

Asia Region Operational Plan

ROP 2022

MASTER FINAL Strategic Direction

Summary

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Country Name: Asia Regional Program



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ROP 22 PEPFAR Acronyms

Abbreviations and Acronyms

ACM	Active Case Management
AEM	AIDS Epidemic Model
AFP	The Armed Forces of the Philippines
AHD	Advanced HIV Disease
AHF	AIDS Healthcare Foundation
AHI	Acute HIV Infection
AIDS	Acquired Immune Deficiency Syndrome
ALHIV	Adolescents Living with HIV
AFEW	AIDS Foundation East-West in the Kyrgyz Republic
Amref	African Medical and Research Foundation
ANC	Antenatal Care
AP	Andhra Pradesh
ARP	Asia Regional Program
ARPA	American Rescue Plan Act
ART	Antiretroviral Therapy
ARV	Antiretroviral (drug)
ARV	Antiretroviral drug
ASAP	Accelerate and Scale the Asia Program
BBS	Bio-behavioral Survey
BPS	Border Package of Services
BTC	Back to Care
C&T	Care and Treatment
CAB-LA	Long-Acting Injectable Cabotegravir
CADRE	Cyclical Acquired Drug Resistance
CAR	Central Asia Region
CAS	Corrective Action Summary

CAST	Country Accountability Support Team
CBART	Community-Based ART
CBO	Community-Based Organizations
CBS	Case-Based Surveillance
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention (part of HHS)
CETA	Common Elements Treatment Approach
CHAS	Center for HIV and AIDS (Lao PDR)
CHIAs	Community Health and Inclusion Association
CHWs	Community healthcare workers
CIF	Capital Investment Fund
CLHIV	Children Living with HIV
CLM	Community-Led mMonitoring
CODB	Costs of Doing the U.S. government's PEPFAR Business
CoOP	Community of Practice
COP	Country Operational Plan
COVID-19	Coronavirus Disease 2019
CPHL	Central Public Health Laboratory
CPS	Champasak Province (Lao PDR)
CQI	Continuous Quality Improvement
CSO	Civil Society Organization
CVLS	Community Viral Load Suppression
DBS	Dried/dry Blood Spot
DDD	Decentralized Drug Distribution
DFAT	Department of Foreign Affairs and Trade
DHIS2	District Health Information Software 2
DNO	Diagnostic Network Optimization
DOD	U.S. Department of Defense
DQA	Data Quality Assessment
DRS	District of Republican Subordination
DSD	Direct Service Delivery

DSDM	Differentiated Service Delivery Models
DTG	Dolutegravir
DTIS	Drug Treatment Information System
EC	Executive Council
ECHO	Extension for Community Health Outcomes
EFV	Efavirenz
EHCMS	Electronic HIV Case Management System
EID	Early Infant Diagnosis
EMR	Electronic Methadone Register
EpiC	Meeting Targets and Maintaining Epidemic Control
EPM	Enhanced Peer Mobilizer
EPOA	Enhanced Peer Outreach Approach
EQA	External Quality Assessment
ERP	External Review Panel
FASP	Forecasting and Supply Planning
FAST	Funding Allocation to Strategy Tool
FBO	Faith-Based Organization
FSN	Foreign Service National
FSW	Female Sex Workers
FTE	Full-time Equivalent
FY	Fiscal Year
GAC	Grant Approvals Committee (also Global AIDS Coordinator)
GBV	Gender-based Violence
GF	The Global Fund
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria (also “Global Fund”)
GHSC-PSM	The USAID Global Health Supply Chain Program-Procurement and Supply Management
GIZ	The Deutsche Gesellschaft für International Zusammenarbeit
GOI	Government of India/Indonesia
GOK	Government of Kazakhstan
GOL	Government of Lao PDR

GON	Government of Nepal
GSM	Granular Site Management
HCF	Healthcare Facilities
HCV	Hepatitis C Virus
HCW	Healthcare workers
HF	Health Facility
HHS	U.S. Department of Health and Human Services
HIS	Health Information Systems
HIV	Human Immunodeficiency Virus
HIV RT	HIV Rapid Testing
HIVST	HIV Self-Testing (or Self-Tests)
HMIS	Health Management Information System
HPDB	HIV Patient Database
HQ	Headquarters
HRH	Human Resources for Health
HRSA	Health Resources and Services Administration (part of HHS)
HTS	HIV Testing Services (formerly HIV Testing and Counseling – HTC)
HW	Health Workers
IBBS	Integrated Bio-Behavioral Survey
ICASS	International Cooperative Administrative Support Services
ICM	HIV Interim Coordination Mechanism
ICT	Information and Communication Technology
IEC	Information, Education, and Communication (materials)
IHBSS	Integrated HIV Behavioral and Serologic Surveillance
IIT	Interruption in Treatment
IP	Implementing Partner
IPT	Isoniazid Preventive Therapy
IPV	Intimate Partner Violence
ISME	Implementation Subject Matter Expert
iFSW	Informal Sex Worker

ISO	International Organization for Standardization (also Informatics-Savvy Organization)
JKN	Jaminan Kesehatan Nasional (Indonesia)
KP	Key Populations
KSCDID	Kazakhstan Scientific Center for Dermatology and Infectious Diseases
LE(S)	Locally Employed (Staff)
LGU	Local Government Unit
LIMS	Laboratory Information Management Systems
LIS	Lab Information Systems
LIVES	Listen, Inquire about needs and concerns, Validate, Enhance safety, and Support
LMIS	Lab Management Information Systems
LOE	Level of Effort
LTFU	Loss/lost To Follow Up
M&E	Monitoring and Evaluation
MAT	Medication-Assisted Therapy/Methadone-Assisted Therapy
MDGs	Millennium Development Goals
MER	Monitoring, Evaluation, and Reporting
MH	Maharashtra
MH	Mental Health
MHIF	Mandatory Health Insurance Fund
MMD	Multi-Month Dispensing
MMT	Methadone Maintenance Treatment/Therapy
MOH	Ministries of Health
MOU	Memorandum of Understanding
MPI	Cambodia Master Patient Index
MPR	Minimum Program Requirements
MSM	Men who have Sex with Men
MSW	Male Sex Workers
MTCT	Mother-to-Child-Transmission
NACO	National Aids Control Organization
NAP	National AIDS Program

NCD	National Capital District (Papua New Guinea)
NCDs	Non-Communicable Diseases
NCHADS	Cambodia National Center for HIV/AIDS, Dermatology, and STDs
NCLE	National Center of Laboratory and Epidemiology
NCR	National Capital Region
NDoH	National Department of Health (Papua New Guinea)
NFHS	National Family Health Survey
NGO	Non-Governmental Organization
NHSP	National HIV Strategic Plan
NIH	National Institutes of Health (part of HHS)
OCA	Organizational Capacity Assessments
OGAC	Office of the U.S. Global AIDS Coordinator and Health Diplomacy (Dept. of State)
OHASIS	One HIV/AIDS, and STI Information System
ONHIS	One National HIV Information System
ORA	Online Reservation and Case Management App
OU	Operating Unit
OVC	Orphans and Vulnerable Children
PARCU	PEPFAR Asia Region Coordination Unit
PATH	Program for Appropriate Technology in Health
PBFW	Pregnant and Breastfeeding Women
PCO	PEPFAR Coordination Office
PDI	Peer-Driven Intervention
PDR	Pre-treatment Drug Resistance
pDTG	pediatric Dolutegravir
PEP	Post-Exposure Prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHA	Provincial Health Authority
PHC	Primary Healthcare Center
PHO	Provincial Health Office
PITC	Provider Initiated Testing and Counseling

PLHIV	People Living with HIV
PLL	Planning Level Letter
PMTCT	Prevention of Mother-to-Child HIV Transmission
PNG	Papua New Guinea
PNTT	Partner Notification Tracing and Testing
POART	PEPFAR Oversight and Accountability Response Team
POC	Point of Care (also point-of-contact)
POCT	Point-of-Care Testing
PopVLS	Population Viral Load Suppression
PP	Priority Populations
PQ	Program Quality
PR	Principal Recipient
PrEP	Pre-Exposure Prophylaxis
PSE	Population Size Estimate
PSE	Private Sector Engagement (also Population Size Estimate)
PSF	Patient Satisfaction Feedback (Cambodia)
PSM	Procurement and Supply Management
PSNU	Priority Sub-national Unit
PT	Proficiency Testing
PWID	People Who Inject Drugs
QA	Quality Assurance
QA/QI/QM	Quality Assurance/Improvement/Management
QI	Quality Improvement
RAC	Republican AIDS Center (Tajikistan)
rHIVda	rapid HIV diagnostic algorithm
RITA	Recent Infection Testing Algorithm
RM	Responsibility Matrix
RNC	Tajikistan Republican Narcology Center
RNR	Risky Network Referral
ROP	Regional Operational Plan
RT	Rapid Testing

RTK	Rapid Test Kit
RTRI	Rapid Test for Recent Infection
S&D	Stigma and Discrimination
S/GAC	Office of the U.S. Global AIDS Coordinator and Health Diplomacy (Bureau in the State Dept.)
SD	Service Delivery
SDART	Same Day ART
SDGs	Sustainable Development Goals
SDS	Strategic Direction Summary
SEIT	Safe and Ethical Index Testing
SHI	Social Health Insurance
SI	Strategic Information
SID	Sustainability Index Dashboard
SIMS	Site Improvement through Monitoring System
SMS	Short Message Service (e.g., text messaging)
SNS	Social Network Strategies
SNU	Sub-National Unit
SOP	Standard Operating Procedure
SPM	Strategic Planning Meetings
STI	Sexually Transmitted Infection
SVK	Savannakhet Province (Lao PDR)
SW	Sex Workers
TA	Technical Assistance
TAD	Take-Away Dosages
TB	Tuberculosis
TG	Transgender People
TGW	Transgender Women
TI	Targeted Intervention
TLD	Tenofovir/Lamivudine/Dolutegravir
TPT	TB Preventive Treatment
TWG	Technical Working Group

U.S.	United States
U=U	Undetectable equals Untransmissible (or Untransmittable)
UICs	Unique Identifier Codes
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
US	United States (of America)
USAID	United States Agency for International Development
USG	United States Government
VCCT	Voluntary Confidential Counseling and Testing
VCT	Voluntary Counseling and Testing
VIA	Visualized with 5% Acetic Acid
VL	Viral Load
VLC	Viral Load Coverage
VLS	Viral Load Suppression
VLSM	Viral Load Management System
VTC	Vientiane Capital (Lao PDR)
WB	World Bank
WHO	World Health Organization
WLHIV	Women Living with HIV

1.0 Vision and Goal Statement

The PEPFAR Asia Region Program (ARP) comprises 12 diverse countries: Burma (Myanmar), Cambodia, India, Indonesia, Kazakhstan, Kyrgyz Republic, Lao PDR, Nepal, Papua New Guinea (PNG), Philippines, Tajikistan, and Thailand. Since its 2019 regionalization, the ARP vision has been to coalesce as a unified region to maximize impact and promote efficiencies to advance and sustain epidemic control, with special attention to key populations (KPs), people living with HIV (PLHIV), and those at risk within their networks.

In ROP 22, the ARP aims to achieve collective progress towards the UNAIDS 90-81-73 (i.e., using PLHIV as the denominator) benchmarks for attaining and maintaining epidemic control.

To date, two countries have reached epidemic control¹ and 73% community viral load suppression: Cambodia and Thailand. A major focus of the region in ROP21 was to protect and maintain gains that were threatened by the COVID-19 pandemic. In ROP22, the region will strive to rebound from the COVID-19 impact and focus on the following four key themes:

1. Achieve and sustain epidemic control using evidence-based, equitable, people-centered HIV prevention and treatment services.
2. Support resilient and capacitated country health systems, communities, enabling environments, and local partners to build enduring capabilities.
3. Strengthen cooperation and coordination for greater impact, burden sharing, and sustainability.
4. Employ an equity lens with a persistent focus on reducing persistent inequalities

Accordingly, in ROP22 the region will strive to:

- focus on closing gaps in the clinical cascade such as viral load suppression (VLS);
- accelerate the scale-up of effective interventions such as case-finding through index testing, HIV self-testing (HIVST), and social network strategies (SNS); pre-exposure prophylaxis (PrEP); multi-month dispensing (MMD);
- strengthen partnerships with key stakeholders including civil society organizations (CSO) networks and multilateral partners;
- advance PEPFAR’s minimum program requirements (MPRs);
- assess progress towards sustainable control of the HIV/AIDS epidemic;
- and share lessons learned and best practices within the region and more broadly.

Notably, the region’s ability to control the HIV epidemic and sustain HIV impact with equitable access will involve both deepening key population approaches and strategies as well as integrating gender-transformative approaches into HIV prevention, clinical and health systems programs. Country-level strategies and shifts to address program gaps and priorities are described in the country narrative section below.

Based in Bangkok, Thailand, the PEPFAR Asia Region Coordination Unit (PARCU) serves as the regional advisory platform and facilitates agencies’ adherence to Office of Global AIDS Coordinator (S/GAC) guidance on planning, budgeting, program implementation, results monitoring, and reporting. The PARCU itself is composed of three members: the Asia Region

¹ The PEPFAR Strategy for Accelerating Epidemic Control (2017-2020) indicates that in the context of controlling the HIV/AIDS pandemic, “epidemic control” is reached when the total number of new HIV infections falls below the total number of deaths from all causes among HIV-infected individuals, with both new infections and deaths among people living with HIV low and declining (Source: <https://www.state.gov/wp-content/uploads/2019/08/PEPFAR-Strategy-for-Accelerating-HIVAIDS-Epidemic-Control-2017-2020.pdf>)

PEPFAR Coordinator, one CDC representative, and one USAID representative. The Asia Region PEPFAR Coordination Office (PCO) supports the PARCU and provides regional operational support. The ARP PCO includes the PEPFAR Coordinator, a Deputy PEPFAR Coordinator, a regional Strategic Information Advisor, and an Administrative Assistant. Together the PARCU and ARP PCO provide leadership and support to the 12 PEPFAR countries in the Asia Region in collaboration with the stewardship of the ARP Executive Council (EC) - an advisory group with representatives from each country and the PARCU – that was launched in ROP 21. During ROP22, PARCU will continue shepherding technical exchange groups (TEGs) to help coordinate and translate best practices quickly and efficiently into programmatic impact, whose launch is planned for ROP21. PARCU will help facilitate platforms and activities to enhance regional collaborative efforts to share expertise through the facilitation of technical exchanges among countries. These exchanges will share effective approaches and best practices for KP programming such as PrEP; targeted case finding including index, self, and social network testing strategies; harm reduction programming; addressing mental health; gender-affirming service delivery; differentiated service delivery (DSD) models; stigma and discrimination (S&D) reduction interventions; improving data use; and scaling up community-led monitoring (CLM). Staffing for the PARCU and the PCO are reflected in the PARCU ROP22 budget.

In ROP22, \$3.25 million in PEPFAR funding will support **unifying collaborations** in the region that enhance sharing of knowledge, resources, best practices, and tools. For ROP22, CDC and USAID both propose activities that build upon their ROP21 activities.

CDC will support three unifying collaboration activities. The **Laboratory Community of Practice (Lab COOP)** activity serves the 12 Asia region countries — as well as laboratory regional stakeholders and partners (WHO, Project ECHO, etc.) — by creating a consortium for sharing of information, best practices, and cross collaborations in support of achieving unmet MPRs, reaching UNAIDS 95-95-95 goals, and transitioning the program to host country/regional resources. During ROP21, the COOP was established along with a Terms of Reference (TOR); the lead technical partner (Amref) was identified; initial lab assessments were completed (Burma, Cambodia, India, Kazakhstan, Kyrgyz Republic, Lao PDR, Tajikistan, and Thailand); and statements of work for ‘on-ground’ lab consultants were developed. Viral load “road maps” will be developed before the end of ROP22. During Year 2 (ROP22), the activity will continue to institutionalize the lab COOP through a series of ongoing activities (e.g., technical webinars) and new activities (e.g., identification of entities to serve as rotating “secretariats”; development of monitoring dashboards). During ROP21, the **Building a Community of Practice for Border Programming** activity focused on the development and scale up of a comprehensive Border Package of Services (BPS) including HIV/TB services in India (Andhra Pradesh, Mizoram, Nagaland, and Manipur). To date, PATH has been identified as the lead technical partner, workplans have been developed, initial planning sessions held, and BPS provision are ongoing in the Northeast States. Additional activities in ROP21 will focus on strengthening collaborations and engagements among community-based organizations (CBOs) and faith-based organizations

(FBOs) related to the BPS, as well as sharing lessons learned. Year 2 (ROP22) will scale learnings from Year 1 as well as expand BPS interventions to selected high-risk corridors. Additional activities include demonstrating an online quality improvement /monitoring system connecting source and destination programs, border interventions, mobile KP programs, and hosting a regional information sharing platform to share challenges and successes around services for people who migrate. The **Capacity Building for Community-Led Monitoring (CLM)** activity aims to support, advocate for, and empower community-led organizations to advance their role in accountability of HIV and health programs, with a particular focus on technical assistance to strengthen CSOs' capacity to carry out in-country CLM activities. During the first two quarters of ROP21, UNAIDS was identified as the lead technical partner, workplans were developed, an initial inter-agency regional call with country teams occurred, and initial technical assistance assessments are underway. By the completion of ROP21, existing CLM projects and initiatives will be mapped, stakeholder consultations and workshops will be held, and capacity-building plan/strategy for CSOs will be developed. Year 2 (ROP22) will focus on implementing the capacity-building plans, including rolling out training materials, creating resource mobilization strategies, incorporating community data into national monitoring and evaluation (M&E) systems, providing direct technical assistance as needed, helping communities assess progress made towards CLM development (using the CLM progression matrix tool), and sharing of lessons learned and best practices.

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 (e.g., where there are existing activities already occurring such as CLM), CDC will work with the interagency PEPFAR team and/or Executive Council to identify potential opportunities for supplemental regional support that can strategically complement existing programming and how share lessons learned from country-level activities and teams for regional advancement.

Using the regional unifying collaboration funds, **USAID** will continue work begun with regional Key Population Investment Fund support and continued in ROP21 under ARP regional funds. The unifying collaboration activities are designed 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**. The first area focuses 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. Work includes the following objectives:

- 1) Support regional KP networks and TA partners to build CSO capacity for community-based services through advocacy for introduction of policies and provision of TA to scale up proven HIV innovations in the region. Areas include TA and CSO capacity building primarily for scale-up of:
 - KP-led approaches;

- TG health services competency and gender affirming care;
 - PrEP demand creation and preparation for CAB-LA;
 - Expanded SDART, CB-ART, CB VL monitoring; and
 - KP DSD
- 2) Assess and respond to shifting drug use patterns in Central Asia through supporting sub-regional efforts in the Central Asia Region to pivot HIV programming and catalyze KP-led programs to address shifting HIV risk behaviors among people who use drugs, including ongoing technical assistance at the country level to reach out to psychoactive drug users at risk for HIV in Central Asia and improve HIV service delivery options
 - 3) Enhance regional sharing of evidence to advocacy and action through advancing regional learning exchanges and sharing platform(s) to promote consultations and disseminate lessons learned and innovations, including:
 - Peer-to-peer knowledge exchange between countries
 - Connecting, convening, and enabling roles among KP networks and CSOs
 - Data use for quality improvement; knowledge management
 - 4) Promote KP CSO south-to-south support for sustainability through supporting institutionalization of KP HIV and health services in government and CSOs at local, national and regional levels through advocacy for policy change and TA for KP CSO certification and accreditation at the national level, including:
 - Access to health services reimbursement
 - Alternative financing mechanisms for KP CSOs
 - Strategic purchasing of HIV services through social enterprise, social contracting, blended approaches

PEPFAR will support scaling services through TA support and ensure that KP networks and regional KP CSOs have the support they need to play a key role in providing TA moving forward.

An assessment is about to be launched for countries in Central Asia as they move toward responding to shifting drug use patterns. KP CSO capacity building will follow to better address those emerging needs, including improving reach to younger drug users and enhancing linkage to care for synthetic drug users not covered by traditional HIV services for people who inject drugs. ROP21 funding has also already supported regional KP CSO south-to-south knowledge exchange and timely updates on key technical topics related to HIV and HIV service provision through virtual exchanges and webinars. Additionally, efforts to foster a few local social enterprises throughout the region have begun.

In ROP22, particular focus will be on the following:

- Continuing scale-up of PrEP services and enhance linkage to treatment for KPs in select countries;
- Expanding transgender health programs in select countries;

- Supporting KP CSO sustainability through social enterprise, domestic health financing, or blended mechanism in select countries;
- Institutionalizing the regional learning and sharing platform on PrEP services, ART, and innovative approaches for KP prevention and links to treatment; and
- Enhancing regional KP networks to provide technical assistance and advocate for policy changes on KP prevention and links to treatment programs

This second activity to support KP CSO sustainability is looking across the region as a whole, and also examining country-level readiness for specific interventions, in consultation with country programs and stakeholders to support KP CSO sustainability. In ROP21, PEPFAR is starting to develop metrics for the areas described in this slide that will enable us to track policy movement for social contracting, expanding social health insurance reimbursement menus, and replicating models in the region for social enterprises. Concept notes for seed funding for KP CSO social enterprises in several countries are being evaluated, and their implementation will lead to developing guidelines and best practices in this arena.

Objectives for ROP22 include:

- 1. Policy and regulatory environment:**
 - a. Use of Maturity Model in collaboration with USAID and UNAIDS to focus countries on end goals and indicators of domestic investments to end HIV
 - b. Continued development of action plans in multiple countries to remove obstacles to domestic budget transfer to KP organizations
- 2. Social health insurance (SHI) and social contracting:**
 - a. Knowledge transfer of feasible social contracting and social health insurance reimbursement models in the Asia region (Thailand, India, Philippines)
 - b. Ongoing support for CHW and CBO certification and accreditation in countries in which this is required to access health services reimbursement
- 3. Social enterprises**
 - a. Incubation and scale-up of selected social enterprise ideas in KP-led organizations in Asia
 - b. Generation of lessons learned and data on factors related to success and evidence on income that can be generated to contribute to sustainability of KP services in these organizations

The following section includes brief narratives about country-specific strategic approaches in ROP22, organized by the epidemic control categories outlined in the ROP22 Planning Level Letter (PLL).

Countries at epidemic control and 73% community viral load suppression (Cambodia, Thailand)

Cambodia has achieved epidemic control (84-99-97) and will intensify its efforts to ensure an equitable and sustainable program while fostering country ownership. To do this, Cambodia will transition to a country-owned HIV response that increases local partner and community engagement, and domestic resources for the HIV/AIDS response. The response will use real-time recency data to detect and respond to HIV outbreaks; improve case finding through index testing; promote HIV self-testing and virtual outreach; scale up KP-friendly PrEP services and improve continuation rates; implement and expand the Master Patient Index nationwide; and optimize treatment. Treatment optimization will include the following goals: Support the national program to initiate 90-95% of newly diagnosed PLHIV on ART within 7 days of diagnosis (rapid ART initiation). Rapidly scale up same-day ART (ART started on the same day as HIV diagnosis, SDART) to at least 80%; PLHIV on TLD (tenofovir, lamiduvine, dolutegravir) from 40% to 80%; TPT completion from 54% to 70%; and viral load (VL) coverage over 95%, with at least 85% of VL turnaround time less than 10 days.

Thailand

Thailand's ROP22 vision is to advance and sustain HIV epidemic control, with special attention to key populations (KP), young people living with HIV (PLHIV), and those at risk within their networks. PEPFAR Thailand will continue to advocate for the advancement of national progress toward epidemic control; use data-driven approaches to scale up differentiated service delivery models with fidelity; work with governments to increase domestic financing for Key Population-led Health Services (KPLHS); strengthen policy frameworks, systems, and technical capacity to improve the HIV clinical cascade; and program transition for sustainability.

Thailand, at 94-86-84 for all PLHIV, will continue to implement index and recency testing for case surveillance to identify potentially active transmission clusters, integrate HIV-self testing into current strategies, and increase uptake of same-day ART (SDART), 6 months of ARVs dispensed (MMD) and viral load (VL) testing, including community-based differentiated service delivery (DSD) options. In ROP22, PEPFAR Thailand will increase its focus on KP youth and promote integration of coaching and quality improvement activities into the national quality system to sustain key HIV interventions. This will include integration of community-led monitoring (CLM) and data for quality improvement (QI) purposes. Facility and community-based settings will accelerate the institutionalization of pre-exposure prophylaxis (PrEP) and KP-led health services. PEPFAR Thailand and its partners will continue to provide targeted technical assistance (TA) and support at the provincial level to increase national impact, adjust catalytic intervention packages to address "the last mile" and gaps, and promote local ownership by engaging multisectoral and CBO collaboration. PEPFAR Thailand will further support the sustainability of community-based organizations (CBOs)/Civil Society Organizations (CSOs) through social contracting and social enterprise models developed in partnership with key

stakeholders, including the National Health Security Office (NHSO) and the private sector. Thailand CSO partners will also serve as regional technical assistance (TA) partners working to build south-to-south exchanges with CSOs in other countries in the region to share experiences and learning.

