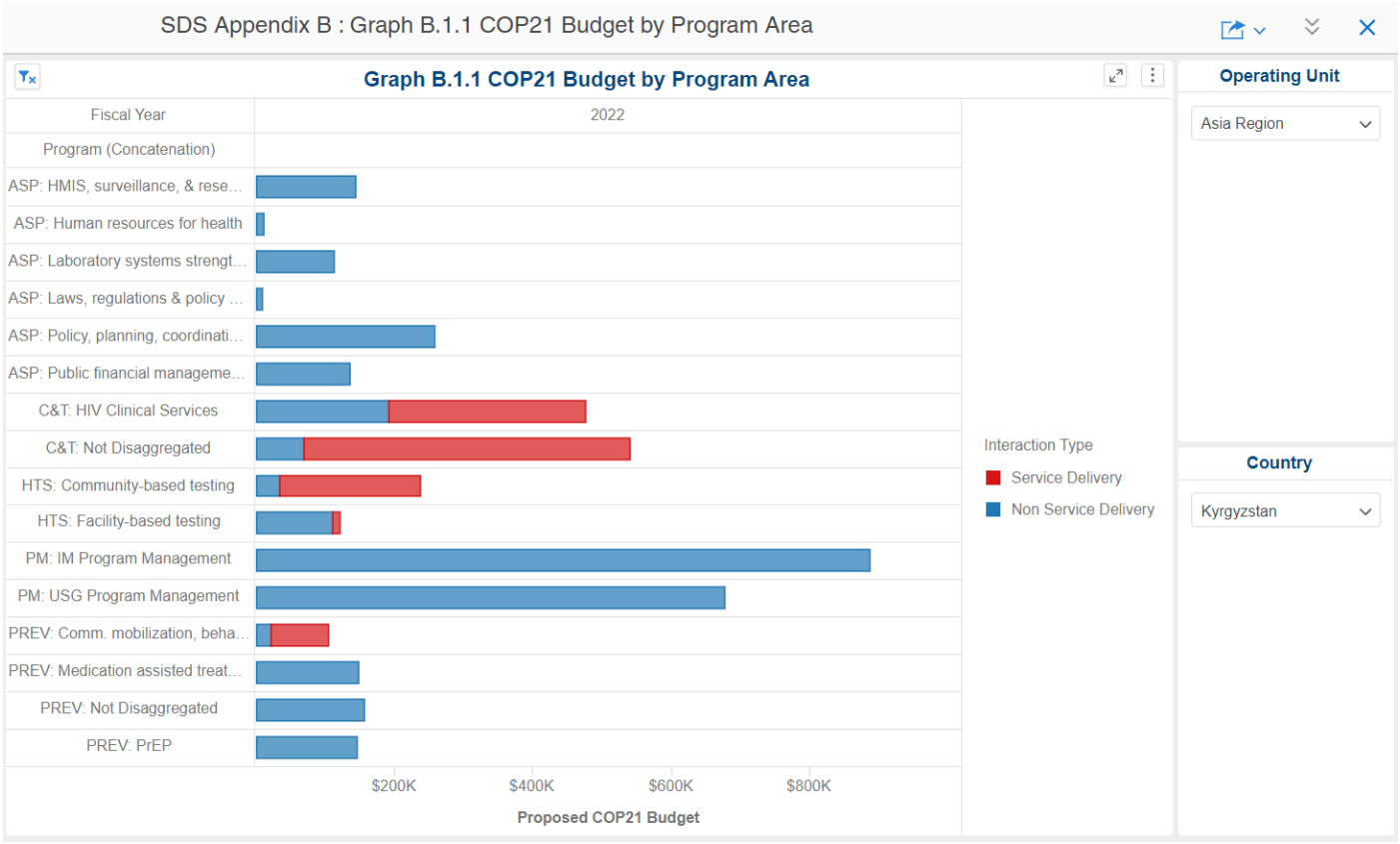
Indonesia



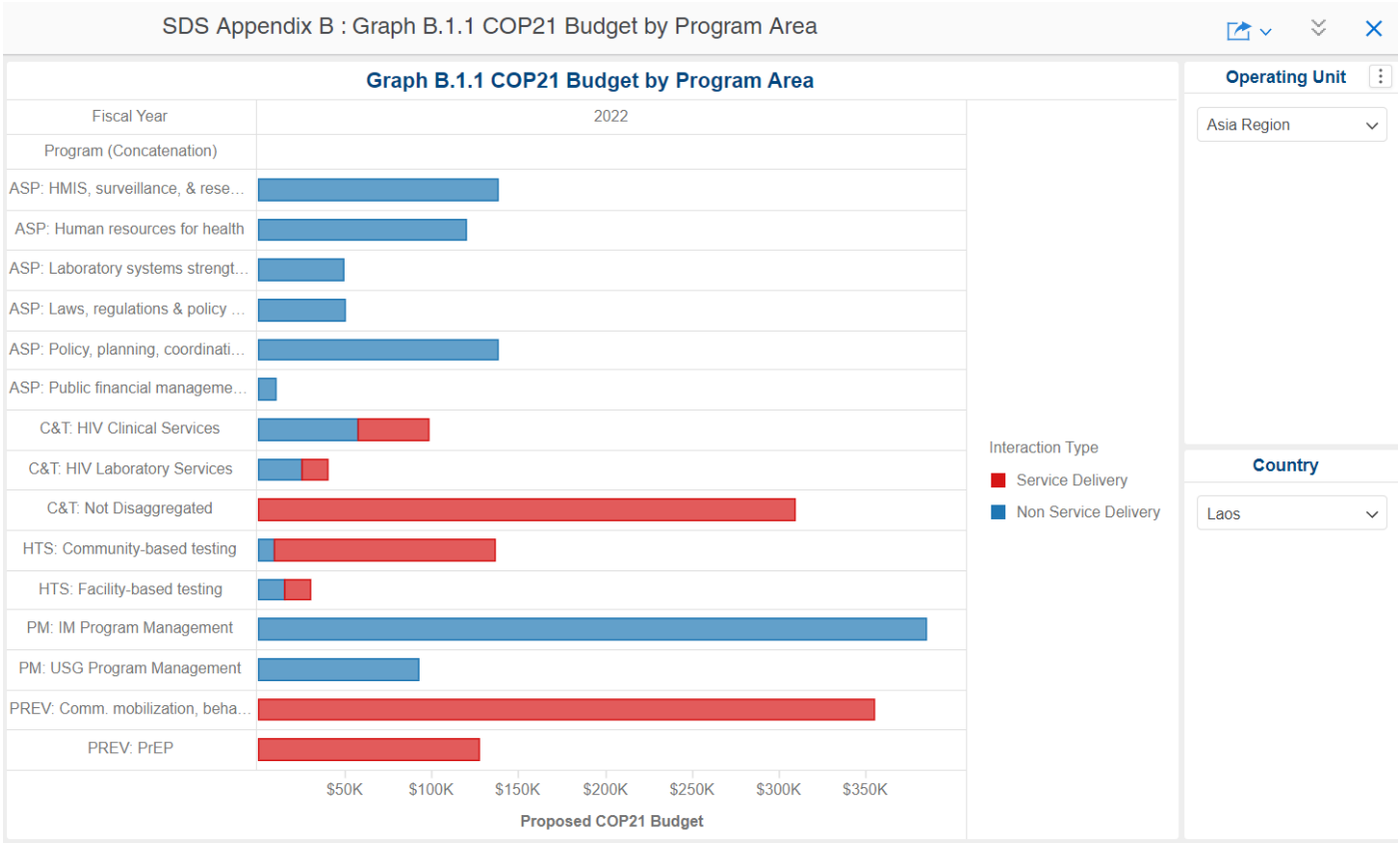
Kazakhstan



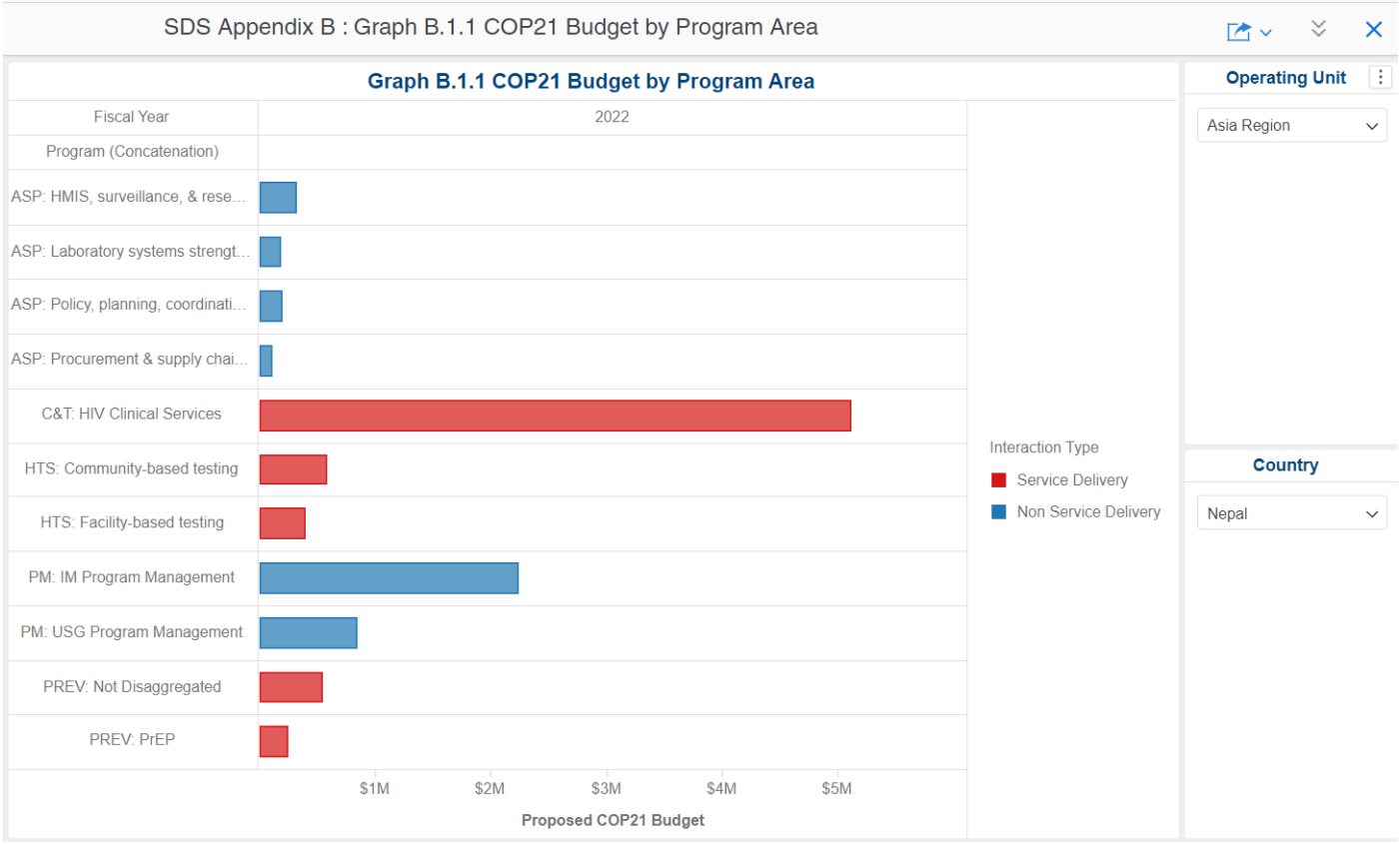
Kyrgyz Republic



Lao PDR:



Nepal



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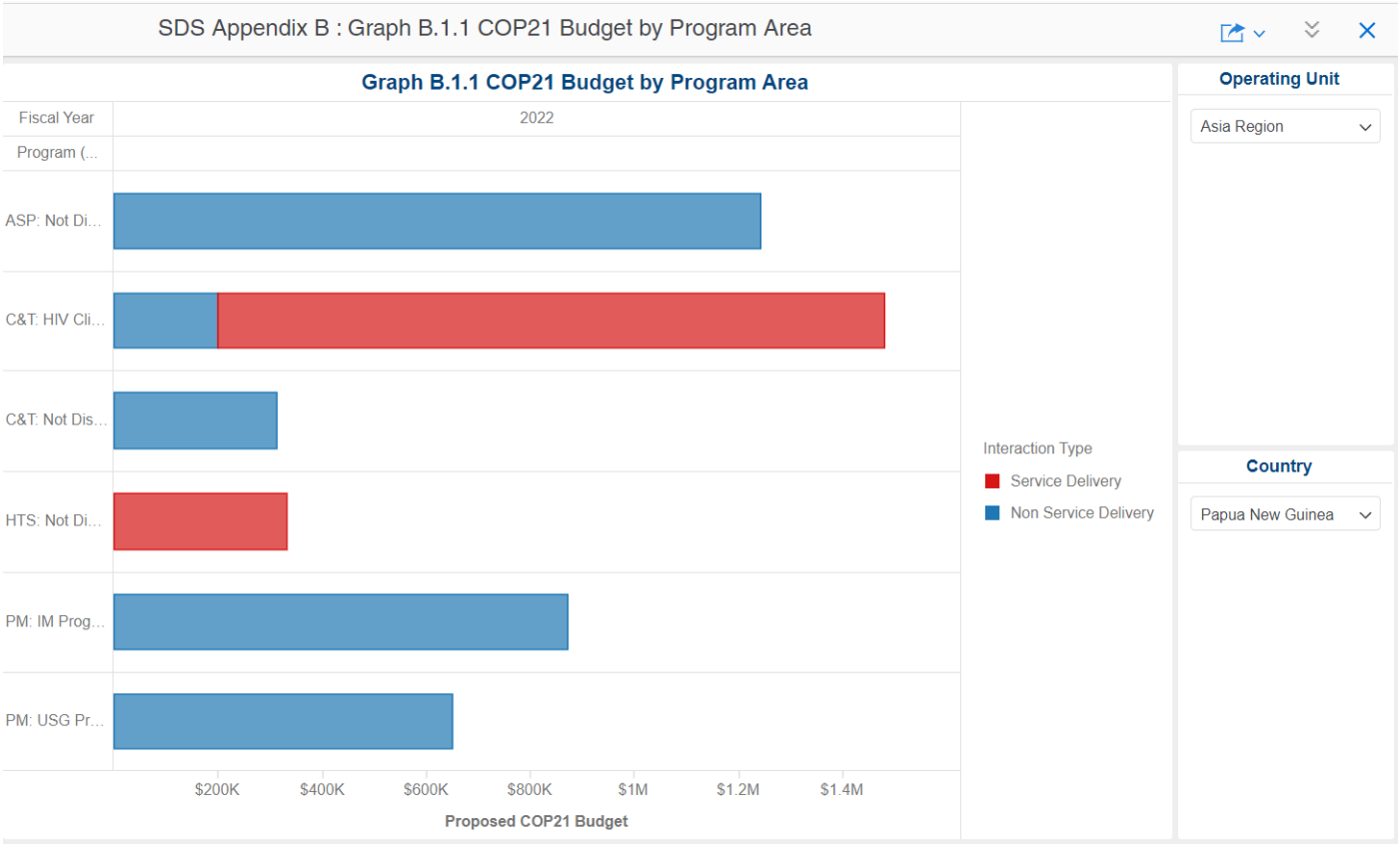
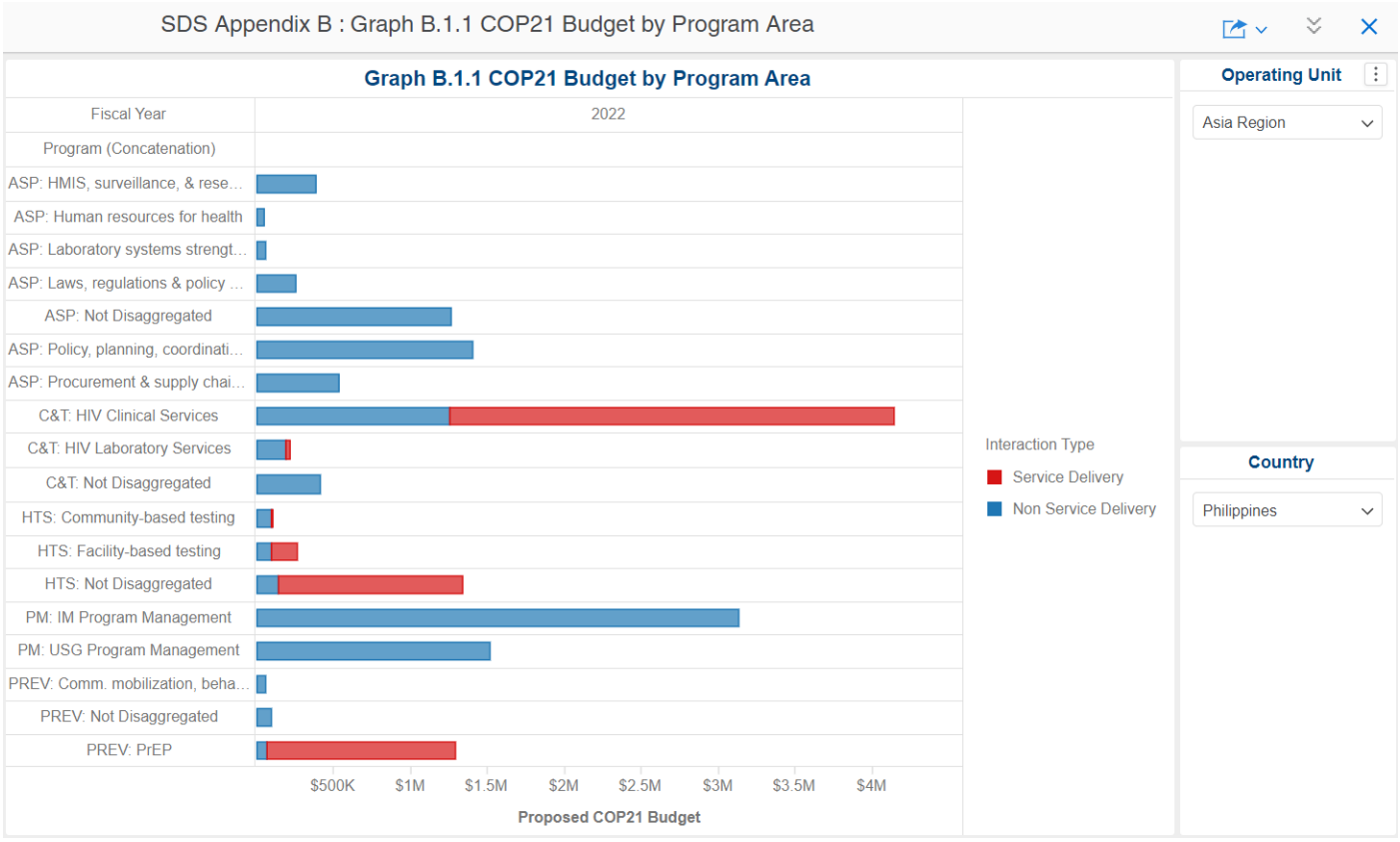
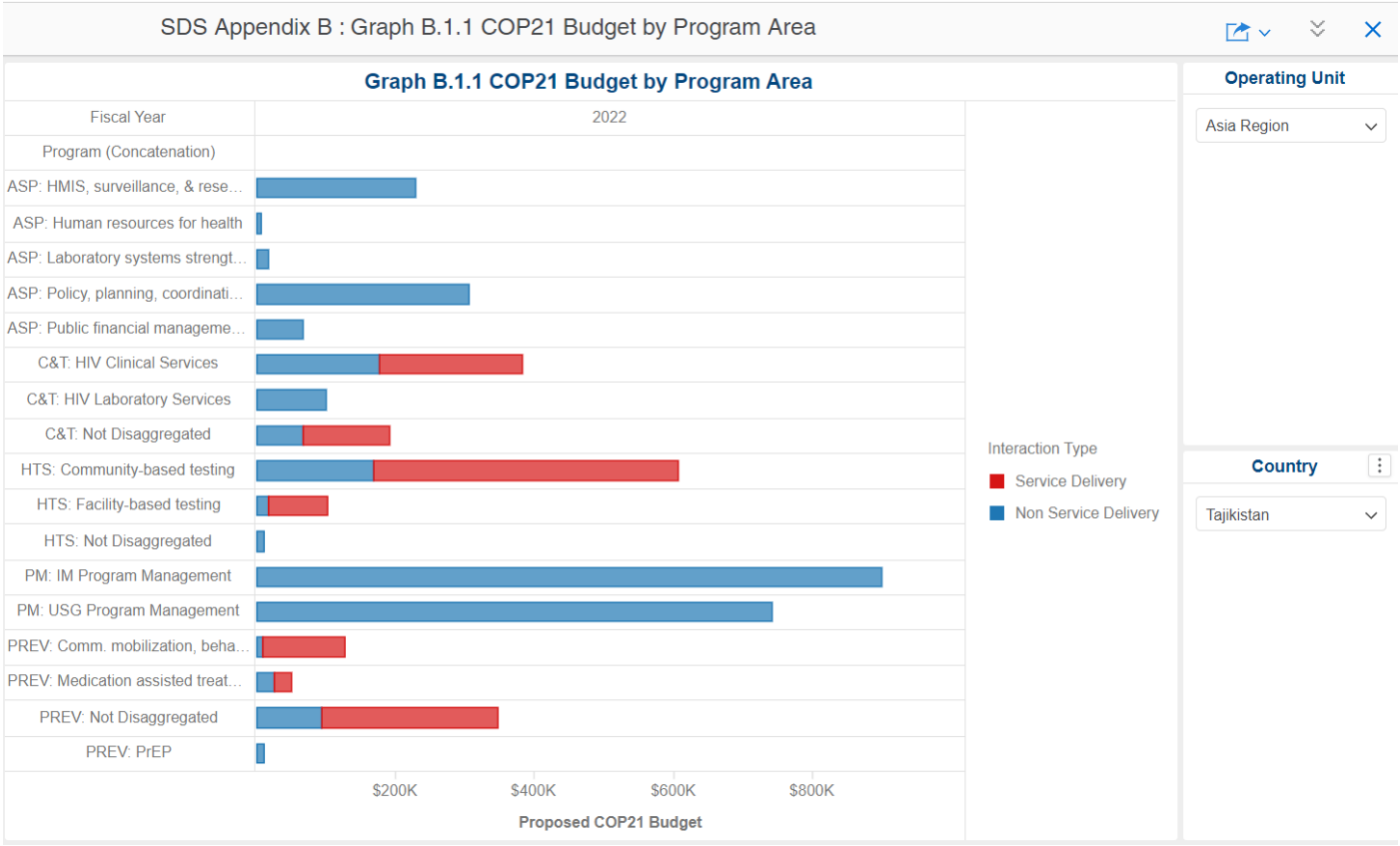