Countries at epidemic control that have not achieved 73% community viral load suppression (Nepal)

Nepal, at 87-73-43, will continue to support the Government of Nepal's (GoN) national HIV program and concentrate on sustainability planning as it continues to close the gap on the 1st and 2nd UNAIDS 95s. Nepal will continue efforts to stem the negative impact of COVID-19 that has threatened Nepal's progress towards achieving epidemic control. In ROP22, in line with the National HIV Strategic Plan (NHSP) 2021-26 and the country priorities identified in the PLL, PEPFAR Nepal will work closely with all partners to strengthen the continuum of HIV prevention, diagnosis, treatment, and viral load suppression interventions. Interventions will be focused on geographic locations with the greatest concentration of key and priority populations at high risk for HIV infection and with a high number of HIV positive individuals as demonstrated through the HIV treatment services TX_CURR indicator. PEPFAR Nepal will continue to scale-up HIV prevention services focusing on PrEP (pre-exposure prophylaxis), as well as high yield positivity, targeted HIV testing approaches including index case testing, SNS, and other peer driven case finding approaches among key and priority populations. Recency assay will be employed to identify recent HIV transmissions and prompt mitigation responses will be taken to control clusters of outbreaks among population groups or geographies. A targeted focus will be to support treatment coverage through institutionalizing DSD approaches including scaling-up MMD, integrating advanced HIV disease management, improving case management and treatment continuity among treatment cohorts by reducing interruption in treatment (IIT) and, tracing and re-engaging return to treatment (RTT) service recipients. PEPFAR Nepal will continue optimizing diagnostic networks by identifying gaps in the viral load cascade. PEPFAR Nepal will provide technical assistance in forecasting, quantification, and procurement of VL testing reagents. The program will continue to strengthen leadership capacity of provincial health departments and civil society to strengthen and improve provincial response. In ROP22, PEPFAR Nepal will continue to work closely with the Government of Nepal (GON), UNAIDS, and the Global Fund to Fight AIDS, Tuberculosis, Malaria (GFATM; hereafter referred to as GF) to develop and implement HIV program sustainability plans.

Countries near epidemic control and 73% community viral load suppression (Burma)

Burma, at 85-77-72², is committed to prioritizing continuity of treatment and maintaining progress toward epidemic control by mitigating the impact of the country’s political upheaval, as well as the impact of COVID-19, on the HIV continuum of care for KPs [REDACTED] PEPFAR Burma in ROP22 will invest in CSO and KP-led differentiated HIV service delivery at the clinic and community distribution point-levels and will work closely with civil society and non-governmental stakeholders to support the HIV Interim Coordination Mechanism (ICM) and implementation of the HIV Interim Action Plan. PEPFAR Burma’s priority for ROP22 is to mitigate the current instability by ensuring treatment continuity and VL coverage and suppression, working with community and KP-led groups to find the missing and get them on treatment – and expand access to KP efforts, including PrEP in high burden districts of Kachin, and Mandalay. Burma will also focus on expanding index testing, optimizing differentiated HIV testing services (including introducing HIVST and SNS), prioritizing treatment continuity, and increasing VL coverage. Innovations and differentiated care will be supported by strengthening capacity of PLHIV and KP networks, CSOs, and private sector to fill gaps in HIV service delivery; coordinating with stakeholders to ensure continuity of HIV commodity supply and program data collection; and expanding CLM by CSOs and KP networks. [REDACTED] Burma has planned to provide technical assistance in providing services for intimate partner violence and gender-based violence.

Countries with declines in new infections and mortality but not at epidemic control or 73% community viral load suppression (India, Indonesia, Laos, Tajikistan)

India is at 78–64–55 and PEPFAR **India** is aligned with National AIDS Control Program to address gaps in the cascade with evidence-based, person – centered service delivery, leveraging key synergies with the national health mission, Global Fund partners, community, and the private sector. In ROP 22, we will expand evidence-based programming and close gaps to support comprehensive prevention, case finding and linkage; differentiated service delivery treatment strategies; expand viral load access; and work with all stakeholders to reduce stigma and discrimination. PEPFAR India will continue to work with the national government and focus on the highest burden and prevalence geographies to innovate, accelerate and scale proven strategies using granular data and CQI in support of the goal to end HIV as a public health threat by 2030.

For ROP22, PEPFAR India held a stakeholder meeting to receive input from the GOI, community and all stakeholders. In ROP22, and in alignment with the GOI and stakeholder priorities, we will focus on closing the first 95 gap with comprehensive strategies for case finding including index testing and social network testing, virtual interventions and HIV self-testing. We will apply lessons learned during COVID-19 and continue to implement and expand/scale person -centric prevention and treatment service delivery along with PrEP

² 94% viral load suppression among those with a viral load test [2019, pre-coup; 2020 status unavailable]

implementation. The diagnostic network optimization results will be utilized for expanded public sector VL coverage. In alignment with the GOI's goals to 'break the silos and build synergies', PEPFAR India will continue to work with all partners including the private sector to ensure expanded health service delivery with a focus on health equity and integrated service delivery. The priority population for OVC interventions continues to be children living with HIV, adolescents living with HIV, their siblings, single and double orphan children of PLHIV.

The National AIDS Control Organization (NACO) has succeeded in achieving the targets of the Millennium Development Goals (MDGs) by 2015 (over 50% reduction in annual new HIV infections and AIDS-related deaths). The seven-year National Strategic Plan on HIV/AIDS and STI (2017-2024) clearly articulates the plan for ending HIV as a public health threat by 2030, by ensuring universal coverage of HIV prevention, treatment to care continuum of services that are effective, inclusive, equitable and adapted to specific needs. PEPFAR India works in alignment with the country's vision and goals, at the national level and in specific geographies.

India will continue to address systemic issues affecting VL scale-up and ensure access to VL testing through differentiated models to close remaining gaps in low VL testing coverage among pregnant and breastfeeding women (PBFW), non-suppressed population, low VL testing coverage and suppression among infants, children, adolescents, and low EID at 2 months. PEPFAR India will work collaboratively with the MOH and other stakeholders to conduct a comprehensive step wise DNO to increase access to testing and network efficiencies based on dual sample type and right mix of POCT and lab-based testing. PEPFAR India will develop and implement a strategically tiered and functional national diagnostic network that leverages Government of India's incredible investments in rapid expansion of molecular technology/platforms during COVID-19 pandemic to increase the testing capacity in public sector and meet the third 90 coverage targets.

Quality improvement, quality assurance and continuous quality improvement will be a priority for ROP 22, along with consolidation of the programmatic gains in the areas of HIV prevention, testing, care and treatment. PEPFAR India will continue to scale up quality, person-centered treatment strategies to impact treatment continuity including facility and community-based strategies for service delivery, MMD, SDART and support for TLD transition. SIMS visits will be conducted at the site level to verify that the Minimum Program Requirements are met with, along with analysis of the MER data.

In alignment with the priorities of the GOI, community-led monitoring (CLM) continues to be an accountability mechanism for HIV responses at different levels for PEPFAR India. The CLM activities are led and implemented by local community organizations of people living with HIV, networks of key populations, other affected groups, or other community entities. Additionally, there is a national community system strengthening working group, which has developed tools in

consultation with communities and the GOI. PEPFAR India will continue to support these efforts to achieve and accelerate the goals.

Indonesia, at 72-28-14, will continue to support the Government of Indonesia (GOI) National AIDS Program (NAP) to progress towards achieving epidemic control despite the public health threat caused by the COVID-19 pandemic since 2020. In ROP21, Indonesia has stepped up rapidly to contain the pandemic through massive vaccination campaigns, stabilizing health systems, strengthening healthcare workforce capacity, and optimizing the use of HIV/TB laboratory networks supported by PEPFAR to scale COVID-19 testing, treatment and prevention. Built on these strong foundations, in ROP22 PEPFAR Indonesia will work closely with government counterparts at national and sub-national levels, GF, UN agencies, local agencies, and civil society organizations (CSOs) to reach the country's Sustainable Development Goals (SDGs). PEPFAR will support the NAP to intensify index testing implementation, increase viral load testing coverage through strategic partnerships with private laboratories, and accelerate TLD provision to TX_NEW and TX Curr clients at 137 facilities and 13 CSOs across Jakarta and Greater Jakarta.

PEPFAR will also assist the GOI in further improving HIV services delivery, ensuring service quality by monitoring site performance through CQI, securing the availability of needed HIV commodities, promoting data transparency and use to inform health system decisions, and coordinating closely among national, provincial, district health offices and civil society for effective management of HIV and other health diseases.

PEPFAR's strategic focus in Indonesia over the ROP22 period will be threefold:

- (1) to move towards epidemic control using evidence-based, equitable, persons-centered HIV prevention and treatment services in 13 highest burden districts across Jakarta and Greater Jakarta. Here, the program will build upon results achieved through Special Initiative funding (Accelerate and Scale the Asia Program-- ASAP) to strengthen application of PEPFAR MPRs; increase testing efficiencies; improve treatment continuity; and accelerate provision of 3 months MMD and VL testing;
- (2) to support resilient and capacitated country health systems, communities, enabling environments, and local partners to build enduring capabilities. The program will continue to strengthen program management (including HIS and HRH) and financial systems to ensure attainment and maintenance of epidemic control and will support local partners to build enduring capabilities within the national HIV response; and
- (3) to strengthen cooperation and coordination for greater impact, burden sharing, and sustainability, with improved collaboration with the GF to better align resources and improve treatment continuity.

The program will also align the strategic focus with the country-level technical directives, which are:

- Continue to advocate with the government to advance MPRs;
- Strengthen the use of case profiling/segmentation data to increase testing efficiencies;
- Expand online testing services and HIVST for hidden populations;
- Strengthen national M&E systems to improve the reporting of higher-risk individuals who were tested;
- Improve ART client monitoring and tracking;
- Identify and address treatment challenges to reduce treatment interruptions and mortality;
- Advocate for the rapid fade out of legacy ARVs and quickly transition to TLD;
- Establish a phased transition plan and the timeline for 3MMD in Jakarta and Greater Jakarta;
- Incorporate Advanced HIV Disease (AHD) management approaches in alignment with WHO guidelines; and,
- Strengthen collaboration with GF to better align resources and improve continuity of treatment.

Lao PDR, at 76-55-40, will continue to accelerate efforts to achieve epidemic control, with special attention to KP, PLHIV, and those at risk within their networks. Lao PDR will continue to advocate for the advancement of national progress toward epidemic control; use data-driven approaches to invest in the highest burden areas and scale up DSD models for KP with fidelity; work with the national government to increase domestic financing for HIV services; and, strengthen policy frameworks, systems, and technical capacity for evidence-based programming. PEPFAR Laos will support the advancement of HIV self, index, and recency testing policy and implementation at national scale. Recency efforts will involve establishing response teams to investigate clusters of recent infections and strengthen recency data sharing with CBOs. PrEP expansion and demand creation will occur in three provinces among targeted high-risk MSM and TG and serodiscordant couples. PEPFAR will address gaps in linkage and treatment continuity through enhanced case management, SD/Rapid ART initiation, MMD, IIT reduction, TPT, Point of Care (POC) ART sites, TLD transition, and VL decentralization. Considering the immediate need to address systemic and sustainability gaps, PEPFAR will strengthen data use for planning and monitoring from DHIS2 and HIV Lab quality system including VL monitoring, and initiate KP-led community monitoring in ROP22.

Tajikistan, at 70-61-56, will continue implementing KP and other high-risk populations person-centered policies and practices through aggressive roll-out of MPRs, including DSD, 6MMD, expanded PrEP services and uptake, and antiretroviral (ARV) dispensing strategies in three out of five SNU in Tajikistan, which made up about 70% of the nationally estimated PLHIV and

ART patients. Tajikistan will scale up effective and efficient case finding. To address the gap in the first UNAIDS 95 of the 95-95-95 strategy, focus will continue to be placed on generating and utilizing accurate and precise data on population groups where new transmission is occurring through effective case surveillance and recency testing and HIV services coverage by population and locations to design and implement programs to effectively address needs. To ensure sustained impact, the program will continue building on and strengthening the existing system of provision services at facility and community levels through supporting various partners and coordinating its activities with a range of stakeholders. To improve performance along the HIV treatment cascade, the program will implement person-centered HIV case-finding strategies that will be continuously modified based on performance to remain relevant and effective.

In Tajikistan, the effectiveness of ART is assessed through routine viral load (VL) monitoring with results available at six, 12 months after initiation of ART, and yearly thereafter if virologically suppressed. The effectiveness of ART is assessed at site and above-site levels to identify gaps in viral load coverage (VLC) and suppression (VLS) by location and by population e.g., age, sex, risk group. With support from PEPFAR and other partners, the country has achieved 92% viral suppression (among VL tested ART clients), including among KPs; though in the last fiscal year it achieved less than 90% VLC. Recent efforts to bridge the gap in VLC have been impacted by supply chain challenges led to VL tests stock outs in Tajikistan and inability of HIV positive labor migrants to return to the country due to COVID-19 related flight restrictions. To improve VLC, PEPFAR/Tajikistan will work with the country partners to avoid disruptions in supplying VL reagents. Recency surveillance has been designed and approved with implementation expected in late FY22 continuing into FY23 and beyond within the routine HIV counseling and testing program. Aggregate surveillance data describing where and among whom recent infections are occurring among newly diagnosed PLHIV will be shared widely with Tajikistan stakeholders on an ongoing basis. With respect to performance management, PEPFAR Tajikistan implements a robust performance management program that includes routine reviews of expenditures and progress reports. This is supplemented by regular strategic and technical discussions with implementing partners to review this progress and to identify best practices for further implementation. Tajikistan PEPFAR team will also continue to plan Site Improvement Monitoring (SIMS) and Data Quality Assurance (DQA) visit to ensure engagement and oversight at the level of service.

Countries with increasing new infections or mortality (Kazakhstan, Kyrgyz Republic, Papua New Guinea, Philippines)

Kazakhstan, at 80-64-55, will continue implementing key person-centered policies and practices through aggressive roll-out of MPRs, including DSD, expanded PrEP services and uptake, and antiretroviral (ARV) dispensing strategies (6MMD), as well as provide above-site support for sustainability of the HIV epidemic response in two PEPFAR-supported sites in Kazakhstan.

Given the limited geographic ‘footprint’, PEPFAR Kazakhstan will aim to design and implement innovative and impactful service-delivery programming that may serve as a model for the national program as well as to support key system-strengthening activities that can improve national-level program performance. To achieve the PEPFAR vision and goals, Kazakhstan will scale up effective and efficient case finding, including index testing, social and risky network strategies, active and enhanced peer outreach approaches, and self-testing, ensuring protected consent and confidentiality. Focused and innovative programming to improve case-finding among key populations will be emphasized. Quality improvement programs will be implemented at the facility and community levels to better ensure availability, uptake, and continuity of non-clinical and clinical HIV-related services. To ensure sustained impact, PEPFAR Kazakhstan will continue strengthening resilient and capacitated country health systems, communities, enabling environments, and local partners. PEPFAR Kazakhstan will strengthen cooperation, coordination, and accountability across U.S. government, donors, country government leaders, community leaders representing HIV-impacted populations, and multilateral institutions in the design and leadership of HIV services. PEPFAR Kazakhstan will continue to advance programs by making programmatic adjustments, supporting laboratory systems, and supporting key population and PLHIV led CBOs and facilities to scale-up HIV testing. PEPFAR will focus on sustainability of the community part of the national HIV response, including financial sustainability by using the tool for assessing costs and financing to achieve sustained epidemic control, and through policy support for social contracting.

In Kazakhstan, VL suppression is routinely monitored at the site and above-site levels to address gaps in viral load coverage and suppression by demographics and location. PEPFAR Kazakhstan will continue to provide a granular site-management (GSM) to improve VL coverage and suppression levels in SNU. GSM will employ a collaborative quality-improvement approach at the site level to systematically identify key barriers and practical solutions for a particular program area. Recency surveillance has been designed and approved with implementation expected in late FY22 and continuing beyond via the routine HIV counseling and testing program in Kazakhstan. Aggregate data by age, sex, risk group and location among newly identified HIV clients with recent infection will be shared with country stakeholders (MOH, civil society, health facilities, international partners, and donors) on an ongoing basis to guide public health response as well as prevention and control measures. PEPFAR Kazakhstan will implement a robust performance management program that includes routine reviews of expenditures and progress reports.

Kyrgyz Republic, at 82-54-51, will continue implementing key client-centered policies and practices through aggressive roll-out of MPRs, including differentiated service delivery, 6MMD, expanded PrEP services and uptake, and antiretroviral (ARV) dispensing strategies--including community-based ART in 4 SNU, including two oblasts and two cities. To achieve the PEPFAR vision and goals, Kyrgyz Republic will scale up effective and efficient case finding, including index and self-testing, ensuring consent and confidentiality is protected. Programs will be

designed and implemented at the facility and community levels to better ensure available, uptake and retention of such services. Focus will continue to be placed on generating and utilizing accurate and precise data on program coverage by population to design and implement programs to more effectively address programmatic gaps. PEPFAR Kyrgyz Republic will continue to advance programs that have been successfully implemented in FY22 into FY23 and to make programmatic adjustments to improve performance and impact. These include, continuing to scale PrEP, moving forward with differentiated service delivery at community level (CBART, CB-PrEP) support the inclusion of local laboratories into EQA and proficiency testing (PT) programs and to achieve ISO 15189 accreditation for these labs. In addition, PEPFAR Kyrgyz Republic will implement a client-centric HIV case-finding strategy to improve performance along the HIV treatment cascade—this includes distribution of HIV self-testing to high-risk populations in the community and care facilities, index testing focused to those clients on ART but not yet virally suppressed and leveraging the population ‘networks’ to identify and to refer individuals for testing in the community.

Viral load suppression is routinely monitored at that site and above-site levels to assess gaps in viral load coverage and suppression by location and by population e.g., age, sex, risk group. With the focused support of PEPFAR e.g., granular site-management, VL coverage and suppression levels have been steadily improving over the past six quarters. Recency surveillance has been designed and approved with implementation expected in late FY22 continuing into FY23 and beyond via the routine HIV counseling and testing program. Aggregate surveillance data describing where and among whom recent infections are occurring among newly diagnosed PLHIV will be shared widely with in-country stakeholders on an ongoing basis. PEPFAR Kyrgyz Republic implements a robust performance management program that includes routine reviews of expenditures and progress reports. This is supplemented by regular strategic and technical discussions with implementing partners to review this progress and to identify best practices for further implementation.

Papua New Guinea is at 79-68-14 (87% viral load suppression among viral load tested ART clients) nationally and 90-100-51 (94% viral load suppression) in the National Capital District (NCD), the only PEPFAR sub-national unit (SNU) in PNG. In ROP21, PEPFAR PNG was focused on protecting investments by mitigating the impacts of COVID-19 whilst transitioning to a dolutegravir-based regimen antiretroviral treatment. In ROP22, PNG is laser-focused on achieving sustained epidemic control in the NCD, and to utilize learning to provide above site TA to advance national-level epidemic control through a person-centered approach. PEPFAR PNG is focused on capacitating the Provincial Health Authority (PHA) in the NCD to continue essential programs necessary for sustaining epidemic control. PEPFAR PNG will continue to increase activities to ensure saturation along the HIV care continuum including index testing, expanding test and start, addressing continuity and interruption in treatment, and increasing VL testing coverage in the NCD. With the success of PEPFAR PNG in transitioning over 90% of

eligible PLHIV in NCD to TLD in ROP21, PEPFAR also contributed to the national TLD transition through working with donors and the NDoH to reach over 94% in viral load suppression in PEPFAR SNU. To reach saturation in the NCD, PEPFAR PNG has an additional focus on improving services through targeted above-site TA support at the national level, increasing focus on high-risk populations including introducing innovative prevention interventions for key populations, and increasing coverage of testing and treatment services for PMTCT and pediatric/CLHIV case management. In ROP22, PEPFAR will operationalize DNO recommendations with the aim of achieving 95% viral load testing coverage and 95% viral load suppression. Recency testing is not being considered for ROP 22.

In ROP22, PEPFAR PNG will focus on institutionalizing CLM to drive improvement of services for vulnerable and key populations. Additional person-centered treatment services will be enhanced including differentiated service delivery models (DSDM) to ensure geographic coverage of ART dispensation, increase KP-friendliness and VL testing, and enhance interventions to reduce treatment interruption. PEPFAR PNG will also increase focus on QA/QI by conducting SIMS and DQA assessments and through the institutionalization of QA/QI activities. PEPFAR PNG will sustain and support the institutionalization of index testing through above-site TA targeting GF-funded provinces, including social network testing in key populations. PEPFAR PNG will also work to institutionalize effective and evidence-based ACM practices led by PEPFAR in NCD to non-PEPFAR HIV sites to reduce treatment interruption, utilizing an improved data and information system at the national level. With a reduction in funding levels and PEPFAR's only PSNU, the NCD, reaching saturation, PEPFAR PNG will shift to provide above-site TA nationally and in strategic high-burden provinces. PEPFAR PNG will provide TA for strengthening pediatric treatment services to reduce MTCT. PEPFAR PNG will additionally strengthen collaboration with partners and develop a joint strategic approach to address high-burden HIV provinces outside the NCD, sharing proven models implemented by PEPFAR with donor partners to expand their focus and geographic reach.

Philippines, at 66-42-40, will build on achievements to date and continue to target and scale up key HIV prevention and treatment service gaps. Focus will be on public and community sites and select military facilities in the National Capital Region (NCR), Central Luzon, CALABARZON, Western and Central Visayas – the five highest burden SNUs in the country. Efforts in ROP22 will advance equity in service provision through tailoring interventions to the most vulnerable communities, while addressing systemic barriers to care. As the national case-finding rate for 2021 approaches pre-pandemic levels, PEPFAR will increase case-finding through implementation of targeted approaches, including index testing, community-based screening, expanded peer outreach (EPOA), and social networking strategies. Focus will be on the two regions whose case finding has not normalized – the National Capital Region and Central Visayas. Efforts to expedite confirmatory testing and improve linkage to treatment will support the expansion and accreditation of the rapid HIV diagnostic algorithm (rHIVda) in selected sites.

Building on lessons learned during the COVID pandemic, PEPFAR will continue to expand on and institutionalize differentiated service delivery, including the use of courier services, promotion of six-month ART dispensing and the use of online platforms for telehealth. PEPFAR will support return-to-care and treatment adherence through implementation of person-centered case management to holistically address the varied health concerns of clients, including trans and mental health.

Viral load testing coverage is very low in the Philippines. Only 40 percent of PLHIV are virally suppressed. In ROP22, the Philippine team will use inputs from the laboratory optimization assessment to be undertaken in ROP21 to expand the use of the GeneXpert platform and increase efficiencies in laboratory network viral load testing. PEPFAR will engage community partners to generate demand and facilitate VL testing uptake. The unstable supply of viral load cartridges due to procurement and supply chain (PSM) barriers is a main barrier to viral load suppression targets. The USG-donated VL cartridges in ROP21 will provide a bridging supply as the PEPFAR program assists the DOH in addressing PSM-related challenges. Building on the momentum of community-led PrEP delivery, PEPFAR will maintain distribution and demand generation, strengthen public sector PrEP dispensing, and support policy changes to include the task shifting towards community provision of PrEP. Support for continuous quality improvement via clinical mentoring/coaching, medical case management, psychosocial assessment, and the effective use of data for decision-making – including CLM inputs – will cut across the prevention and treatment cascade. Apart from input to CQI, PEPFAR CLM will complement DFAT, UNAIDS, and Global Fund efforts to promote health system accountability and responsiveness. It will build on community capacity to manage, analyze, and utilize data from PEPFAR-supported CLM platforms. In line with the PLL directives, efforts at the above-site level will focus on quality improvement, expansion of rapid treatment initiation and viral load coverage, the transition to domestic procurement of TLD, PrEP and viral load cartridges, and building sustainability. The Philippines will leverage regional resources to build CSO capacity for community-based services with specific inputs on gender affirming care, SDART expansion, and differentiated service delivery for KP including PrEP. The Philippines Sustainable Development Goal (SDG) for HIV is to reduce the number of people newly infected with HIV per 1,000 uninfected population to zero as a long-term objective. Current estimates indicate 23,100 new infections in 2023 alone, signaling the urgent need to fast-track key interventions to strengthen the country’s prevention, care and treatment program. The program’s activities to support targeted case detection, SDART, aggressive TLD transition, and expanded PrEP provision and viral load coverage are detailed further in the SDS.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

The 12 ARP countries' combined population is approximately 1.9 billion, with an estimated 3.99 million people living with HIV (PLHIV) ranging from 9,200 in Kyrgyz Republic to approximately 2,319,000 in India. Individual country partner government results are presented in Table 2.1.1. The ARP HIV epidemics vary by country and fall into three categories: mature epidemics that have peaked, epidemics on their decline, and growing epidemics in KP, especially MSM, PWID, and female sex workers (FSW) and their clients.

The ARP countries are at varying stages of progress towards meeting the PEPFAR-defined benchmarks of epidemic control and 73% community VLS. Cambodia and Thailand have reached epidemic control and met the 73% community VLS benchmark; Nepal has achieved epidemic control, but not 73% VLS, and Burma is closing in on these benchmarks (pre-coup data). Other countries, including India, Indonesia, Laos and Tajikistan, are experiencing declining new infections and mortality, but have not achieved either epidemic control or 73% VLS. And the remaining ARP countries—Kazakhstan, Kyrgyz Republic, Papua New Guinea, and Philippines—are all experiencing increases in new infections or mortality. Philippines has the fastest growing HIV epidemic in the Asia-Pacific region: according to UNAIDS estimates³, the number of new HIV infections in the Philippines increased 340% from 5,000 in 2010 to over 17,000 in 2020. Treatment coverage among diagnosed PLHIV (2nd 90) is noticeably low in Indonesia (39%), Kyrgyz Republic (67%), and Philippines (63%), highlighting the persistent weaknesses in the health systems coupled with poor access, particularly for key populations.

2.2 New Activities and Areas of Focus for COP22, Including Focus on Client ART Continuity

Countries at epidemic control and 73% community viral load suppression (Cambodia, Thailand)

Cambodia will revise the Prevention and Treatment TWG's TOR to address KP testing and continuum treatment to improve integration with sexual health care. The program will also expand PrEP to CBOs and improve KP-friendly service delivery. PEPFAR will expand HIV self-testing, including through private sector and virtual outreach; use recency data for site investigation and timely public health response; and scale-up Master Patient Index and unique identifiers for patients.

In ROP22, **PEPFAR Thailand** will work aggressively to achieve and sustain UNAIDS 95-95-95 goals among KP and other vulnerable population groups disproportionately affected by HIV in

³ Accessed on April 16, 2022 from <https://www.unaids.org/en/regionscountries/countries/philippines>

priority locations, closing the remaining gaps in the 2nd and 3rd 95, towards epidemic control. PEPFAR Thailand 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.