Philippines



Tajikistan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2022
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C&T: Not Disaggregated
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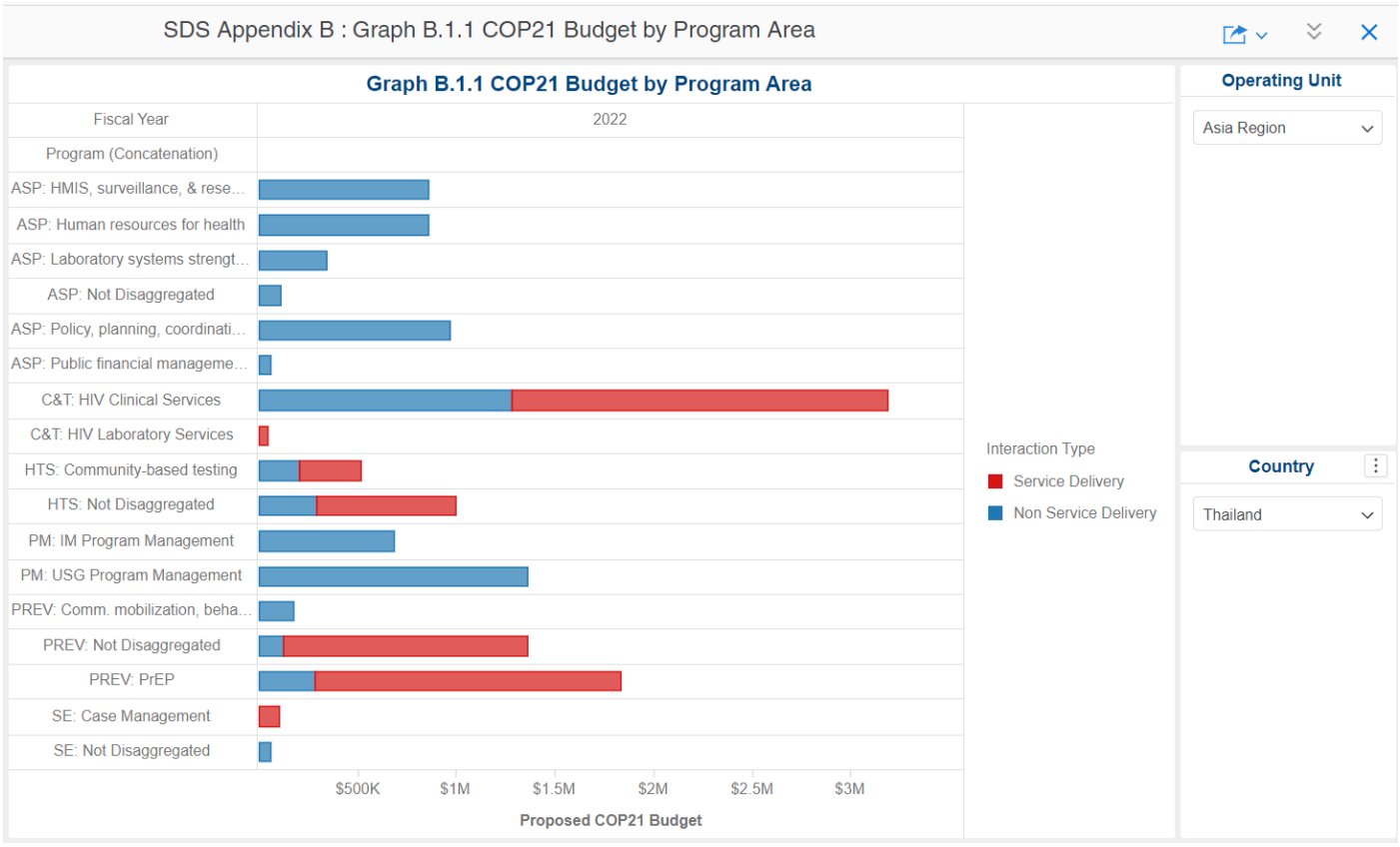
HTS: Facility-based testing
HTS: Not Disaggregated
PM: IM Program Management
PM: USG Program Management
PREV: Comm. mobilization, beha...
PREV: Medication assisted treat...
PREV: Not Disaggregated
PREV: PrEP
$200K
$400K
$600K
$800K
Proposed COP21 Budget
Interaction Type
Service Delivery
Non Service Delivery
Operating Unit
Asia Region
Country
Tajikistan

Thailand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PM: IM Program Management
PM: USG Program Management
PREV: Comm. mobilization, beha...
PREV: Not Disaggregated
PREV: PrEP
SE: Case Management
SE: Not Disaggregated
$500K
$1M
$1.5M
$2M
$2.5M
$3M
Proposed COP21 Budget
Interaction Type
Service Delivery
Non Service Delivery
Operating Unit
Asia Region
Country
Thailand

Table B.1.2 ROP21 Total Planning Level in Asia Region (Updated for ROP21)

	Table E.1.2 ROP21 Total Planning Level			
	Applied Pipeline	**New Funding**	**ARPA Funds**	**Total Spend (applied pipeline and new funding only)**
	$US	**$US**		**$US**
PARCU	$723,250	$4,276,750	-	$5,000,000
Burma	$ 4,633,766	$ 11,300,284	$673,050	$ 15,934,050
Cambodia	$1,600,178	$5,579,822	180,000	$7,180,000
India	$14,559,661	$16,289,796	$225,162	$30,849,457
Indonesia	$4,506,063	$ 9,546,955	$435,000	$ 14,053,018
Kazakhstan	$957,574	$2,670,426	$228,000	$3,628,000
Kyrgyz Republic	$2,235,257	$1,921,243	$256,500	$4,156,500
Lao PDR	-	$2,080,000	$80,000	$2,080,000
Nepal	-	$10,696,250	$296,250	$10,696,250
Philippines	$6,027,043	$10,500,000	$500,000	$16,527,043
PNG	$672,800	$4,217,500	$317,500	$4,890,300
Tajikistan	$1,731,721	$2,461,624	$293,345	$4,193,345
Thailand	$3,184,608	$10,326,392	$511,000	$13,511,000
Total Asia Region	**40,831,921**	**91,867,042**	**3,995,807****	**$132,698,963**

****ARPA Funds to be added to ROP20: $1,465,538**

Table B.1.3 Resource Allocation by Program Area (Updated for ROP21)

Asia Region

B.1.3 COP21 Budget by Program Area					
Interaction Type	**Fiscal Year**	**Program**	**Subprogram**	**Proposed COP21 Budget**	**Percent of COP 21 Proposed Budget**
Total				**$132,698,963**	**100.00%**
Non Service Delivery	2022	**Total**		**$94,699,561**	**100.00%**

Non Service Delivery	2022	C&T	**Total**	**$15,163,785**	**100.00%**
Non Service Delivery	2022	C&T	HIV Clinical Services	$8,727,975	100.00%
Non Service Delivery	2022	C&T	HIV Drugs	$364,249	100.00%
Non Service Delivery	2022	C&T	HIV Laboratory Services	$1,503,957	100.00%
Non Service Delivery	2022	C&T	Not Disaggregated	$4,567,604	100.00%
Non Service Delivery	2022	HTS	**Total**	**$5,383,945**	**100.00%**
Non Service Delivery	2022	HTS	Community-based testing	$631,944	100.00%
Non Service Delivery	2022	HTS	Facility-based testing	$1,555,622	100.00%
Non Service Delivery	2022	HTS	Not Disaggregated	$3,196,379	100.00%
Non Service Delivery	2022	PREV	**Total**	**$8,844,797**	**100.00%**
Non Service Delivery	2022	PREV	Comm. mobilization, behavior & norms change	$887,445	100.00%
Non Service Delivery	2022	PREV	Condom & Lubricant Programming	$255,209	100.00%
Non Service Delivery	2022	PREV	Medication assisted treatment	$301,065	100.00%
Non Service Delivery	2022	PREV	Not Disaggregated	$6,178,936	100.00%
Non Service Delivery	2022	PREV	PrEP	$1,222,142	100.00%
Non Service Delivery	2022	SE	**Total**	**$155,351**	**100.00%**
Non Service Delivery	2022	SE	Case Management	$19,170	100.00%
Non Service Delivery	2022	SE	Not Disaggregated	$136,181	100.00%
Non Service Delivery	2022	ASP	**Total**	**$30,397,281**	**100.00%**
Non Service Delivery	2022	ASP	HMIS, surveillance, & research	$6,700,340	100.00%
Non Service Delivery	2022	ASP	Human resources for health	$1,523,002	100.00%
Non Service Delivery	2022	ASP	Laboratory systems strengthening	$3,313,929	100.00%
Non Service Delivery	2022	ASP	Laws, regulations & policy environment	$1,751,944	100.00%
Non Service Delivery	2022	ASP	Not Disaggregated	$4,693,720	100.00%
Non Service Delivery	2022	ASP	Policy, planning, coordination & management of disease control programs	$9,642,284	100.00%
Non Service Delivery	2022	ASP	Procurement & supply chain management	$1,562,153	100.00%
Non Service Delivery	2022	ASP	Public financial management strengthening	$1,209,909	100.00%
Non Service Delivery	2022	PM	**Total**	**$34,754,402**	**100.00%**
Non Service Delivery	2022	PM	IM Closeout costs	$512,045	100.00%
Non Service Delivery	2022	PM	IM Program Management	$20,591,380	100.00%
Non Service Delivery	2022	PM	USG Program Management	$13,650,977	100.00%
Service Delivery	2022	**Total**		**$37,999,402**	**100.00%**
Service Delivery	2022	C&T	**Total**	**$22,348,853**	**100.00%**

Service Delivery	2022	C&T	HIV Clinical Services	$18,800,281	100.00%
Service Delivery	2022	C&T	HIV Laboratory Services	$90,100	100.00%
Service Delivery	2022	C&T	Not Disaggregated	$3,458,472	100.00%
Service Delivery	2022	HTS	**Total**	**$5,960,623**	**100.00%**
Service Delivery	2022	HTS	Community-based testing	$1,786,458	100.00%
Service Delivery	2022	HTS	Facility-based testing	$955,012	100.00%
Service Delivery	2022	HTS	Not Disaggregated	$3,219,153	100.00%
Service Delivery	2022	PREV	**Total**	**$7,733,312**	**100.00%**
Service Delivery	2022	PREV	Comm. mobilization, behavior & norms change	$951,375	100.00%
Service Delivery	2022	PREV	Medication assisted treatment	$25,000	100.00%
Service Delivery	2022	PREV	Not Disaggregated	$2,826,284	100.00%
Service Delivery	2022	PREV	PrEP	$3,930,653	100.00%
Service Delivery	2022	SE	**Total**	**$1,956,614**	**100.00%**
Service Delivery	2022	SE	Case Management	$1,886,958	100.00%
Service Delivery	2022	SE	Psychosocial support	$69,656	100.00%

Burma

B.1.3 COP21 Budget by Program Area					
Interaction Type	**Fiscal Year**	**Program**	**Subprogram**	**Proposed COP21 Budget**	**Percent of COP 21 Proposed Budget**
Total				**$15,934,050**	**100.00%**
Non Service Delivery	2022	**Total**		**$11,743,990**	**100.00%**
Non Service Delivery	2022	C&T	**Total**	**$1,188,356**	**100.00%**
Non Service Delivery	2022	C&T	HIV Clinical Services	$212,700	100.00%
Non Service Delivery	2022	C&T	HIV Drugs	$26,588	100.00%
Non Service Delivery	2022	C&T	Not Disaggregated	$949,068	100.00%
Non Service Delivery	2022	HTS	**Total**	**$490,533**	**100.00%**
Non Service Delivery	2022	HTS	Facility-based testing	$201,623	100.00%
Non Service Delivery	2022	HTS	Not Disaggregated	$288,910	100.00%
Non Service Delivery	2022	PREV	**Total**	**$1,063,927**	**100.00%**
Non Service Delivery	2022	PREV	Not Disaggregated	$582,425	100.00%
Non Service Delivery	2022	PREV	PrEP	$481,502	100.00%
Non Service Delivery	2022	ASP	**Total**	**$4,524,321**	**100.00%**

Non Service Delivery	2022	ASP	HMIS, surveillance, & research	$856,933	100.00%
Non Service Delivery	2022	ASP	Human resources for health	$230,000	100.00%
Non Service Delivery	2022	ASP	Laboratory systems strengthening	$890,167	100.00%
Non Service Delivery	2022	ASP	Policy, planning, coordination & management of disease control programs	$2,180,350	100.00%
Non Service Delivery	2022	ASP	Procurement & supply chain management	$132,938	100.00%
Non Service Delivery	2022	ASP	Public financial management strengthening	$233,933	100.00%
Non Service Delivery	2022	PM	**Total**	**$4,476,853**	**100.00%**
Non Service Delivery	2022	PM	IM Closeout costs	$300,000	100.00%
Non Service Delivery	2022	PM	IM Program Management	$2,576,303	100.00%
Non Service Delivery	2022	PM	USG Program Management	$1,600,550	100.00%
Service Delivery	2022	**Total**		**$4,190,060**	**100.00%**
Service Delivery	2022	C&T	**Total**	**$1,657,171**	**100.00%**
Service Delivery	2022	C&T	HIV Clinical Services	$971,180	100.00%
Service Delivery	2022	C&T	Not Disaggregated	$685,991	100.00%
Service Delivery	2022	HTS	**Total**	**$540,020**	**100.00%**
Service Delivery	2022	HTS	Facility-based testing	$274,941	100.00%
Service Delivery	2022	HTS	Not Disaggregated	$265,079	100.00%
Service Delivery	2022	PREV	**Total**	**$1,923,213**	**100.00%**
Service Delivery	2022	PREV	Comm. mobilization, behavior & norms change	$351,475	100.00%
Service Delivery	2022	PREV	Not Disaggregated	$797,140	100.00%
Service Delivery	2022	PREV	PrEP	$774,598	100.00%
Service Delivery	2022	SE	**Total**	**$69,656**	**100.00%**
Service Delivery	2022	SE	Psychosocial support	$69,656	100.00%

Cambodia

B.1.3 COP21 Budget by Program Area					
Interaction Type	**Fiscal Year**	**Program**	**Subprogram**	**Proposed COP21 Budget**	**Percent of COP 21 Proposed Budget**
Total				**$7,180,000**	**100.00%**
Non Service Delivery	2022	**Total**		**$7,180,000**	**100.00%**
Non Service Delivery	2022	ASP	**Total**	**$4,637,522**	**100.00%**
Non Service Delivery	2022	ASP	HMIS, surveillance, & research	$550,932	100.00%

Non Service Delivery	2022	ASP	Laboratory systems strengthening	$832,795	100.00%
Non Service Delivery	2022	ASP	Not Disaggregated	$619,900	100.00%
Non Service Delivery	2022	ASP	Policy, planning, coordination & management of disease control programs	$2,233,895	100.00%
Non Service Delivery	2022	ASP	Public financial management strengthening	$400,000	100.00%
Non Service Delivery	2022	PM	**Total**	**$2,542,478**	**100.00%**
Non Service Delivery	2022	PM	IM Closeout costs	$10,000	100.00%
Non Service Delivery	2022	PM	IM Program Management	$1,063,000	100.00%
Non Service Delivery	2022	PM	USG Program Management	$1,469,478	100.00%