PEPFAR Thailand will continue to implement people-centered approaches in community-based and facility-based settings to improve SDART, MMD, TLD transition, TB preventive therapy (TPT) integration, DSD, and high yield KP case finding strategies, including index testing, social network strategy (SNS), enhanced peer mobilization, and HIV self-testing. The quality of HIV services will be prioritized by strengthening community-facility linkage, differentiated care models to facilitate client treatment continuity, and use of CLM data for quality improvement. Sustaining gains through continuous quality improvement (CQI) approaches in laboratory, clinical services, and program data will continue with monitoring and evaluation (M&E) dashboards and improved performance metrics and systems. These will allow for better patient monitoring to reduce program loss and return patients to treatment.

Additionally, PEPFAR Thailand will continue to focus on the use of new lab technology for TB case finding; continue implementation of TPT; promote development and implementation of telemedicine and other digital health solutions to reduce healthcare provider workload and patient visits aligning with COVID pandemic mitigation; use CLM data for quality improvement; implement S&D e-learning among health care providers and medical and nursing students; implement and strengthen Bangkok's current telehealth system; and, support and expand treatment and viral load literacy and enhanced adherence counseling on U=U concept to ensure ART continuity in the context of COVID-19. Support to CBOs will focus on HIV self-testing, Online2Offline booking for health services, telehealth, and community-based DSD (e.g., PrEP, ART, and VL testing). Advocacy with the NHSO for expansion of HIV services qualifying for CBO reimbursement will continue.

In ROP22, Thailand will continue to support the provincial Ending AIDS network to demonstrate strong local political commitment and collaboration between health facilities, CSOs, and private sectors to improve the quality of HIV services within the network in 10 of the 14 PEPFAR supported provinces. In ROP21, Chiang Rai and Phuket committed to implementing the provincial Ending AIDS strategic plans and are currently close to achieving the 95-95-95 goals. MOPH will collaborate with the Healthcare Accreditation Institute to certify provinces as Ending AIDS provinces to ensure integration into the government system to sustain the ending AIDS goal.

Countries at epidemic control that have not achieved 73% community viral load suppression (Nepal)

Nepal will scale up multi-month dispensing and other person-centered modalities. Advanced HIV disease management will be integrated into the treatment program to address HIV related mortalities and treatment interruptions due to such illnesses. Integration of mental health services into the chronic HIV care program. To address critical gaps, Nepal will focus on viral load literacy, collection of VL samples in the community service outlets, linking VL sample collection with ART pick-up, and ensuring uninterrupted access to VL reagents and a trained workforce to address the huge VL coverage and population level VL suppression gaps.

Countries near epidemic control and 73% community viral load suppression (Burma)

PEPFAR **Burma** will ensure the continuity of HIV services for key and priority populations, [REDACTED] by empowering and strengthening the capacity of CSOs, KP/community networks and peer supporters to bring HIV services to the communities. This will be achieved using differentiated approaches of prevention and enhanced outreach interventions including virtual approaches by KP network members for hard-to-reach key populations, community-based screening by trained KP testers, decentralized and community-based ARV dispensing, and active follow-up of treatment interruption by peer supporters to fill gaps in the HIV services cascade.

Private sector viral load testing capacity, including NGO and private labs, will continue to be improved by providing technical support for conducting a diagnostic network optimization exercise, updating efficient sample flow network, promoting use of dried blood spot specimens, using QA/QI measures to strengthen capacity and improve performance of private and NGO labs, establishing strategic partnerships with key stakeholders and other disease programs, and promoting comprehensive U=U messaging through various channels.

Adapting to the current epidemiology, political context and Covid-19, PEPFAR Burma has made several strategies shifts in ROP22. Burma has shifted to invest in CSO / KP-led HIV service delivery at clinics and community distribution points, and CLM in collaboration with local groups and UNAIDS. [REDACTED] Burma will refine its HIV testing to include a high yield mix of index testing, mobile testing, VCT, community-based screening, PITC, and will introduce social network testing and HIVST to access hard-to-reach KP networks, first time testers, clients of sex workers, hidden key populations, and those who prefer not to come into the clinic for testing that would be more comfortable ordering a HIVST online. PEPFAR will launch the first Virtual KP HIV Service Center where trained KP peers will work in a virtual "call center" to provide assisted HIVST, manage home delivery of HIVST kits, and case management for confirmatory testing and treatment initiation. Expanding harm reduction services, PEPFAR will introduce community-based Buprenorphine, and introduce PrEP to PWID in Kachin and Yangon. Burma will continue to innovate in harm reduction by supporting MMT centers in

Kachin and Sagaing, introducing gender-sensitive harm reduction including female-only drop-in-centers. [REDACTED]

PEPFAR Burma will introduce a new visual tool, B-OK Beads, to describe U=U, viral suppression and community viral load, based on the South African model developed through human centered design. Continuing support for gender-affirming care, clinics in Yangon and Mandalay will provide a comprehensive package of services tailored for transgender women, including hormone monitoring. Finally, Burma will further invest in mental health and psychosocial support at community and clinic level in ROP22 to address depression, anxiety and trauma-related stress disorders among key populations, PLHIV and people at risk for HIV. This will include training front line healthcare workers to provide basic Psychosocial First aid, Continuing the Common Elements Treatment Approach (CETA) at select sites, and referrals for additional services.

Countries with declines in new infections and mortality but not at epidemic control or 73% community viral load suppression (India, Indonesia, Lao PDR, Tajikistan)

India will scale integrated strategies for KP (one stop centers); build on lessons learned from listening exercises for young key populations and informal sex workers (iFSW); focus on priority populations including high risk migrants; leverage Government of India one stop centers and Sampoorna Suraksha⁴ for HIV/STI testing. India will also develop differentiated models to increase VL testing access, such as hub & spoke, community led camps, and DBS.

PEPFAR **Indonesia** will further scale facility-based testing strategies to ensure primary focus on KP and strategic priority populations, such as TB patients. The program will use data to target TA to facilities that serve the highest numbers of people in key and priority populations. In ROP22, the program will also intensify social network strategies among MSM and PLHIV to reach members of these networks with HIV testing services. Client risk segmentation analyses will provide critical data on the placement and targeting of SNS interventions.

Indonesia will leverage access to HIVST services and commodities through the UNITAID HIV Self Testing Africa (STAR III) initiative or through GF's PRs to provide PLHIV network members with HIVST kits. Reactive individuals identified through HIVST will be navigated directly to confirmatory testing in facility settings. The program will continue to support MOH to rapidly scale PrEP in selected sites in Jakarta and Greater Jakarta, with resources provided through GF. PEPFAR partners will assist government counterparts in PrEP strategic planning, effective implementation, and monitoring by developing innovative tools to register PrEP clients and stock management of PrEP commodities.

⁴ Designated one stop centers for the provision of HIV/STI testing and a comprehensive package of services and referrals for at-risk HIV negative people.

PEPFAR will work closely with the National Expert Panel for ART to adopt WHO guidelines to implement MMD. The program will assist the national government in developing the MMD Road Map to outline strategic planning and implementation phases for execution of MMD in priority provinces, targets and timelines. In ROP22, PEPFAR Indonesia plans to initiate one-stop MMD and VL testing services in Jakarta. The program will monitor the initiative's progress with site-level data and gradually expand this activity to high-volume sites in Jakarta. Indonesia will further prioritize improving CSO organizational capacity, with customized TA provided to PEPFAR and GF-supported CSOs to implement effective programming and access Government of Indonesia financing for long-term sustainability.

Lao PDR will advocate for decentralized delivery of PrEP. Laos will also establish a mechanism to respond to clusters of recent infections; establish and improve referral systems using peer health educators; and promote differentiated care at ART/POC sites to improve access to treatment. Home delivery & alternative point for ARV pickup for KP will also be a focus.

Countries with increasing new infections or mortality (Kazakhstan, Kyrgyz Republic, Papua New Guinea (PNG), Philippines)

Implementing innovative case finding methods is a priority for **Kyrgyz Republic** and **Kazakhstan**, including for SNS and EPOA, as well as index testing and self-testing. All three CAR countries plan to expand PrEP. **Kyrgyz Republic** will also focus on MAT expansion, including in community and facility for the former. **Kazakhstan** will optimize TLD, and **Tajikistan** will focus on broadening MMD criteria, including offering ART as a multi-month starter pack to newly diagnosed PLHIV. Granular site management techniques as a part of continuous quality improvement are key at the site level. **Kazakhstan** will implement social contracting of HIV services and implement the Sustained Epidemic Control tool as a follow-on to the fiscal space analysis conducted in FY2022.

Papua New Guinea (PNG) will focus on ensuring safe and ethical index testing, adhering to World Health Organization (WHO) guidelines, and social network testing through peer-driven case finding for KPs in NCD. They will provide TA for the national roll-out and scale-up of the new three-test HIV testing algorithm. PEPFAR PNG will utilize HIV rapid test kits (RTK) to further enhance case finding through index and community testing. The RTKs will have a dual purpose to also contribute to multiplex HIV testing, specifically syphilis, as PNG has one of the highest rates of sexually transmitted infections (STI) globally and is one of the lowest-treatment access countries, especially for key populations. PEPFAR PNG will pursue an oral pre-exposure prophylaxis (PrEP) Feasibility Assessment, focusing on key populations with the additional inclusion of high-risk women, those who face gender-based violence (GBV), and serodiscordant couples. Additionally, the program will support ANC HIV testing for pregnant women and focus on enhancing case finding to prevent MTCT. PEPFAR PNG will address stigma and discrimination in facilities against PLHIVs and KPs, in collaboration with the KP Consortium

and Igat Hope, a civil society organization (CSO) led by people living with HIV (PLHIV).

PEPFAR PNG will strengthen reporting systems, including the HIV Patient Database (HPDB) and integration of other health information systems (HIS) to ensure there is better reporting and tracking of true PEPFAR linkage to treatment. PEPFAR PNG will enhance the use of case profiling data for targeted interventions for KPs and high-risk populations, applying best practices from clinics that provide high-quality KP-friendly services. Activities to increase treatment initiation and continuity among PLHIV will be key for PNG, which faces ongoing challenges with interruption in treatment and retention in care in the NCD and nationally. PEPFAR PNG will support NDoH with six (6) months of buffer stock at the national level and three (3) months of buffer stock at the site levels, which will influence prescriber behavior to implement six (6) month MMD. PEPFAR PNG will additionally strengthen DSDM, especially for KPs and those most at-risk for treatment interruption, which includes increasing community and mobile dispensing and establishing additional refill and satellite sites to ensure geographic coverage of services. PEPFAR PNG will also increase the quality of services through collaboration with facilities to implement recommendations from the Community-Led Monitoring Activity.

The **Philippines** will engage in recency activities, and support advocacy and tool development to streamline the rHIVda accreditation process. They will also establish civil society partnerships to strengthen specimen referrals for rHIVda confirmatory testing, especially in NCR and CALABARZON. The Philippines will establish person-centered case management systems in more sites to address holistic health concerns among clients, including trans- and mental health. The program will work to support policy changes to include the task-shifting towards community provision of PrEP, sustaining the momentum of community-led PrEP delivery, and optimize the use of community GeneXpert machines to increase access to VL testing. Additionally, they will facilitate the transition to domestic procurement of TLD, PrEP, and viral load cartridges by addressing persistent supply chain bottlenecks. In line with the Philippine Government Department of Health (DOH)'s devolution and Universal Health Care mandate, PEPFAR will build capacity of regional government health offices in strategic information, CQI, and budget development and execution to assume greater responsibility of the HIV response. Additionally, the program will collaborate with the regional Lab Communities of Practice to foster peer-to-peer exchange amongst laboratory staff, clinicians, policy-makers, and partners, and leverage expertise across the region.

2.3 Investment Profile

Investment data for the region has many gaps. The most complete data exist for clinical care, treatment, and support, with all countries reporting. Among the 12 ARP countries, host government contribution to the HIV response in this program area exceeds 90% in both **India**

and **Thailand** and is at or over 80% for **Indonesia** and **Kazakhstan**.

For **Burma, Cambodia, Kyrgyz Republic, Nepal, PNG, and Tajikistan**, GF was the largest funding source, but in Nepal the split between GF and PEPFAR approaches 50/50. 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.

Tajikistan has a strong political commitment to protecting its population from HIV. The Government of Tajikistan agreed to commit 33% of funds annually for implementation of the national HIV and AIDS program from 2021-2025.

Procurement of key commodities

The HIV response in **Burma** is a mix of domestic and donor investment. The government has traditionally supported all methadone (~\$1 million) and 80% of anti-retroviral drugs (ARV) for the country. Other major donors include PEPFAR, Global Fund and Access to Health. After the political upheaval, the de facto government continues to support ARV and methadone; however, there has been a decrease in the value of the local currency. Global Fund, PEPFAR and Access to Health are committed to continuing essential, lifesaving support services, working closely together to maximize programmatic impact toward epidemic control. Global Fund is the largest donor and supports other HIV commodities including HIV test kits and some ART.

The Royal Government of **Cambodia** (RGC) has agreed, as a matching fund for the current Global Fund grant, to significantly increase their financial contribution for ARVs from \$1.5 million in 2020 to \$5 million by 2023. This represents an increase in domestic funding for ARVs from 25% of all ARVs in 2020 to 79% in 2023.

The Government of **Nepal** procured 100% of ARVs and HIV Test Kits in 2020, and continues to do so, as compared to 2019 when GF procured 100% of ARVs; PEPFAR and GF support viral load reagents, HIV self-test kits, recency testing assays, PrEP medicines, and emergency supply of ARVs and HIV test kits.

Based on the co-financing agreement between the Government of **Laos** (GOL) and Global Fund, GF procured 100% of ARV and RTK commodities needed for FY22, with the understanding that GOL will cover full cost of ARV, RTK, and viral load reagent commodities needed for FY23. Currently, GOL's procurement of HIV commodities is heavily dependent on GF and GOL's

ability to continue to receive funding from GF.

The Government of **Kazakhstan** funds 84 percent of the National HIV Response and 100 percent of ART procurement. The ART procurement covers 80 percent of PLHIV on treatment in FY2021 and the GOK is planning to increase treatment coverage. However, the devaluation of the national currency by 25 percent at the beginning of 2022 associated with economic sanctions on Russia could negatively impact the national HIV response by affecting purchasing volume, supply-chain disruptions, financial transaction delays and increase in product costs.

The **Kyrgyz** government has been significantly increasing procurement of ARVs (60%), with GF ARV procurement decreasing to 40% overall, demonstrating strategic commitment to universal ART access, in addition to its focus on treatment and laboratory monitoring.

PNG remains reliant on donors to fund the national HIV program and associated drugs and commodities. In PNG, GF procures over 50% of ARVs. Full transition to TLD will reduce total expenditure in PNG. However, the ongoing COVID-19 pandemic and subsequent surges throughout PNG diverted limited national resources to the country's COVID response.

The **Philippine** DOH funds almost 100 percent of ART procurement and is expected to remain the primary funding source for drug procurement. However, advocacy will be needed in ROP22 to increase the DOH's procurement of TLD in order to support a more aggressive transition nationally and expand coverage to more eligible clients. In ROP21, PEPFAR and the Global Fund pooled PrEP procurements to support the country's launch and scale-up of PrEP. In the same year, PEPFAR responded to the Philippines Government's urgent request for assistance by procuring viral load testing kits sufficient to cover the national need. In ROP22, PEPFAR will not procure commodities to support the DOH. Instead, the program will provide technical assistance to facilitate the transition to domestic procurement of TLD, PrEP and viral load cartridges by addressing persistent supply chain bottlenecks and establishing sustainable pooled procurement mechanisms.

Tajikistan's National AIDS Centre with the network of 65 regional centers are responsible for HIV programs development, implementation and evaluation. The government is currently fully funding some essential HIV/AIDS interventions as: AIDS centers infrastructure and staff costs; HIV testing for pregnant women and those planning to get married; formula for children born to HIV-positive mothers; social support to children with HIV; blood centers and HIV safety; medical waste management.

The Government of Tajikistan approved the National program to counter the epidemic of HIV and AIDS for the period 2021-2025 (see below table) and agreed to commit 33% of funds annually for implementation of the program.

The GFATM remains the main resource of funding to cover procurement of ARV drugs, HIV test and laboratory consumables in the country. The GFATM committed to fund only 46% of annual finance needs to implement the National AIDS program.

National program to counter the epidemic of human immunodeficiency virus and acquired immunodeficiency syndrome in the Republic of Tajikistan for the period 2021-2025 years

Strategic directions	2021	2022	2023	2024	2025	Total	%	2021-25 Trend
HIV prevention among key populations and vulnerable groups	\$3,240,757.74	\$3,582,783.56	\$3,525,846.54	\$3,630,573.15	\$3,861,903.57	\$17,851,864.58	46.20%	
Ensuring universal access to HIV treatment	\$2,078,790.79	\$2,082,130.90	\$2,273,067.51	\$2,350,525.18	\$2,424,861.00	\$11,219,375.38	29.00%	
Reducing HIV transmission from mother to child	\$ 478,733.12	\$ 507,367.75	\$ 523,431.29	\$ 551,052.42	\$ 559,503.57	\$ 2,620,088.17	6.80%	
Ensuring the safety of donated blood and improve infection control	\$ 533,669.58	\$ 435,725.18	\$ 353,458.30	\$ 312,644.96	\$ 337,493.25	\$ 1,972,991.26	5.10%	
Raising awareness and prevention of HIV infection among young people, teenagers, young women and girls	\$ 162,478.16	\$ 149,324.86	\$ 176,727.56	\$ 211,278.79	\$ 170,373.31	\$ 870,182.68	2.30%	
Overcoming the barriers and strengthen the supportive environment	\$1,071,405.88	\$ 765,003.97	\$ 849,976.17	\$ 661,342.34	\$ 774,503.57	\$ 4,122,231.93	10.70%	
Total	\$7,565,835.27	\$7,542,336.22	\$7,702,507.39	\$7,717,416.84	\$8,128,638.28	\$38,656,734.00		

Thailand’s government investment in the HIV response was 98% in 2019 (latest available data). ARVs, condoms and lubricants, laboratory reagents, other supplies, and medicines were all procured with domestic funds with only a small number of rapid test kits procured by international donors for certain targeted interventions. In ROP22, PEPFAR Thailand will procure a small volume of HIV self-test kits to support case-finding strategies.

2.4 National Sustainability Profile Update

In 2021, Cambodia, India, Indonesia, Kazakhstan, Kyrgyz Republic, Nepal, Philippines, Papua New Guinea, Tajikistan and Thailand completed the Sustainability Index Dashboard (SID). Of these countries, Kyrgyz Republic, Nepal, Philippines, and Tajikistan implemented the first SID-lite in partnership with the partner country government, UNAIDS, and other stakeholders. Some countries found that their respective SID scores remained constant or increased: Cambodia, India, Kazakhstan, Papua New Guinea and Thailand. Other countries such as Burma were unable to conduct the SID in 2021. Indonesia reported decreases in some SID element scores in 2021 Planning Coordination, Service Delivery, and Commodity Security and Supply Chain. Other countries noted no increases or lower scores upon administering the first SID-lite (i.e. Kyrgyz Republic, Philippines, Nepal), highlighting areas that will be addressed in the upcoming year. Across the region, the SID revealed common themes that each country will be addressing to strengthen the sustainability efforts for the HIV response among KPs over the next year. These

strategies include continued capacity building for local partners and partner country government entities to increase ownership and engagement; sustained and strengthened community-led monitoring, focused effort on advocacy on country domestic funding contributions; and diversification of funding including private sector. Quality of service delivery, including ensuring reliability of supply chain, features as a priority. The foundation of these efforts is supportive policies that enable strategies such as ARV multi-month dispensing, differentiated service delivery, expanded viral load coverage, etc. All countries will continue advocating for evidence-based policy and programmatic shifts to improve responses at the country level.

Burma was unable to update the SID and Responsibility Matrix (RM) due to the 2021 political crisis. In SID 2019, four elements were found to be “sustained”; no SID elements were deemed “unsustainable.” Based on the findings from SID 2019 and current health system and service delivery issues resulting from the political crisis, in ROP22 Burma will continue addressing critical service delivery gaps in five PEPFAR priority States and Regions, namely Yangon, Mandalay, Kachin, Shan (North) and Sagaing to improve the KP prevention continuum; finding missing cases through targeted case finding approaches; maintaining continuity of treatment; resuming VL coverage and sustaining VL suppression; empowering CSO and KP networks to deliver KP-led interventions; scaling up CLM; and strengthening supply chain system for HIV commodities to ensure 6 months for MMD, TLD, and VL commodities at all levels. Global Fund and Access to Health have sustained investment in Burma despite challenges. To build sustainability, PEPFAR Burma awarded TB/HIV Agency, Information and Services program in ROP21, a five-year program that builds the capacity of and transitions to indigenous partners over the course of the project.

Cambodia continues to demonstrate the sustainability of its national programs. Planning and coordination scores have been high for all four SID rounds because of strong partner coordination and SNU accountability as evidenced in the 2021 SID scores. The technical and allocative efficiencies and quality management elements have been consistently high. Cambodia has seen a steady improvement in scores for Public Access to Information, Human Resources and across the Strategic Information domains. In SID 2021, commodity security and supply chain, resource mobilization, and private sector engagement scores were low. In ROP22, PEPFAR will continue to improve efficiency and support domestic resource mobilization. PEPFAR will also work with the private sector – both for-profit and non-profit – to increase involvement in HIV service delivery and improve sustainability of KP-focused civil society organizations.

India continues to make progress towards greater sustainability, trending towards higher scores in each domain since 2019. The Governance, Leadership and Accountability systems have shown significant progress in the areas of Planning and Coordination and Civil Society engagement. The areas of Policies and Governance, Private Sector Engagement, and Public Access to Information continue to have some gap areas. The National Health System and service

delivery areas are improving steadily. With respect to Strategic Financing, the National HIV/AIDS program is funded with 95% domestic resources. The Government of India (GOI) leads the Strategic Information elements, with PEPFAR India providing technical assistance in the areas of IBBS, Surveillance, and Data Management systems. PEPFAR India is moving toward transitioning to local partners and continues to have strong local partner engagement, with many interventions already taken on and scaled by the GOI. The host government contribution to the HIV response is above 95% in India. The Global Fund supports ARV procurement, community system strengthening activities, and KP interventions in the virtual space. PEPFAR 's contribution to the total national investment is less than 5% with ongoing transition to local partners.

Indonesia reported decreases in some SID elements scores in 2021: Planning Coordination, Service Delivery, and Commodity Security and Supply Chain. After consultation with the national and subnational stakeholders and a careful review of the ROP22 PLL, PEPFAR Indonesia prioritizes USG Support to the National and Sub National AIDS program in the following areas: 1) Policies and Governance; 2) Service Delivery; and 3) Public Access to Information.

- Policies and Governance. According to the National Action Plan, the transition to TLD will be gradually implemented in all provinces in Indonesia from 2020 to 2024. HIV treatment guidelines have also accommodated the same day ART initiation policy. However, such policy applications may differ at the sub-national level.
- Service Delivery: Public policy and regulation for a continuum of services for HIV emerged in 2013. However, its implementation has varied by district/municipality. Not all local governments can support linkages between health facilities and the KP community. Some regions regularly fund this type of engagement for community groups at large; however, most SNU do not support these activities. PEPFAR Indonesia will prioritize the Service Delivery element, specifically those which were agreed upon in the consultative meeting with stakeholders: 1) at the national level, increase the availability of these community-friendly services; 2) support inclusion and coordination of services for HIV in children; and 3) enhance linkages between facility and community-based HIV services at all levels in Indonesia.
- Public Access to Information: The Government of Indonesia shares national HIV and AIDS expenditure and surveillance data, including program and service delivery performance data, publicly within one year after completion. Official letters to the affiliated institutions are also required to access additional analysis and raw data. However, according to an epi review conducted in 2020, no specific activities for data dissemination and to promote data use in the program were conducted in recent years. To facilitate access to data and assist in disseminating and building local capacity, PEPFAR Indonesia awarded its first local partner in ROP21 for maintaining and expanding CLM,

influencing policymakers through evidence-based data, and enhancing community-led advocacy.

The **Kazakhstan** SID 2021 has shown improvements in domains such as Technical and Allocative Efficiencies, Market Openness, National Health System and Service Delivery, Policies and Governance since SID 2019. The GOK still needs to involve civil society in decision-making activities, especially in national health financing, implementation of the policies for civil society domestic funding as well as officially recognizing the role of community-based workers. The data for decision making, data quality assurance, and data review for quality issues demonstrated persistent gaps to be addressed. PEPFAR Kazakhstan recommends that the GOK can benefit from cost-effectiveness or efficiency studies and lowering unit costs by reducing fragmentation (e.g., pooled procurement, resource pooling, etc). The responsibility matrix demonstrates that there is minimal domestic funding for HIV-related community-based organizations.

Kyrgyz Republic conducted its first SID-lite in FY22 and identified several SID elements as sustainability vulnerabilities with lower scores: Private Sector Engagement, Domestic Resource Mobilization, and HRH. PEPFAR Kyrgyz Republic will prioritize these areas and will also continue strengthening essential elements as Service Delivery and Epidemiological and Health data in ROP22. Investments to private sector engagement were a gap that needs to be filled in, and PEPFAR will lead on this effort with baseline assessment in COP22. Funds to support domestic resource mobilization were primarily allocated from PEPFAR and partner government according to the Investment profile data (Table 2.3.1). However, sustainability concerns all stakeholders and there are, and will be, few investments from GF and other funders. Regarding HRH investments, most of healthcare workforce is supported through government funding, some support from PEPFAR, and planned support for HRH payment harmonization and results-based funding introduction by GF. Overall, there was an increase in HIV funding in the recent years due to additional funding for COVID-19 impact mitigation. It reflected similarly with an upward trend in investments to Service Delivery and Epidemiological and Health Data by the Government of Kyrgyz Republic, GF, and PEPFAR.

Efforts for transitioning to local partners and greater domestic responsibility will remain a strategic priority for PEPFAR and other development partners. There is a national road map for transitioning to local funding and partners, including transition of PR role from UNDP/GF to the Ministry of Health under the ongoing GF grant. Under PEPFAR there are three local partners (RAC, RPNC, AFEW), and further transition will require a strategic, multi-year, staged approach in partnership with local governments and institutions. Local partner capacity and resources to be increased and improved, and PEPFAR will continue strategic support of capacity development of local partners; as an example, in ROP22, selected local CBOs will be trained on reporting and

other organizational development gaps/needs will be addressed to ensure smooth transitioning in several years from international NGOs to local CSOs.

PEPFAR Laos continued to invest in service delivery systems, laboratory quality improvement, and data use for decision making. Global Fund continues to provide substantial resources to supply HIV/AIDS commodities as well as provide support for FSW and MSM/TG focused intervention at the community level in geographical areas beyond PEPFAR target provinces. Although Government of Laos (GOL) has indicated its increased co-finance commitment with GF to secure health products (ARVs, OI drugs, lab equipment and reagents) since FY21 (Year 1), as seen from the HIV Resource Alignment profile, the level of GF funds fluctuates drastically depending on the year-to-year agreement between GOL and GF. For example, due to GOL's failure to fully meet the cost sharing agreement for HIV commodities in Year 2, GOL will bear 100% of HIV commodities cost for ROP22 (Year 3). Therefore, the supply chain and commodity security also remain sustainability concerns.

PEPFAR Laos not only works closely with the indigenous partners in the program implementation and the MOH in the overall HIV response but also with the local CSOs in the area of KP community service delivery. However, due to the low national HIV prevalence among KPs as well as the strict government control over the establishment of CSOs, the number of the local CSOs remain limited in Laos and their technical, managerial, and financial capacities still require significant strengthening.

PEPFAR Laos will continue to invest in the technical capacity building of the MOH and community-based organizations through technical assistance and mentorship from the USG prime partners and contractors. In addition to insufficient capacity, the GOL requirement to establish an MOU between the GOL and CSOs, for CSOs to implement the activities with the community, presents another hurdle for transition to indigenous partners. However, PEPFAR Laos remains committed to build sustainability by strengthening technical, organizational and financial capacities of local CSOs. In ROP22, PEPFAR Laos will continue to develop a strategy for CLM with local KP-led organizations and establishing a mechanism for them to directly identify the key system barriers affecting access to quality services and informing the national HIV response.

Nepal finalized its first SID exercise in November 2021. The SID exercise revealed that 11 of 17 sustainability elements assessed have sustainability gaps and scored as emerging sustainability elements needing continued investment and support. These emerging sustainability elements included Policy and Governance, Civil Society Engagement, Public Access to Information, Service Delivery, Human Resource for Health, Commodity Security and Supply Chain, Quality Management, Laboratory, Private Sector Engagement, Domestic Resource Mobilization, and Data for Decision Making Ecosystem. While Market Openness was scored as achieving sustainability, the remaining five elements such as Planning and Coordination, Technical and

Allocative Efficiency, and three elements under Strategic Information (i.e. Epidemiological and Health Data, Financial/Expenditure Data, and Performance Data) were identified as approaching sustainability in the 2021 SID dashboard. Accordingly, in ROP22 PEPFAR Nepal has prioritized supporting interventions such as: 1) strengthening the national HIV program capacity in coordination, planning, policy and guideline adaptation, and program monitoring; 2) supporting institutionalization of person-centered differentiated service delivery models including rollout of MMD; 3) assisting finalization and implementation of an HIV sustainability plan including domestic resource mobilization and allocative efficiencies; 4) building capacity of local CSOs and implement CLM; 5) strengthening the national laboratory system including VL testing labs to improve access to VL testing and achieve 78% PopVLS; 6) supporting national laboratory standards implementation including core HIV lab service QI/QA interventions at ART and VL labs; and 7) intensifying data use for decision making by supporting rollout of one national HIV information system (ONHIS) in all HIV service provision sites and integration/interoperability with eLMIS and HMIS.

The **PEPFAR Philippines** team completed the country's first SID-lite exercise in FY22Q2. In ROP22 PEPFAR will increase support to improve HIV expenditure tracking and reporting at the local government unit (LGU) level. This will be critical as domestic spending on the HIV program and associated medicines/commodities occurs primarily at the national level. As part of the Philippine Government's devolution of increasing financial responsibility and program management to LGUs, PEPFAR will build LGU capacity to effectively budget for and manage HIV service provision.

The exercise included limited participation of various country stakeholders in the process; this will be rectified in next year's process. The SID-lite identified elements with low scores in the areas of Quality Management, Laboratory Systems, and Financial/Expenditure. The PEPFAR Philippines ROP22 above site activities proposed in Table 6 aim to strengthen these SID elements. In addition, the team will work with UNAIDS, WHO, and the GF grant (2021-2023) funds to address the low score areas of the SID by transitioning commodity security and supply chain to the national program.

In ROP22, resources will target key systems gaps including Quality Management and Laboratory. PEPFAR Philippines will continue to support the national CQI program, providing mentoring to the NDOH for monitoring and aggregating site- and sub-national level data for national level improvement and decision making.

PEPFAR Philippines will support LGUs to adopt social contracting models and increase government spending for prevention and testing services. Moreover, it will establish sustainable financing for critical community-led interventions (i.e., peer outreach, community-based screening, and PrEP delivery) and consequently result in strengthened complementary community systems. PEPFAR will build the institutional capacity of CBO implementing sub-

partners in preparation for the eventual transition to direct funding.

Papua New Guinea (PNG) completed the SID-lite in 2021 and identified several areas of focus for ROP22 including HRH, commodity and supply chain, laboratory, and strategic information. There are notable achievements in public access to information, service delivery, domestic resource mobilization, and technical and allocative efficiencies from the previous SID analyses. PEPFAR PNG is also working closely with the Government of PNG (GoPNG), GF, Australian Department of Foreign Affairs and Trade (DFAT) and other partners to scale up recognized best practices in the NCD to other provinces and provincial health authorities (PHAs) in PNG through working with partners including GF and DFAT. PEPFAR PNG will support HRH technical capacity strengthening through identifying gaps in the National Department of Health (NDoH) and National Capital District (NCD) PHA to ensure coverage of key positions and components of the national HIV program. In commodities and supply chain, PEPFAR PNG will continue to provide TA at the national level to ensure there are no commodity gaps and that there are no stock-outs at the facility level. Additionally, PEPFAR PNG will support the DNO exercise implemented by Global Fund to ensure adequate laboratory capacity for VL testing coverage and to strengthen facility, provincial, and national SI systems are equipped and integrated to ensure better tracking of PLHIV data and decrease risks of treatment interruption. PEPFAR PNG will also work with UNAIDS and the NDoH to ensure more accurate epidemiological estimates are available for financial and programmatic planning of commodities and services.

According to the latest available data, in addition to the decrease in PEPFAR funding across previous years, there are expectations that donor investments in HIV programming will also decrease. PEPFAR PNG is closely monitoring the situation and is working with partners to have a better understanding of the funding landscape to ensure HIV support at the national and NCD levels remain intact.

PEPFAR PNG will continue institutional strengthening activities initiated in ROP22 by conducting Organizational Capacity Assessments (OCA) to determine the readiness of local organizations to directly manage USG funds. However, CSOs and indigenous partners in PNG still require significant assistance before a transition is made, even at a small scale.

Tajikistan has conducted its first SID-lite in FY22 and identified several SID elements as sustainability vulnerabilities with lower scores needing continued investment and support: Private sector engagement (0.00), Quality Management (0.67) and Domestic Resource Mobilization (3.89). Accordingly, in ROP22 PEPFAR Tajikistan has prioritized all of them, but also continue strengthening essential elements as Service Delivery (3.31), increase Civil Society Engagement (6.75), Epidemiological and Health data (4.49) and Laboratory (4.98).

Funding of the national response is one of the critical elements for ensuring sustainability. There are some positive signs in government allocations to HIV/AIDS national response; however, the

public share of total HIV/AIDS spending remains very low. ARV medications have not been procured through public funds but there is planning to initiate the procurement of ARV drugs in Tajikistan. State budget allocations partially support the activities of the HIV/AIDS prevention and control institutions such as wages; infrastructure costs; the purchase of medications (for OIs) and diagnostic reagents (rapid tests, etc.); nutrition for infants born to HIV positive mothers; and monthly allowances for HIV positive children. Social contracting is essential for purchasing services from non-state actors using public funds; in FY21 the Ministry of Health and Social Protection, where social protection responsibilities have been vested since 2014, provided social contracts to one CBO to offer HIV prevention services to the KP. There was an increase in HIV funding in recent years due to additional funding for COVID-19 impact mitigation.

Transitioning to local partners and increasing domestic responsibility will remain a strategic priority for Government and development partners. A phased expansion of funding for HIV programs is outlined in the new HIV Program for 2021-2025. Transition of PR role from UNDP/GF to the Ministry of Health is discussed regularly, UNDP is working to strengthen the capacity of local organizations to gradually transition the role of the GF PR. Under PEPFAR there are two local partners, Republican AIDS Center and Republican Narcology Center, and for further transition the program will need to develop a strategic approach in partnership with local governments and institutions. PEPFAR will continue strategic support of capacity development of local partners to ensure smooth transitioning from international NGOs to local CSOs. In ROP22 Tajikistan is planning to support capacity building activities for local CBOs to apply and implement social contracting funds.

Thailand is rated as an upper-middle income country that has a robust response to HIV/AIDS. As a result, of the 17 elements evaluated, nine were “sustained,” (dark green) while eight elements are currently “approaching sustainability” (light green) reflecting the strong sustainability of its overall HIV/AIDS response. Since 2019, significant progress has been made in the critical area of domestic financing. The government has increasingly recognized the importance of the contributions made by CSOs in HIV service provision and in meeting national targets. NHSO is improving the social contracting mechanism by having all CSOs register as NHSO’s node of HIV services, which helps CSOs to reimburse more costs of HIV related services. However, being a node of HIV services and having reimbursement based on monthly performance could disrupt CSO programming. Some CSOs do not have their own buffer funds during the first 2-3 months of the fiscal year to provide services before they receive reimbursement from NHSO. Program/project-based funding remains the key mechanism in FY21 and FY22 even though plans to reimburse by performance were considered.

Although Thailand achieved high SID scores, some critical gaps remain, such as private sector engagement (improved from SID-2019 but still relative low scale of involvement) and quality improvement, the latter of which was addressed in the national strategic plan but has not been

fully implemented. In ROP22, PEPFAR Thailand will address these gaps by increasing private sector engagement in provincial Ending AIDS activities and establishment of the national QI committee. In terms of planning and coordination, coordination mechanisms exist; however, the effectiveness of these mechanisms remains an issue. CSO participation has improved but needs further strengthening. In addition, policy barriers to the provision of needles and syringes to harm reduction programming for people who inject drugs (PWID) remain; and transgender women's health services have not been included in universal health coverage. Likewise, sex work remains illegal. In-service training for health care providers and community health workers is largely supported by donor funding, and little progress has been made in transitioning to domestic resourcing. These areas still need to be monitored and accelerated towards sustainability.

2.5 Alignment of PEPFAR investments geographically to disease burden

In **Cambodia**, PEPFAR supports above-site TA focuses on the areas that account for more than 80% of PLHIV in the country (Phnom Penh, Battambang, Banteay Meanchey, Siem Reap, Kandal, Kampong Cham, Kampong Speu and Sihanoukville). PEPFAR has provided technical and managerial support to the National Center for HIV/AIDS, Dermatology, and STD (NCHADS) to implement high-quality HIV services for PLHIV. According to 2021 AEM data, HIV prevalence among MSM is 6.7% in Phnom Penh and 10.9% in Siem Reap. The prevalence among TG is 18.6% in Phnom Penh and 8.4% in Siem Reap. PEPFAR has worked with NCHADS and partners to increase the number of PrEP sites to 14 from 8 high-burden provinces.

In ROP22, in coordination with the Royal Thai Government (RTG) and the Global Fund (GF), PEPFAR **Thailand** will continue to focus its investment in 14 high-burden provinces, in which 53% of all new HIV infections occur (Jan – Dec 2020), and where 58% of new MSM and TG infections occur. Projected ART coverage in FY22 indicates the following PEPFAR Thailand categorizations: 8 are scale-up saturation, 1 scale-up aggressive, 2 are sustained, and 3 are centrally supported. Among 14 PEPFAR-supported provinces, 9 reached 3rd 90 (PVLS \geq 73%) and 5 had PVLS $<$ 73%. To support national epidemic control, approaches will focus on maintaining 5 SNUs at above site level (Phuket, Nakorn Ratchasima, Nonthaburi receiving 100% central support; and Chiang Rai and Ubon Ratchathani receiving central support, DSD and TA support), intensifying PEPFAR site level interventions in 5 provinces with PVLS $<$ 73% (namely: Bangkok, Khon Kaen, Pathum Thani, Phitsanulok, and Samut Prakan) and maintaining 4 sites (Chiang Mai, Chon Buri, Songkla and Udon Thani) with PVLS \geq 73% to intensify prevention (PrEP) & index testing program. Targeted interventions include community-based PrEP among most-at-risk MSM and TG; strategic case-finding strategies such as KP-led index testing with the option to self-test; SDART initiation and improved linkage to care and retention through intensive case management and differentiated care and treatment services; and ensuring VL testing to monitor VL suppression.

In ROP22, PEPFAR **Nepal** will continue supporting a total of 37 districts with a high estimated number of KP at risk of HIV infection and a high number of PLHIV with direct service delivery (DSD) and TA-SDI support. PEPFAR will continue to provide 26 districts with a full package of HIV prevention, care, treatment, and VL testing services to FSWs and their clients, MSM, MSW, and transgender people in the community level clinic and drop-in centers; and provide TA to public health facilities providing ART service in the 37 districts. The program will focus on increasing VL testing coverage, reducing IIT, and increasing retention across the cascade. These program and geographical alignments are based on national program alignment exercises taking into account expertise and comparative advantages of the program, and avoiding duplication of efforts and resources among stakeholders. GFATM will work with people who inject drugs (PWID), prisoners and migrant population and support the GON ART program in geographies not prioritized by PEPFAR.

Burma categorizes townships into high and low HIV burden townships by assessing 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 percent of FSW, 80 percent of MSM, and 89 percent of PWID are located there. Among high priority townships, 113 (68 percent) are in the five high-burden states/regions (Yangon, Mandalay, Kachin, Shan [North] and Sagaing) in which PEPFAR invests.

In **India**, HIV prevalence is concentrated among key and vulnerable populations, and PEPFAR India will develop, implement and scale proven, life-saving interventions in the 45 most populous districts of six 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), Telangana, and the North East (NE) states of Mizoram, Manipur, and Nagaland.

In **Indonesia**, the Government of Indonesia has led the HIV program with strategic support from international partners. In ROP22, PEPFAR will continue work in 13 districts in Jakarta and Greater Jakarta. These 13 districts cover 12% of the estimated KP, 19 percent of the estimated PLHIV, and 48,632 of the PLHIV not yet on treatment. In 2022, GFATM partners will take over community-based case finding efforts in these 13 districts, with PEPFAR implementing partners conducting case finding among MSM and PLHIV partners only. Moreover, PEPFAR technical assistance will be directed to strengthening the provision of partner notification (index testing); improving the use of client segmentation data to increase testing efficiencies; and expanding online testing services and HIVST among hard-to-reach key populations.

In ROP22, PEPFAR will provide support to seven ART sites in five provinces (Champasak, Luang Namtha, Luang Prabang, Savannakhet, Vientiane Capital) in **Lao PDR**, accounting for 92 percent of all PLHIV and 96 percent of HIV+ MSM/TG. This includes five sites located in border provinces along the Mekong River and two 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. PEPFAR will provide support to integrate surveillance of recent infections into national HMIS, and support data analysis, interpretation and use with Laos MOH and other stakeholders to identify areas of recent or ongoing transmission to inform a public health response. PEPFAR KP program will provide the comprehensive prevention package to MSM and TG in three of the five provinces - Vientiane Capital, Champasak, and Savanakhet, where the national surveillance indicated a higher HIV prevalence.

In **Tajikistan**, the HIV burden is concentrated in four out of five SNU. PEPFAR works in Dushanbe, Districts of Republican Subordination, and Sughd SNUs that account for 67 percent

of the total estimated number of PLHIV and for 63 percent 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 three oblasts. The current PEPFAR-supported program implements targeted KP-focused activities in these three oblasts. In ROP21, with PEPFAR support, the number of PLHIV receiving treatment increased by 12 percent in PEPFAR-supported SNUs and further closed the gaps towards the 95-95-95. 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. PEPFAR Tajikistan will also provide above-site support for high-volume sites with poor performance in Khatlon region (non-PEPFAR SNU), as achieving 95-95-95 targets nationally depends considerably on the progress in this SNU.

In **Kazakhstan**, PEPFAR provides support in two SNUs: Pavlodar and East Kazakhstan oblasts. The HIV burden in these SNUs accounts for about 20 percent of all PLHIV and the rate of new infections is 50-80 percent higher than the national average. These SNUs also include a significant number of PWID and MSM. In ROP22, PEPFAR will focus on the improvement of linkage to care, rapid ART initiation, intensive support for ART adherence, and scaling up PrEP among KP populations. Moreover, PEPFAR will continue case finding and case management activities among MSM in East Kazakhstan oblast that started in ROP21.

In the **Kyrgyz Republic**, the HIV burden is concentrated in four SNUs where PEPFAR works, which account for 81 percent of all PLHIV. The current PEPFAR-supported program implements targeted KP-focused activities in these four SNUs (Bishkek, Chui oblast, Osh city, and Osh oblast). PEPFAR case finding contributed to half of the new HIV cases found in FY21. Chui oblast will require the greatest assistance across the HIV cascade, and Osh city and oblast will require a follow-up case finding and PrEP among MSM according to the recent BBS results (lowest awareness on PrEP and testing rates).

PEPFAR **PNG** supports one (1) SNU, the NCD, which accounts for an estimated 12.4% of all PLHIVs in PNG, 14.1% of those who have been diagnosed, and 16.4% of those on treatment. The NCD has the highest HIV prevalence among KP groups, including MSM/TG and FSW, of all three (3) cities included in the 2017 IBBS. There are preliminary plans for a population survey in ROP21 conducted with funding by DFAT with the assistance of UNAIDS, which will further inform PEPFAR programming. In previous ROPs, the NCD had the largest number of PLHIVs nationally, but with PEPFAR support to decrease new infections, it now is estimated to have the fifth most PLHIVs, trailing Morobe, Eastern Highlands, Enga, and Simbu. The NCD records the second highest prevalence at 1.38 percent behind the island of Manus. PEPFAR PNG will collaborate and partner with development partners including GF, DFAT, UNAIDS, NDoH, and PHAs through pursuing a joint strategy, information sharing, and providing TA on proven models in the NCD to assist donors to expand successes in the NCD to other high-burden and

priority provinces.

In the **Philippines**, reported HIV cases show five regional areas of concentration (i.e., NCR, CALABARZON, Central Luzon, Central and Western Visayas), making up over 76% of all reported cases in the country. Please see Section 2.1 for more information.

2.6 Stakeholder Engagement

Participatory consultations occurred with key stakeholders, both nationally and regionally, throughout the ROP22 development process and at critical junctures. Between January and May 2022, each of the 12 countries in the region held events attended by a range of key stakeholders, including MOH, CSOs, GF, UNAIDS, WHO, World Bank, and the private sector. In the last two weeks of January, country teams held in-country meetings to introduce priorities for the next year and provide the opportunity for all participants to inform the ROP22 development. During these country meetings, 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, as identify key strategic directions. The teams reviewed progress, activities, and complementarity across all development partners. PEPFAR teams discussed in detail the development of ROP22 plans, to ensure alignment and inclusive planning, and to obtain preliminary commitments of others to ambitious PEPFAR targets and goals. These important stakeholders recognized the significant movements that were made to ensure that KP and PLHIV 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 DSD for prevention, care, and treatment, and sustainable organizational development through south-to-south CSO exchanges and targeted regional TA. As one example of an in-country consultation, the Government of Kazakhstan, the Global Fund country team, UNAIDS, civil society from Central Asia and PSNUs community organizations participated in PEPFAR Kazakhstan's ROP22 retreat. The stakeholders recommended to include support of PrEP implementation at the site and policy levels, support community organizations in receiving state funding, assist GF in implementation of the Stigma Index, increase community participation in decision making and monitoring of the national HIV response, especially monitoring of ART procurement and the transparency of procurement and include and increase gender-sensitive services such as assistance for IPV victims, support to shelter, support women leadership in the PEPFAR-supported CSOs. As another example, the PNG ROP22 consultation meetings occurred on February 7, 8, 25, and March 7, 24, and 31, ensuring a wide range of stakeholder inputs into PEPFAR's strategy, including new components including the PrEP Feasibility Assessment. In Tajikistan's country consultations in January 2022, a particular area of discussion was changes in epidemic and HIV transmission routes, effective cases finding strategies with scaling up HIV self-testing with effective return of results and linkage of clients to the services based on test results (HIV negative to PrEP and HIV positive to follow up confirmatory tests and eventually to

ART), HIV recency testing implementation, and community-led monitoring. Across the region, each country's strong stakeholder engagement continued, and team received broad-based support and input on key factors affecting the long-term sustainability of the national program. In Indonesia, consultation meetings with national and sub-national stakeholders in priority districts resulted in recommendations and action items: 1) analyze MMD data with treatment retention and use finding to advocate with national and sub-national government to accelerate 3 months MMD; 2) intensify engagement with the provincial government for the implementation of the HIV Program; 3) have Jakarta PHO share lessons learned with the Banten and West Java PHO re: using site-level data to monitor progress, PrEP implementation, and a solid partnership between health facilities and CSO for treatment continuity; and 4) ensuring children living with HIV are strategically prioritized by provide TA to analyze unsuppressed viral load patients which involves several pediatric cases, collaborate with relevant CSOs, and to continue the systematic TA on pediatric commodities distribution.

During February 7-9, 2022 the ARP held its regional (pre-ROP) Strategic Planning Meetings (SPM). These meetings were designed to facilitate regional exchange on ROP22 strategic direction from countries based on their in-country discussions, discuss the alignment of country approaches and targets with those specified in the ARP PLL and hold discussions with multilateral organizations and civil society organization networks on their regional strategic direction priorities, as well as perspectives on regional successes and challenges. The SPM observations provided further indications that during ROP22 the region should focus on, at a minimum, advancing all MPRs (with PrEP scale-up, test and start, and DSD as priorities); increasing collaboration & coordination with Global Fund (including assessing PrEP regional investments); and exploring sustainability from multiple angles (including CSO sustainability).

On March 19th and during March 23-25, 2022 the ARP held its (Virtual) ROP22 PEPFAR Regional Meetings. These discussions provided another opportunity for key stakeholders to engage in dialogue and develop a shared country-driven understanding with Partner Country Government, multilateral partners and civil society for ROP 2022 direction. These meetings focused on presenting and discussing final plans for the ARP constituent countries to reach final consensus on the key policies, strategies, and activities to be undertaken for ROP 2022, toward the goal of achieving and sustaining epidemic control of HIV. S/GAC noted areas where important inputs by communities seemed unresolved and warranted further discussion or action were included as part of SGAC's Corrective Action Summary (CAS); PEPFAR teams are required to address these issues before they finalize and submit their ROP materials.

Below are descriptions of key stakeholder engagements, broken down by broad stakeholder groups, with select country examples.

1. Partner country government(s)

In the last two weeks of January, partner country governments were engaged in dialogue during in-country consultations. During these consultations, governments provided their initial feedback related to the PEPFAR program's progress and proposed strategic direction and activities for ROP22. For example, the Papua New Guinea NDoH and KP Advocacy Consortium attended these meetings and provided inputs into the overall PEPFAR PNG ROP22 strategy. In addition, PEPFAR PNG, GF, the Department of Foreign Affairs and Trade (DFAT), and UNAIDS united around the data and a common understanding of PNG's key population epidemic and focused interventions. Feedback was incorporated into the ROP22 strategy, whilst fostering strategic synergies with Global Fund, DFAT and UNAIDS, guided by NDoH strategic direction. In Philippines, following receipt of the PLL, consultations were held with several PLHIV and KP community groups and partners. PEPFAR Philippines also engaged the Department of Health at both the central and regional levels, the Armed Forces of the Philippines, the Global Fund, UNAIDS, WHO, and other key stakeholders. The Philippines teams presented the ROP development process, strategic priorities, and technical directives, and solicited input and feedback on the direction of the program. In Tajikistan, stakeholder inputs were used to develop the ROP22 strategies, priorities, and targets. One of the suggestions made by both MoH staff and CBOs was to extend PEPFAR support to at least Khatlon, one of two non-PEPFAR SNU as it accounted for about 29% of the country estimated adult PLHIV.

2. Global Fund and other external donors

As a key stakeholder, Global Fund was engaged throughout the ROP22 process, with key inputs during the in-country consultations and pre-ROP Strategic Planning Meetings. Substantial engagement of GF and other external stakeholders is critical to the success of PEPFAR whether it be to share assessments of the current regional HIV situation and trends, ensure complementarity (and avoid duplication) of activities, prioritize recommendations for action, or convey consistent messaging to government policy and decision-makers. Going forward for the region, more engagement with multilateral partners is needed. One of the main observations from the regional (pre-ROP) Strategic Planning Meetings was to increase collaboration & coordination with GF at the regional level and plans are underway to have explore PrEP regional investments with GF. Burma's ROP22 strategy was built hand-in-hand with key stakeholders including the Global Fund. [REDACTED] In Nepal, Global Fund along with other partners, were involved in two rounds of national level consultation workshops during which FY21 performance, COP22 guidance and PLL budget and recommendations were shared and presented as well as priorities were discussed and vetted. Inputs from stakeholders were used to develop the ROP22 strategies, priorities, and targets. PEPFAR Indonesia will continue to collaborate with GF on strengthening and expanding community-led monitoring efforts to ensure the provision of person-centered care across the HIV cascade. As a result of engagement with GF during the ROP22 planning process, PEPFAR Indonesia also plans to enhance collaboration with the GF in

the three priority areas: treatment continuity, technical assistance at the district level (e.g., strengthening the clinical mentoring system in Jakarta and Greater Jakarta), and the systematic deployment of the SIHA 2.0 upgrade (using quarterly data analysis of SIHA 2.0 for programmatic improvement in the 13 priority districts).