India

B.1.3 COP21 Budget by Program Area					
Interaction Type	**Fiscal Year**	**Program**	**Subprogram**	**Proposed COP21 Budget**	**Percent of COP 21 Proposed Budget**
Total				**$30,849,457**	**100.00%**
Non Service Delivery	2022	**Total**		**$24,369,799**	**100.00%**
Non Service Delivery	2022	C&T	**Total**	**$6,755,159**	**100.00%**
Non Service Delivery	2022	C&T	HIV Clinical Services	$3,271,970	100.00%
Non Service Delivery	2022	C&T	HIV Laboratory Services	$1,195,750	100.00%
Non Service Delivery	2022	C&T	Not Disaggregated	$2,287,439	100.00%
Non Service Delivery	2022	HTS	**Total**	**$3,174,654**	**100.00%**
Non Service Delivery	2022	HTS	Community-based testing	$100,000	100.00%
Non Service Delivery	2022	HTS	Facility-based testing	$1,000,000	100.00%
Non Service Delivery	2022	HTS	Not Disaggregated	$2,074,654	100.00%
Non Service Delivery	2022	PREV	**Total**	**$5,392,394**	**100.00%**
Non Service Delivery	2022	PREV	Comm. mobilization, behavior & norms change	$630,000	100.00%
Non Service Delivery	2022	PREV	Condom & Lubricant Programming	$255,209	100.00%
Non Service Delivery	2022	PREV	Medication assisted treatment	$128,865	100.00%
Non Service Delivery	2022	PREV	Not Disaggregated	$4,219,320	100.00%
Non Service Delivery	2022	PREV	PrEP	$159,000	100.00%
Non Service Delivery	2022	ASP	**Total**	**$2,643,506**	**100.00%**
Non Service Delivery	2022	ASP	HMIS, surveillance, & research	$924,683	100.00%
Non Service Delivery	2022	ASP	Laboratory systems strengthening	$75,000	100.00%

Non Service Delivery	2022	ASP	Laws, regulations & policy environment	$85,000	100.00%
Non Service Delivery	2022	ASP	Not Disaggregated	$973,740	100.00%
Non Service Delivery	2022	ASP	Policy, planning, coordination & management of disease control programs	$585,083	100.00%
Non Service Delivery	2022	PM	**Total**	**$6,404,086**	**100.00%**
Non Service Delivery	2022	PM	IM Program Management	$4,497,413	100.00%
Non Service Delivery	2022	PM	USG Program Management	$1,906,673	100.00%
Service Delivery	2022	**Total**		**$6,479,658**	**100.00%**
Service Delivery	2022	C&T	**Total**	**$4,584,000**	**100.00%**
Service Delivery	2022	C&T	HIV Clinical Services	$3,795,000	100.00%
Service Delivery	2022	C&T	Not Disaggregated	$789,000	100.00%
Service Delivery	2022	HTS	**Total**	**$109,000**	**100.00%**
Service Delivery	2022	HTS	Not Disaggregated	$109,000	100.00%
Service Delivery	2022	SE	**Total**	**$1,786,658**	**100.00%**
Service Delivery	2022	SE	Case Management	$1,786,658	100.00%

Indonesia

B.1.3 COP21 Budget by Program Area					
Interaction Type	**Fiscal Year**	**Program**	**Subprogram**	**Proposed COP21 Budget**	**Percent of COP 21 Proposed Budget**
Total				**$14,053,018**	**100.00%**
Non Service Delivery	2022	**Total**		**$10,511,975**	**100.00%**
Non Service Delivery	2022	C&T	**Total**	**$2,543,916**	**100.00%**
Non Service Delivery	2022	C&T	HIV Clinical Services	$1,935,681	100.00%
Non Service Delivery	2022	C&T	HIV Drugs	$337,661	100.00%
Non Service Delivery	2022	C&T	Not Disaggregated	$270,574	100.00%
Non Service Delivery	2022	SE	**Total**	**$19,170**	**100.00%**
Non Service Delivery	2022	SE	Case Management	$19,170	100.00%
Non Service Delivery	2022	ASP	**Total**	**$5,110,480**	**100.00%**
Non Service Delivery	2022	ASP	HMIS, surveillance, & research	$2,005,559	100.00%
Non Service Delivery	2022	ASP	Human resources for health	$245,000	100.00%
Non Service Delivery	2022	ASP	Laboratory systems strengthening	$76,196	100.00%
Non Service Delivery	2022	ASP	Laws, regulations & policy environment	$790,000	100.00%
Non Service Delivery	2022	ASP	Not Disaggregated	$200,000	100.00%

Non Service Delivery	2022	ASP	Policy, planning, coordination & management of disease control programs	$892,206	100.00%
Non Service Delivery	2022	ASP	Procurement & supply chain management	$751,519	100.00%
Non Service Delivery	2022	ASP	Public financial management strengthening	$150,000	100.00%
Non Service Delivery	2022	PM	**Total**	**$2,838,409**	**100.00%**
Non Service Delivery	2022	PM	IM Closeout costs	$202,045	100.00%
Non Service Delivery	2022	PM	IM Program Management	$2,191,950	100.00%
Non Service Delivery	2022	PM	USG Program Management	$444,414	100.00%
Service Delivery	2022	**Total**		**$3,541,043**	**100.00%**
Service Delivery	2022	C&T	**Total**	**$2,934,362**	**100.00%**
Service Delivery	2022	C&T	HIV Clinical Services	$2,066,681	100.00%
Service Delivery	2022	C&T	Not Disaggregated	$867,681	100.00%
Service Delivery	2022	HTS	**Total**	**$606,681**	**100.00%**
Service Delivery	2022	HTS	Not Disaggregated	$606,681	100.00%

Kazakhstan

B.1.3 COP21 Budget by Program Area					
Interaction Type	**Fiscal Year**	**Program**	**Subprogram**	**Proposed COP21 Budget**	**Percent of COP 21 Proposed Budget**
Total				**$3,628,000**	**100.00%**
Non Service Delivery	2022	**Total**		**$2,991,519**	**100.00%**
Non Service Delivery	2022	C&T	**Total**	**$167,266**	**100.00%**
Non Service Delivery	2022	C&T	HIV Clinical Services	$146,166	100.00%
Non Service Delivery	2022	C&T	Not Disaggregated	$21,100	100.00%
Non Service Delivery	2022	HTS	**Total**	**$152,655**	**100.00%**
Non Service Delivery	2022	HTS	Community-based testing	$21,100	100.00%
Non Service Delivery	2022	HTS	Facility-based testing	$118,555	100.00%
Non Service Delivery	2022	HTS	Not Disaggregated	$13,000	100.00%
Non Service Delivery	2022	PREV	**Total**	**$255,210**	**100.00%**
Non Service Delivery	2022	PREV	Not Disaggregated	$176,245	100.00%
Non Service Delivery	2022	PREV	PrEP	$78,965	100.00%
Non Service Delivery	2022	ASP	**Total**	**$822,552**	**100.00%**
Non Service Delivery	2022	ASP	HMIS, surveillance, & research	$160,587	100.00%
Non Service Delivery	2022	ASP	Laboratory systems strengthening	$52,155	100.00%

Non Service Delivery	2022	ASP	Laws, regulations & policy environment	$194,500	100.00%
Non Service Delivery	2022	ASP	Policy, planning, coordination & management of disease control programs	$209,400	100.00%
Non Service Delivery	2022	ASP	Procurement & supply chain management	$49,310	100.00%
Non Service Delivery	2022	ASP	Public financial management strengthening	$156,600	100.00%
Non Service Delivery	2022	PM	**Total**	**$1,593,836**	**100.00%**
Non Service Delivery	2022	PM	IM Program Management	$615,197	100.00%
Non Service Delivery	2022	PM	USG Program Management	$978,639	100.00%
Service Delivery	2022	**Total**		**$636,481**	**100.00%**
Service Delivery	2022	C&T	**Total**	**$450,490**	**100.00%**
Service Delivery	2022	C&T	HIV Clinical Services	$240,890	100.00%
Service Delivery	2022	C&T	Not Disaggregated	$209,600	100.00%
Service Delivery	2022	HTS	**Total**	**$133,791**	**100.00%**
Service Delivery	2022	HTS	Community-based testing	$125,500	100.00%
Service Delivery	2022	HTS	Facility-based testing	$8,291	100.00%
Service Delivery	2022	PREV	**Total**	**$52,200**	**100.00%**
Service Delivery	2022	PREV	Comm. mobilization, behavior & norms change	$42,200	100.00%
Service Delivery	2022	PREV	PrEP	$10,000	100.00%

Kyrgyz Republic

B.1.3 COP21 Budget by Program Area					
Interaction Type	**Fiscal Year**	**Program**	**Subprogram**	**Proposed COP21 Budget**	**Percent of COP 21 Proposed Budget**
Total				**$4,156,500**	**100.00%**
Non Service Delivery	2022	**Total**		**$3,102,146**	**100.00%**
Non Service Delivery	2022	C&T	**Total**	**$259,800**	**100.00%**
Non Service Delivery	2022	C&T	HIV Clinical Services	$192,200	100.00%
Non Service Delivery	2022	C&T	Not Disaggregated	$67,600	100.00%
Non Service Delivery	2022	HTS	**Total**	**$143,800**	**100.00%**
Non Service Delivery	2022	HTS	Community-based testing	$33,800	100.00%
Non Service Delivery	2022	HTS	Facility-based testing	$110,000	100.00%
Non Service Delivery	2022	PREV	**Total**	**$468,350**	**100.00%**

Non Service Delivery	2022	PREV	Comm. mobilization, behavior & norms change	$20,000	100.00%
Non Service Delivery	2022	PREV	Medication assisted treatment	$147,200	100.00%
Non Service Delivery	2022	PREV	Not Disaggregated	$156,250	100.00%
Non Service Delivery	2022	PREV	PrEP	$144,900	100.00%
Non Service Delivery	2022	ASP	**Total**	**$665,778**	**100.00%**
Non Service Delivery	2022	ASP	HMIS, surveillance, & research	$143,398	100.00%
Non Service Delivery	2022	ASP	Human resources for health	$9,560	100.00%
Non Service Delivery	2022	ASP	Laboratory systems strengthening	$111,820	100.00%
Non Service Delivery	2022	ASP	Laws, regulations & policy environment	$8,000	100.00%
Non Service Delivery	2022	ASP	Policy, planning, coordination & management of disease control programs	$257,800	100.00%
Non Service Delivery	2022	ASP	Public financial management strengthening	$135,200	100.00%
Non Service Delivery	2022	PM	**Total**	**$1,564,418**	**100.00%**
Non Service Delivery	2022	PM	IM Program Management	$886,878	100.00%
Non Service Delivery	2022	PM	USG Program Management	$677,540	100.00%
Service Delivery	2022	**Total**		**$1,054,354**	**100.00%**
Service Delivery	2022	C&T	**Total**	**$755,490**	**100.00%**
Service Delivery	2022	C&T	HIV Clinical Services	$283,440	100.00%
Service Delivery	2022	C&T	Not Disaggregated	$472,050	100.00%
Service Delivery	2022	HTS	**Total**	**$214,364**	**100.00%**
Service Delivery	2022	HTS	Community-based testing	$202,800	100.00%
Service Delivery	2022	HTS	Facility-based testing	$11,564	100.00%
Service Delivery	2022	PREV	**Total**	**$84,500**	**100.00%**
Service Delivery	2022	PREV	Comm. mobilization, behavior & norms change	$84,500	100.00%

Lao PDR

B.1.3 COP21 Budget by Program Area					
Interaction Type	**Fiscal Year**	**Program**	**Subprogram**	**Proposed COP21 Budget**	**Percent of COP 21 Proposed Budget**
Total				**$2,080,000**	**100.00%**
Non Service Delivery	2022	**Total**		**$1,089,250**	**100.00%**
Non Service Delivery	2022	C&T	**Total**	**$82,198**	**100.00%**

Non Service Delivery	2022	C&T	HIV Clinical Services	$57,198	100.00%
Non Service Delivery	2022	C&T	HIV Laboratory Services	$25,000	100.00%
Non Service Delivery	2022	HTS	**Total**	**$24,099**	**100.00%**
Non Service Delivery	2022	HTS	Community-based testing	$9,099	100.00%
Non Service Delivery	2022	HTS	Facility-based testing	$15,000	100.00%
Non Service Delivery	2022	ASP	**Total**	**$505,297**	**100.00%**
Non Service Delivery	2022	ASP	HMIS, surveillance, & research	$138,199	100.00%
Non Service Delivery	2022	ASP	Human resources for health	$120,000	100.00%
Non Service Delivery	2022	ASP	Laboratory systems strengthening	$49,098	100.00%
Non Service Delivery	2022	ASP	Laws, regulations & policy environment	$50,000	100.00%
Non Service Delivery	2022	ASP	Policy, planning, coordination & management of disease control programs	$138,000	100.00%
Non Service Delivery	2022	ASP	Public financial management strengthening	$10,000	100.00%
Non Service Delivery	2022	PM	**Total**	**$477,656**	**100.00%**
Non Service Delivery	2022	PM	IM Program Management	$385,250	100.00%
Non Service Delivery	2022	PM	USG Program Management	$92,406	100.00%
Service Delivery	2022	**Total**		**$990,750**	**100.00%**
Service Delivery	2022	C&T	**Total**	**$365,500**	**100.00%**
Service Delivery	2022	C&T	HIV Clinical Services	$41,000	100.00%
Service Delivery	2022	C&T	HIV Laboratory Services	$15,000	100.00%
Service Delivery	2022	C&T	Not Disaggregated	$309,500	100.00%
Service Delivery	2022	HTS	**Total**	**$142,500**	**100.00%**
Service Delivery	2022	HTS	Community-based testing	$127,500	100.00%
Service Delivery	2022	HTS	Facility-based testing	$15,000	100.00%
Service Delivery	2022	PREV	**Total**	**$482,750**	**100.00%**
Service Delivery	2022	PREV	Comm. mobilization, behavior & norms change	$355,250	100.00%
Service Delivery	2022	PREV	PrEP	$127,500	100.00%

Nepal

B.1.3 COP21 Budget by Program Area					
Interaction Type	**Fiscal Year**	**Program**	**Subprogram**	**Proposed COP21 Budget**	**Percent of COP 21 Proposed Budget**
Total				**$10,696,250**	**100.00%**

Non Service Delivery	2022	**Total**		**$3,840,189**	**100.00%**
Non Service Delivery	2022	ASP	**Total**	**$771,504**	**100.00%**
Non Service Delivery	2022	ASP	HMIS, surveillance, & research	$313,048	100.00%
Non Service Delivery	2022	ASP	Laboratory systems strengthening	$178,884	100.00%
Non Service Delivery	2022	ASP	Policy, planning, coordination & management of disease control programs	$181,186	100.00%
Non Service Delivery	2022	ASP	Procurement & supply chain management	$98,386	100.00%
Non Service Delivery	2022	PM	**Total**	**$3,068,685**	**100.00%**
Non Service Delivery	2022	PM	IM Program Management	$2,229,304	100.00%
Non Service Delivery	2022	PM	USG Program Management	$839,381	100.00%
Service Delivery	2022	**Total**		**$6,856,061**	**100.00%**
Service Delivery	2022	C&T	**Total**	**$5,119,105**	**100.00%**
Service Delivery	2022	C&T	HIV Clinical Services	$5,119,105	100.00%
Service Delivery	2022	HTS	**Total**	**$962,226**	**100.00%**
Service Delivery	2022	HTS	Community-based testing	$572,671	100.00%
Service Delivery	2022	HTS	Facility-based testing	$389,555	100.00%
Service Delivery	2022	PREV	**Total**	**$774,730**	**100.00%**
Service Delivery	2022	PREV	Not Disaggregated	$536,653	100.00%
Service Delivery	2022	PREV	PrEP	$238,077	100.00%

Papua New Guinea

B.1.3 COP21 Budget by Program Area					
Interaction Type	**Fiscal Year**	**Program**	**Subprogram**	**Proposed COP21 Budget**	**Percent of COP 21 Proposed Budget**
Total				**$4,890,300**	**100.00%**
Non Service Delivery	2022	**Total**		**$3,276,010**	**100.00%**
Non Service Delivery	2022	C&T	**Total**	**$511,594**	**100.00%**
Non Service Delivery	2022	C&T	HIV Clinical Services	$200,000	100.00%
Non Service Delivery	2022	C&T	Not Disaggregated	$311,594	100.00%
Non Service Delivery	2022	ASP	**Total**	**$1,242,030**	**100.00%**
Non Service Delivery	2022	ASP	Not Disaggregated	$1,242,030	100.00%
Non Service Delivery	2022	PM	**Total**	**$1,522,386**	**100.00%**
Non Service Delivery	2022	PM	IM Program Management	$871,550	100.00%

Non Service Delivery	2022	PM	USG Program Management	$650,836	100.00%
Service Delivery	2022	**Total**		**$1,614,290**	**100.00%**
Service Delivery	2022	C&T	**Total**	**$1,281,670**	**100.00%**
Service Delivery	2022	C&T	HIV Clinical Services	$1,281,670	100.00%
Service Delivery	2022	HTS	**Total**	**$332,620**	**100.00%**
Service Delivery	2022	HTS	Not Disaggregated	$332,620	100.00%

Philippines

B.1.3 COP21 Budget by Program Area					
Interaction Type	**Fiscal Year**	**Program**	**Subprogram**	**Proposed COP21 Budget**	**Percent of COP 21 Proposed Budget**
Total				**$16,527,043**	**100.00%**
Non Service Delivery	2022	**Total**		**$10,991,761**	**100.00%**
Non Service Delivery	2022	C&T	**Total**	**$1,852,889**	**100.00%**
Non Service Delivery	2022	C&T	HIV Clinical Services	$1,254,444	100.00%
Non Service Delivery	2022	C&T	HIV Laboratory Services	$184,445	100.00%
Non Service Delivery	2022	C&T	Not Disaggregated	$414,000	100.00%
Non Service Delivery	2022	HTS	**Total**	**$327,389**	**100.00%**
Non Service Delivery	2022	HTS	Community-based testing	$94,445	100.00%
Non Service Delivery	2022	HTS	Facility-based testing	$94,444	100.00%
Non Service Delivery	2022	HTS	Not Disaggregated	$138,500	100.00%
Non Service Delivery	2022	PREV	**Total**	**$208,890**	**100.00%**
Non Service Delivery	2022	PREV	Comm. mobilization, behavior & norms change	$54,445	100.00%
Non Service Delivery	2022	PREV	Not Disaggregated	$90,000	100.00%
Non Service Delivery	2022	PREV	PrEP	$64,445	100.00%
Non Service Delivery	2022	ASP	**Total**	**$3,944,832**	**100.00%**
Non Service Delivery	2022	ASP	HMIS, surveillance, & research	$384,444	100.00%
Non Service Delivery	2022	ASP	Human resources for health	$49,444	100.00%
Non Service Delivery	2022	ASP	Laboratory systems strengthening	$60,000	100.00%
Non Service Delivery	2022	ASP	Laws, regulations & policy environment	$249,444	100.00%
Non Service Delivery	2022	ASP	Not Disaggregated	$1,267,500	100.00%
Non Service Delivery	2022	ASP	Policy, planning, coordination & management of disease control programs	$1,404,000	100.00%

Non Service Delivery	2022	ASP	Procurement & supply chain management	$530,000	100.00%
Non Service Delivery	2022	PM	**Total**	**$4,657,761**	**100.00%**
Non Service Delivery	2022	PM	IM Program Management	$3,137,761	100.00%
Non Service Delivery	2022	PM	USG Program Management	$1,520,000	100.00%
Service Delivery	2022	**Total**		**$5,535,282**	**100.00%**
Service Delivery	2022	C&T	**Total**	**$2,925,282**	**100.00%**
Service Delivery	2022	C&T	HIV Clinical Services	$2,890,282	100.00%
Service Delivery	2022	C&T	HIV Laboratory Services	$35,000	100.00%
Service Delivery	2022	HTS	**Total**	**$1,380,000**	**100.00%**
Service Delivery	2022	HTS	Community-based testing	$10,000	100.00%
Service Delivery	2022	HTS	Facility-based testing	$170,000	100.00%
Service Delivery	2022	HTS	Not Disaggregated	$1,200,000	100.00%
Service Delivery	2022	PREV	**Total**	**$1,230,000**	**100.00%**
Service Delivery	2022	PREV	PrEP	$1,230,000	100.00%

Tajikistan

B.1.3 COP21 Budget by Program Area					
Interaction Type	**Fiscal Year**	**Program**	**Subprogram**	**Proposed COP21 Budget**	**Percent of COP 21 Proposed Budget**
Total				**$4,193,345**	**100.00%**
Non Service Delivery	2022	**Total**		**$2,942,539**	**100.00%**
Non Service Delivery	2022	C&T	**Total**	**$342,209**	**100.00%**
Non Service Delivery	2022	C&T	HIV Clinical Services	$176,047	100.00%
Non Service Delivery	2022	C&T	HIV Laboratory Services	$98,762	100.00%
Non Service Delivery	2022	C&T	Not Disaggregated	$67,400	100.00%
Non Service Delivery	2022	HTS	**Total**	**$194,500**	**100.00%**
Non Service Delivery	2022	HTS	Community-based testing	$168,500	100.00%
Non Service Delivery	2022	HTS	Facility-based testing	$16,000	100.00%
Non Service Delivery	2022	HTS	Not Disaggregated	$10,000	100.00%
Non Service Delivery	2022	PREV	**Total**	**$138,317**	**100.00%**
Non Service Delivery	2022	PREV	Comm. mobilization, behavior & norms change	$8,000	100.00%
Non Service Delivery	2022	PREV	Medication assisted treatment	$25,000	100.00%

Non Service Delivery	2022	PREV	Not Disaggregated	$94,027	100.00%
Non Service Delivery	2022	PREV	PrEP	$11,290	100.00%
Non Service Delivery	2022	ASP	**Total**	**$624,562**	**100.00%**
Non Service Delivery	2022	ASP	HMIS, surveillance, & research	$229,182	100.00%
Non Service Delivery	2022	ASP	Human resources for health	$7,080	100.00%
Non Service Delivery	2022	ASP	Laboratory systems strengthening	$16,500	100.00%
Non Service Delivery	2022	ASP	Policy, planning, coordination & management of disease control programs	$305,800	100.00%
Non Service Delivery	2022	ASP	Public financial management strengthening	$66,000	100.00%
Non Service Delivery	2022	PM	**Total**	**$1,642,951**	**100.00%**
Non Service Delivery	2022	PM	IM Program Management	$899,787	100.00%
Non Service Delivery	2022	PM	USG Program Management	$743,164	100.00%
Service Delivery	2022	**Total**		**$1,250,806**	**100.00%**
Service Delivery	2022	C&T	**Total**	**$331,150**	**100.00%**
Service Delivery	2022	C&T	HIV Clinical Services	$206,500	100.00%
Service Delivery	2022	C&T	Not Disaggregated	$124,650	100.00%
Service Delivery	2022	HTS	**Total**	**$523,761**	**100.00%**
Service Delivery	2022	HTS	Community-based testing	$438,100	100.00%
Service Delivery	2022	HTS	Facility-based testing	$85,661	100.00%
Service Delivery	2022	PREV	**Total**	**$395,895**	**100.00%**
Service Delivery	2022	PREV	Comm. mobilization, behavior & norms change	$117,950	100.00%
Service Delivery	2022	PREV	Medication assisted treatment	$25,000	100.00%
Service Delivery	2022	PREV	Not Disaggregated	$252,945	100.00%

Thailand

B.1.3 COP21 Budget by Program Area					
Interaction Type	**Fiscal Year**	**Program**	**Subprogram**	**Proposed COP21 Budget**	**Percent of COP 21 Proposed Budget**
Total				**$13,511,000**	**100.00%**
Non Service Delivery	2022	**Total**		**$7,660,383**	**100.00%**

Non Service Delivery	2022	C&T	**Total**	**$1,281,569**	**100.00%**
Non Service Delivery	2022	C&T	HIV Clinical Services	$1,281,569	100.00%
Non Service Delivery	2022	HTS	**Total**	**$499,600**	**100.00%**
Non Service Delivery	2022	HTS	Community-based testing	$205,000	100.00%
Non Service Delivery	2022	HTS	Not Disaggregated	$294,600	100.00%
Non Service Delivery	2022	PREV	**Total**	**$580,995**	**100.00%**
Non Service Delivery	2022	PREV	Comm. mobilization, behavior & norms change	$175,000	100.00%
Non Service Delivery	2022	PREV	Not Disaggregated	$123,955	100.00%
Non Service Delivery	2022	PREV	PrEP	$282,040	100.00%
Non Service Delivery	2022	SE	**Total**	**$56,572**	**100.00%**
Non Service Delivery	2022	SE	Not Disaggregated	$56,572	100.00%
Non Service Delivery	2022	ASP	**Total**	**$3,198,280**	**100.00%**
Non Service Delivery	2022	ASP	HMIS, surveillance, & research	$855,705	100.00%
Non Service Delivery	2022	ASP	Human resources for health	$861,918	100.00%
Non Service Delivery	2022	ASP	Laboratory systems strengthening	$344,600	100.00%
Non Service Delivery	2022	ASP	Not Disaggregated	$110,550	100.00%
Non Service Delivery	2022	ASP	Policy, planning, coordination & management of disease control programs	$967,331	100.00%
Non Service Delivery	2022	ASP	Public financial management strengthening	$58,176	100.00%
Non Service Delivery	2022	PM	**Total**	**$2,043,367**	**100.00%**
Non Service Delivery	2022	PM	IM Program Management	$685,407	100.00%
Non Service Delivery	2022	PM	USG Program Management	$1,357,960	100.00%
Service Delivery	2022	**Total**		**$5,850,617**	**100.00%**
Service Delivery	2022	C&T	**Total**	**$1,944,633**	**100.00%**
Service Delivery	2022	C&T	HIV Clinical Services	$1,904,533	100.00%
Service Delivery	2022	C&T	HIV Laboratory Services	$40,100	100.00%
Service Delivery	2022	HTS	**Total**	**$1,015,660**	**100.00%**
Service Delivery	2022	HTS	Community-based testing	$309,887	100.00%
Service Delivery	2022	HTS	Not Disaggregated	$705,773	100.00%
Service Delivery	2022	PREV	**Total**	**$2,790,024**	**100.00%**
Service Delivery	2022	PREV	Not Disaggregated	$1,239,546	100.00%

Service Delivery	2022	PREV	PrEP	$1,550,478	100.00%
Service Delivery	2022	SE	**Total**	**$100,300**	**100.00%**
Service Delivery	2022	SE	Case Management	$100,300	100.00%

B1.1.4 (Updated for ROP21)

Asia Region

Table B.1.4: COP21 Resource Allocation by Program and Beneficiary

Program	Fiscal Year	Beneficiary	Proposed COP21 Budget	Percent to Total
Total			**$132,698,963**	**100%**
C&T	2022	**Total**	**$37,512,638**	**28%**
C&T	2022	Key Pops	$14,242,884	11%
C&T	2022	Non-Targeted Pop	$19,083,732	14%
C&T	2022	OVC	$500,000	0%
C&T	2022	Priority Pops	$3,686,022	3%
HTS	2022	**Total**	**$11,344,568**	**9%**
HTS	2022	Key Pops	$6,197,273	5%
HTS	2022	Non-Targeted Pop	$2,443,548	2%
HTS	2022	Priority Pops	$2,703,747	2%
PREV	2022	**Total**	**$16,578,109**	**12%**
PREV	2022	Key Pops	$11,467,734	9%
PREV	2022	Non-Targeted Pop	$2,390,355	2%
PREV	2022	Priority Pops	$2,720,020	2%
SE	2022	**Total**	**$2,111,965**	**2%**
SE	2022	Key Pops	$205,837	0%
SE	2022	Non-Targeted Pop	$119,470	0%
SE	2022	OVC	$1,786,658	1%
ASP	2022	**Total**	**$30,397,281**	**23%**
ASP	2022	Key Pops	$6,377,406	5%
ASP	2022	Non-Targeted Pop	$23,109,285	17%
ASP	2022	Priority Pops	$910,590	1%
PM	2022	**Total**	**$34,754,402**	**26%**
PM	2022	Key Pops	$527,374	0%

PM	2022	Non-Targeted Pop	$34,227,028	26%

Asia Regional/PARCU

Table B.1.4: COP21 Resource Allocation by Program and Beneficiary

Program	Fiscal Year	Beneficiary	Proposed COP21 Budget	Percent to Total
Total			**$5,000,000**	**100%**
C&T	2022	**Total**	**$178,829**	**4%**
C&T	2022	Key Pops	$39,609	1%
C&T	2022	Non-Targeted Pop	$139,220	3%
HTS	2022	**Total**	**$376,715**	**8%**
HTS	2022	Key Pops	$240,000	5%
HTS	2022	Non-Targeted Pop	$136,715	3%
PREV	2022	**Total**	**$736,714**	**15%**
PREV	2022	Key Pops	$600,000	12%
PREV	2022	Non-Targeted Pop	$136,714	3%
SE	2022	**Total**	**$79,609**	**2%**
SE	2022	Key Pops	$79,609	2%
ASP	2022	**Total**	**$1,706,617**	**34%**
ASP	2022	Key Pops	$650,797	13%
ASP	2022	Non-Targeted Pop	$1,055,820	21%
PM	2022	**Total**	**$1,921,516**	**38%**
PM	2022	Non-Targeted Pop	$1,921,516	38%

Burma

Table B.1.4: COP21 Resource Allocation by Program and Beneficiary

Program	Fiscal Year	Beneficiary	Proposed COP21 Budget	Percent to Total
Total			**$15,934,050**	**100%**
C&T	2022	**Total**	**$2,845,527**	**18%**
C&T	2022	Key Pops	$2,606,239	16%
C&T	2022	Non-Targeted Pop	$239,288	2%
HTS	2022	**Total**	**$1,030,553**	**6%**
HTS	2022	Key Pops	$1,030,553	6%
PREV	2022	**Total**	**$2,987,140**	**19%**

PREV	2022	Key Pops	$2,227,409	14%
PREV	2022	Non-Targeted Pop	$759,731	5%
SE	2022	**Total**	**$69,656**	**0%**
SE	2022	Key Pops	$69,656	0%
ASP	2022	**Total**	**$4,524,321**	**28%**
ASP	2022	Key Pops	$983,400	6%
ASP	2022	Non-Targeted Pop	$3,540,921	22%
PM	2022	**Total**	**$4,476,853**	**28%**
PM	2022	Non-Targeted Pop	$4,476,853	28%

Cambodia

Table B.1.4: COP21 Resource Allocation by Program and Beneficiary

Program	Fiscal Year	Beneficiary	Proposed COP21 Budget	Percent to Total
Total			**$7,180,000**	**100%**
ASP	2022	**Total**	**$4,637,522**	**65%**
ASP	2022	Key Pops	$1,551,000	22%
ASP	2022	Non-Targeted Pop	$3,086,522	43%
PM	2022	**Total**	**$2,542,478**	**35%**
PM	2022	Non-Targeted Pop	$2,542,478	35%

India

Table B.1.4: COP21 Resource Allocation by Program and Beneficiary

Program	Fiscal Year	Beneficiary	Proposed COP21 Budget	Percent to Total
Total			**$30,849,457**	**100%**
C&T	2022	**Total**	**$11,339,159**	**37%**
C&T	2022	Key Pops	$234,171	1%
C&T	2022	Non-Targeted Pop	$9,775,312	32%
C&T	2022	OVC	$500,000	2%
C&T	2022	Priority Pops	$829,676	3%
HTS	2022	**Total**	**$3,283,654**	**11%**
HTS	2022	Key Pops	$1,100,000	4%
HTS	2022	Priority Pops	$2,183,654	7%

PREV	2022	**Total**	**$5,392,394**	**17%**
PREV	2022	Key Pops	$2,130,000	7%
PREV	2022	Non-Targeted Pop	$790,148	3%
PREV	2022	Priority Pops	$2,472,246	8%
SE	2022	**Total**	**$1,786,658**	**6%**
SE	2022	OVC	$1,786,658	6%
ASP	2022	**Total**	**$2,643,506**	**9%**
ASP	2022	Key Pops	$245,000	1%
ASP	2022	Non-Targeted Pop	$2,398,506	8%
PM	2022	**Total**	**$6,404,086**	**21%**
PM	2022	Non-Targeted Pop	$6,404,086	21%

Indonesia

Table B.1.4: COP21 Resource Allocation by Program and Beneficiary

Program	Fiscal Year	Beneficiary	Proposed COP21 Budget	Percent to Total
Total			**$14,053,018**	**100%**
C&T	2022	**Total**	**$5,478,278**	**39%**
C&T	2022	Key Pops	$5,140,617	37%
C&T	2022	Non-Targeted Pop	$337,661	2%
HTS	2022	**Total**	**$606,681**	**4%**
HTS	2022	Key Pops	$606,681	4%
SE	2022	**Total**	**$19,170**	**0%**
SE	2022	Non-Targeted Pop	$19,170	0%
ASP	2022	**Total**	**$5,110,480**	**36%**
ASP	2022	Key Pops	$1,962,842	14%
ASP	2022	Non-Targeted Pop	$3,147,638	22%
PM	2022	**Total**	**$2,838,409**	**20%**
PM	2022	Key Pops	$6,100	0%
PM	2022	Non-Targeted Pop	$2,832,309	20%

Kazakhstan

Table B.1.4: COP21 Resource Allocation by Program and Beneficiary

Program	Fiscal Year	Beneficiary	Proposed COP21 Budget	Percent to Total
Total			**$3,628,000**	**100%**
C&T	2022	**Total**	**$617,756**	**17%**
C&T	2022	Key Pops	$310,240	9%
C&T	2022	Non-Targeted Pop	$307,516	8%
HTS	2022	**Total**	**$286,446**	**8%**
HTS	2022	Key Pops	$247,432	7%
HTS	2022	Non-Targeted Pop	$39,014	1%
PREV	2022	**Total**	**$307,410**	**8%**
PREV	2022	Key Pops	$280,920	8%
PREV	2022	Non-Targeted Pop	$26,490	1%
ASP	2022	**Total**	**$822,552**	**23%**
ASP	2022	Key Pops	$42,250	1%
ASP	2022	Non-Targeted Pop	$780,302	22%
PM	2022	**Total**	**$1,593,836**	**44%**
PM	2022	Key Pops	$129,540	4%
PM	2022	Non-Targeted Pop	$1,464,296	40%

Kyrgyz Republic

Table B.1.4: COP21 Resource Allocation by Program and Beneficiary

Program	Fiscal Year	Beneficiary	Proposed COP21 Budget	Percent to Total
Total			**$4,156,500**	**100%**
C&T	2022	**Total**	**$1,015,290**	**24%**
C&T	2022	Key Pops	$636,850	15%
C&T	2022	Non-Targeted Pop	$378,440	9%
HTS	2022	**Total**	**$358,164**	**9%**
HTS	2022	Key Pops	$288,164	7%
HTS	2022	Non-Targeted Pop	$70,000	2%
PREV	2022	**Total**	**$552,850**	**13%**
PREV	2022	Key Pops	$512,550	12%
PREV	2022	Non-Targeted Pop	$40,300	1%
ASP	2022	**Total**	**$665,778**	**16%**

ASP	2022	Key Pops	$179,820	4%
ASP	2022	Non-Targeted Pop	$485,958	12%
PM	2022	**Total**	**$1,564,418**	**38%**
PM	2022	Key Pops	$272,540	7%
PM	2022	Non-Targeted Pop	$1,291,878	31%

Lao PDR

Table B.1.4: COP21 Resource Allocation by Program and Beneficiary

Program	Fiscal Year	Beneficiary	Proposed COP21 Budget	Percent to Total
Total			**$2,080,000**	**100%**
C&T	2022	**Total**	**$447,698**	**22%**
C&T	2022	Key Pops	$309,500	15%
C&T	2022	Non-Targeted Pop	$138,198	7%
HTS	2022	**Total**	**$166,599**	**8%**
HTS	2022	Key Pops	$127,500	6%
HTS	2022	Non-Targeted Pop	$39,099	2%
PREV	2022	**Total**	**$482,750**	**23%**
PREV	2022	Key Pops	$482,750	23%
ASP	2022	**Total**	**$505,297**	**24%**
ASP	2022	Non-Targeted Pop	$465,297	22%
ASP	2022	Priority Pops	$40,000	2%
PM	2022	**Total**	**$477,656**	**23%**
PM	2022	Non-Targeted Pop	$477,656	23%

Nepal

Table B.1.4: COP21 Resource Allocation by Program and Beneficiary

Program	Fiscal Year	Beneficiary	Proposed COP21 Budget	Percent to Total
Total			**$10,696,250**	**100%**

C&T	2022	**Total**	**$5,119,105**	**48%**
C&T	2022	Key Pops	$2,626,648	25%
C&T	2022	Priority Pops	$2,492,457	23%
HTS	2022	**Total**	**$962,226**	**9%**
HTS	2022	Key Pops	$571,022	5%
HTS	2022	Priority Pops	$391,204	4%
PREV	2022	**Total**	**$774,730**	**7%**
PREV	2022	Key Pops	$595,846	6%
PREV	2022	Priority Pops	$178,884	2%
ASP	2022	**Total**	**$771,504**	**7%**
ASP	2022	Key Pops	$82,800	1%
ASP	2022	Non-Targeted Pop	$688,704	6%
PM	2022	**Total**	**$3,068,685**	**29%**
PM	2022	Non-Targeted Pop	$3,068,685	29%