3. Civil Society/Community

Civil society and community organizations are an invaluable asset to the region, which is characterized by concentrated epidemics. In ROP 22, collaboration with community groups, NGOs, and clients/service users helped stakeholders diagnose and pinpoint persistent problems, challenges, and barriers with service uptake and client outcomes at the site level. In the ROP planning process, PEPFAR India reviewed granular data and collaboration with community groups, CSOs, and clients/service users helped stakeholders diagnose and pinpoint persistent challenges and barriers with service uptake and outcomes at the site level. The stakeholders meeting assured that the partners from Tajikistan and especially CBOs working with KPs and PLHIV had the opportunity to be meaningfully engaged with the PEPFAR processes to design and support services to address health needs of PLHIV and especially of those from KP communities. Both in Thailand and at the regional level, APCOM has been a vocal supporter and advocate for KP funding and programming during the ROP22 process. APCOM has shared its concerns with SGAC about funding cuts in ROP22 and the expected impact on KPs service provision, which has led to important discussions about present and future programming in Thailand and the region. APCOM's Executive Director, Mr. Midnight Poonkasetwattana was also selected by SGAC to provide CSO perspective remarks on behalf of Asia at the COP/ROP22 opening plenary on Monday, February 28th; a testament to the important role of CSOs, and APCOM, on the Asia regional platform. In ROP22, PEPFAR Burma will work closely with civil society and non-governmental stakeholders to support the HIV Interim Coordination Mechanism (ICM) and implementation of the HIV Interim Action Plan. PEPFAR Burma's ROP22 strategy focuses on Enhanced Targeted Case Finding, prioritizing treatment continuity, and increasing VL coverage.

4. Private Sector

The ability of PEPFAR countries to achieve epidemic control will rely on a multi-sectoral response, including that of the private sector. It is important to engage private sector in ROP discussions for numerous reasons including to identify leverage points (e.g., innovations, donors) avoid duplication of (e.g., parallel distribution systems), and ensure access to services outside the public sector. PEPFAR Burma has leveraged the private sector to expand access to Viral Load testing among the national and PEPFAR ART cohort -- and supports social franchising clinics to deliver HIV services through the private sector. Kyrgyz Republic Private sector engagement is

one of the areas identified by as a gap in the recent SID, and PEPFAR team will conduct an assessment of private sector engagement in health, including HIV in ROP22, to increase its presence and engagement. In Burma, a significant portion of the clients at PEPFAR sites are relying on VL testing through the public sector which has been severely impacted by the coup. Ongoing discussions with the private sector and other stakeholders will be necessary to troubleshoot this issue.

2.7 Stigma and Discrimination

In **Cambodia**, stigma and discrimination is an ongoing concern. PEPFAR will collaborate with the government to train health care providers on non-discrimination, work with CSOs to increase KP participation through the community scorecard and patient feedback systems and build capacity of PLHIV and KP networks to enhance their participation in QA/QI discussion forums at community, provincial and national levels.

In ROP21, **PEPFAR Thailand** developed ThaiDriSti S&D e-learning modules adapted from Bangalore's DriSti best practice to reduce stigma attitudes and intent to discriminate among medical and nursing students in two universities in Bangkok. In ROP22, PEPFAR Thailand will continue to support the implementation of this program and advocate for it to be included in the medical and nursing student curricula. PEPFAR Thailand will collaborate with UNAIDS Thailand and the national S&D task force led by the Human Rights Committee to move forward implementation of the national S&D action plans by various stakeholders including government and non-government sectors. CDC HQ S&D central funding through UNAIDS Thailand will be allocated to HIV focused CSOs to develop U=U communication messages, empower PLHIV and KP, and reduce self-stigma. This fund will also be allocated to a human rights CSO to implement a non-discriminatory employment policy by advocating no mandatory HIV testing before employment through four major employee councils and labor unions covering more than 400,000 members.

To address S&D, PEPFAR **Nepal** is providing training and mentoring to service providers; ensuring service recipients' right to access service without stigma and discrimination is visibly posted and followed at all service delivery points; supporting the national S&D reduction toolkit/training curriculum revision in collaboration with the national program and GF partners; implementing CLM as a mechanism to monitor and address S&D; and providing DSD to KP in community-level KP-friendly clinics and drop-in centers. In addition, PEPFAR will support UNAIDS to complete the Stigma Index 2.0 survey and plan to implement recommendations based on the results in collaboration with all HIV stakeholders implementing in the country.

Burma still enforces a punitive legal framework that creates barriers to health services for all key populations, including drug policies that can inhibit risk disclosure and access to services. [REDACTED] Stigma and discrimination have been identified as some of the key barriers in accessing HIV services in Burma and negatively impact across all stages of care and treatment cascade for PLHIV particularly key populations. The country is planning to conduct the Stigma Index 2.0 to gather evidence on how stigma and discrimination impacts the lives of PLHIV; PEPFAR Burma will provide TA and support implementation of this survey. PEPFAR Burma will support and sustain critical community-led responses to address stigma and discrimination, human rights, and gender equality through the partnership with UNAIDS, including KP-led targeted sensitization workshops, public campaigns, GBV awareness-raising, and will support linkage to services, legal rights, and legal awareness among KP. Health care provider sensitization sessions led by PLHIV/KP networks, combined with structural interventions, will also be expanded to non-public HIV facilities to provide services to KPs in a non-stigmatizing and competent manner.

Given marginalization of KP and stigma faced in accessing prevention, testing and treatment services, PEPFAR **India** will continue to work towards provision of stigma-free services to all vulnerable and stigmatized populations it serves through rigorous training of service staff, maintenance of confidentiality and ethical service provision, emphasis on U=U to reduce stigma among positive communities, and KP and PLHIV-friendly, community-based and community-driven strategies. Additionally, PEPFAR, in collaboration with UNAIDS and in coordination with other NACO partners under the GF, will introduce S&D questions in surveillance among PLHIV, as well as support advocacy for measurement of S&D via the PLHIV HIV Stigma Index 2.0. With UNAIDS' network and credibility among national, state, and district positive networks as well as with community resource groups at all levels, this index will help advance the 10-10-10 societal enabler targets. Working in collaboration with other Asia region countries, India will implement comprehensive programmatic strategies to reduce S&D at scale and promote partner government and community leadership at the country and regional level.

Indonesia published Stigma Index 2.0 national survey findings, indicating that much of the S&D PLHIV experience stems from internalized stigma, which has a higher prevalence than S&D from external perpetrators. Internalized stigma affects self-confidence, relationships, capacity to manage stress, and aspirations to have children. Compared to the 2020 Stigma Index results, there has been an improvement in HIV services in Indonesia. However, based on consultations with KP stakeholders, there are limited differentiated HIV services for young KP, PLHIV with disabilities, and aging PLHIV, which should be prioritized. The other structural barrier is the lack of an accountability mechanism to address HIV-related S&D. In close collaboration with MOH, UNAIDS, WHO, and CSOs, PEPFAR Indonesia will continue to provide TA for CSOs and CBOs to advocate for removing HIV-related policy barriers at the sub-national level. Moreover, UNAIDS will be taking the lead to work with the Human Right Commission to

strengthen the promotion of the rights of PLHIV and KPs and establish an accountability mechanism to address S&D. PEPFAR partners will continue to further the Human Rights agenda by advancing the protection of PLHIV and KP from HIV-related S&D.

In **Lao PDR**, S&D towards MSM/TG & PLHIV in communities and health facilities is one of the critical barriers hindering access to and retention in HIV services. In ROP22, PEPFAR will provide TA to support PLHIV and KP CBOs conducting CLM activities to identify S&D (among other access barriers) experienced by PLHIV, MSM, and TG, and work with MOH to address S&D issues and advance the rights of PLHIV and KP communities. In FY22, MOH and stakeholders developed and updated the national HIV S&D guidelines to improve people-centered HIV services. MOH will implement S&D e-learning among health care providers and conduct regular S&D surveys to monitor and apply findings to mitigate attitudes and practices at health facilities, aiming to improve service satisfaction among PLHIV. The survey results will generate and inform practical solutions such as awareness-raising through IEC materials.

HIV-related S&D is also a persistent challenge in **Tajikistan**. PEPFAR will support the country's implementation of the Action Plan intended to address key findings from the HIV Stigma Index and the Global Partnership to eliminate all forms of HIV related stigma and discrimination. Moreover, CLM as an instrument for oversight of quality of HIV services in Tajikistan is expected to be a great resource to continuously refine support intended to address this issue.

PEPFAR **Kazakhstan** will support GF in implementing the Stigma Index 2.0 survey in 2023 by providing technical assistance during the interview, report writing, and dissemination stages. In addition, PEPFAR will support a small grant to a local HIV-related community organization to address stigma issues at the national and local levels.

The PEPFAR **Kyrgyz** team has supported jointly with GF/UNDP and UNAIDS implementation of PLHIV Stigma Index 2.0 and will support action plan development in ROP22 to ensure barriers and gaps identified are included in the plan. S&D issues as well as ethics and safety of services are tracked through SIMS, but also through CLM activity launched in COP21. A feedback and reporting mechanism implemented by the community IP will continue gathering feedback from KPs, and data will be triangulated with other sources such as SIMS and CLM. Facility health providers will continue being sensitized on S&D issues to ensure non-stigmatized service delivery for PLHIV and KPs.

CLM is one of PEPFAR **PNG**'s key strategies to mitigate stigma and discrimination (S&D). Additionally, PEPFAR will implement new measures in supported facilities to reduce S&D 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. PEPFAR PNG will also identify well-performing sites and develop mentorship opportunities for lower-performing sites to improve HIV service provision quality and decrease S&D.

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 index testing among key populations in particular. In ROP22 the PEPFAR Philippines program will target programs to PWID through above-site level advocacy and draw from regional examples of evidence-based medication-assisted treatment strategies to expand services to PWID. Alternative case finding and testing strategies, such as self-testing and social network strategies, will be pursued to increase KP access. Safe and ethical index testing training will include provider screenings for intimate partner violence and will ensure appropriate elicitation of contact information. Additionally, internalized and/or anticipated stigma prevents timely access to care and treatment services among PLHIV and MSM. In ROP22, PEPFAR will continue implementation of person-centered, KP competent case management training for providers. This will be complemented by the inclusion of stigma reduction into the broad PEPFAR-developed U=U and TLD campaign that the national program has adopted. PEPFAR will also institutionalize capacity building to reduce S&D in standard military training curricula. PEPFAR will conduct a qualitative assessment of quality of HIV care as part of its CLM activities and will expand stigma reduction QI activities to focus on KPs, using the existing QIS+D Network. Aligning activities with identified PEPFAR priorities, the network will be augmented to include community-based providers. PEPFAR will provide mentoring to include community monitoring data on stigma into QI plans.

3.0 Geographic and Population Prioritization

Across the 12 countries, the ARP will support 184 SNUs in ROP 22; a small increase from 178 in ROP21. Burma added two (scale-up aggressive) SNUs and India added five (scale-up aggressive). India also reduced the number of scale-up saturation SNUs from four to three resulting in a net gain of 6 SNUs for the region in ROP22. With the exception of Burma and India, countries will support the same prioritization categories and number of SNUs as in ROP21. Of the 184 SNU, none are “attained”; 4 are “scale up to saturation”; 135 are “aggressive scale-up”; 7 are “sustained”; and 28 are “central support or above site”. All SNUs for Burma (30), Kyrgyz Republic (4), Nepal (37), Philippines (5), and Tajikistan (3) are “scale-up aggressive”; all Cambodia’s SNUs (25) are all “central support”; all Kazakhstan’s SNUs (2) are “sustained”; and Papua New Guinea’s 1 SNU is “scale-up saturation”. Indonesia has 8 “scale-up aggressive” and 5 “sustained” SNUs; India has 42 “scale-up aggressive” and 3 “scale-up saturation” and Thailand has 3 “central support”; 8 scale-up saturation” and 1 “scale-up aggressive and 2 “sustained” PSNUs.

4.0 Client-Centered Program Activities for Epidemic Control

Figure 4.0.1 Overview of 95/95/95 Cascade, FY21

1.1 – 4.4 COP22 Client-centered program activities for Epidemic Control. Describe your program funded in COP22 focused on the following priority areas:

4.1 Finding people with undiagnosed HIV and getting them started on treatment

Cambodia will continue to address key structural barriers and gaps in case finding for KPs through the increased use of real time recency data to refining testing modalities such as index testing/PNTT (with a yield of 43% among partners who were tested), peer network testing (PDI+), HIVST, and virtual outreach testing through social media. The country has incorporated safe and ethical index testing into the PNTT and VCCT programs, and assessment findings into the national training program and field visits. The country has a linkage to treatment rate of 97%. Cambodia has worked to scale up HIVST from Phnom Penh to an additional three provinces with a high burden of HIV among KP in ROP20, and eight provinces in ROP21. During ROP22, Cambodia will focus on increasing use of HIVST, especially for hard-to-reach KP, including through online outreach and the private sector.

In Cambodia, HIV recency has been implemented nationally, in 68 VCCT sites. Through December 2021, covering over 22 months, results show that among 218 HIV recent infections, 80 percent were among males, and 76 percent were among those aged 20-34 years old. Over 50 percent were among MSM. Nearly 80 percent of the cases were from four VCCT sites: Chhouk Sar, Siem Reap, Battambang and Mongkul Borei hospitals. PEPFAR will support integration of recency into the national HIV surveillance system to link recency results to index testing and the treatment database for surveillance purposes.

In **Thailand**, the country strategic plan recommended index testing to improve case finding, but index testing remains a challenge in both community and facility settings. In ROP22, Thailand case finding strategies will focus on highly targeted index partner testing - which has been expanded to all PEPFAR health care facilities - and continue to enhance community-based index testing in KPLHS sites. Index partner testing services continue to provide higher yield compared with other modalities. There will be a focus on increasing the uptake of index testing services and partner acceptance. Index testing targets will focus on new HIV+ and/or virally unsuppressed KP groups. Thailand will continue supporting index testing QI activities, and refining index testing models through the introduction of an Index Plus model where mixed approaches will be used including an HIV self-test option for partners, social network strategy using digital coupons, and options for home delivery of HIV self-test kits for partners. Supportive supervision activities were tested in ROP21 and will continue in ROP22 and

integrated as part of routine quality improvements. Facility-based index testing training will focus on partner elicitation skills and ensure partners are reached for testing. Strategies specifically to reach youth for HIV services will be added and HCWs will be trained in youth friendly services. PEPFAR Thailand will work with GF to examine feasibility of leveraging GF support to assist with index testing and HIV self-testing expansion.

For community-based index testing at KPLHS sites, KP-led CHWs have been trained rigorously on providing motivational interviewing (MI) approaches to motivate index clients to notify their partners to get tested and empower PLHIV with behavior change strategies. Self-testing will be one of the key methods used to bring in index partners and their networks to receive HIV testing, prevention, treatment, care and support.

HIV self-test (HIVST) will continue to expand in Thailand using facilities, peer outreach, online approaches and other client distribution services (e.g., pharmacies). Additionally, PEPFAR Thailand will finalize enrolling participants in the first assisted HIVST pharmacy-delivered model, analyze data, and disseminate results. HIVST will be integrated, where feasible, with index testing, social network strategy (SNS), mobile community-based services, and extended-hour clinics or ad-hoc, offsite VCT services as an additional option to increase uptake of HIV testing among partners/networks of HIV+ and high-risk HIV- clients.

For the HTS modality to increase higher case finding while reducing the impact of the COVID-19 pandemic, Thailand continues to increase layered KP prevention interventions (KP_PREV) and provide HIV prevention testing focused on KP groups. Thailand will expand high risk clients from index partners and their networks, and networks of adolescents and youth groups by using the HIVST approach. Our FY2023 HIV+ targets have been allocated proportionally to VCT which includes online reach interventions and KPLHS testing (59%), index testing (19%), mobile testing (15%), SNS and other community testing (7%). Thailand will implement online reach and recruit interventions via dating applications and social media, SNS, and peer mobilization to reach high burden networks targeted on the last mile hard to reach KP groups. These groups will receive one stop-KP-friendly HIV testing at KPLHS sites where KP clients learn their individual HIV status within an hour, and will be linked to HIV prevention, care and treatment packages.

For those clients who are HIV negative, a prevention package will be offered depending on their HIV and STI risk. The prevention package at KPLHS and facility-based sites include PrEP/PEP services (free of charge for all Thais), STI prevention/treatment, condoms and lubricant, and HIV prevention education. For those testing positive for STIs, KPLHS will link clients to receive STI treatment at key health facility networks and advise clients to bring their network(s) to get HIV testing. STI clients identified in facility-based sites will be referred to STI treatment in the same facility with partner testing and management according to the national STI treatment guidelines. Clients testing HIV positive will be offered an HIV treatment package including index testing services, ART and U=U information to reduce stigma and discrimination,

and then link clients to initiate same day ART at pair-hospital or network hospitals based on their health insurance scheme registration.

To fill the gaps of the 2nd 95, we will expand the PEPFAR Thailand treatment intervention package to improve ART coverage including SDART, MMD, enhanced adherence counselling (EAC), TLD transition, and reduce interruption in treatment (IIT) and stigma and discrimination in healthcare settings. To achieve the 2nd 95 in ROP22, our strategy is to focus on same-day linkage of all newly diagnosed HIV positive clients and to initiate ART at pair-hospitals or at the hub of SDART service provision such as the Thai Red Cross Research Center (TRCARC) or the Institute for HIV Research and Innovation (IHRI). In FY2022, over 100% of linkage to treatment occurred due to PLHIVs who are not in the target of HTS_POS from VCT modality in health facilities but were carried over from existing years or transferred from non-PEPFAR supported sites. Proxy linkage to ART in PEPFAR supported government sites was nearly 100%. This successful practice will be expanded to non-PEPFAR supported sites in FY23 through above site TA support. In addition, to increase coverage of SDART initiation in PEPFAR-supported sites, MOPH will conduct coaching to sites with late ART initiation, including PLHIV presented with OI that are not contraindicated to delay ART initiation. IHRI and TRCARC will continue to be hubs to initiate SDART in Bangkok and vicinity provinces for clients from KPLHS sites before the referral of PLHIV to long term ART in health facilities.

In ROP22, PEPFAR Thailand will complete data analysis of web-based, respondent-driven sampling (RDS) for HIV prevalence and incidence surveillance among MSM and provide TA to MOPH for preparing web-based RDS among transgender women (TGW); use online reach to offline testing at convenient and client-friendly service facilities; continue to incorporate recency testing into the national public response system; and continue to build capacity of public sector and community-based workers in monitoring and evaluation (M&E) and QI using site-level data to support.

Nepal will focus on targeted HIV case finding strategies to meet the 1st 95 target and course-correct linkage to ART services. Based on program results, successful interventions for identifying undiagnosed PLHIV include index testing, sexual network testing, enhanced peer outreach, and social network strategies. PEPFAR will build on these successful interventions and leverage targeted HIV self-testing to find harder-to-reach KP. PEPFAR will scale up recency testing to identify hotspots of ongoing recent infection and respond based on the surveillance findings to curb further HIV transmission risks. PEPFAR will ensure care providers are trained 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). In addition to newly diagnosed PLHIV, PEPFAR Nepal will also work in community settings to trace, locate, and link known PLHIV not yet linked to ART. The program will work

collaboratively with GF IPs, PLHIV networks, and KP networks for maximum impact and efficiency. Immediate linkage to and initiation on ART will be ensured by availing service directories at all testing sites, leveraging virtual platforms to facilitate referral and linkage, providing accompanied referrals by peer navigators to ART sites, providing regular mentoring and supervision to improve counseling skills, tracing newly diagnosed PLHIV in the community and providing ongoing ART literacy, U=U, and disclosure counseling until they are enrolled and started on treatment.

PEPFAR will also support integration of M&E systems, including complete roll-out of one national HIV information system using UICs. The Nepal program self-monitors performance daily with the help of its real-time online DHIS2-based data recording and reporting system, which allows for performance to be closely tracked.

To find the hardest-to-reach KP, PEPFAR **Burma** will employ an Enhanced Case Finding approach, empowering trained peer leaders from key populations. To this end, the program will invest in a dedicated social media team, as much of the outreach has been driven online and underground due to the coup and COVID-19. For the first time, the program will launch a Virtual KP HIV Service Center, a viral call center that will deliver outreach, case management and assisted HIV self-testing. Finally, PEPFAR will launch six PrEP Community Distribution Points with local CSOs and KP-led groups. The program will refine its HIV testing mix toward high-yield modalities, including index testing, mobile testing, VCT, community-based screening, social network testing, and HIV self-testing and PITC. PEPFAR will introduce HIVST at PEPFAR sites and within communities to reach first time testers, clients of sex workers, and hard-to-reach KP networks, including hidden or young KP who would be more comfortable ordering an HIVST online. Emphasis will be placed on immediate ART initiation by building relationships with the local national AIDS program through an accompanied referral. PEPFAR Burma will also provide technical assistance to build capacity of HTS service providers in improving overall HTS testing yields in five PEPFAR prioritized states and regions by optimizing a strategic mix of targeted case finding approaches. TA will also support expansion of index testing into non-PEPFAR sites, in collaboration with GF partners, by developing SOPs, M&E guidelines, and training modules, and applying lessons learned and best practices from PEPFAR sites. To bring HIV testing services to communities, the program will build the capacity of KP peers to conduct community-based screening with QA measures. To ensure direct and immediate linkage from testing to treatment, development and implementation of standardized linkage SOPs among testers and service providers will be supported.

In alignment and in collaboration with the GOI, PEPFAR **India** has made great strides in the support and expansion of evidence-based case finding strategies. The program continues to expand and support a comprehensive strategic mix of case finding, including index testing, social network strategy and self-testing, to ensure all ages and priority populations have access to testing, linkage to care and treatment, and life-long ART. India has demonstrated and will continue to scale index testing services in different locations, including targeted interventions, OST centers, integrated testing and screening centers, ART centers, and new integrated service

delivery locations such as the GOI flagship Sampoorna Suraksha Centers and the newly inaugurated transgender clinics and other integrated health centers. The program works to expand integrated services through leveraging partnerships and referrals, including expansion of services for non-communicable disease and the national viral hepatitis program. In recognition of new populations seeking testing through virtual platforms, including adolescents and young adults, India is working with the GOI and GF partners to increase opportunities for outreach and testing, including self-testing.

With GF partners accelerating case finding in PEPFAR-supported districts, PEPFAR **Indonesia** will focus its efforts on strengthening safe and ethical index testing in 109 facilities in Jakarta; 28 facilities in Greater Jakarta; eight CSOs; and the Update Status online platform. The program will promote 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.

PEPFAR Indonesia will also implement face-to-face and virtual differentiated outreach strategies to identify non-diagnosed and recently infected key and priority population PLHIV. KP case finding will focus on MSM, where gaps remain the most significant. Client risk segmentation will be used to optimize the focus and impact of outreach and testing, which is an approach that employs taking a granular look at the characteristics that differentiate individuals meeting specific HIV cascade criteria, such as being newly diagnosed and initiating HIV treatment, or achieving HIV viral suppression. Targeted HIV testing modalities – specifically PITC for TB patients, VCT for key and priority populations, and social network strategies among MSM and PLHIV – will be prioritized. The program will continue to provide above-site support to the government at the sub-national level to implement community-based screening and HIVST intervention models to access hard-to-reach individuals with critical outreach and testing services.

Site-level TA and monitoring will ensure direct and immediate linkage of clients from testing to treatment. Together with CSO partners, the program will optimize peer navigation SOPs across all targeted Jakarta and Greater Jakarta facilities, with CSO and facility performance-based incentives strategically implemented to systematize optimal linkages. In addition, TA will emphasize adaptation and operationalization of SOPs, district-level clinical mentoring, and the systematic use of the MOH cohort and patient records system (SIHA 2.0 upgrade) to track provision of rapid ART and TLD to PLHIV clients. PEPFAR Indonesia will continue in ROP22 to provide support at national and sub-national levels to analyze data from the SIHA 2.0 upgrade to strengthen the HIV program.

In **Lao PDR**, the MOH increased its efforts to closely monitor and follow up index testing data weekly, using a list of newly registered ARV cases, PLHIV lost to follow up, and PLHIV with unsuppressed VL, to facilitate the follow-up process of index clients in FY22. Main index testing challenges identified were low offer and acceptance of index testing among newly diagnosed PLHIV. In ROP22, PEPFAR will continue to promote index testing in both facility and

community settings using the following approaches: 1) train healthcare workers and community-based supporters on index testing communications to ensure that index testing is offered to all eligible individuals identified in ART sites; 2) focus on demand creation to improve acceptance among positive clients and raise awareness; 3) provide supportive supervision to health facilities; 4) strengthen monitoring system to address gaps in acceptance, partner elicitation skills, and linkage to PrEP among discordant partner of index testing; and 5) combine HIV self-testing with index testing (Index testing Plus model) to encourage uptake of index testing services from 50% to 70% and link partners to appropriate prevention and treatment services. To improve the quality of HIV testing, PEPFAR will support the establishment and strengthening of the external quality assurance (EQA) program for HIV serology to support 140 testing sites in the initial phase and all 200+ testing sites in the next phase.