Papua New Guinea

Table B.1.4: COP21 Resource Allocation by Program and Beneficiary

Program	Fiscal Year	Beneficiary	Proposed COP21 Budget	Percent to Total
Total			**$4,890,300**	**100%**
C&T	2022	**Total**	**$1,793,264**	**37%**
C&T	2022	Non-Targeted Pop	$1,793,264	37%
HTS	2022	**Total**	**$332,620**	**7%**
HTS	2022	Non-Targeted Pop	$332,620	7%
ASP	2022	**Total**	**$1,242,030**	**25%**
ASP	2022	Non-Targeted Pop	$1,242,030	25%
PM	2022	**Total**	**$1,522,386**	**31%**
PM	2022	Non-Targeted Pop	$1,522,386	31%

Philippines

Table B.1.4: COP21 Resource Allocation by Program and Beneficiary

Program	Fiscal Year	Beneficiary	Proposed COP21 Budget	Percent to Total
Total			**$16,527,043**	**100%**

C&T	2022	**Total**	**$4,778,171**	**29%**
C&T	2022	Key Pops	$55,000	0%
C&T	2022	Non-Targeted Pop	$4,359,282	26%
C&T	2022	Priority Pops	$363,889	2%
HTS	2022	**Total**	**$1,707,389**	**10%**
HTS	2022	Key Pops	$40,000	0%
HTS	2022	Non-Targeted Pop	$1,538,500	9%
HTS	2022	Priority Pops	$128,889	1%
PREV	2022	**Total**	**$1,438,890**	**9%**
PREV	2022	Key Pops	$1,080,000	7%
PREV	2022	Non-Targeted Pop	$290,000	2%
PREV	2022	Priority Pops	$68,890	0%
ASP	2022	**Total**	**$3,944,832**	**24%**
ASP	2022	Key Pops	$215,000	1%
ASP	2022	Non-Targeted Pop	$3,526,500	21%
ASP	2022	Priority Pops	$203,332	1%
PM	2022	**Total**	**$4,657,761**	**28%**
PM	2022	Non-Targeted Pop	$4,657,761	28%

Tajikistan

Table B.1.4: COP21 Resource Allocation by Program and Beneficiary

Program	Fiscal Year	Beneficiary	Proposed COP21 Budget	Percent to Total
Total			**$4,193,345**	**100%**
C&T	2022	**Total**	**$673,359**	**16%**
C&T	2022	Key Pops	$151,650	4%
C&T	2022	Non-Targeted Pop	$521,709	12%
HTS	2022	**Total**	**$718,261**	**17%**
HTS	2022	Key Pops	$690,261	16%
HTS	2022	Non-Targeted Pop	$28,000	1%
PREV	2022	**Total**	**$534,212**	**13%**
PREV	2022	Key Pops	$187,240	4%
PREV	2022	Non-Targeted Pop	$346,972	8%

ASP	2022	**Total**	**$624,562**	**15%**
ASP	2022	Key Pops	$33,500	1%
ASP	2022	Non-Targeted Pop	$591,062	14%
PM	2022	**Total**	**$1,642,951**	**39%**
PM	2022	Key Pops	$109,050	3%
PM	2022	Non-Targeted Pop	$1,533,901	37%

Thailand

Table B.1.4: COP21 Resource Allocation by Program and Beneficiary

Program	Fiscal Year	Beneficiary	Proposed COP21 Budget	Percent to Total
Total			**$13,511,000**	**100%**
C&T	2022	**Total**	**$3,226,202**	**24%**
C&T	2022	Key Pops	$2,132,360	16%
C&T	2022	Non-Targeted Pop	$1,093,842	8%
HTS	2022	**Total**	**$1,515,260**	**11%**
HTS	2022	Key Pops	$1,255,660	9%
HTS	2022	Non-Targeted Pop	$259,600	2%
PREV	2022	**Total**	**$3,371,019**	**25%**
PREV	2022	Key Pops	$3,371,019	25%
SE	2022	**Total**	**$156,872**	**1%**
SE	2022	Key Pops	$56,572	0%
SE	2022	Non-Targeted Pop	$100,300	1%
ASP	2022	**Total**	**$3,198,280**	**24%**
ASP	2022	Key Pops	$430,997	3%
ASP	2022	Non-Targeted Pop	$2,100,025	16%
ASP	2022	Priority Pops	$667,258	5%
PM	2022	**Total**	**$2,043,367**	**15%**
PM	2022	Key Pops	$10,144	0%
PM	2022	Non-Targeted Pop	$2,033,223	15%

APPENDIX C: Minimum Program Requirements, updated for ROP21

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]	Test and Start: Scaled with fidelity to all regions/sites by expansion of ART facilities including decentralized and satellite sites. Enhanced SD ART has been adopted in the new NSP IV (2021-2025). Linkage: 83% of retention at 12 months in 2019 (for 2018 ART initiation cohort).
	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. As of Dec 2020, TLD among newly initiated ART was 44% and TLD among all ART was 12% among all ART in 5 PSNUs. Supply shortage was encountered in 2020. Increased proportion is planned in 2021 for all ARV clients.
	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]	MMD: Adopted and saturated for all stable ART clients since early 2020 due to the COVID-19 outbreak. As of Q1, FY21, 6MMD was 70% among all on ART (137,897/196.995) nationally.
	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 and on-going aggressive scale-up: TPT among newly enrolled in HIV care in 5 PSNUs increased from <10% (2018) to 26.3% (2019) and 39% in 5 PSNUs (2020). National program and GF sites developed an aggressive plan to scale-up TPT coverage starting from 2021 with a revised TPT indicator which is for all eligible PLHIVs.
	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.	DNO: Adopted with partial DNO exercise to optimize VL sample network mapping and sample drainage plan for all high throughput and POC machines (4 Abbotts, 1 bioMerieux, 3 BioCentric, 33 GeneXperts) in 2019 and 2020. Ongoing VL program monitoring TA to ensure 100% access to VL and rapid TAT conducted with timely corrective actions. Standard DNO exercise using CDC tools will be initiated in 2020 and a follow-up assessment is planned in ROP21.

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 adopted in all PEPFAR sites. Nationwide scale-up implementation of index testing is planned in 2021 by convening a national consultation workshop among all key stakeholders and CSOs. HIVST: National HTS guideline revised to include HIVST as part of the national testing algorithm. With PEPFAR support, the national program has planned to scale up HIVST implementation in parallel to the HIVST demonstration project in selected sites in late 2020. Both plans are being delayed, awaiting the arrival of procured test kits. Laboratory protocol for HIVST verification exercise to assess users' friendliness was developed, and data collection has been suspended due to the second wave of COVID in late 2020 and the impact of the coup on Feb 1.
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]	PrEP for MSM/TGW started in July 2020 at three facilities (Latha National AIDS Program, MAM Hlaingtharyar clinic and PSI TOP Center) in Yangon. 581 clients are on PrEP (Feb 2021). PrEP demonstration for PWID planned to start in Kachin in early 2021 through NAP and AHRN clinics. This was delayed due to the coup. With PEPFAR TA, a national PrEP DHIS2 tracker, PrEP SOP, PrEP M&E Framework, and PrEP training sessions for service providers were provided for the PrEP kick-off. PEPFAR TA will continue along with the PrEP expansion plan to other sites in high burden regions and to other key populations such as FSW.
	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	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. *(no change from ROP20)*

	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]	Service Quality Monitoring Tools (SQMS) to assess the minimum standard for quality of care given by public sectors were developed with PEPFAR's TA support. SQMS electronic dashboard with DHIS-2 for ART services and PWID MMT services are being developed for national use. (Prototype completed in Jan 21 and the data visualization dashboard and score calculation are in progress.) There are ongoing site assessments with SQMS for ART services at selected public sector sites. National TOT for Laboratory CQI practices with RTCQI concept were conducted and data collection tools were developed and piloted. CQI practices planned to scale-up in ROP20 and ROP21 in 5 PSNUs.
	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.	The U=U message was promoted on Facebook social media around WAD2020, in close collaboration with NAP/MOHS. The U=U message has been integrated in the adherence counselling module. U=U literacy for service providers (public sectors, KP/CSO) will be promoted through HCW sensitization training and KP/CSO capacity building training in 5PNSUs until full saturation.
	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. *(no change from ROP20)*
	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 *(no change from ROP20)*
	6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Policy adopted nationally, but not actively rolling out *(no change from ROP20)*
	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. *(no change from ROP20)*

Site Level MPRs	1. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	Burma's linkage to ART has been increasing over time to over 95% linkage in Q1 FY21 after a deep dive analysis that traced the patient journey. In the post-coup environment, it is even more important to move to immediate - or where possible - Same Day ART to avoid extra trips to the clinic. We will use a 1:1 case management model to ensure linkage to ART, building on our key learnings from the deep dive analysis.
	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.	At PEPFAR site, 43% of TX_NEW are started with TLD and 22% of TX_CURR are on TLD regimen.
	3. 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. *(no change from ROP20)*
	4. 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.	In FY21 Q1, 86% of TX_CURR (9594) is on MMD, with 52% of those receiving 3-5 months MMD and 48% are on 6 months or more MMD. The proportion of 6 month MMD has significantly increased from 9% in FY20Q1 to 48% in FY21 Q1.

Cambodia

	Minimum Program Requirement	Status
Care and Treatment	1. Technical Priorities: Client-Centered Treatment Services to ensure no interruption in treatment and treatment continuity for current and new clients. Ensure continuity of treatment for current and new clients using a client-focused approach by monitoring patient adherence and interruption in treatment (IIT) and responding rapidly by applying the national standard operating procedures "Re-engagement of PLHIV in care" nationwide. Monitor implementation through plan-do-check-act cycle of continuous quality improvement (CQI) program.	(A) 47% of PLHIV LTFU re-engaged (B) 89% retention at 12 months (C) 80% retention at 24 months
	2. Adoption and implementation of Test and Start (SDART), with demonstrable access across all age, sex, and risk groups (PLL#3, MPR#1). Rapidly scale up same-day ART (SDART) and rapid ART initiation	80% of newly diagnosed PLHIV initiated on ART within 7 days

	(within 7 days of HIV diagnosis) with demonstrable access across all age, sex, and risk groups. Monitor implementation through the plan-do-check-act cycle of continuous quality improvement (CQI) program.	
	3. Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are>4 weeks of age and weigh >3 kg (PLL#3, MPR#2).Optimize ART by offering TLD to all new HIV clients and rapidly transitioning all current clients to TLD. Monitor implementation through the plan-do-check-act cycle continuous quality improvement (CQI) program.	(A) 28% of PLHIV on TLD (B) 90% of newly diagnosed PLHIV on TLD
	4. Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD) (PLL#3, MPR#3). Implement multi-month dispensing (MMD) in all provinces for current and new PLHIV, moving from 3 to 6 months MMD. Monitor implementation through the plan-do-check-act cycle of continuous quality improvement (CQI) program.	(A) 42% of PLHIV on ART received 3+MMD (B) 5% of PLHIV on ART received 6MMD
	5.Ensure that all PLHIV, including children, complete TB preventive treatment (TPT) by addressing system barriers (e.g. stock out of TPT drugs, suboptimal data management quality)	28% of PLHIV completed TPT
	6. Increase viral load coverage by identifying site level barriers and implementing remediation activities using continuous quality improvement (CQI), focusing on sites that have VLC <80%. Continue to reduce viral load turnaround time.	(A) 81% VL coverage (B) 69% VL with TAT <10 days
	7.Client-Centered Services: Community-based Treatment Support, and Stigma and Discrimination (MPR C&T #1, #3; PPHSS #3)	
	8.Strengthen & support coordination between community and facility-based ART services to ensure continuous and seamless client-centered HIV treatment for sustaining epidemic control. TA support to NCHADS to: i) improve quality and effectiveness of client-centered continuity of treatment and return to treatment strategy including Community Action Approach (CAA), SDART, U=U, MMD and TLD transition; and ii) promote KP friendly services to reduce stigma and discrimination for increase access to, and uptake of HIV prevention and treatment services among KPs through strengthen the health for all and motivation counseling and encourage adaptation of ART guideline to ensure KP friendly services.	CAA has been rolled out nationwide (all 69 ART clinics in 18 provinces funded by GF) Retention in Q4: 95.6% 42% of PLHIV on ART received 3+MMD 90% of newly diagnosed PLHIV on TLD
Case Finding	1. Implement safe and ethical index testing nationally incorporating WHO's 5Cs into routine practice and addressing challenges with acceptance rates and contact elicitation.	(A) Used assessment findings to in-cooperate into the national training program and filed visit tools. (B) 14% of partners of index cases with recent infection tested for HIV (C) 55% of children <15 years with an HIV positive biological parent tested for HIV
	2. Implement quality-assured recency surveillance nationally and use real-time recency data (from national VCCT database) to find outbreaks of new transmission and tailor response with targeted prevention strategies.	(A) 84% of newly identified PLHIV received rapid test for recent infection (B) 89% of PLHIV with recent infection received viral load test

	3. Institutionalize routine, active case management. Using a client-focused approach, ensure direct and immediate linkage of clients from testing to treatment across age, sex and risk groups in coordination with community-based outreach.	(A) 97% of new PLHIV enrolled in ART (B) 89% ART retention at 12 months (C) 97% of patients on ART virally suppressed
	3. TA support to NCHADS to: (1) Address gaps in case findings for KP through refining testing modalities such as social networking (PDI+), and HIV self-testing with the increased use of social media and social network, and (2) Strengthen PNTT management through motivational counseling to CAA staff and ensure safe services for better partner elicitation and partner testing including HIVST for partner testing (address challenges around low acceptance rates).	New case diagnosed: 4,082 in 2020 HIV testing yield in 2020: 51% for Index testing, 8% for recency testing
Prevention and OVC	1. Scale up PrEP services for young and high risk MSM, TG and FEW in all HIV high burden areas; explore the online and community PrEP delivery options and injectable PrEP, and addressing barriers to implementation.	PrEP implemented in 7 sites and 367 clients enrolled
	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 Cambodia context*
Policy & Public Health Systems Support	1. Scale-up of case surveillance and unique identifiers for patients (PLL#4, MPR: Policy & System #7) Implement newly developed HIV case-based surveillance (CBS) system nationally, expanding it from 30 to all 69 ART clinic sites, for timely and accurate reporting, patient monitoring, and outbreak detection. This includes migrating current datasets from legacy databases into new system, developing functional and program reequipments SOPs, training national and sub-national IT staff and maintaining data security.	(A) Data from legacy databases (ART, VCCT, B-IACM and Lab) migrated into one database using the DHIS2 platform (B) Project roadmap developed (complementing key activities from the new GF grant: 2021-2023)
	2. Evidence of treatment and viral load literacy activities supported by Ministry of Health (MPR: Policy & System #3) Incorporate U=U messages into health-care provider counseling services and increase viral load literacy of health care providers and clients to reduce stigma and improve patient outcomes.	(A) All provinces in Cambodia adopt and implement U=U messages (B) 51% of health care providers understood U=U
	3. Assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management (MPR: Policy & System #2) Use the CQI program to monitor mortality and ART optimization (e.g. treatment continuity/interruption in treatment, SDART, MMD, TPT, VLC, etc.)	(A) CQI program is being implemented in 25 provinces (B) PLHIV mortality rate is <1%

	4. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity (MPR: Policy & System #6) Update the HIV reporting system to monitor and report morbidity and mortality outcomes for all PLHIV for infectious and non-infectious diseases.	Key variables of morbidity and mortality outcomes are identified and planned to include into Patient registration form (Form B), quarterly report template, and ART database.
	5. Support the National Institute of Public Health (NIPH) to manage national HIV external quality assurance (EQA), including development of HIV serum panels and distribution of the serum panels to 69 VCCTs/labs, routinely analyze results and take corrective actions. Support NIPH to maintain ISO Accreditation.	(A) 82% (58/60) of labs enrolled in HIV EQAS program, including HIV recency test, with core >80%
	6. Support the National Institute of Public Health's plans to export their ISO expertise (that was built through PEPFAR support) for ISO accreditation of NCHADS and Siem Reap laboratories	(A) 67% of non-conformities identified are addressed (B) Siem Reap Lab got 4 Stars (June 2019 assessment) using Laboratory Quality Management System (LQMS) check list
	7. Scale-up of case surveillance and unique identifiers for patients (PLL#4, MPR: Policy & System #7) Provide technical assistance to NCHADS on implementation of the HIV CBS system, including updating project roadmap, documenting all aspects of the project so that it can transition smoothly to NCHADS for maintenance and sustainability (e.g. maintenance of web-based cloud services, maintaining system functionality, making programming changes), train NCHADS IT staff and develop SOPs to maintain security standards of the HIV surveillance system.	UCSF and CDC international Subject Matter Experts regularly participate in bi-weekly Cambodia Strategic Information Technical Working Group to review and revise project roadmap and partners' responsibilities.
	8. Use real-time recency data (PLL #2) Provide technical assistance to the NCHADS on recency assay implementation, including routine analysis of project data and development of project reports and manuscript	UCSF and CDC international Subject Matter Experts analyze and use project data for routine monitoring, report writing, and manuscript development.
	9. Sustain Epidemic Control (MPR: Policy& Syst #5, SID) Develop and implement a plan to sustain the gains made towards epidemic control TA to improve quality of services through integrating HIV services into hospital management and leadership, and specifically developing an integrated model of HIV and non-communicable disease (NCD) at referral hospitals.	HIV and NCD integrated model piloted in two hospitals (based on the current achievement as of February 2021)
	10. Private Sector Engagement and Increasing Market Openness (MPR: Policy & Syst #5, SID) Support policy approval for HIV certification program to certify HIV services by the private sector. Develop HIV certification program standards for private sector to provide HIV services.	Draft of standards and procedures for certifying private HIV service providers in place

	11. Scale-up of case surveillance and unique identifiers for patients (PLL#4, MPR: Policy & System #7) SI Leadership, governance and granular data use for decision making. Collaborate with US CDC to improve the capacity of the NCHADS' data management unit and relevant units and the SI TWG to maximize the use of CBS program data and other studies to improve program performance at site level by better data analysis and use to drive decision making. Support NCHADS's DMU to implement and rollout real-time data entry and use at site level to improve program management.	>40% of ART clinics able to do data entry in real-time. 50% of provinces can analyze and use data for monitoring and strategic planning purposes.
	12. TA support to NCHADS to better use of national prevention database granular analysis for micro planning.	Linkage is 97% in Q4 2020
	12.Community Engagement in Quality Monitoring (ROP 21 Technical Priority) Community Monitoring System: Support national and sub-national KP monitoring tools and quality assurance through: (1) TA to NCHADS and GF partners to scale up the implementation of "Patient Satisfaction Feedback" (PSF) system to be used as an S&D monitoring platform for KP and PLHIV at facility-based. 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 to improve services. (2) TA to HACC and FonPAM/DFonPAM to implement the community score card for KP to provide feedback on prevention to care and treatment services and use as feedback loop back to community. (3) Work with NAA, NCHADS, MoWA, HACC and FonPAM/DFonPAM to scale up community GBV reporting and referral network for legal, social, and medical supports for KP experiencing GBV (includes intimate partner violence) including prompt referral and access to PEP (4) Strengthen key performance indicator (KPI) for CLM	Patient satisfaction to 15 ART services GBV referral system for KPs expanded into 2 HIV high burden provinces