Based on performance data and learnings from the past two ROP cycles, in ROP 22 **Tajikistan** will focus on expanding and strengthening case finding strategies, including index testing, social and risky network strategies, active and enhanced peer outreach approaches, and online reach and testing. The program will expand HIVST by continuing to support demand generation, differentiated and integrated HIVST. These strategies will be informed by data reviews and client risk segmentation for deeper analysis of testing data and direct recruitment towards highest-risk subpopulation and individuals. In ROP22 the program will emphasize online activities to reach more KPs, expand online activities through the introduction of online reservation applications offering self-directed risk screening to understand personal risks and receive necessary services, online counseling, HIV testing appointments, HIVST kit ordering, and referral to other services and KP-friendly service providers. Tajikistan will also promote implementation of the Community Health Center as a safe alternative for KPs facing S&D at traditional HIV service sites, which will provide a comprehensive package of services, including online and in-person counseling, HIV testing, referrals for HCV and STI treatment and testing, linkage to HIV treatment, and PreP counseling and referrals and distribution.

PEPFAR **Kazakhstan** will also continue to develop and implement an innovative HIV self-test distribution and utilization service in East Kazakhstan oblast. The service will facilitate network-based distribution of HIVST kits and will be linked with the online anonymous partner notification service, which is expected to improve uptake especially among HIV-positive PWID and MSM who fear stigma and discrimination. Distribution of HIVST kits will go beyond AIDS Centers to reach and increase uptake of HIV testing services among targeted populations. The program will focus on higher risk populations coupled with 'assisted' services on how to use the kits and what to do with the results, including linkage to prevention for HIV negative KP and early start of ART for PLHIV. As there are still HIV cases identified with low CD4 count and high VL levels at diagnosis indicating late HIV diagnosis, Kazakhstan will focus on early HIV diagnosis and linkage to ART. In addition to the online system and HIVST kits, the program will continue training facility and community staff that will coordinate this intervention, develop detailed SOPs and visual algorithms, and provide performance-based financial incentives. HIVST kits will contain details on the testing process (which will be developed using human-centered design methods), and referral information, including for PreP. An SMS messaging

system will support people to report their test results and connect with a health facility for confirmatory testing and treatment and for peer support. Financial incentives will be provided to people returning their test results. At the community level, PEPFAR will continue to support KP and PLHIV-led CSOs to further scale up index testing and social network testing through peer navigators. PEPFAR will scale up its enhanced peer outreach approach and intensify online outreach and index testing among MSM.

Current case finding volumes are not enough to achieve 95-95-95 in **Kyrgyz Republic**. Therefore, further refinement of testing strategies and granular data analysis on who is missing and not reached will be at the core of case finding for ROP22. The testing strategy aims to maintain a diverse case-finding portfolio based on identified innovations and gaps, and highlights further scale-up of community-based modalities to reach those most at risk, leveraging self-testing as a screening tool for improved case finding and subsequent referral to prevention and PrEP services. The program will support targeted IPT focused on specific categories of PLHIV: those not on ART, those on ART but not virally suppressed, and those newly diagnosed with HIV, ensuring ethical and safe HTS services with robust systems in place to prevent, report, and monitor. Kyrgyz Republic will continue to actively promote online self-elicitation and partner notification approaches and will add risky network referral (RNR) to complement index testing and capture social networks of index cases.

The program will continue to expand self-testing through various offline channels and will continue using online platforms for tailored messaging to increase demand for HIVST using the HIVST demand generation strategy. There are also plans to add distribution of self-tests through vending machines and provide online self-test give-away services at Bishkek AIDS Center targeting KPs. Community-level case finding in Kyrgyz Republic will include the following: mixed method case finding strategies; expansion of SNS/RNR; online outreach; self-testing; intensifying case finding in populations with the highest yields (MSM, TG, partners of PLHIV not self-identified as KP, clients of FSW and SW); intensifying EPOA analysis of recruitment networks using e-coupons and engaging PrEP clients as “seeds;” ad continuing work with private clinics, labs, and rehabilitation service providers to refer people with risky behaviors for HIV to testing. In order to reach with testing those hard-to-reach populations, EpiC has started working with private facilities and health providers who already provide medical services to people from key populations (MSM, SW and their clients, PWID) and familiar with their risks related to STI and HIV (e.g., STI doctors, proctologists, gynecologists, urologists, narcologists). Some of the key populations prefer to seek health services at private facilities, rather than going to government funded health facilities. EpiC has developed referral materials (posters, leaflets) about project testing services to be shared/posted in the private health facilities. Health providers of these facilities can also share information about EpiC with clients who they think might benefit from community-based services – HTS, HIVST, PrEP.

Based on results of case finding efforts among migrants and returnees with risky behaviors in the South of Kyrgyz Republic in ROP21, PEPFAR will make a decision regarding potential testing in this population. For case finding among PWID, Kyrgyz Republic continues strengthened

coordination between AIDS Centers and MAT sites for improved PWID retention and implementation of co-located MAT-ART, and implementation of social network and active outreach testing approaches among PWID to complement case-finding gains from index testing. In addition, Kyrgyz Republic plans to structure testing interventions among synthetic drug users, to address alleged shifts in the drug scene from heroin to synthetic drug use, using the findings of the regional assessment activity by EpiC in ROP21 and the IBBS (2021) findings.

Papua New Guinea (PNG), at 90-100-51 in NCD, will optimize case finding among KP networks and institutionalize index testing in PEPFAR PSNUs, including through ANC testing and early infant diagnosis testing. PEPFAR PNG has provided TA to optimize pediatric ART treatment and ensure better treatment outcomes with the introduction of pDTG 10mg, but the need for additional support at the above-site level and to operationalize the guidelines remains. PEPFAR PNG will increase capacity of facilities in the NCD to provide MTCT and treatment services for pediatric/CLHIV to reach saturation. The program will further strengthen HMIS and SI systems to monitor and improve ANC and pediatric/CLHIV case management to support achieving saturation in the NCD. Increased visibility of pediatric and ANC data will inform decision-making and increase focused support from partners. Through CLM, PEPFAR PNG will enhance case finding among KPs, including addressing S&D in facilities and strengthening HIV services to properly identify KPs and provide differentiated care for MSM, TG, and FSW. The program will focus on improving index testing in the NCD while providing TA for national scale-up of the new three-test HIV testing algorithm, including supporting ANC HIV testing for pregnant women. PNG will continue implementation of targeted VCT and index testing in ROP22 and will provide additional TA to support expansion of test-and-start and SDART approaches to decrease risk of patient loss prior to treatment initiation. While significant progress has been achieved to decrease the number of days between diagnosis and ART initiation for PLHIV, PEPFAR PNG will continue to support these efforts at PEPFAR-supported sites.

Philippines will support key populations including PWID, MSM, TG, and FSW, in Greater Metro Manila (i.e., NCR, Central Luzon, and CALABARZON), Western and Central Visayas, expanding case-finding through safe and ethical index testing, social network strategy testing, and self-testing, and recency testing. Strategies to support linkage and same-day ART will be prioritized.

4.2 Ensuring viral suppression and ART continuity

Viral load suppression rates in the Asia region were reported at 90% for PEPFAR-supported PSNUs in 9 out of the 11 countries as of FY21 Q4. The continued progress in VLS rates across the region requires not only analyzing data at the PSNU and site level to inform programming, but also understanding and addressing understanding barriers impeding achievement.

While barriers are country-specific, and even localized, there are numerous barriers reported within the region, many of which were impacted by COVID-19:

- **(Limited Access)** including limited access to optimized DTG-based regimens; lack of viral load supplies at ART clinics; lack of GeneXpert machines at ART and POC ART

sites; delayed delivery of PCR viral load tests; and need to optimize laboratory networks for VL testing; insufficient ART clinic coverage in remote areas; some PLHIV living far from ART clinics

- **(Movement/Migration)** persons without viral load are sometimes outside of PEPFAR-supported districts and in some cases outside the country
- **(Insufficient provider capacity/KP sensitivity)** insufficient provider competency and ability to understand and address barriers to VL testing uptake; key population retention rates sometimes impacted by quality and friendliness of facilities and providers;
- **(Lack of person-centered approaches)** lack of targeted and tailored approaches for under-served populations (e.g., VLS is low among young ages in Thailand, but this population is under-served); lack of person-centered case management (e.g., insufficient gender-affirming care for transgender persons; inadequate counseling and mental health services) and treatment strategies;
- **(COVID interruptions)** task shifting from viral load testing to cover COVID-19 testing priorities; clinic closures, limited hours, and reduced access.

In ROP 22, across the region there were numerous solutions and interventions to address the aforementioned VLS barriers:

- **(Site-level responses)** supportive supervision and mentoring; targeted technical assistance and site visits; granular site management, including site-level prioritization analyses;
- **(Person-centered approaches)** differentiated service delivery (e.g., for mobile PLHIV, including migrants and prison settings; decentralizing VL services; community ARV refills); adherence support, including person-centered approaches like home visits and SMS-notifications; case management (including with community peers); one-stop shops (OSSs); targeted strategies to keep KPs in care including addressing quality and friendliness of facilities and providers;
- **(Monitoring and Evaluation)** monitor VL commodities at the site-level, including strengthening CSO capacity to monitor; ensure continued monitoring of VL QI plans to maintain VLC; data deep dives among ART clinics that performed poorly
- **(Communication Strategies)** Amplify campaigns around U=U and treatment literacy including demand generation for TLD; IT apps to facilitate VL appointments and send VL alerts/reminders; onsite or online coaching; generating age, gender and behavior specific messages for counselling and adherence support;
- **(Multilateral Collaboration)** with Global Fund and other external donors;
- **(CSO Engagement):** CSO engagement to help identify and reduce barriers to accessing services among key populations
- **(Laboratory Access Optimization)** complete diagnostic network optimization, including efficient use of specimen transport; DBS; placing GeneXperts near key sites; capitalize

on CDC Regional Laboratory Community of Practice (Lab Coop) Project regional and local assets.

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.

The following section details country-specific approaches to addressing issues impacting the treatment cascade including VL testing and coverage, Interruption in Treatment (or loss to follow up), ART retention, site-level changes for linkage and ART continuity, addressing equity barriers, MMD, TLD transition, and incorporating CLM monitoring data into decision-making.

[REDACTED] Limited lab and clinic interaction contributes to inefficient sample networking flow and delays in VL test result turnaround time to clients. Burma is working with GHSC-PSM partners to ensure adequate supply of reagents and lab commodities supply for VL labs in coordination with GF PRs. PEPFAR continues to make VL testing a priority among the PEPFAR cohort: PEPFAR partner Lan Pya Kyel provides VL testing in Yangon in partnership with the Global Fund. Burma has leveraged the private sector and NGO laboratories to resume routine VL testing services for PLHIV/ARV clients receiving care in the public sector. Following the ROP2022 guidance, Burma's viral load testing results of the PEPFAR cohort increased from 50% (as seen in FY21 and FY22 results) to 60%. However, a significant portion of the clients at PEPFAR sites are relying on VL testing through the public sector which has been severely impacted by the coup. Of those who have received VL testing, 95% VL suppression is estimated based on previous program results among the PEPFAR cohort. Burma continues to support improving VL coverage and suppression with TA on advocacy, coordination, monitoring and corrective actions to resume routine VL testing services with efficient VL sample networking flow in 5 PEPFAR priority states and regions. Specific TA will focus on monitoring TA support through the VL-Technical Working Group (TWG), completing a follow-up DNO exercise to optimize VL sample flow and VL test result turnaround time; amplifying VL demand creation activities with U=U messaging through social media platforms, campaigns, trainings, and hotline services; and mentoring health care workers and counselors to implement case management SOPs for ARV clients with detectable VL.

Given the current political crisis and increasing conflicts in many areas, PEPFAR Burma will focus its TA and program delivery on ensuring the continuity of ART services by utilizing innovative and adapted differentiated person-centered approaches; providing necessary coordination, networking and care for the national ART cohort at PEPFAR sites and in

communities; and coordinating with major donors to fill service gaps. Emphasis will be placed on immediate ART initiation through an accompanied referral at the site level. Community leadership in HIV care and treatment will be strengthened through peer navigators to support decentralized drug dispensing, adherence and improving active follow-up; and service-availability mapping and HIV service directory mobile application will continue to be supported and updated regularly. PEPFAR Burma will support guidelines/SOP updating and capacity building on ART management including management of Cycle of Interruptions and Return to ART and promote Differentiated Service Delivery such as MMD, decentralized drug distribution, TLD transition, and rapid ART initiation through the HIV Interim Coordination Mechanism and in collaboration with key stakeholders. Treatment and viral load literacy will be strengthened through various channels including training, job-aids, campaigns and messaging on social media platforms; quality improvement of ART services will be enhanced by expanding the Service Quality Monitoring System and Community Led Monitoring interventions.

In **Cambodia**, as of December 2021, 92% of all patients on ART received a viral load test, of whom 98% were virally suppressed. Ten provinces had viral coverage less than 90%. The main challenges have been a lack of viral load supplies at ART sites, many PLHIV migrating to work outside of Cambodia and some PLHIV living far from ART clinics. In COP22, Cambodia will continue to work with NCHADS and Global Fund to ensure the availability of VL tubes at ART clinics, and work with NCHADS and partners to do a deep dive among ART clinics that performed poorly. We developed and got endorsement from the MOH on the “reengaging patients into care and treatment” SOP in mid-Q3 FY20. Since implementing this SOP, over 80% of patients who missed their clinical appointment by less than 28 days were reengaged in Q1 FY21. In COP22, we will continue to provide training, re-training and conduct site visits at ART clinics which perform poorly.

Besides the importance of ensuring sustainability and decentralization of care from referral facility to primary care, it is concerning that the viral load test coverage is still considerably low in **Indonesia**. As of December 2021, the MOH reported VL suppression rate was at 14% (20,747). PEPFAR Indonesia will support treatment continuity efforts that move PLHIV to viral suppression, including systematizing rapid or same-day ART, and advocacy efforts accelerate TLD provision to all current PLHIV on treatment. The program will also support MOH to develop and operationalize an MMD roadmap that accelerates MMD provision to eligible PLHIV across Indonesia and provide above site support to the GF partners for the implementation of 3 MMD. Additionally, the program is prioritizing laboratory network strengthening for viral load to support the Government of Indonesia in its efforts to scale up viral load testing services to support the 95-95-95 goal. It is crucial for the Indonesian government to strengthen its commitment to improve its laboratory services to increase its capacity to conduct viral load testing at a level that grows the number of Indonesians who are virally suppressed.

PEPFAR **Kazakhstan** will scale-up patient-centered approach in facilities and community peer

counselling for treatment initiation and retention. Counseling will include individual and groups activities messaging U=U and will include treatment and viral load literacy. To ensure uninterrupted access to ART, PEPFAR Kazakhstan will continue to implement DDD and address stigma issues by legal counseling and education. An Online Reservation and Case Management App (ORA) for all case management clients will help access services at the community and facility levels that will help patients adhere to treatment (TB, STI, social services, legal counseling, etc.). VL coverage will be improved through centralized procurement of VL test kits.

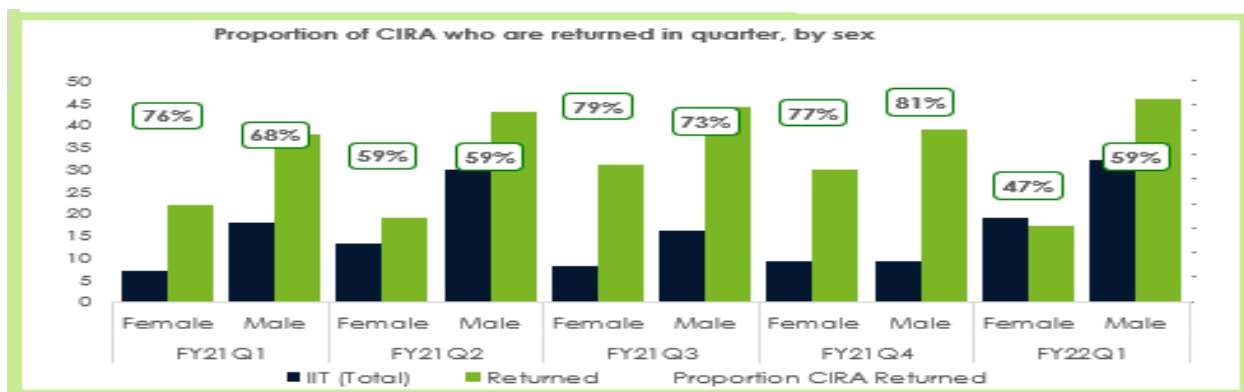
The cycle of Interruption and return to ART differs varies by gender in Kazakhstan. The interruptions are higher in men comparing to women. This difference is presumed to be related to more risky behavior among men due to substance abuse. PEPFAR Kazakhstan closely works with sites to improve transfer procedures and tracking, which include active follow-up calls and visits within one week of miss contact; close collaboration between nurses and peers.

Continuous and significant efforts are undertaken at facility and community levels focusing on person-oriented case management and adherence support through nurse-led project and community-based interventions. GSM project introduced in PEPFAR supported SNU in Kazakhstan has demonstrated its effectiveness. We achieved a constant increase in viral load testing coverage and viral load suppression rates over the quarters in two SNUs.

PEPFAR Kazakhstan will continue efforts on adherence support through person-centered management by generating age, gender and behavior specific messages for counselling and adherence support along with scale up of 6 months ARV dispensations. In ROP22, PEPFAR Kazakhstan will continue ongoing activities with special focus on quality and sustainability of viral load testing including supply chain for VL testing and centralized procurement of VL tests.

The cycle of Interruption and return to ART over the quarters differs depending on gender in **Kyrgyz Republic**. In the graph below (green bars) interruptions are higher in men comparing to women. This difference is presumed to be related to more risky behavior among men.

PEPFAR closely works with sites to improve transfer procedures and tracking, which include active follow-up calls and visits within one week of miss contact; close collaboration between nurses and peers.



Continuous and significant efforts are undertaken at facility and community levels focusing on the person-centered case management and adherence support through nurse-led project and community-based interventions. The Granular Site Management (GSM) project introduced in PEPFAR supported SNUs in Kyrgyz Republic demonstrated its effectiveness. The program achieved constant increase in viral load testing coverage and viral load suppression rates over the quarters, on the level of 98% and 95%, respectively.

In ROP 22, hospitals country wide in Kyrgyz Republic will incorporate HIV RT for patients who falls for indications to be tested for HIV. Thus, the time between 1st test and confirmation will be decreased and procedures will be developed to address, improve linkage to treatment and decrease treatment interruption since diagnosis confirmation. PEPFAR will continue efforts on adherence support through person-oriented management, generating age, gender and behavior specifics messages for counselling and adherence support along with scale up of 6 months ARV dispensations and GSM focus on underperforming sites in Kyrgyz Republic.

In 2021, **Laos** transitioned from centralized HIV testing in 11 provincial and district ART sites and 4 new point-of-care ART sites, causing VL testing interruptions. Prior to FY21, VL testing coverage in Laos remained over 89%. In Q4 2021, PEPFAR implemented intensive QI activities in collaboration with multidisciplinary teams to verify VL appointments, which resulted in an increase in VL testing coverage. Unfortunately, VL coverage decreased in Q1 of 2022 due to the ongoing COVID-19 pandemic travel restrictions and workload. In ROP22, the program will increase QI activity at the expanded POC ART sites as well as provincial ART hospitals to ensure VL testing completeness. Laos will collaborate with the national center of laboratory and Epidemiology (NCLE) to expand and increase access to VL testing using available GeneXpert machines for TB/Covid-19 testing for VL testing in all provinces and at ART and POC ART sites. The program will continue to support the “VLAOS” electronic based platform that sends VL results and creates instant reminder lists of patients who miss annual VL testing to increase VL testing coverage. Enhanced adherence monitoring and supervision by the “Community Based Supporters” will help ensure KP clients receive timely VL testing and continue the home delivery of ARV to KP started due to COVID-19 restrictions. The program will also

intensify U=U messaging to prevent Interruption to Treatment (IIT) in ROP22.

In Laos, one challenge to ensuring ART continuity is addressing the gaps in linkage to treatment from VCT to ART sites. In 2021, only 79% of HIV positive clients from VCT sites were registered in DHIS2-ART-Tracker systems based on patient matching analysis. Gaps in DHIS2 data quality also affected the low linkage such as the case when patient IDs were not matched properly due to incomplete and incorrect format of ART ID entered in DHIS2-VCT System, and when the patient records of the PLHIVs who were supposed to be linked from VCT were missing. To close this gap, in ROP22, PEPFAR Laos will support strengthening the referral flow and improve data quality from VCT to ART sites by establishing the Standard of Procedure (SOP) for data quality improvement and assurance. The program will promote QI and coaching at VCT, ART and POC ART sites. The program will also improve linkage to treatment by increasing the same day initiation of ART, which has increased from 5% in 2017 to 28% in 2021; in FY22 Q1, 64% of newly diagnosed PLHIV received ART within 7 days. In ROP22, the program will continue to support the government's expansion of POC ART sites for ART initiation to bring the treatment close to the clients and of the peer health educators to facilitate the linkage. The expansion of POC ART sites will be essential to ensure the better linkage to treatment and treatment continuity. Through the POC expansion, about 100 POC staff were trained in the PEPFAR-supported capacity building on provision of care and treatment services. POC will also facilitate ART refill in provincial residence and reduce transportation time. PEPFAR Laos will also advocate with the MOH and CHAS to explore options towards decentralized distribution of ARV (and PrEP for KP) and intensify accompaniment and adherence services to the unsuppressed and newly initiated KP living with HIV.

In Laos, the Center for HIV and AIDS (CHAS) works with ART facilities, CSOs and PLHIV peers to routinely conduct CQI activities to reduce interruption in treatment by tracking and tracing those who missed ART appointments and interrupted treatment. Although MER data showed that the majority of IIT cases did not return to treatment, the IIT "Track & Trace" activities conducted by CHAS and PEPFAR since Q1 FY21 demonstrated a significant reduction in IIT. During FY21, PEPFAR Laos worked with CHAS to develop IIT case lists for 7 ART sites in 5 provinces and conducted a quarterly virtual QI meeting. In Q1/FY22, missed ART appointments were 11.9% overall, with IIT results ranging from 6.5% at Friendship and Setthathirat Hospitals to 32.5% at Mahosod. IIT results were high at Luang Namtha (18.8%) and Mahosod (32.5%). After Track & Trace, we identified data entry delays as the main factor for missed ART/IIT, IIT declined to 0.95% in Mahosod and 5.4% in Luang Namtha site. Overall IIT in PEPFAR-supported sites after tracking reduced to 1.8%. In Laos, the MPR of TLD transition is high at 92% of PLHIV receiving TLD regimen as of Q1, 2022 and Multi Month Dispensing at 87% of PLHIV receiving more than 3 months of MMD, including 5% receiving 6 months MMD. The coverage of 3 months MMD was not different across age, gender, or population groups (KP vs general population PLHIV). In ROP 22, QI coaching will be conducted to sites with low coverage of 3 months MMD. PEPFAR Laos will continue working with the government and

stakeholders on supply management of ART to support the extension to MMD to 5-6 months.

In **Nepal**, enrollment of PLHIV into the national ART program, ensuring their treatment continuity and achievement of sustained VL suppression remain the major focus of PEPFAR/Nepal. In ROP22, PEPFAR/Nepal plans to support 21,193 PLHIV on ART and achieve at least 95% VL suppression among them. To achieve these planned targets Nepal 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 person-centered differentiated service delivery models including MMD and ART dispensing in the KP friendly clinics; (4) set up appointment reminders to clients (via SMS messages and phone calls); (5) track interruption in treatment cases through phone calls, home visits, and peer and social networks to increase retention, return to treatment; (6) implement U=U messaging at health facility and community settings; (7) increase ART and VL literacy interventions; (8) conduct regular screening and service recipient segmentation based on adherence barrier and treatment interruption risks, and provide tailored risk reduction and treatment adherence supports; and 9) leverage CLM and SIMS findings and recommendations to identify treatment continuity barriers and inform mitigation interventions.

To address challenges of VL testing and suppression gaps, Nepal continues to optimize VL diagnostic networks and sample transportation systems as well as continuously identify barriers and timely address them. Use of data to inform progress and pivoting interventions will remain a priority; hence, regular use and updating of VL tracker to identify, monitor and conduct viral load testing of all eligible strengthened. Therefore, our interventions and strategies to address the barriers and achieve VL test coverage and suppression is depicted below.

Nepal ROP22 Strategies to Accelerate Viral Load Testing Coverage and to Address Bottlenecks to the Service Uptake			
Bottlenecks to VL testing uptake and coverage	VL literacy and demand creation	Sample collection and transport	VL testing and turnaround time
Limited VL literacy among service providers & PLHIV	Strengthen U=U messaging in community and clinical settings	Assign VL focal person, use VL tracking logbook at all ART sites	Support VL testing sites to increase efficiency of testing (workflow, human resources, training)
Failure to link VL sample collection with clinic visits	Community partners, peer counselors, case managers emphasize VL testing and VLS during peer group meetings	Link ART pick-up with VL sample collection	Ensure optimum operation of VL testing machines, reduce breakdowns
VL machine failures	Mentor/support ART clinicians to request timely VL testing	Leverage KP clinics and community outreach for VL mobilization and sample collection	Ensuring VL reagent availability
VL reagent stockouts	Monitor and support VL coverage at each ART site	Regularly map VL testing referral network, system and processes, and timely specimen transportation	Implement VL EQA program at all VL testing sites
VL data quality gaps due to incomplete documentation			
ART site failure to adhere to national standards on VL sample collection			

PEPFAR Philippines will prioritize strategies to maintain individuals on ART, promote adherence and decrease interruption in treatment. Strategies will include strengthened person-centered care, TLD expansion, and scale-up of differentiated service delivery approaches. PEPFAR will also promote return-to-care strategies for lost-to-follow-up PLHIV and support improved treatment adherence through case management. Support will be provided for the expansion of viral load testing access and coverage via point-of-care (POC) or near-POC testing platforms to PLHIV in all PEPFAR supported regions. Treatment interruption is one of the highest in the region, with 9 out of the 10 facilities with the greatest number of lost to follow-up cases in the National Capital Region (range: 66-935, FY22 Q1 MER data). When considering the proportion of total caseload however, public sector sites receiving TA support across the three highest burden regions saw the highest levels of treatment interruption. Differences across site type (DSD vs TA) in terms of age profile of the predominantly MSM-PLHIV cohort were noted. To improve linkage to treatment, PEPFAR will expand implementation of same-day and rapid ART initiation through rHIVda confirmatory testing expansion at the site level and support for ART baseline labs. PEPFAR will improve treatment continuity through expansion of differentiated ART delivery, expanded TLD transition and strengthened person-centered case management systems to address the holistic health concerns of clients, including gender-affirming care for trans women. Differentiated service delivery will occur through MMD expansion, the use of courier delivery services, such as Grab, and use of telehealth platforms.