	13. Strengthen CSO-led service delivery by capacitating CSOs to become social enterprises: (1) TA to Chhouk Sar Clinic and other NGO or private clinics to implement social enterprise model in delivering accessible, KP friendly, comprehensive HIV and STI prevention and treatment, and reproductive health services at free or affordable prices. This model can be a brand-recognized model for expanding in other major urban areas. In partnership with the GF, we will support this endeavor and encourage the development of such services in urban areas where KP HIV transmission remains prevalent. Services are offered at no charge to poor KPs. Establishing fee-based services that might appeal to middle-up clients such as home-based testing, private appointments, additional lab and vaccination services could be established to subsidize operating costs and sustainability, (2) Work with Mission new awards through the U.S. Small Business Applied Research (S-BAR) initiative to capacitate local MSM, TG, EW and PWID/PWUD organizations to explore social enterprise models to provide partial organizational support. For example, home self-test kit delivery, home-based counseling for fees, other possible drop in center services.	1,173 KP enrolled in ART at Chhouk Sar Clinic in Phnom Penh Chhouk Sar (KP friendly) clinic branding model developed Chhouk Sar clinic model replicated in 1 additional HIV high burden areas
	14. Working closely with the Royal Government of Cambodia (RGC) and the GF, strengthen budget planning and execution at the national and sub-national level. This activity will strengthen the capacity of sub-national units in budget execution as part of the sub-decree on decentralization. This activity will include HIV budgeting and resource tracking into the new provincial health management function. This activity aligns with the Prime Minister's HIV/AIDS health financing (SorChorNor #213) policy #6 on integration of HIV/AIDS service into the overall health system.	3 Provinces
Site Level MPRs	1. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	Not applicable to the Cambodia Context
	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.	*Not applicable to the Cambodia Context*
	3. 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.	
	4. 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
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. **In process:** Linkage improving quarterly (all age, sex and risk groups) (introduction of peer navigators, SDART, and integrated service delivery strategies)
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: The National transition to DTG is underway, and DTG is the preferred first- and second-line regimens for adults, including women of childbearing age (with informed choice), and children (weight-appropriate). Patients on NNRTI-based regimens (e.g., nevirapine and efavirenz) are being transitioned to DTG-based regimens. Up to 40% of PLHIV at PEPFAR-supported sites have been transitioned to DTG based regimens compared with 22% as the national average.
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 MMD) 08/2018: National 3-month MMD and 6-month MMD with decentralized community-based pick-up is being scaled-up aggressively, with a renewed impetus since the pandemic interrupted regular access. Efforts accelerated to increase MMD across all geographies, with the doubling of MMD in PEPFAR current geographies. PEPFAR India anticipated the need for liberalization of MMD policies, and community dispensation of ART, and also leveraged GF Partner to support home delivery of services to mitigate LTFU.
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**: TPT for PLHIV is a national policy in India since 2017 and is implemented by the National HIV and TB program with 76 % coverage across the country PEPFAR supports improved implementation of TPT and the use of shorter regimens to improve uptake and completion rates 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 a national policy in all PEPFAR-supported districts, and in non-PEPFAR districts- and is available to all PLHIV in over 500 ART centers. Per letter dated 6th August 2020 from NACO, routine VL testing is expanded for all PLHIV at all ART centers across the country, PEPFAR provides TA to accelerate RVL for all via a differentiated approach of rapid scale up of public sector labs, optimizing PPP, expansion of hub and spoke model, Community-led approaches like organizing camps for reaching the unreached with KP and C/ALHIV focus at remote locations (approved 6/24/19). The COVID 19 pandemic has severely affected VL testing, and through these approaches, PEPFAR India is trying to recover lost ground, and still hopes to achieve 100% VL coverage by 2022 with the right mix of public sector and private sector optimization. **Ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups:** Clinic monthly progress reports track OIs 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.
6. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	**Adopted 7/2019:** Index testing (national policy) scaled-up under the release of the revised TI strategy. A regional Index Testing TOT training was conducted (New Delhi, 07/2019), and since, PEPFAR India has supported the development of the national operational guidelines for index texting, as well as the roll-out of TOT and cascade trainings for all states of the country. **In progress with milestones reached**: GOI received $ 1 million (GF 2018-2020) to pilot self-testing. Under India's National Strategic Plan, 2017-2024,Self-testing was approved to start in the private sector and PEPFAR India collaborated with UNITAID (PATH India) to improve access to self-testing kits for KP via Yes4me (on-line platform). Under ROP 21, assisted and unassisted self testing will be demonstrated and the learnings from this model, will lead to the development of the National HIV self testing policy.
7. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[6]	**Adopted 8/2018 (among those at highest risk):** High level meeting with GOI, PEPFAR, UNAIDS, WHO and stakeholders (January 2019) followed adoption. The national program has developed a draft PrEP technical guideline and is currently under review for finalization by the competent authority. In ROP21, PEPFAR India will focus on demonstrating various models of PrEP service delivery and quality assurance both in the private and public sectors.
8. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 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.
9. 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.
10. 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 is supporting CQI as a routine element of site management, enabling real time use of data to identify, understand and analyze barriers, and take action to close the CQI loop. Treatment, Prevention and SI partners are using this data to identify areas that need improvement. To improve data quality, tools are being prepared to automate processes prone to manual error.
11. 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	**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

providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	interface to improve result uptake. 8/10 regional reference VL labs are accredited (including 4 from PEPFAR districts), with a TAT of less than 14 days. **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.
12. 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.
13. 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 GF funding 15% of the remaining requirement.
14. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	**Adopted.** Clinic monthly progress reports track OIs 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 and is undertaking a landscape analysis to study the global methodologies to ascertain the best approach for India.
15. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	**Under Progress.** Phase 1 of the Project "Strengthening Overall Care for HIV" (SOCH) – NACO's integrated data system is nearing completion and Phase 2 is under development. In the next phase, the system will integrate case-based surveillance through unique IDs which will be issued across the entire health program, by Ministry of Health. PEPFAR participates in the Project steering committee and will inform this process to enhance patient tracking and increase retention.

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]	*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 (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. *National Level:* 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]	*Sub national level:* 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. *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. With PEPFAR support, the National AIDS Program (NAP) has placed 1st order of TLD through the GF 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	*Sub national level*

	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.	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]	<u>*Sub national level:*</u> 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. <u>*National level policy:*</u> 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 GF 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.	<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 (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 GF 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 FY21 Q2. PEPFAR will advocate with MOH for an update to the testing algorithm and pilot of community based confirmatory testing. ARVs are available as of March 31, 2021. 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.	In December 2020, Kazakhstan received a voluntary license allowing purchasing generic DTG and TLD from the International Medical Patent Pool. It means that in 2022 Kazakhstan will be able to start TLD.
	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 has started in April of 2021 and 15 people were enrolled (12 - MSM and 3 – HIV-negative partners in the discordant couples). PrEP will be free for individuals at risk for HIV.
	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.	Kazakhstan uses more 3-5 MMD. In Q2FY20, 2, 272 PLWH were on 3-5 MMD. InQ2, 3, 101 PLWH were on 3-5 MMD 36.5% increase.

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	1. 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.
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential),	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

	transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.	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.
	3. 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.
	4. 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. **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 is 90%. **ROP21 Plan**: Test & treat policy adopted and implemented nationwide and part of routine treatment service. Improve uptake of SDART for eligible PLHIV.
	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 recommend TLD as the first line drug regimen for adult and children including women of childbearing age and children weighting >35kg. **Current Update:** All 11 ART facilities in Lao PDR have administered TLD regimen to all newly diagnosed PLHIV and rapidly transitioned those PLHIV on current TLE ART regimen to TLD; Full transition of PLHIV to TLD expected by end of 2021. In FY20, a few sites had low uptake of TLD due to remaining TLE in stocks. **ROP21 Plan:** QI activities to improve uptake of TLD at all ART sites. Working with MoH, Clinton Foundation and other partners to get pDTG for small children.
	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**: MMD 3-6 months included in the national guidelines 2017. **Current Update:** All 11 ART facilities in Lao PDR show steep increasing trend for MMD 3-4 months during 2016-2019, All existing 11 ART facilities and new ART POC sites implement MMD 3—4 months (80%). **ROP21 Plan**: Working with the government and Health and Nutrition Services Access Project (HANSA) to determine and support ARV drug supply stock management for 6MMD, while continuing to expand point-of-care ART to cover provinces with no ART sites including promoting telehealth for differentiated ART service delivery.
	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**: MOH guidelines recommended 9H as preferred TPT regimen for newly diagnosed PLHIV and current PLHIV on treatment whose active TB is excluded. **Current Update:** Uptake of TPT was 30% among newly diagnosed PLHIV and 55% among current PLHIV on treatment in 2020. **ROP21 Plan**: QI activities to improve uptake of TPT for PLHIV and continue monitoring the national implementation of TPT for PLHIV.
	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 supports VL testing. VL testing and suppression are included in the national QI indicator list for all ART sites to closely monitor and improve. **ROP21 Plan**: PEPFAR will continue to improve and monitor VL testing and suppression at 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 Bangkok, Lao program adopted and implemented passive index testing/partner and risk network referral testing among MSM/TG through EpiC financial and TA support in Vientiane Capital since FY19, and expanded to Savannakhet and Champasak in FY20. Through CDC TA, index testing SOP was finalized by the end of FY20. The SOP encompasses 5 Cs principles and IPV screening tools to ensure no harm to clients. Self-testing is one of the testing strategies used among MSM/TG in PEPFAR supported provinces. **ROP21 Plan**: Scale up Index Testing services, strengthen coaching/supportive supervision, monitor site performance and identify lessons to improve targeted HIV case finding nationwide, integrate monitoring of index testing in DHIS2 EpiC, with its expanded geographical coverage, will scale up testing targets with CHAS/MOH's and the GF/AFAO's procuring test kits for index testing targets including self-testing kits. PEFAR will continue to mobilize CHAS, MOH and GF to procure Oral Quick test kits to strengthen self-testing sustainably.
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:** PrEP pre-implementation among MSM/TG has been conducted since Q2 FY20. PrEP guidelines were finalized in Q3 FY20. **ROP21 Plan**: with CHAS procurement mechanism and funding for PrEP commodities (PrEP drugs and self-testing kits), PrEP will be implemented among MSM/TG in Vientiane Capital, Savannakhet and Champasak 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 Health Systems	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, some OI drugs are covered by patients due to decrease in GF funding. **ROP21 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 implementing QI activities as part of the activities; National ART QI list of indicators has been established and monitored at both central and site levels. **ROP21 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 (i.e., SD/rapid ART, MMD, TPT, LTFU, VL monitoring & suppression, Index Testing and S&D). Incorporate CLM input for QI.
	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. **Current Update:** Enhanced adherence counseling (EAC) package being developed; EAC trainings conducted for 11 ART sites in 8 provinces; U=U adopted in the HIV prevention roadmap; health care providers have been educated on U=U. **ROP21 Plan**: Monitoring use of EAC flipchart and form for PLHIV who have unsuppressed VL or are at high risk of interrupting treatment.
	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/Chias, a CSO, is receiving funding through EpiC because of the Decree 238 as a sub grantee **ROP21 Plan**: Because of limited numbers of CSOs in Lao PDR, Chias 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 15% of total ARV drugs nationwide. **Current Update:** Data generated by EpiC with high yield of HIV positive among MSM/TG demonstrated that such model is worth investing. **ROP21 Plan**: CHAS/GF commits to procure HIV testing, self-testing kits and PrEP for EpiC implementation while scaling up EPOA/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. **ROP21 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. **ROP21 Plan**: Capacity and infrastructure for application of DHIS2 as HIV CBS will built and rolled out in all ART sites.

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]	A Test and Start strategy is being implemented nationally and PEPFAR is providing TA and monitoring ways to improve program results. The National HIV Testing and Treatment Guidelines 2020 recommends direct and immediate linkage to treatment for all eligible cases. Furthermore, PEPFAR/Nepal is supporting ART initiation at the site at which HIV is diagnosed to ensure immediate linkage to treatment.
	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]	The Nevirapine-based regimen has been phased out. More than 90% of eligible clients on first line regimens have been transitioned to TLD across ART sites throughout the country. We anticipate that the remaining 10% of eligible clients will be transitioned to TLD by May 2021.
	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 incorporated in the National HIV Testing and Treatment Guidelines 2020. However, implementation of MMD has been hampered by government concerns about insufficient stocks of ARVs. The Government of Nepal approved 13 PEPFAR-supported clinics as ARV dispensing sites. With this expansion, there are a total of 24 community-based ART sites (3 for initiation and dispensing and 21 for dispensing) in PEPFAR districts in Nepal. Currently, around 7% of clients on ART are getting 3-6 months 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.[6]	The provision of TPT and cotrimoxazole is in place and is being provided as per national guidelines to all PLHIV.

[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

	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.	National stakeholders including the National government and VL service sites have agreed to VL optimization and approved a strategy. The country is also currently assessing the feasibility of using provincial labs with PCR machines (currently being used for COVID-19 testing) for HIV VL 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.[7]	Index testing (resumed and scaled-up) and HIV self-testing scaled up nationally through EpiC and GF partner agencies. Children with an HIV positive biological parent are being tested systematically as part of efforts to improve program quality
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]	PrEP is being implemented and scaled-up through all 19 PEPFAR supported city clinic sites. National PrEP SOP drafted and expected to be endorsed by the end of ROP20.
	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	*Not applicable to the Nepal context*

[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).

	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.[9]	HIV testing and treatment is free from government hospitals and through PEPFAR implementing partners. HIV services are also covered by Social Health 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.[10]	Nepal is committed to improving the quality of HIV services and has already implemented joint periodic QA monitoring with the national government in both PEPFAR-supported and other government sites. In ROP21, the PEPFAR program will continue to institute CQI methodologies to drive HIV service improvements at PEPFAR sites and will also advocate for the adoption of CQI 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.	National treatment literacy manual has been revised with an emphasis on U=U, TLD regimens and VL testing and suppression messages and is ready for endorsement for national execution. A training of trainers (TOT) on treatment literacy has been conducted. It will be rolled out in all PEPFAR districts in ROP20. The national stigma and discrimination reduction toolkit/ training curriculum was also revised in collaboration with the GF's implementing partner.
	4. Clear evidence of agency progress toward local, indigenous partner direct funding.	PEPFAR/Nepal conducted a capacity assessment of local partners and developed a capacity building plan based on the assessment for each partner. The plans are reviewed on a quarterly basis and relevant capacity building activities are conducted. EpiC subcontracts to 21 local/indigenous partners, 57% of which are KP/PLHIV led and run.
	5. Evidence of host governments assuming greater responsibility of the HIV response including	GON has assumed 100% of the funding for ARVs (including TLD); ART counselors at ART sites; and HIV test kits.

[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

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

	demonstrable evidence of year after year increased resources expended.	
	6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Morbidity and mortality are being reported through a regular reporting system, but in aggregate. Training for the roll-out of the one national HIV information system has commenced. The system allows for recording and reporting of morbidity and mortality outcomes for each client. The HIV information system will also track reasons for mortality.
	7. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	The Government of Nepal is in the process of implementing UIC across all the national sites. One national HIV information system has already been developed and piloted. A TOT was conducted and roll-out training started.
Site Level MPRs	Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	The Test and Start strategy is being implemented across all sites and PEPFAR is providing support in PEPFAR districts. The National HIV Testing and Treatment Guidelines 2020 recommends direct and immediate linkage to treatment for all eligible cases.
	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.	Nevirapine-based regimens have been phased out. More than 90% of the eligible clients on first line regimens have been transitioned to TLD across ART sites throughout the country.
	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.	Nepal does not currently require user fees for HIV 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.	DSD including MMD for 3 to 6 months is included in the National HIV Testing and Treatment Guidelines 2020. Government approved 13 PEPFAR supported clinics as ARV dispensing sites. With this, there are a total 24 community-based ART sites (3 for initiation and dispensing and 21 for dispensing) Currently, around 7% of clients on ART are getting 3-6 months MMD.

Papua New Guinea

	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, and with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	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%.
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens.	PNG National Guidelines for HIV Care and Treatment (September 2019) has updated ART regimens. • Includes TLD as first line ART to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential). • Children >20kg to use a single DTG based regimen as part of the first line, NVP-based regimens removed. TLD transition > 20kg completed. TLD transition for children <20kg, guidelines reviewed to introduce DTG 10mg dispersible tablets. Process for procurement of 10mg DTG initiated.
	3. Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	Differentiated service delivery models (DSDM), including 3+/6-month multi-month dispensing (MMD) policy adopted into care and treatment guidelines. However, implementation is hampered by low ART stock levels and TLD transition. By the end of Q1 FY21, 97.3% of eligible clients in the nine PEPFAR-supported sites had transitioned to TLD.
	4. All eligible PLHIV, including children and adolescents, should complete TB preventive treatment (TPT) by the end of COP21, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	TB preventive treatment a national policy. National uptake 12%. 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 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 (EID) testing. PEPFAR PNG plans to begin DNO activities as a key strategy to increase VL coverage for PEPFAR-supported sites, in collaboration with multilateral partners including the GF and UNAIDS.

	viral load testing and results delivered to caregiver within 4 weeks.	
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 should be offered testing for HIV.	PNG HIV Care and Treatment Guidelines (September 2019) includes steps for offering index client family and partner HIV testing services. Index testing policy adapted, and phased roll 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. Provide TA for national guidelines and scale-up.
	2. Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.	PNG HIV Care and Treatment Guidelines (September 2019) includes steps for offering index client family and partner HIV testing services. Index testing policy adapted, and phased roll 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. Provide TA for national guidelines and scale-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)	PrEP currently is not available locally or online, with import restrictions unclear. Some advocacy has been done among multilateral partners. PEPFAR PNG plans to scale up advocacy and the drafting of PrEP guidelines or policies in ROP21.
	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	N/A

	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.	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.	National HIV Quality Improvement (QI) is part of the NDoH HIV program after the launching of HIV Quality Improvement Framework. PEPFAR PNG continues to use analyses, including the REDCap Survey results, LTFU Audit, and other sources to identify QA/QI issues. Additionally, USAID plans to conduct SIMS assessments in ROP21, which was delayed due to COVID-19 disruptions.
	3. Evidence of treatment and viral load 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 PNG supported U=U activities to increase awareness around VL testing and suppression and its role in HIV prevention. USAID's implementing partner had several events through radio events.
	4. Clear evidence of agency progress toward local, indigenous partner direct funding.	In ROP20, USAID increased the number of sub-grantees to 11 total, and in ROP21 additional sites and funding for civil-society and KP organizations will continue to be considered and prioritized.
	5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	NDoH is responsible for procurement of ART. Timely adequate funding is a challenge. Impact of Covid-19 makes this more challenging.
	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 (NID) to allow for linking of HIV patient data with vital statistics and case monitoring.
	7. Scale-up of case 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.