Papua New Guinea will expand active case management and 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. PEPFAR PNG also will utilize evidence based IIT prevention and BTC strategies through 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. PEPFAR PNG will implement active case management which is currently part of the routine clinical service package. PEPFAR PNG will provide a comprehensive 180-day package to minimize risks of treatment interruption for those newly on treatment. PEPFAR PNG will implement early tracking and enhance facilities' ability to track and reconnect with clients to ensure they have ART and continue to be on treatment. DSDM will be utilized including mobile services, satellite sites, and other dispensing methods to ensure clients are able to access ART in the most convenient way possible. PEPFAR PNG will strategize contingency plans in case of COVID-19 related lockdowns, holiday seasons, and travel restrictions to ensure clients' ART access does not experience disruptions.

PEPFAR PNG will strengthen data collection and reporting for data utilization to track clients and ensure treatment continuity. PEPFAR PNG will increase the capacity and resources for peer educators, navigators, client patients, and healthcare workers to play critical roles in regular follow-up, making sure that clients are supported and retained in care through pre-visit

appointment reminders through phone calls, SMS messages, and home visits to ensure ART adherence, retention in care, and timely VL testing. To provide continued access to ARVs, PEPFAR-supported facilities will work closely with the Government of PNG (GoPNG) to innovate and scale quality, client-centered treatment options, including decentralized ART initiation and flexible-hour clinics for testing and ART services. PEPFAR PNG will continue to advocate and provide TA to ensure that larger bottles are procured, increasing dispensing efficiency and to also contribute towards treatment continuity by ensuring clients have more stock on hand.

For VL suppression, PEPFAR PNG will continue to strengthen implementation of point-of-care (POC)/near-POC VL testing, decentralization, optimization, and DBS collection and processing. PEPFAR PNG will continue to improve functionality of VLSM at CPHL to capture VL testing done outside of CPHL on GeneXpert platforms. PEPFAR PNG will continue focusing on activities that support PLHIV on ART and ensure ART beneficiaries achieve and maintain VL suppression. PEPFAR PNG will additionally support laboratory supply assessments and microplanning. PEPFAR PNG will collaborate with GF to support the DNO exercise to determine VL testing capacity for HIV for increased coverage. Access to VL testing and subsequent viral suppression will be improved through DNO activities, demand creation through U=U messaging, and enhanced adherence counseling. PEPFAR-supported sites will conduct CLM and assisted navigation aided by CSOs, and will emphasize results through U=U messaging and VL alerts.

PEPFAR PNG will provide TA and monitor HIV commodities including ARVs, testing and VL supplies. In ROP22, PEPFAR PNG will expand quarterly VL surge campaigns, as well as routine and mobile VL testing modalities to increase testing coverage for eligible PLHIV. PEPFAR PNG will provide TA to operationalize recommendations from the DNO exercise.

Tajikistan is moving toward full access to VL coverage as well as ensuring 95% VL suppression and 95% retention. PEPFAR Tajikistan provides TA to AIDS centers to make request to the GF funded HIV project to ensure sufficient amount of ARVs to better transition to more than 3 months MMD. PEPFAR Tajikistan will continue working on improved case-profiling of individuals who are unsuppressed and intensify index testing and referrals of the positive network members to treatment. In Tajikistan, male and female patients in age bands from 30 to 44 almost equally tend to drop off treatment but these groups has higher rate of interruption in treatment comparing to patients from age bands below 30 or above 44. In Tajikistan, males are almost two times more vulnerable to IIT comparing to females. Female patients were more likely to return to treatment comparing to male patients. To reduce the number of clients interrupting treatment, PEPFAR Tajikistan will continue implementing treatment education, facility and community-based case management, peer support, appointment reminders to clients (via SMS messages and phone calls) about upcoming scheduled drug refill date, tracking and tracing algorithm to return to treatment clients with missed visits, widened

eligibility criteria for MMD, site-specific mentoring to ensure HIV services are client and especially KP-centered, and will implement granular site management approach with focus on sites with highest IIT prevalence. Index testing will also be used to re-engage patients back to treatment. To enhance ART retention PEPFAR Tajikistan will continue implementing 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. Tajikistan peer educators, navigators, 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 using calls, SMS messages, and home visits to ensure ART adherence, retention in care, and timely VL testing. Tajikistan will be working with GF funded HIV project to ensure uninterrupted supply of VL reagents, including VL tests and universal access to VL testing. To further improve viral suppression, PEPFAR Tajikistan will promote demand creation with U=U messaging and will be supporting enhanced adherence counseling. For those who are not virally suppressed, robust adherence counseling and enhanced support strategies will be provided. PEPFAR will track VL results to ensure timely delivery and recording of results for all PLHIV on ART in all PEPFAR-supported sites.

PEPFAR India has excelled in peer linkage. The expansion of same day and rapid ART and will continue to strengthen linkage services with the feedback received through community led monitoring. We are focusing efforts to close gaps through proven, evidenced based strategies and person- centered care, demonstrated and scaled under the most extreme circumstances of COVID 19 to maintain the gains. Using granular data and CQI for impact, PEPFAR India has been focusing on decreasing interruption in treatment across all age bands and genders. We will continue to expand person-centered care with MMD, decentralized community-based ART, welcome back drives, community art refill groups for families and children, community literacy campaigns, and improved data tracking and monitoring and evaluation. In ROP21, PEPFAR India demonstrated several KP community-led models for integrated programs, including transgender clinics across three different states, integrated care strategies for people who use drugs with a special focus on young people. In coordination with the GOI, PEPFAR India will continue to expand integrated strategies to increase sustainability, health access and equity through efficient integrated programming and further decrease barriers to care. This goal is in alignment with the GOI goals of expanding one-stop centers. PEPFAR India will continue to support the national government on the rapid roll out of DTG based regimens, which is currently at 85% nationally. PEPFAR India has worked closely with the GOI to rapidly expand viral load coverage and to strengthen the viral load laboratory network by establishing a robust sample referral and linkages and diagnostic network optimization. PEPFAR India has worked with communities to increase viral load demand generation and will continue to expand VL coverage both at the facility, including through the expansion of DBS to ensure coverage of all geographies and the efficient use of other point-of-care platforms. In this regard, PEPFAR India

will continue to expand access community-based testing through hub and spoke strategies and other decentralized strategies.

In ROP22, **PEPFAR Thailand** will explore innovative models to maximize existing telehealth strategies to support ART retention and enhance the PEPFAR treatment package at all PEPFAR-supported sites. PEPFAR Thailand will collaborate with the Department of AIDS and STI (DAS), Bureau of Epidemiology (BOE), MOPH, and NHSO to set up MMD and VLS data sharing between CBO and facility-based settings to promote retention to treatment, enhance VLC and VLS among KPs and improve CBO-facility linkages.

The proportion of PLHIV receiving 3-5 MMD and 6MMD were similar for both men and women (47% and 29% for women and 47% and 29% for men, respectively). Children 10-14 years had MMD 13-24 weeks but these numbers were small. 6MMD and MMD > 3 months increased, particularly during the COVID-19 lock down in the second half of FY21.

6MMD has been included in the HIV National Guidelines and the NHSO allows hospitals to dispense ART for a maximum period of 6 months. The social security scheme (SSS for employees) allows hospitals to dispense ART for a maximum period of 3-4 months. PEPFAR Thailand will work with the government to move more people from 3-5 months (3-5MMD) to 6 or more months (6MMD). PEPFAR Thailand will support TLD transition for all PLHIV by June 2022 and ensure 3-6MMD can be maintained after TLD transition. Therefore, in ROP22, we will coordinate with health care facilities to prescribe for 3-5MMD. Moreover, we will work with partners in Thailand to support the TLD transition that will fully transition to all PLHIV around the end of FY2022 and to ensure 3-6MMD can be maintained after the TLD transition.

In ROP22, Thailand will promote enhanced adherence counseling, and treatment literacy around the U=U concept to PLHIV with unsuppressed viral load. We will promote mental health and substance abuse screening and refer eligible cases for proper management to reduce IIT. In addition, PEPFAR Thailand will implement differentiated service delivery 2.0 through integration of HIV treatment and NCD care to support aging cohort PLHIV and PLHIV with co-infections with TB/hepatitis and NCD, and reduce unnecessary visits for PLHIV by expanding telehealth support in PEPFAR-supported sites.

PEPFAR Thailand will expand peer navigator support for KP clients for treatment and promote retention and VLS through: case management, enhanced counseling, MMD, flexible scheduling for ART follows up, telehealth, automated appointments and reminders to improve VL coverage, immediate missed appointment tracing, community and PLHIV networks, treatment and viral load literacy, and U=U message promotion. Index testing will also be used to re-engage patients back to treatment.

While the VLS rates in FY2021 in PEPFAR-supported sites were high (>90%) among those who tested, data showed low VLS among young male and female groups. VL testing gaps remain a challenge in PEPFAR supported sites with a large proportion of VL testing gaps in 2

big cities: Bangkok and Chiang Mai. Factors associated with low VLC in big cities with many mobile workers may be partly due to the exchange among different health insurance schemes according to the working status and between public and private hospitals. The national HIV data may not capture all health insurance schemes. The majority of PLHIV are under the national universal coverage scheme (approx. 80%) with a small portion under other health insurance schemes. Other factors associated with decreasing viral load coverage during the past 2 years among working age groups may be due to the MMD and ARV postal delivery policies to minimize hospital visits during the COVID-19 pandemic. Hence, some PLHIV did not come to ART clinic for blood testing including VL testing. Moreover, at least one PEPFAR-supported hospital paused viral load lab testing for a few months to prioritize only COVID-19 testing during the COVID-19 pandemic. Some health care workers were shifted to work on COVID activities.

PEPFAR Thailand interventions will focus on: promotion of digital health applications to assist health care workers and clients to manage VL appointments and reminders; promotion of adolescent health services for adolescents living with HIV in order to receive appropriate services per their unique needs; scale-up one-stop VL service for KPs at community-based sites and integrate community-based VL services to promote community-facility VL linkage and collaboration to fill the gap of VLC; and implementation of the national VL strategic plan to improve the quality of VL service.

To facilitate eligible KP clients for VL testing to monitor their health outcomes, community-based VL testing through GeneXpert at 5 KPLHS sites in 3 provinces will be implemented to enhance the VL testing coverage in PEPFAR supported provinces and advocate for community-based VL testing reimbursement.

4.3 Prevention, specifically detailing programs for priority programming

[REDACTED] Burma has shifted to investing in CSO and KP-led differentiated HIV service delivery at clinic and community distribution points, as well as CLM in collaboration with local groups and UNAIDS. Burma will expand PrEP to all KP in additional regions in high-burden Kachin and Mandalay. The program will strengthen enhanced outreach approaches and refine its HIV testing strategy to focus on high-yield modalities that reach deep into KP communities through social network testing to access hidden KP, partners of KP and first-time testers with HIVST through secondary and peer-led distribution. In close coordination with Myanmar's Drug Users network, Burma continues to innovate in Harm Reduction (HR) services, introducing women-only HR services, community-based Buprenorphine, and expanded needle and syringe programs that include distribution through peers, clinics, and private pharmacies.

PEPFAR TA will ensure operationalization of differentiated care for MAT, [REDACTED] scaling up take-home dosing for Methadone; strengthening MAT/ART linkages with the expansion of the Drug Treatment Information System (DTIS); community-based overdose management; and empowering PWID peer networks to lead KP-competent service delivery for standard harm reduction services. To meet the needs to incorporate KP friendly, violence-informed HIV service delivery, PEPFAR will provide TA to NGOs and CSOs by facilitating LIVES training for service providers and supporting identification of violence and provision of first-line support through LIVES.

Cambodia has developed an SOP for PrEP delivery through community-based organizations. In ROP22, PEPFAR partners will work to initiate new CBO sites for PrEP delivery and implement injectable PrEP.

Nepal will prioritize scale up of access to HIV risk screening and counseling, provision of PrEP and PEP, stigma reduction, gender-based violence reduction, STI diagnosis and management, SBC (including digitized materials) for service demand generation, KP and PP peer engagement and counseling, use of a virtual platform (Merosathi) for online information, counseling, service referral, and ensuring access to condom and lubricants at all HIV service delivery points.

The program will build on its success of introducing and rapidly scaling PrEP implementation to make PrEP accessible to more KP and PP. Currently PrEP is available for FSW, MSW, MSM, and TG accessing services in PEPFAR-supported KP-friendly city clinics. Recent approval of the national PrEP SOP will help to scale up PrEP uptake and accessibility beyond the city clinics. To this end, the program will continue working with the national government and GF to expand access to PrEP to more KP and PP, including PWID and sero-discordant couples. PrEP literacy and adherence support will be strengthened to ensure PrEP continuity throughout periods during which clients are at high risk for HIV infection. PEPFAR will ensure availability of PrEP medicine in supported sites. HIV testing services, including screening and follow-up, will remain an integral part of PrEP services in accordance with national guidelines.

PEPFAR India is aligned with the GOI to expand evidence-based strategies to close the first 95 gap. Through the GOI's flagship targeted intervention program, HIV testing is incorporated into the national prevention program for KP; and training on index testing services has been rolled out across the targeted intervention (TI) programs. The program will continue to expand on this effort, reaching out to KP not currently registered in the TI program, and provide options for comprehensive prevention. PEPFAR will support the Government of India's flagship prevention strategy, Sampoorna Suraksha Centers, in which at-risk and high-risk HIV-negative people are offered prevention, testing, and other services through an integrated care model. The program will continue to expand integrated prevention and testing programs for KP, high-risk migrants, young people and adolescents, women (including informal sex workers), and people in the virtual space; and will continue to work with the GOI, GF partners, and communities on PrEP

scale-up.

PEPFAR India implements OVC interventions in 45 districts across the six states of Maharashtra, Telangana, Andhra Pradesh, Manipur, Mizoram and Nagaland. The priority populations for OVC_SERV are children living with HIV, adolescents living with HIV, their siblings, and single- and double-orphan children of PLHIV. In addition to delivering and strengthening HIV services, interventions will ensure linkage to general health services, access to social safety nets, education programs, linkage to violence against children and gender-based violence services, and nutritional support for OVC beneficiaries.

Index testing approaches at HIV testing centers and ART centers will be further enhanced for early identification of HIV-positive biological children of PLHIV. In addition, collaboration with GF PMTCT implementing partners will be strengthened to identify and register HIV-exposed infants. Enrollment of newly identified HIV-positive children into treatment services will be fast-tracked. Coordination between OVC and clinical and prevention IPs will be strengthened to facilitate index testing for biological children and siblings of PLHIV and C/ALHIV on ART, bi-directional referrals for enrollment of C/ALHIV into OVC services, as well as to enable tracking of viral load coverage and viral suppression among C/ALHIV in the OVC program.

For improving the ART adherence rates among ALHIV, adolescent-friendly health centers will be established to provide comprehensive and specialized services for ALHIV, which include age-appropriate disclosure support, treatment literacy, adherence counseling, and peer support groups.

PEPFAR India will accelerate and expand KP service packages with a focus on sustainability, quality and community led monitoring. Integrated programs include services across the HIV prevention to treatment cascade with expanded services and referrals through leveraging partnerships, including expansion of services for non-communicable diseases and the national viral hepatitis program. In ROP22, the program will continue to scale transgender clinics, integrated programs for PWID, MSM, SW, and programs for young people and adolescents. It will also continue to expand and coordinate with the private sector for services across the continuum. India will continue to assess the impact of KP-specific programming through CLM. As an example of an innovative strategy for outreach, PEPFAR and the GOI worked to reach remote communities through the 'health on bike strategy' in Nagaland, which will be scaled to reach other remote communities in hard-to-reach locations.

PEPFAR **Indonesia** is providing TA for policy development and capacity building of community and care providers of PrEP and HIV self-testing, as well as developing demand creation and community engagement for the use of innovative prevention, testing, and screening strategies. These efforts further support the development of the Prevention Roadmap under the

HIV National Action Plan. In addition, the program will implement a comprehensive HIV prevention package of peer-led prevention services using community-based supporters and peer volunteers. Outreach will focus on referring clients at risk to community-based testing, including HIVST, PrEP, and facility-based TB and HIV testing services.

PEPFAR Indonesia will continue to provide above-site support to the MOH and Provincial Health Office to rapidly scale PrEP in selected sites in Jakarta and Greater Jakarta, with resources provided through GF. Moreover, PEPFAR, through USG partners, will assist government counterparts in the strategic planning, effective implementation, and monitoring of PrEP interventions through the development of innovative tools to register PrEP clients and stock management of PrEP commodities.

PEPFAR **Kazakhstan** will continue scaling up KP programs, targeting MSM and PWID populations. These include investments in case-finding activities (index testing, recency, and SNS) and prevention of HIV acquisition among at-risk populations (PrEP). PrEP is a new initiative that has shown success in the country since implementation initiation in April 2021. The GOK aims to roll out PrEP to 2,690 people at risk, including KP, by 2025. As part of ROP22 implementation, PEPFAR will support the GOK PrEP scale-up with policy and site-level work at two SNUs through Friendly Clinics, training staff on PrEP coverage and continuation. GF TA will provide PrEP to MSM and TG in six regions, accelerating and expanding PrEP among high-risk groups. PEPFAR Kazakhstan will support community PrEP counseling and referral of clients to PrEP and focus on routine training and monitoring of PrEP implementation.

PEPFAR **Kyrgyz Republic** will continue to tailor and scale up KP programs, also targeting MSM and PWID populations. This includes investments in interventions that identify newly diagnosed (index testing, SNT, RNR) and prevention of HIV acquisition among at-risk populations (PrEP). In collaboration with the GF/UNDP, all people testing HIV-negative are referred to PrEP and other prevention programs supported by the GF in the country (condoms, lubricants, NSPs).

PEPFAR will strengthen strategies for comprehensive KP prevention, including scale up of MAT programs. The program will improve the quality of integrated KP models for single-window services where PWID will receive integrated MAT/ART/PrEP and HIV testing. One-Window approach services will serve as one-stop access points for “holistic health care,” providing a continuum of essential services including prevention, testing, linkage, treatment, and treatment continuity.

There is a steady decrease in the number of PWID on methadone, mainly due to high mortality among PWID with co-morbidities, low popularity of MAT among young PWID, and a shift to use of new psychoactive substances, especially among young people. However, adherence and retention to therapy among clients is high, especially among PWID/PLHIV. FY22Q1 results

demonstrated that 99 percent of PWID/PLHIV were on MAT/ART and viral suppression was 95 percent. Kyrgyz Republic continues dispensing methadone for several days. Due to the stabilization of the COVID-19 situation, more than 60 percent of clients received methadone for five days in Q1. The program will revise the eligibility criteria for take-away-dosages (TAD) of methadone to make the program more attractive to young PWID, and to remove formal registration requirements to enroll in the program. It will support revision of the clinical protocol on MAT, where the average therapeutic doses of methadone will be increased, and buprenorphine will be included; implement a communication strategy and demand creation for MAT; and support granular site management as a QI effort.

PEPFAR will significantly increase patient-centric PrEP as part of national expansion and considers community-based PrEP as a must to make this expansion possible. Testing for PrEP enrollment requires standard HTS to ensure HIV-negative status. Once enrolled in a PrEP program, clients will be tested every three months for HIV with an assay that meets WHO sensitivity requirements. PrEP expansion activities include: 1) PrEP integration into existing prevention and ART services (including MAT sites); 2) continued roll-out of PrEP, including DSD model implementation for PrEP delivery with dispensation at the community level; 3) implementation and integration of e-PrEP into the Electronic HIV/AIDS Case-Management System (EHCMS); 4) initiation of national discussions on injectable long-acting PrEP with special focus on PWID, and 5) implementation of a national PrEP training curriculum and plan as well as CBO and HCW trainings with close coordination and collaboration between facility and community providers. PEPFAR will address some of the existing barriers through above-site activities, such as CSO licensing and community health provider certification.

PEPFAR **Laos** focuses on reducing HIV transmission among MSM and TG persons and their sexual partners and improving and extending the lives of those living with HIV by strengthening the HIV prevention, care and treatment cascade among KP and their sexual partners to contribute towards the Laos Ministry of Health's (MOH)'s and UNAIDS 95-95-95 epidemic control goals. The program offers a comprehensive prevention package, including community-based prevention outreach – the Enhanced Peer Mobilizer (EPM) approach – to focus on behavioral change communication and distribution of condoms and lubricants, HIV testing including HIV self-testing using OraQuick, index testing, and PrEP for those tested negative. Prior to FY20, activities were focused in Vientiane Capital (VTC), Savannakhet Province (SVK) and Champasak Province (CPS) where national surveillance indicated a higher HIV prevalence. In FY20, with PEPFAR's shift in focus, the program consolidated and implemented in VTC only. However, from Q2 FY 21, implementation resumed in SVK and CPS provinces.

HIV self-testing is used as part of the EPM model and offered to all MSM and TG reached by the program. Self-test kits are an effective prevention tool as they encourage KP to stay negative by easily allowing them to confirm their status. HIV self-testing is used as an option for accessing HIV testing, and partners of newly identified positive clients are encouraged to know

their status and come for confirmatory testing if their test is found to be reactive. HIV self-testing is also a critical tool for increasing case finding in the community, especially for those less inclined to access facility-based HIV testing services due to fears of stigmatization and discrimination, and inconvenient hours of governmental facilities.

The Laos program will continue to scale up the HIV self-testing, particularly in VTC, taking into account COVID restrictions. Likewise, index testing will be also scaled up with an integrated HIV testing option for partners, and peer-to-peer virtual coaching will be provided by VTC's community-based supporters to improve uptake in SVK and CPS. PrEP was initiated in FY21 with national guideline development and launched in VTC in the second quarter, although the COVID-19 lockdown initially hindered implementation. PrEP uptake has been slow due to cultural barriers; and access to PrEP is limited in provincial hospitals. PrEP is now fully rolled out in the five ART sites in three KP-focused PEPFAR-supported provinces. During ROP22, Laos will focus on demand creation for PrEP by increasing confidence among CBS and healthcare workers at the health facilities for better communication and raising PrEP awareness among MSM and TG, targeting negative index clients. As PrEP medication is dependent on the GOL/GF's quantification of ARV drugs, PEPFAR will closely monitor the PrEP quantification and distribution planning process with the key stakeholders.

Papua New Guinea (PNG) supports a prevention package for those who test negative and for KPs and high-risk individuals, including motivational interviewing and education. In ROP22, PEPFAR PNG will support the roll-out of the new HIV Testing Guidelines, which will ensure increased quality of index testing in PEPFAR-supported facilities. The program will also provide TA to donors, government partners, and other stakeholders to ensure case finding strategies can be implemented with the highest ethical and confidentiality standards. The program will use HIV RTKs procured through the ARPA Emergency Commodity Fund to address decreased HIV testing in the NCD and to assist the NDoH and NCD PHA in roll-out of the three-test algorithm, index testing, and in ANC testing to prevent MTCT.

To reach saturation in the NCD and to support mothers and children, PEPFAR will strengthen HMIS and SI systems to monitor pediatric/CLHIV cases to improve decision-making and increase focused support from partners and the GoPNG. With very limited data for pediatric cases and MTCT, PNG estimates over 450 CLHIVs in the NCD, of which only 51 percent are estimated to be on treatment. With vertical transmission rates as high as 28 percent, only 63 percent of HIV-infected pregnant women are receiving ART. Facility-based births are low, with only 15 percent of pregnant women ever having an HIV test during ANC according to 2020 data; 52 percent of Papua New Guinean women have unsupervised deliveries. In ROP22, PEPFAR PNG will provide TA for improved EID. MTCT and treatment services will be a priority in PEPFAR SNUs as the country reaches saturation. PEPFAR PNG has provided TA to optimize pediatric ART treatment with the introduction of pDTG 10mg to ensure better treatment outcomes in ROP21, but the need for additional support at the above-site level and to

operationalize the guidelines remains in ROP22.

PEPFAR PNG will increase partnership with CSOs including the KP Advocacy Consortium to increase quality and coverage of KP-friendly index testing, using data and findings from previous index and KP-friendliness assessments in ROP22. PEPFAR will strengthen person-centered prevention services targeting KP in particular, through the piloted introduction of PrEP, risk reduction education and counseling, and condom promotion. At the facility level, PEPFAR PNG will provide KP sensitization training for the community to reduce stigma and discrimination against PLHIV and KPs, including those who experience GBV, and support demand creation for HIV services among KPs, including MSM, TG, and FSWs. GBV remains a major barrier to health services in PEPFAR PNG. An estimated 51 percent of Papua New Guinean women between the ages of 15 and 49 have faced intimate partner violence, one of the highest rates in the world (Lancet, 2022). According to the 2017 IBBS, 41 to 45 percent 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 ROP22, PEPFAR PNG increased its targets to provide increased services to victims of GBV and to strengthen referral networks of community organizations that support GBV survivors. With the official launch of the National Sexual and Gender-Based Violence (SGBV) Guidelines by the NDoH in ROP21, PEPFAR PNG will continue TA to PEPFAR-supported sites to implement the guidance with fidelity; and above-site support will ensure non-PEPFAR sites are able to adopt policies ensuring increased GBV service quality and coverage nationally.