Philippines

	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, and with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	**Adopted, but not to scale because of confirmatory testing.** A Test-and-Start policy has been in place since 2016. Central confirmatory testing at NRL-SACCL however has proved to be a persistent barrier. In response to this, the rapid HIV diagnostic algorithm (rHIVda) was developed, that decentralizes confirmatory testing. Forty-one percent (1,988/4,796) of newly diagnosed cases from June to December 2021 were confirmed using the rapid HIV diagnostic algorithm or rHIVda. To date, of the >160 treatment facilities across the country, only 22 are licensed and capable of conducting the new algorithm. Notably, of the 11 rHIVda facilities in Greater Metro Manila, 6 are supported by USAID-PEPFAR. WHO and UNAIDS are currently providing technical assistance to develop a more aggressive roll-out plan. There is no regular monitoring of Test and START access across age, sex, and risk groups.
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens.	**TLD Transition Plan developed, but TLD to be limited to ART naive clients until national program procures.** Treatment guidelines have been revised to include TLD, SDART, and MMD but have yet to be signed by the Department of Health. The absence of any policy initially hampered the rapid and broad uptake of GF-procured TLD for 15,000 clients that arrived in 2020. A policy directive has since been issued on the 4th of December 2020 and enrollment of naive ART clients is ongoing as stipulated in the TLD Transition Plan. Transitioning all PLHIV clients on ART to TLD will however face an uphill battle given regulatory requirements before national procurement of TLD will be possible through the DOH. Given the identified processes, earliest possible national procurement is expected in 2024.
	3. Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	**Yes, but not to scale.** Treatment guidelines have been revised to include TLD, SDART, and MMD but have yet to be signed by the Department of Health. Six-month MMD is mentioned in the draft but contingent on availability of ARV supplies. Across the country, 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. Patches of decentralized drug distribution are present currently due in large part to interventions initiated during the height of the lockdown from March-May 2020.
	4. All eligible PLHIV, including children and adolescents, should complete TB	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.

	preventive treatment (TPT) by the end of COP21, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	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 viral load testing and results delivered to caregiver within 4 weeks.	Viral load testing rate was 17% among PLHIV diagnosed in 2020. 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 should be offered testing for HIV.	**Policy pending.** 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. Index and self-testing have both been incorporated into the draft of the HTS guideline revisions, which is still to be vetted, approved, and signed by the Department of Health. Regulatory clearance is available for prick-based HIV self-test kits but not for oral swab kits. WHO-pre-approved prick-based self-testing was piloted in three cities (Manila City, Iloilo City, and Davao City) in 2020.
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)	**PrEP policy signed and Joint PEPFAR-GF PrEP implementation running.** A co-developed PrEP distribution plan between PEPFAR and the GF pooled drugs to ensure broader coverage to areas outside of shared sites. Further harmonization in terms of dispensing protocols is underway. Monitoring of uptake and consumption is slated to determine timing of successive procurement. There has been a successful demand creation campaign and pilot for PrEP among MSM in the Philippines, including through social media. However, national PrEP procurement is unlikely until 2023 and PrEP is currently not covered by the national health insurance program.
	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	*Not applicable for the Philippines context*

	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.	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 the 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.	Philippines is a new PEPFAR program and will ensure CQI into site and program management plans. Above site collaboration between WHO and USAID-EpiC to develop the tools is ongoing. CQI protocols are to be piloted in all EpiC sites.
	3. Evidence of treatment and viral load 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. Only 35% of MSM and transgender women are aware of U=U (2018 IHBSS, DOH-EB). 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. Treatment literacy and U=U incorporated into the DOH-NASPCP's Manual of Procedures for Combination Prevention of the DOH-NASPCP with support from UNFPA/UNAIDS. Other pockets of community-led campaigns also tackle treatment and viral load literacy. 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. Harmonization of HIV and TB surveillance systems have not been successful because of confidentiality-related legal barriers stipulated in the AIDS Law. These barriers have also been the reason for challenges around COVID-HIV integration.
	7. Scale up of case 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. Current migration of HARP to the new OHASIS will accommodate the generation of most MER indicators. 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.

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]	Nationally scaled with fidelity
	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]	Nationally scaled with fidelity
	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	Nationally scaled with fidelity

	groups, including 100% access to EID and annual VL testing and results delivered to caregiver within 4 weeks.	
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]	Implementing 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]	Implemented in select regions and populations
	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 found in PEPFAR supported SNUs in 2019 calendar year, a total of 678 (97 initiation was 8 days. Out of those initiated on ART, 21% started ART in the same day or, due to the Other 20% of the patients newly found to be HIV positive and started ART in 2019, initiated treatme remaining period of ROP19 and in ROP20, PEPFAR will work closely with local AIDS centers and CS Support4Health initiative and supporting peer counselors will work to further promote implementa age bands, groups of population and sites. The new case identification and treatment initiation data efforts on the 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 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) 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. In FY20, proxy linkage to treatment was reported as greater than 100% at PEPFAR-supported sites. **ROP21 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 kg **Current Update**: Two companies registered DTG 1 company registered for TLD Documents submitted to national essential drug list for approval **ROP21 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:** In FY20, 88% of patients at PEPFAR-supported facilities benefited from MMD ≥ 3 months and 38% of patients benefited from MMD ≥ 6 months. 10 provinces reported offering MMD ≥ 6 months as of FY21 Q1.

		The national differentiated care service delivery manual developed including DSD for health facilities and CBOs, MMD 6 months, fast-track refill, etc. **ROP21 Plan**: Full implementation in PEPFAR supported sites including community-based services (69 in 2021 and 42 sites in 13 provinces in 2022) Monitor the national implementation of MMD
	4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of ROP21, 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 **ROP21 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 PEPFAR-supported sites by February 2020 In healthcare facility setting, 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 In community-based providers, launched the GeneXpert VL testing targeted for KPs at drop-in-centers under PEPFAR-supported sites. **ROP21 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 PEPFAR-supported sites Launch and implement high quality of index testing (treat & test) to integrate into routine VCT clinics in all PEPFAR-supported sites. Self-test protocol approved by Thai MOPH's EC. Project launched in August 2020. Approximately 500 MSM/TG women enrolled and picked up the test kit at pharmacies. Utilizing GF's oral fluid test kit to implement at KPLHS to improve case finding **ROP21 Plan**: Index testing: Develop supportive supervision, monitor site performance and identify lessons for improvement to improve targeted HIV case finding. Assess program performance and identify successful elements. Expand index testing to other GF supported sites. Advocate for integration of index testing as part of HTS service. Anticipate self-test kits registered with/ approved by Thai FDA by the end of FY 2021 (ROP20) Finalize HIVST implementation guideline Scale-up oral fluid self-testing at KPLHS sites as one of case finding strategies Policy advocacy for Thailand MOPH to adopt unassisted self-testing method use for KP clients in particular to scale-up index testing and partner notification
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, TG, SW and PWID, sero-discordant couples, recurrent STI/PEP cases . **Current Update**: Nationally, 103 hospitals were trained on PrEP implementation and M&E this FY. In FY 2020, PrEP was actively implemented in 78 health care facilities in 30 provinces. In FY 2021, NHSO aims to increase PrEP availability to 152 sites in 55 provinces. In FY21 Q1, 16 sites reported PrEP results supported by CDC (four provinces) and 12 sites reported PrEP results supported by USAID (seven provinces). Community-based PrEP services under Princess PrEP program and national PrEP by NHSO is being implemented at 10 KLPHS sites and 7 hospitals in 7 provinces **ROP21 Plan**: Provide site level TA to MoPH to maintain PrEP implementation in PEPFAR support sites and above sites TA to support other PrEP providers nationally. Train additional facilities including 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,	*Not applicable in the Thailand context*

	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]	**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 (10,000 cases) under NHSO has been implemented since FY 2020. **ROP21 Plan**: The national guidelines recommended that all HIV-positive clients be automatically screened for TB by chest x-ray, likewise, women screened cervical cancer annually. HIV-positive women can get free cervical cancer screening if they have abnormal symptoms or screen abnormal at baseline. All women with cervical cancer can access 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 levels. 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: PEPFAR works closely with MOPH and Health care accreditation institute (HAI) to support coaching for hospitals with poor performance on HIV treatment PEPFAR, MOPH, and HAI introduced the 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 **ROP21 Plan**: PNC concept introduced to 4 CDC-supported provinces in 2020 and 13 provinces in 2021. Expand QI activities to cover 42 sites in 13 provinces in 2022. Key QI topics included SDART, MMD, retention to care, improve VL coverage, enhance adherence counseling, S&D CQI etc.

		QA and QI provincial network consisting of health care providers, community health workers and provincial officers 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 PEPFAR to support S&D assessment and training 3x4 at 110 health care facilities in 77 provinces and 10 KPLHS providers **ROP21 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 include U=U message and stigma and discrimination reduction .
	4. Clear evidence of agency progress toward local, indigenous partner direct funding.	**Policy status**: PEPFAR already worked with indigenous partner (>95%) **Current Update**: CDC works with Thai MOPH and BMA USAID has supported local civil society organizations to receive an increasing proportion of their financing directly from the Thai Government.
	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 have established morbidity and mortality reporting system. The MOPH system (approximately 1,000 public health hospitals) and Bangkok Smart Monitoring System (approximately 70 public health facilities in Bangkok) are routinely submitting data. Morbidity and mortality data are available up to 2019 and being updated through 2021. HIV-comorbidity data have been updated and mortality data will be re-analyzed to include non-infections as cause of deaths. **ROP21 Plan**: Establish automatic updates of quarterly morbidity and mortality data and dissemination in MOPH website. Promote data use by public health officers for QI and public access.
	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 under

		MOPH were analyzed for morbidity and mortality reports. Data has been disseminated through Division of Epidemiology website and HIV info Hub. Start DQA and DQI in PEPFAR supported sites. **ROP21 Plan**: integrate HIV recency testing in case surveillance for high 3-4 HIV burden provinces and link to response. Continue recent infection data use for public health response in Bangkok. Continue to develop Bangkok case-based surveillance for HIV related co-morbidity and mortality to increase report coverage for non-MOPH health facilities.
Site Level MPRs	1. 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 7 provinces) implemented test and start across all age, sex, and risk groups. In FY20, proxy linkage from testing to treatment was reported as ≥ 100% overall. **ROP21 Plan**: PEPFAR will continue to support sites to achieve direct and immediate linkage of clients from testing to treatment (≥95%) in ROP21.
	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.	**Policy status**: National guidelines 2020 recommend TLD as the preferred first line regimen for adults including women of childbearing age and children weight >35 kg; NVP-based regimen was removed from the treatment regimen in adults. 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:** The Thai FDA approved DTG from two companies and TLD from one company. The MOPH and Thai AIDS society submitted a letter to the 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 at the end of ROP19. **ROP20 Plan**: PEPFAR will support the government and PEPFAR- supported sites for TLD transition and monitor TLD transition at national level.
	3. 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 symptoms or screen abnormal at baseline. All women with cervical cancer can access to free treatment under universal health coverage scheme.; Demonstrated PrEP package (10,000 cases) under NHSO has implemented since FY 2021 All HIV positive clients can screen TB and do chest x-ray for free of charge. **ROP21 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.
	4. 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 2020 recommended MMD3-6 months for stable PLHIV receiving ART. Currently, the national AIDS program by NHSO allows 6-month supply. However, the social security scheme and civil servant medical benefit scheme allows for only 1-3-month supply. MOPH already discussed a social security scheme to extend the 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 a 6-month MMD manual in ROP19. About 83% of PEPFAR-supported sites were implementing MMD 6 months at the beginning of FY21. **ROP21 Plan:** increase MMD6 months to all PEPFAR-supported sites including community sites. PEPFAR will monitor the national implementation of MMD in ROP21.
	5. Implementing community-led monitoring (CLM)	**Current Update:** PEPFAR is piloting implementation of CLM in 5 provinces. MOPH is exploring potential integration of CLM as part of the national QI process **ROP21 Plan:** Finalize CLM tools and document lessons learned. Discuss with MoPH, NHSO, provincial health office, and sites to make action plans to remediate gaps in service based on CLM results. Use data to support integration of CLM as part of national QI plans. Explore independent mechanism for CLM.

APPENDIX D: Response to Civil Society Network Recommendations

Asia Region Responses to
Consolidated Feedback and Observations from
Asia-Pacific Regional Key Population Networks
Regional Operational Plan (ROP) 21

Overall
At the regional level, significant movements were made to ensure that KP communities are able to meaningfully engage with the PEPFAR processes to design and support services to address their needs in health and human rights.

OBSERVATION	RESPONSE
OVERALL	
The KP Networks have observed that, although the KP participation is actively required in these processes, it is not clear how the KP communities at country level were consulted or have contributed to the development of COP21.	Each individual country team had virtual or in person stakeholder's meetings in January 2021 to solicit input. In addition, some countries may have had several separate meetings with CSOs when ROP21 activities resumed in April 2021. Most engagement with CSOs takes place at the country level and so will vary between countries. In January-February 2021, and again in April 2021, PEPFAR ARP also hosted regional stakeholder meetings that brought together CSOs, to discuss their unique needs across the region.
YOUTH LEAD	
Too often, the term "young people" is used to unite all of us and reduce us to one set of needs. As young people, we are not a homogeneous group but a diverse group with a unique set of needs in the context of the HIV response. In these 2 days, I observed that only a few countries have mentioned young people in their intervention, and this makes me feel young people are left behind in the process, I hope in the future that all communities will have equal opportunities to be meaningfully engaged in the country programs.	Thank you for this observation. We will keep that in mind moving forward. We would like to learn from the regional CSOs how many young people they have in their membership. We would also be interested in discussing how you will recruit young people to your organizations or tap into new organizations with young people. This could help both to consult with young people as part of the planning and implementation processes and to better design activities for young people. India has already done some listening exercises with young KP in a high burden state and is working closely with UNICEF on translating the ALL IN for Adolescent HIV recommendations in India. https://www.unaids.org/en/resources/campaigns/all-in

The country presentations show that young people have a share in the current growing HIV epidemic. How will the interventions address the needs of young key populations especially those who cannot access services because of informed consent?	We agree that reaching young key populations is important to reaching epidemic control, and you will see differing approaches within the region. It is best to look at country-level plans; for example, India and Thailand both have targets for young KP activities. Thailand has activities that focus on young MSM and TGW and this year will explore the use of HIVST to enhance access to HIV services. The DataPack was developed based on ART coverage in all populations and disaggregated by sex and age. Young KP are included as part of this target setting strategy. We would be happy to connect you with the country teams for further information.
How will the young KP take part in the implementation of these programs?	Please see above. These questions are linked.
Asia Pacific Network of People Living with HIV (APN+)	
Only Kazakhstan and Philippines have highlighted programs on Removing legal barriers by creating policy or programs to remove Stigma and Discrimination (S&D) and acknowledging the importance of addressing the S&D that are still embedded in the AIDS response	Although only Kazakhstan and Philippines have highlighted programs on removing legal barriers by creating policy or programs, many other PEPFAR country teams—e.g., Burma, India, and Thailand--also work in this area, usually in collaboration with GF and other multilaterals. There is also a multi-country S&D initiative among health care facilities to improve service delivery. For Burma, continued support for legal reform for key populations has been paused since the military coup on February 1, 2021. The resumption of this work will be based on the political environment. PEPFAR Burma is focused now on continued access to HIV prevention, care, and treatment in this critical moment with its partners, contributing to the coordinated response and working directly with the CSO networks to fill critical HIV services gaps.
What are the specific interventions related to addressing human rights, gender, age related barriers, S&D, from other PEPFAR country plans in implementing ROP21?	Please consult the SDS for more information. We are also happy to connect you with country teams for more detailed follow up.
It has been reiterated that Lost To Follow Up (LTFU) is high in many of PEPFAR country. What are some innovative activities to reach LTFU clients?	Innovative activities to reach LTFU include utilizing peers, navigators, and health care workers to assist and track PLHIV through the clinical cascade; scaling up differentiated service delivery, same-day ART, MMD, TLD, and TB preventive therapy activities; reminder SMS messages and phones calls, and tracking defaulters through phone calls, home visits and social networkers.
We, People Living with HIV (PLHIV), are very excited to see that PEPFAR has pushed for Dolutegravir (DTG) drug and Multi-month Dispensing to be rolled out in the Asia Region.	Yes, all countries in the ARP have made advances in MMD. And all countries, with the exception of Kazakhstan and Thailand, have rolled out DTG regimens.
We hope that PEPFAR is able to push the implementation of initiatives that will address the legal barriers, stigma and discrimination, in the countries	We agree. See previous responses.

Asia Pacific Transgender Network (APTN)	
Not all countries specified clear interventions on addressing legal, human rights, gender and age-related barriers.	See response to previous question.
From the country budgets, what is the allocation for direct awards or sub-awards to KP-led community organizations and groups?	PEPFAR has a global target of having 70% of funds going to local organizations by the end of FY20. Country budgets vary, and it is better to make direct contact with country teams to discuss this topic.
In the context of technical assistance, do the countries also have allocation for seeking regional technical assistance utilizing expertise of regional networks and organizations in the region?	As part of the thinking around activities planned under ROP21 Unifying Collaborations (outlined in the PLL), PEPFAR country teams can plan/request for regional TA related to existing proposals.
Many of countries mentioned about engaging/working with CBO/CSOs but not all have proposed interventions focused on sustainability and organizational capacity development of CBO/CSOs (beyond capacity building on service delivery)	Financial sustainability of CSOs is a PEPFAR priority in Asia and was specifically identified in the PLL for some countries in particular. There are also sustainability and capacity building activities for CSOs planned under the ROP21 Regional Unifying Collaboration activities.
Most countries did not mention about differentiated service delivery models for transgender women, including integration of gender-affirming care service (e.g.,. GAHT). Will the same HIV service delivery interventions also capture data on transgender men and trans-masculine people?	Several PEPFAR programs have particular focus on TGW, including Burma, India, and Thailand. For example, Burma has launched the first transgender-focused clinic in the country in Yangon called the "Ma Bay Dar Clinic" (named by the TG community after the water hyacinth which "grows beautifully in any condition"). With technical support from Institute of HIV Research and Innovation (IHRI) and the Tangerine Clinic, Burma is providing a suite of services based on the requests from the TG community themselves, including hormonal monitoring (and advocating for the provision of gender-affirming care service), inclusion in national reporting and surveillance systems, and national guidelines. The space is open to all transgender or other communities seeking HIV prevention, care, and treatment. In Thailand, PEPFAR has supported the Tangerine clinic, the transgender health clinic, to provide transgender comprehensive health services including HIV counseling and testing, STI screening, and hormone level measurement, etc. The Tangerine model also implements at all KPLHS PEPFAR supported sites. India has implemented two TG clinics in India, one in Manipur and one in the state of Telangana. Both also serve transgender men We can facilitate connections with country teams for additional details.

Asian Network of People who Use Drugs (ANPUD)	
The community of People who inject drugs (PWID) has been left behind in the region - there are missing approaches to community based/community led service delivery that target the PWID population	Within the COVID epidemic a number of countries, e.g., Burma, India, made advances in the multi-month delivery of methadone involving the community. PWID are a primary focus of each of the Central Asia HIV programs (Tajikistan, Kazakhstan, and Kyrgyz Republic) in both the community and the health facilities. In each of the Central Asian countries, PWID-focused/led community-based organizations are supported for case finding and case management activities. In health facilities, health care providers receive training on working with PWID. In Burma, PEPFAR is working to rapidly adapt services for People who Inject Drugs in the country. Access to harm reduction services are critical. In partnership with the Global Fund, PEPFAR Burma is leading lead community-based harm reduction interventions led by peers, small local shops, pharmacies, and needle and syringe ATMs--and through secondary distribution at shooting galleries--even in remote areas. We use PWID peers on the ground in developing and delivering of services, including methadone/ ART/HTS clinics to ensure continued services in the post-coup environment. Burma is trying to maintain multi-month delivery of methadone with the involvement of PWID community network groups after the coup as well. In India, take home OST was rolled out during the pandemic, and we continue to advocate for this as a long-term approach to OST. India has rapidly scaled low threshold harm reduction, satellite MAT centers, and working on scaling packages of services both men and women who use drugs.
Communities need to be meaningfully engaged in all countries to ensure peer-led HIV services.	Agreed. Most countries have significant activities planned with their communities. We encourage you to reach out to individual country teams for further discussion.
Regional approaches, including joint regional advocacies, are required to address Legal, social and structural barriers and human rights violations along with broadening community space, and creating enabling environment. These include women and girls where they can give their consent to health care.	Agreed. We are open to regional consultations on these topics with our stakeholders.
ANPUD, as a regional network, needs to play important role to conduct human rights advocacy at the regional level for the protection of health and rights of PWID.	Agreed. We suggest it would be helpful to organize a meeting with ARP countries with PWID populations to determine how to strengthen collaboration.

Specific targets needs to be set and explicitly mentioned for each KP group (PLHIV, Transgender people, MSM, SW, PWID and people in closed settings such as prisons). This will help in developing effective approaches on service delivery.	Most countries have established targets for these KP groups, e.g. Burma (MSM, PWID, FSW, TG.); India (FSW, MSM, people in prisons and other enclosed settings, PWID, TG), Indonesia (FSW, MSM, PWID, TG), Kazakhstan (FSW, MSM, people in prisons and other enclosed settings, PWID), Kyrgyz Republic (FSW, MSM, people in prisons and other enclosed settings, PWID), Lao PDR (MSM, TG), Nepal (FSW, MSM, PWID), Philippines (FSW, MSM, PWID, TG), Tajikistan (FSW, MSM, people in prisons and other enclosed settings, PWID), and Thailand (MSM, TG). Burma has worked directly with communities to adapt targets for specific key populations for program implementation.
In most countries, we seem to have lost focus on human rights, community led monitoring and other non-HIV services delivery.	Human rights and community led monitoring are core aspects of individual country strategies. Health areas that relate to HIV prevention and treatment--mental health services, TB prevention and treatment, STI diagnosis and treatment, and OST services--are included in PEPFAR country programs, depending on the particular country. In KPLHS sites in Thailand, mental health screening was offered to all clients by trained KP lay providers during the COVID-19 pandemic. The referral system for those clients who need further treatment was also established with paired hospitals. Thailand is also exploring ways/procedure to include direct community feedback on HIV services and S&D issues as part of the HIV quality improvement process.
Harm Reduction tools such as Needle-Syringe programs and Opioid Substitution Therapy (OST) services need to be prioritized in the region	See previous response.
ANPUD advocates for the integration of HIV/TB and HIV/Viral Hepatitis country programs for PWID.	We recognize this need and will continue to advocate in this area as well.
For a more effective HIV response, ANPUD advocates for innovative approaches to address the needs of people who inject/use stimulant drugs.	Yes, we are working on addressing those as well. India, for example, has rolled out packages of services for people who use drugs, including women who use drugs. We agree with the focus on stimulant use as well and this is part of our efforts.
Asia Pacific Network of Sex Workers (APNSW)	
APNSW has expressly mentioned during the Regional CSO Forum that as a network of Sex Workers, we have not been receiving support from PEPFAR. Very few of our countries are receiving support. But these supports are limited to SW-led organization and network partners.	Thank you for bringing this to our attention.

Very few numbers of APNSW country member and partners received project grant or support. But the support received are limited to SW-led organization and network partners for capacity building and does not include implementation of health service delivery or consulting services for sex workers.	Burma is working with several national sex worker networks to (1) ensure that FSW CSOs can directly deliver HIV services, and (2) build sustainable financing models for CSOs to be able to continue operations even after donor funding. In direct response to requests from the FSW community, Burma is working to develop gender-based violence support and mental health counseling through FSW CSOs, ensure safe and ethnical index testing, and work with UNFPA and partners to ensure access to family planning--especially in the current post-coup environment. India specifically is reaching out to home-based SW in the informal sector. We have begun a listening exercise to best program activities in the physical and virtual space.
PEPFAR country plans do not cover initiatives to protect the rights of sex workers and to decriminalize the population.	Thank you for bringing this to our attention. We would welcome additional dialogue on this point, based on the data. SWING does work with FSW in Thailand, but this effort is funded solely by the National Health Security Office. PEPFAR ensures that its work complements the country's National AIDS Strategy plan, and for the current year we focus mainly on MSM & TG women. However, based on preliminary data, we observe that female patients in many clinics are missed from treatment. We will carefully consider how we can address this problem and will ensure that we consult with existing FSW organizations in the country as part of that process.
From the country presentations, it is clear that FSW is either least consulted or not included in the country programs.	Please keep in mind that country presentations are extremely compressed and do not represent the full range of discussions that take place or even full program details. Many country programs do consult with organizations representing the FSW, for example, Burma, India, Nepal, and Thailand, among others. As indicated above, PEPFAR Burma has consulted with the national sex worker networks to adapt programming for FSW. In ROP21, Burma will (1) ensure that FSW CSOs can directly deliver HIV services and (2) build sustainable financing models for CSOs to be able to continue operations even after donor funding ends. In direct response to requests from the FSW community, Burma is working to develop gender-based violence support and mental health counseling through FSW CSOs, ensure safe and ethnical index testing, and work with UNFPA and partners to ensure access to family planning. FSW networks are also supported as part of the initiatives to (1) implement health care worker sensitization trainings in improving KP friendly services at service facilities; and (2) improve quality of service delivery and client-centered differentiated service delivery through building

	capacity of FSW networks and FSW peer supporters in addressing S&D issues, counseling skills, supporting mental health status and continuity of treatment. As noted above, India is reaching out to home- based SW in the informal sector. We have begun a listening exercise to best program activities in the physical and virtual space.
As one of the key populations, witnessing the exclusion of sex workers is a serious concern. The human rights of my community are being disregarded and left behind.	We will continue to work to support the human rights of sex workers.
APCOM	
We recognize the joint efforts to ensure service delivery to KPs despite interruptions due to COVID-19. But we call to also not forget to address the basic and most immediate needs of key populations such as livelihood and access to employment. This is also an opportunity to expand the differentiated service delivery (DSD) for community-led services.	PEPFAR continues to expand the involvement of KPs and CSOs in community-led services. Leveraging USAID Local Works funds, Burma is leading a program in Kachin State to help ensure that PEPFAR clients have access to drug rehabilitation services, livelihoods support and job opportunities, and guided reintegration back into society after drug treatment. This work becomes even more important in a devolving security situation and unstable job market in Burma.
Increased investment towards the KP organizations and regional initiatives. Increased investments will not only focus on HIV services but also include strengthening the technical, programmatic, operation and finance, advocacy and service delivery capacities of CBOs. This will enable community to contribute to targets and programs.	PEPFAR continues to support KP organizations to strengthen the technical, programmatic, operation and finance, advocacy and service delivery capacities of CBOs.
Expand KP-led / community-led service delivery to include more clinical services such as community-based ART delivery for PLHIV, HIV Testing and PrEP for MSM, harm reduction for PWID, hormone therapy for Transgender community, and sexual health services for sex workers. This can be done by a process of certification by governments that KP lay providers can provide HIV/community-based services	We are working in conjunction with host governments to expand KP and community led service delivery to include more services. With PEPFAR support, Thailand has been working on institutionalizing a CSO certification process for service delivery along with some other countries in the region. In Q3FY21, the Department of Disease Control established the national KP certification committee to review the HIV curriculum and national examination sheet for use in the first national examination of KP certification for HIV services. This examination will take place during Q4FY21. The first batch of certified KP for HIV services will be registered into the national KP certification system during FY21 as planned.
Dedicated funding for organizational capacity building for Regional KP Networks to become eligible for direct funding	This has been included under the current regional proposals.

from PEPFAR and Global Fund, including networks such as APNSW. Highlight the important role of regional networks to strengthen the technical capacities of civil society and key population organizations.	
Through our collective feedback, the Regional KP Networks highlights our important roles in strengthening the technical capacities of civil society and key population organizations at country level. Empowering the key populations and strengthening their respective organizations enables them to effectively participate in these processes, as well as to help become eligible recipients of grants from PEPFAR and Global Fund.	PEPFAR will continue to support the strengthening of the technical capacities of CSOs and KP-led organizations at regional and country levels.
The Regional KP Networks feel empowered to see in USAID's ROP21 regional proposal that KP networks are expressly mentioned, our roles in the Region are specified, potential activities identified, and strengthening regional networks' capacity are highlighted as one of the priorities.	PEPFAR is pleased that you see these key priorities reflected in the ROP plans. Our intent is to incorporate stakeholder feedback and have our program plans reflect that.
My name is Inad of APCOM based in Bangkok. I am a Person living with HIV. I am not a number. I am not an indicator nor a means of verification of any targets. I am a human being – who is equally abled and capable. We work to establish HIV services at the country so that I, and the rest of the KP, as a human being so that we can live a life that is not so different from everyone, a life that is productive, and free from fear and discrimination.	Thank you for sharing your story and reminding us what is important.

APPENDIX E: ARPA Country Summaries

OGAC approved American Rescue Plan Act of 2021 (ARPA) proposals for all 12 countries. In ARP, the total amount budgeted is $2,668,050 , with each country receiving an additional 4-5% based on their ROP21 budget.

Summary of ARPA activities	Total budget (US $)	Portion to be implemented FY21	Portion to be implemented FY22	Expected impact
Burma: PEPFAR proposes to support KPs living with or at risk for HIV in priority areas. PEPFAR will provide the following support: public health education on COVID-19 among KPs in priority areas (all UHF sites and in 5 IDP camps in Kachin); capacity building and support to existing local services for case finding, prevention, and treatment; improve referrals for COVID-19 diagnosis and treatment and access to health and social services; and conduct vulnerability mapping to assess and introduce psychosocial and mental health support.	763,050	90,000	673,050	Strengthen currently weak health systems to manage the impact of COVID-19 and ensure the provision of information and high-quality services reach the most at- risk populations during this volatile time.
Cambodia: Cambodia will shift meetings, trainings, and orientations to virtual platforms and adapt prevention interventions to virtual approaches. Cambodia will provide IPC by moving needs assessments online, creating facility-level SOPs for COVID IPC, training HCWs, and coordinating PPE procurement. ARPA funding will also provide PPE for 70 ART sites, 338 field staff and outreach workers, and for PLHIV.	280,000	100,000	180,000	Adapt HIV programming to reduce the risk of COVID-19 transmission and provide clients with the resources to access key treatments and prevention strategies.
India: PEPFAR proposes to purchase and distribute urgently needed commodities (buprenorphine) in 3 of the hardest hit states to cover current gaps in harm reduction programming; expand IPC practices at HIV testing and treatment centers, including expanding AIC/IPC measures to other facilities serving KPs; prevent, protect, and address COVID-19 among HCW, staff, and beneficiaries through the purchase of PPE kits; promote the COVID-19 vaccine; and test innovative	1,131,950	906,788	225,162	Mitigate the impact of COVID-19 in partnership with the Government of India. The funds will allow PEPFAR to complement the Government's ambition plans to vaccinate the population, prevent the spread of COVID, and ensure the delivery of high quality life-saving health services to KP and PLHIV.

mechanisms for home delivery of ART using courier services, community workers, and buddy systems.				
Indonesia: Indonesia plans to use ARPA funding in six major areas to mitigate the COVID-19 crisis while strengthening HIV programming. ARPA funding will assist Indonesia in providing PPE for clinical and community-based HIV implementers and HIV service delivery clients, provide testing for community and facility-based implementing partners in HIV service delivery settings, decentralize ARV drug distribution, provide treatment continuity by covering transportation and medical service costs for PLHIV and TB clients, enhance laboratory capacity for conducting HIV TB, and COVID-19 diagnostic services, and monitor vaccine coverage among PLHIV on HIV treatment.	475,000	40,000	435,000	Extend Jak-Anter coverage and support the Jak-Support recovery and resilience emergency fund for marginalized key populations, and support PHOs in monitoring vaccine coverage among PLHIV on HIV treatment. ARPA funding will allow Indonesia to continue to provide care and treatment to PLHIV while reducing the transmission of COVID-19.
Kazakhstan: Kazakhstan will use ARPA funding to maximize vaccination efforts to support HIV programming while reducing the spread of COVID-19. ARPA funding will provide critical medical devices for AIDS Centers to support diagnosis and treatment of COVID-19 in the PLHIV community, update the EHCMS system to include a new module for COVID-19 tracking, decentralize drug delivery, strengthen case management, maintain virtual case management service delivery, provide HIV self-testing and COVID prevention commodities.	287,500	40,000	228,000	Mitigate the impact of COVID-19 while supporting programming and the care and treatment of PLHIV.
Kyrgyz Republic:. Kyrgyz Republic plans to use ARPA funding to improve distance learning/mentorship platforms and processes on COVID-19, support PEPFAR sites, provide AgCOVID-19 rapid tests for PLHIV, support home delivery of ARVs/PrEP to clients, address urgent commodity needs, and strengthen virtual case management.	312,500	56,000	256,500	Prevent, prepare, and respond to COVID-19 while mitigating the impact of COVID-19 on PEPFAR programs and beneficiaries and supporting HIV program recovery from the impacts of COVID-19.
Lao PDR: PEPFAR proposes to implement activities that will increase coverage and improve quality of COVID-19 testing and vaccine administration to PLHIV and test innovative service delivery methods through key partnerships. PEPFAR	80,000	0	80,000	Ensure PLHIV maintain access to ARTs and other supportive HIV services, as well as have equal access to safe and supportive COVID-19 testing and

will create monitoring systems for COVID-19 testing and case management, increase vaccination coverage through training HCWs and setting up QI systems to ensure safe testing and access to health care settings. Through the innovative service delivery methods, PEPFAR will support communication and transportation costs of drug delivery, provide home delivery services through coordinated partnerships, and continue to ensure KP access to high quality, linked services through provision of supplies, training and community based events.				vaccinations. PEPFAR activities will also Contribute to meeting and exceeding PEPFAR targets.
Nepal: ARPA funding will be used to support the recovery of Nepal's national HIV program from the worsening impacts of COVID-19. Specifically, PEPFAR will: procure urgent commodities that will help alleviate the impact of COVID-19 and strengthen the existing laboratory capacity; prevent, prepare for, and respond to COVID-19 via IPC, vaccine access, testing, and COVID-19 clinical management; and mitigate COVID-19's impact on PEPFAR programs and beneficiaries through provision of ART services, psychosocial counseling, and improved capacity at health facilities.	520,000	223,750	296,250	Strengthen the existing health systems through capacity building, IPC improvement, innovative service delivery mechanisms and laboratory support in ways that will allow for uninterrupted HIV services and support of the government's response to COVID-19.
Philippines: PEPFAR proposes capacity building and establishment of innovative systems to ensure safe and accessible services. To provide access to COVID-19 testing and vaccinations, PEPFAR will provide PPE to HIV treatment facilities, establish referral networks for testing and help prioritize PLHIV for vaccinations. PEPFAR also will reactivate their courier systems to get HIV drugs to the populations that need them, and increase access to telemedicine for KPs. PEPFAR will provide capacity building in facilities to ensure IPC control measures are in place and facilities are linked to provide continuity of care.	500,000	0	500,000	Increase the volume of HIV testing, ART enrollment, and treatment adherence that has declined during the COVID-19 pandemic. PEPFAR will also build the capacity of the health system to implement innovative service delivery strategies to expand access to drugs, as well as link PLHIV to COVID-19 testing and vaccinations when they do visit facilities.
PNG:. ARPA intervention activities include care and treatment, case finding, prevention, and policy and public health systems support. This funding will allow PNG to mitigate barriers in reaching targets, protect PEPFAR	317,500	0	317,500	Enable PNG to reduce COVID-19 transmission risk among providers and patients, ensure PLHIV have access to COVID testing services, address HR and

investments, and continue IPC activities. PEPFAR will implement IPC measures in facilities to reduce COVID-19 risks and help normalize clinic functions, support the implementation of COVID-19 AgRDT testing in PEPFAR-supported ART sites, strengthen dual testing for VL and COVID-19, and support other differentiated ART delivery approaches.				lab constraints, and support DSDM and community ART.
Tajikistan: ARPA funding will decentralize drug delivery, improve awareness of COVID-19 prevention and infection control, procure PPE, provide online training for HIV services, and support the planning and implementation of vaccinations for PLHIV and their families.	312,500	0	293,345	Respond to COVID-19, mitigate the impact of COVID-19 on HIV programming, and support PLHIV from the impacts of COVID-19 while reducing the spread of COVID-19.
Thailand: PEPFAR Thailand proposes a dual-pronged approach to mitigate the impact of COVID-19 on partners and services: (1) PEPFAR will work with KP CBOs, staff, and clients to increase access of PPE and testing availability (both targeting mobile populations and supporting self-testing during the third wave); and (2) PEPFAR will implement innovative service delivery approaches (i.e., telehealth for HIV care) and ensure basic needs (such as food) are met for KP clients affected by the economic impacts of the pandemic. Lastly, PEPFAR will conduct QI activities to increase coverage of the COVID-19 vaccine and monitor side effects for PLHIV through monitoring systems and support.	520,000	9,000	511,000	Extend services to the KPs who have been most impacted by the COVID-19 pandemic, and maintain high quality, uninterrupted care. The monitoring of COVID-19 vaccines side effects and response will inform national-level policy recommendations on the vaccines for PLHIV in Thailand.