The **Philippines** will continue to support demand creation campaigns for PrEP among MSM and other KP groups, building on the success of social media campaigns in ROP21. PEPFAR will maintain PrEP roll-out through support for community-led demand generation and differentiated PrEP service delivery. Following the inclusion of PrEP into the Philippines National Formulary in ROP21, PEPFAR, GF, and UNAIDS are currently advocating for the DOH to include sufficient funding for PrEP to cover 10,000 high-risk clients in their 2023 budget, based on national targets. Advocacy for scale-up and promotion to other high-risk individuals in addition to MSM will be implemented.

In ROP22, PEPFAR Tajikistan will continue supporting a system in which those providing prevention services will work hand in hand with HTS specialists. There will be continuous efforts to improve linkage from HIV testing to prevention and vice versa. In this synergic system, if individuals report risky behavior and tested negative, they will be linked to prevention services (PrEP, NSP, MAT, etc.) and for those with reactive screening tests to HIV confirmatory testing and afterwards to treatment. HIV testing will continue to remain an integral part of prevention activities. All the individuals covered by prevention services but reported risky behavior will receive HTS services (excluding known HIV positive). Those, known HIV positive, covered by prevention services and reported risky behavior will be offered Index testing

services to find their HIV positive contacts and link them to treatment or HIV negative contacts and link them to prevention services. In terms of PrEP, all the clients initiating PrEP, will be tested for HIV every three months to rapidly detect HIV seroconversion and ensure rapid ART initiation if client became HIV positive. The program will support Republican AIDS Centers to continue running seven Trust Points (TP) that provide needle exchange with targeted IEC, STIs and TB screening, diagnosis, prevention and treatment, condoms promotion, syringe distribution (with GF support for commodities), and referral to MAT, especially for HIV-positive PWID. To maximize case finding, the TPs will provide both VTC and PITC; actively offer HIV self-testing and index testing to clients; and offer PrEP to HIV negative clients with high-risk behavior. TP staff will provide active referral for HIV confirmatory testing throughout the whole HIV testing algorithm for those tested positive in TPs and link them to HIV care and treatment services.

The program will continue to support MAT, which includes funding for TA and program implementation to the Tajikistan Republican Narcology Center (RNC) to increase access and quality of MAT services to PWID at risk of or living with HIV. Key activities include strengthening and improving MAT services for PWID and PWID living with HIV. Support will also be provided to ensure strong coordination and linkage between MAT and HIV services being provided by the RNC and RAC, including expanding integrated HIV/MAT services for PWID.

In ROP22, **Thailand**'s HIV prevention programs will be focused on KP groups. Those clients who are HIV negative will be offered a prevention package depending on their HIV and STI risks. The prevention package at KPLHS sites include PEP services, STI prevention/treatment, condoms and lubricant, and HIV prevention education. For those testing positive for STIs, KPLHS will link clients to receive STI treatment at key health facility networks and advise clients to bring their networks for HIV testing and to maintain HIV negative status. Clients will retest for HIV and STIs every 3 months or at least twice a year. KP clients who have higher risks will be offered PrEP/PEP services following the PrEP/PEP protocol (health facility and community network model) provided in KPLHS sites.

The Royal Thai Government (RTG) is committed to scaling up PrEP uptake. PEPFAR Thailand was successful in advocating to integrate PrEP services into the Universal Health coverage scheme. PEPFAR Thailand also provided TA to build capacity for facility-based settings to build a strong, sustainable foundation for PrEP services. While introducing the country to the implementation of more effective PrEP service models such as Same Day PrEP, PrEP CBO-facility partnership models, PEPFAR Thailand intensified the utilization of targeted social media and online platforms to reach and recruit potential new PrEP clients, TGW in particular, transgender sex workers, male sex workers, female sex workers and, young KPs. In addition, Thailand promoted the PrEP Xpress services to those current PrEP clients who came to KPLHS for PrEP refill to facilitate easy access for returning PrEP clients. Moreover, PEPFAR Thailand will continue to work closely with the Thai government to strengthen and sustain the gain from

KPLHS and facility-based PrEP services through capacity building, sustaining PrEP facility CBO partnership models, and attention to PrEP services for youth groups with a focus on differentiated service delivery outlined in the updated 2021 national PrEP guidelines.

KPLHS sites have worked closely with the Department of Social Development and Welfare and the Ministry of Social Development and Human Security on the prevention of gender-based violence and sexual violence in KPs, in particular, MSM/MSW, TG/TGSW and youth among 15-24 years old. Community health workers under PEPFAR supported KPLHS sites were trained to investigate gender-based violence, intimate partner violence and have SOPs and protocols to follow when working with KP clients. CHWs will transfer clients to receive care and support under the protocol from the Department of Social Development and Welfare.

PEPFAR Thailand will continue to transition site-level index training support to above site support at PEPFAR-supported provinces and continue to provide capacity building support to GF sites at the above site level. All site and above-site level index testing services - including GF sites - will report results to the national database. In ROP22, PEPFAR Thailand will continue to work closely with the MOPH and the NHSO to promote monitoring of index testing as part of routine data monitoring. PEPFAR Thailand will continue to improve quality of index testing services, address low acceptance rate, build supportive supervision into QI routines, and improve data quality (deduplication of offered clients). HIV negative partners identified through index partner testing will be promptly offered PrEP especially if index client is not virally suppressed. Disclosure counseling is available as an option for index clients to facilitate partner testing. HIV self-testing and reaching partners and networks through SNS will be integrated as an option for partner testing.

In Thailand, recency surveillance implementation is ongoing. In ROP22, PEPFAR Thailand will continue to support the implementation of the recency surveillance system at a reduced scale due to budget limitations, monitor RTRI uptake, analyze recent infection trends, identify geographic areas where ongoing transmission is occurring, and promote data use for public health program response in those geographic areas.

PEPFAR Thailand will support proven-effective reach and recruitment of young KPs (15-24 years old) through above site TA including capacity building on the use of online platforms and/or SNS strategy, non-invasive HIV testing such as HIV self-test or HIV/syphilis test kits, youth-friendly services including telehealth options, or home delivery options.

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

The Planning Level Letter (PLL) for ROP22 provided strategic and programmatic priorities for the ARP countries based on successes and challenges met in ROP21 in achieving the minimum program requirements. The following narrative describes the additional country-level strategies

included in the PEPFAR programs in Burma, Indonesia, Kazakhstan, Kyrgyz Republic, Philippines, Papua New Guinea, Tajikistan and Thailand. Cambodia, Laos, Nepal did not list addition country priorities.

BURMA

In ROP22, **Burma** will prioritize ensuring continuity of treatment and maintaining progress toward epidemic control during the humanitarian crisis. PEPFAR Burma will continue to innovate and adjust program delivery and technical assistance to ensure differentiated care such as expanding index testing and introducing self-testing, expanding PrEP through community-based distribution points, and increasing viral load coverage, particularly in remote areas. The program will strengthen CSO and private sector capacity and develop a comprehensive capacity building framework for community system strengthening by working together with technical partners and key donors to build capacity of and empower KP and community networks and self-help groups, enabling them to deliver sustainable, community-led critical HIV responses. Coordination with key stakeholders is critical for continuity of HIV commodity supply and Strategic Information, and PEPFAR Burma will continue supporting the HIV Interim Coordination Mechanism (ICM) by leading relevant thematic working groups and exploring approaches to update HIV estimates, epidemiological data and by supporting routine program data collection to monitor HIV responses at the national level.

INDIA

PEPFAR India, in partnership with the GOI and community partners, excelled in maintaining the gains during through the COVID waves and will continue to scale and implement innovative identified solutions in differentiated case finding strategies, strategies to decrease treatment interruption through expansion of person-centered approaches to treatment. PEPFAR India will continue to focus on differentiated testing strategies including the scale up ethical index testing, social network strategy, and the expansion of HIV self testing. The program, in alignment with the national strategy will continue to innovate around person-centric prevention, utilizing a combination of physical, virtual, behavioral and biomedical prevention tools, including the scale up of PrEP. India will also continue to utilize findings from diagnostic network optimization to expand viral coverage.

PEPFAR India will work with the GOI on community led monitoring initiatives which has been ongoing in ROP21 and will continue in ROP22. PEPFAR India will continue to work closely with the GOI to assess gaps and solutions, leveraging newly released state and district estimates, to support the scale up of person-centered programming and optimal points of intervention.

INDONESIA

PEPFAR **Indonesia** will continue improving Strategic Information at the national and sub-national levels to analyze site-level data to better monitor, identify, and trace those who have missed appointments and who experience interruptions in treatment. This additional focus will strengthen treatment coordination with relevant multi-stakeholders at the national and sub-national levels in PEPFAR priority sites to improve reporting and analysis of TLD and MMD implementation progress in PEPFAR supported sites. Building on the concerted efforts of the program's partners, Indonesia will continue to advocate for policy changes following WHO recommendations to use TLD/DTG regimens as the preferred first-line and second-line treatment for all PLHIV, including pregnant women and those of childbearing age. PEPFAR Indonesia will also actively advocate for rapid phasing out of nevirapine formulations through recommendations of optimal ARV regimens in the national treatment guidelines, removing nevirapine formulations from the national quantification and discouraging the procurement of nevirapine through market analysis for price and supply bottlenecks. Furthermore, building on progress in ROP21, PEPFAR Indonesia will continue incorporating advanced HIV/AIDS disease (AHD) management approaches aligned with WHO guidelines. The program has developed and operationalized management guidelines, SOPs, job aids, AHD recording and reporting tools, and CD4 specimen transporters to move CD4 samples to referral laboratories to initiate AHD programming at facilities in Jakarta. Based on preliminary data in FY21 Q4, one-third of newly enrolled PLHIV in 109 HFs in Jakarta had a baseline CD4 test and almost 50% of those tested showed CD4 levels of <200. Overall, 27% of newly enrolled PLHIV in Jakarta displayed AHD, with hospitals serving 42% of AHD patients among newly enrolled PLHIV.

PEPFAR Indonesia will also implement interventions for individuals with AHD to reduce morbidity and mortality at high burden hospitals in Jakarta and Greater Jakarta. These interventions will include (1) rapid initiation of ART; (2) co-trimoxazole prophylaxis; (3) screening for active TB disease and prompt initiation of anti-TB treatment or TB preventive therapy as indicated. The program will closely collaborate to ensure adequate supplies of CD4 test kits, co-trimoxazole for opportunistic infection (OI) prophylaxis, and cryptococcosis preventive treatment commodities. PEPFAR will continue to provide strategic TA on forecasting and supply planning to MOH and mentorship on monitoring stock availability at health facilities in Jakarta Province. In addition, PEPFAR partners will support improving recording and reporting data for AHD for laboratory commodities and fluconazole in National System Information for HIV/AIDS.

KAZAKHSTAN

PEPFAR Kazakhstan will focus on implementing with fidelity to improve linkage, test and start and reduce interruptions in treatment. PEPFAR Kazakhstan will push to revise the HIV testing algorithm and clinical protocol to reduce the time from diagnosis to treatment and improve the linkage to treatment; improve PLHIV consultation concerns; conduct training to address clinical staff concerns; promote U=U messages; provide cognitive behavioral therapy to clients with

substance abuse; and, adjust community case management for those clients.

PEPFAR Kazakhstan will also accelerate and expand recently introduced PrEP program nationwide. In ROP22, PEPFAR Kazakhstan aims increase patient-centric PrEP coverage for the highest risk KPs through continued demand creation and capacity building of providers, provision of intensive training and mentoring to clinical staff to improve provider's understanding of PrEP and the quality of patient counseling; promotion of community-based PrEP through CSO licensing and certification and ensuring the quality of patient-client counseling at community setting, and data quality assessments. Self-testing negative clients will continue being referred to PrEP. Other strategies will include:

- **Optimization of ART (TLD & DTG-based treatment), pooled procurement.** TLD will be introduced in Kazakhstan in 2023.
- **Strengthening adherence counseling, treatment & VL literacy to achieve VLS.** PEPFAR Kazakhstan will continue ongoing activities with special focus on quality and sustainability of viral load testing including supply chain for VL testing and centralized procurement of VL tests.
- **Development and implementation of regulatory documents to introduce HIV recency testing into routine practice.** Recency surveillance has been designed and approved with implementation expected in late FY22 and continuing beyond via the routine HIV counseling and testing program.

KYRGYZSTAN

In Kyrgyzstan, PEPFAR will focus on the regional technical directive to scale up micro-targeted PrEP, accelerate PrEP services (such as online roll-out), and expand on TA activities. In ROP22, Kyrgyz Republic also aims to increase patient-centric PrEP coverage to 60% of the highest risk KPs as per the 2021 BBS (MSM, PWID, TG) through: continued demand creation and capacity building of providers, provision of intensive training and mentoring to for Family Medical Center staff (including family physicians, infectious diseases and STI specialists) to improve providers' understanding of PrEP and the quality of patient counseling; promotion of community-based PrEP through CSO licensing and certification and ensuring quality patient-client counseling in the community setting; support rollout of e-PrEP register and software improvement; and, regular data quality assessments. Self-testing negative clients will continue being referred to PrEP.

The program will also prioritize case finding by aligning and advancing testing policies and approaches with WHO guidelines while continuing to refine methods to increase the success of index testing (including ensuring safe and ethical testing) and self-testing. The case finding strategy for ROP22 aims to maintain a diverse case-finding portfolio based on identified innovations and gaps and highlights further scaling up of community-based modalities to reach those most at risk and leveraging self-testing as a screening tool for improved case finding

(referral to prevention/PrEP).

PEPFAR will expand appropriate testing modalities including HIV self-testing among most-at-risk populations, NSP program, mobile testing points, and CBOs. PEPFAR Kyrgyz Republic will support integration of ST with key prevention services, e.g., PrEP and provide support “return to care” among those diagnosed previously. In ROP22, Kyrgyz Republic will continue expanding self-testing through various offline channels and will continue utilizing online platforms for tailored messaging to increase demand for HIVST among different populations, using the HIVST demand generation strategy. Kyrgyz Republic team plans to add distribution of self-test through vending machines and provide online self-test give-away service at Bishkek AIDS Center targeting KPs.

For Index Testing, the program plans to strengthen and expand safe and ethical index testing with fidelity and focus to more targeted index partner testing on PLHIV who are not on ART, those who are on ART but are not virally suppressed, and those newly diagnosed with HIV. PEPFAR will continue to actively promote the online self-elicitation and partner notification approaches and will add RNR to complement index testing. Finally, the PEPFAR Kyrgyz Republic program will continue to ensure that these three categories of PLHIV are prioritized and offered confidential, voluntary, index partner testing in full compliance with WHO's Self-Testing and Partner Notification and PEPFAR Guidelines. Kyrgyz Republic will also continue to actively promote the online self-elicitation and partner notification approaches.

The Kyrgyz Republic's protocol on Testing for Recent Infection (TRI) for surveillance was developed by the PEPFAR team and approved by CDC HQ. In 2021, a bio-behavioral survey (BBS) among PWID and MSM was implemented with PEPFAR support and rapid test for recent infection (RTRI) was included into bio-part of the survey, demonstrating the test's feasibility as a routine aspect of the National HIV Testing Algorithm. Kyrgyz Republic is planning to implement test for recent infection (TRI) and the recent infection treatment algorithm (RITA) into the national HIV testing algorithm with technical support from PEPFAR; the approved protocol presents the framework for routinization of TRI and RITA to allow public health officials and providers to trace active HIV transmission networks and target prevention strategies, allocate resources appropriately, and inform advocacy efforts according to the observed clusters of recent infections.

Treatment: Promote the maximal implementation of test and start at a national level, including by addressing barriers to timely linkage and initiation of ART. Continue to support efforts at SDART, while refining case management and systems of client segmentation for treatment continuity, including expanding targeted support for those KPs falling out of care. Given the loss in clients diagnosed but not yet started on ART, each country should document and address the key barriers to rapid / same-day initiation of ART. All countries should track the time to initiation of ART data for all clients and develop interventions to improve uptake of same-day/rapid ART.

Same-day initiation of ART scaled up nationwide in Kyrgyz Republic. Linkage to treatment is significantly improved with median time -- 3 days after diagnosis. PEPFAR Kyrgyz Republic will continue motivating health care providers to ensure prompt initiation of ART in all PLHIV soon after diagnosis. In ROP22, PEPFAR Kyrgyz Republic will support HIV RT utilization in hospital settings to decrease time from 1st test and HIV confirmation and accelerate ART initiation during the in-patient treatment; implement U=U campaign and CB-ART nationwide; underperforming sites will be a subject for GSM review and support.

Multi-month dispensing: Increase MMD in low-coverage countries and begin transitioning clients from 3 to 6MMD in countries with high 3MMD coverage that permit 6MMD by ensuring sufficient stock of ARVs at national and site level, conducting routine monitoring to prevent stockouts, training providers on MMD guidelines, establishing MMD focal person at the facility to review patient files and identify clients not yet on 3 or 6 MMD, and improving treatment literacy among clients/create demand for MMD. In countries where the policy does not permit 6MMD, continue to engage MOHs to adopt 6MMD policy in national TX guidelines.

Kyrgyz Republic has been implementing its-National TLD Transition plan since 2018 along with 3 months MMD as routine. Currently, national coverage with TLD is 83% with the in with relatively higher TLD coverage in the PEPFAR supported sites. VLS among these clients is 95%. In Kyrgyz Republic MMD ART gradually continued expansion with the most proportion of 3-5 MMD up to 60%. In COP 22 PEPFAR Kyrgyz Republic will support scale up 6 MMD through supply-chain management and forecasting to ensure at least 6-month supply of drugs in ROP22.

- Support laboratory accreditation and quality management systems for all HIV and HIV related laboratory testing
- Expand HIV self-testing among most-at-risk populations, and continue to refine testing modalities to improve case finding
- Expand community distribution and management of ART
- Increase patient-centric PrEP coverage/Community PrEP

PHILIPPINES

In ROP22, PEPFAR Philippines will work with multilateral partners including the Global Fund to provide technical assistance to strengthen logistics mechanisms to prevent stock outs of critical commodities including TLD, viral load cartridges and PrEP. PEPFAR will build on the adoption of TLD, Dolutegravir, and PrEP into the national formulary and advocate for a more aggressive transition to domestic (I.e., national and local government) procurement. Support will also be provided to address procurement and supply chain bottlenecks. Furthermore, the program has prioritized the institutionalization of data-driven case management and continuous quality improvement (CQI) to include community-led services through public and community-led monitoring systems. In support of the National Quality Improvement Plan, PEPFAR will support

virtual learning and peer partnerships of service providers, focusing on case management and advanced HIV disease. Technical assistance will be provided to current QI coaches to integrate data into QI activities and documentation of QI activities, complementing the existing QI structures. As stated in Section 2.7, the QIS+D Network will expand to include community-based providers. Further technical assistance will include stigma data from community-led monitoring into QI plans.

PAPUA NEW GUINEA

As one of the countries with increasing new infections or mortality in the PLL, Papua New Guinea (PNG), priorities for PNG in ROP22 include:

- Strengthening implementation of index testing as well as Social Network Testing (SNS) with peer-driven case finding approaches for KPs.
- Refining KP prevention packages (including PrEP) to help identify KPs confidentially at different service and outreach points.
- Increasing collaboration with private providers to strengthen referrals, ART dispensing, and reporting and support CSOs in institutional strengthening. The program will work to reduce interruptions in treatment through DSD models including active case management and MMD, as well as reducing mortality through services such as the TB package of care.
- Support to and advocacy for implementation and operationalization of findings and recommendations from the DNO exercise to optimize HIV VL testing coverage, such as increasing utilization and functionality of GeneXpert Network, addressing demand creation, and sample referral linkages with a formal plan to finalize and monitor the sample referral network; and,
- Continued strengthening of the national QI Framework in the National Capital District (NCD) and increase TA for procurement and quantification exercises to mitigate stock-outs and to ensure continuous commodity coverage in the NCD and nationally.

TAJIKISTAN

In ROP22, PEPFAR Tajikistan will support advocacy and expansion of PrEP coverage among KPs and other populations with a substantial risk in all PEPFAR sites. Tajikistan will identify solutions to address the gap in the first of UNAIDS' 95-95-95 targets (in which the first 95 aims to have 95% of those living with HIV know their status) by:

- Considering self-testing expansion particularly among marginalized, high-risk key populations utilizing effective distribution streams e.g. Trust-Points, pharmacies, on-line, health-care facilities, etc;

- Integrating self-testing with key prevention services, such as PrEP; further develop and refine targeted, impactful case-finding strategies, including index testing and social network testing;
- Enhancing ART initiation, retention, and adherence through strengthened peer navigator and community-based linkage and adherence approaches; and,
- Prioritizing sites with low VLC &/or high % of patients that need to achieve VLS for clinical mentoring.

THAILAND

In the area of prevention, PrEP uptake is still well below the national target. PEPFAR Thailand will continue to support the national PrEP expansion model and scale up daily and event-driven community-based PrEP methods. Thailand will advocate to update national PrEP guidelines to include new options, such as cabotegravir long-acting (CAB - LA), and continue to introduce innovative approaches to achieve the national PrEP targets.

Within case-finding, highly targeted index partner testing has been expanded to all PEPFAR sites, but there are still gaps in service (for example, low uptake of service and low partner acceptance). PEPFAR Thailand will support an innovative case finding model that maximizes the impact of index partner testing, recency, social network strategy, and expands partnerships for HIV self-testing.

There are still gaps in the 2nd 95. PEPFAR Thailand will expand the PEPFAR treatment intervention package to improve ART coverage, SDART, MMD, enhanced adherence counselling (EAC), TLD transition, and reduce IIT, and stigma and discrimination in healthcare settings. We will enhance MMD data sharing between CBO and facility-based settings, maximize telehealth strategies, and explore innovative models to integrate HIV with other co-infections.

Under viral load suppression, PEPFAR Thailand will support the implementation of the national VL strategic plan to improve quality of VL services, promote using digital health application to manage appointments and VL reminders to facilitate health care staff and clients, expand community-based VL testing, and advocate for community-based VL testing reimbursement.

PEPFAR Thailand also wants to ensure consideration of the 10:10:10 targets. PEPFAR Thailand will advocate for non-criminalization policies for KPs and inclusion of the TG health package in universal health coverage. Thailand will also continue to support the KPLHS model to increase HIV friendly one-stop service coverage for KPs in other geographical non- PEPFAR provinces.

Sustainability of KPLHS has increased in urgency in light of the decline in PEPFAR Thailand resources. Recognizing the importance of KPLHS community sites to ending AIDS in Thailand, during ROP22 discussions, stakeholders outlined a path forward with NHSO to increase domestic financing for KPLHS sites. OGAC provided additional one-time funds (\$260,000) to try to support maintaining all PEPFAR-supported KPLHS sites as they plan a transition to increased domestic financing.

4.5 Additional Program Priorities

Policy and guideline changes have the potential for broad impact on HIV programs, services, and systems. This section describes related changes and their intended impact, as well as referencing applicable MPRs. Nepal and Laos do not report additional program priorities at this time.

BURMA

[REDACTED] PEPFAR Burma is working closely with the Interim Coordinating Mechanism to implement the Interim HIV Action Plan with all key stakeholders and community and technical partners.

CAMBODIA

In COP22, **Cambodia** will work with WHO to pre-qualify recency assay tests, with GF to ensure availability of recency assay test kits, and the host government to institutionalize recency testing into the national HIV surveillance system.

INDIA

In **India**, MMD for children has been adopted as national policy. And, person- centric differentiated packages adopted as national policy. PrEP was approved with the release of the guidelines by GOI. The ART operational and technical guidelines were released which provide updated, broad guidance including on different person-centered care strategies and treatment of HIV including rapid ART and advanced disease management. PEPFAR India will continue to support the implementation of the guidelines.

KAZAKHSTAN

In **Kazakhstan**, 2021 policy allowing for a buffer stock in each oblast to mitigate annual stockouts routinely experienced in Q1. Buffer stock will be in place in all oblasts starting in calendar year 2023. PEPFAR team and KSCDID worked closely to improve case finding and optimize ART regimes in Kazakhstan that would bring the country towards epidemic control. Specifically, HIV recency protocol has been developed and cleared by CDC to implement recency testing with the goal of routinizing it into the surveillance system. Generic DTG has been registered on October 28, 2021, and TLD in December 06, 2021. The generic DTG has been purchased and available for PLHIV in 2022. KSCDID plans to provide DTG-based ART to 7,000 PLHIV (48% increase) in 2022. TLD will be purchased in 2023 as there is a lengthy procedure of including TLD into the National Formulary, list of outpatient medicines, etc.

KYRGYZ REPUBLIC

Kyrgyz Republic will aim to remove policy barriers (e.g., formal registration requirement) to improve update of MAT while recognizing the worsening policy environment targeting NGOs and KPs. In March 2022, the **Kyrgyz** MOH approved updated National HIV Clinical Protocols on Prevention and Treatment. Implementation will take place in April 2022 after series of online and offline trainings for medical staff (doctors and nurses) and dissemination of hard and soft copies of approved protocols and SOPs. Algorithm on interactions between HCFs and NGOs is incorporated into the document and NGO staff will be trained accordingly. Implementation will be followed by close monitoring and granular analysis to address possible gaps.

PAPUA NEW GUINEA

Papua New Guinea continues to have a strong focus on providing above-site and policy support to the NCD PHA and NDoH. PNG is working to identify and assist national government financing policies to ensure sustainability of HIV commodities and programming. PNG continues its advocacy and guidelines development for PrEP and will support a PrEP feasibility assessment focused on KPs and high-risk pops. PEPFAR PNG is updating its VL testing strategy and operationalization based on DNO recommendations. Lastly, PEPFAR PNG will aim to optimize ART regimen for pediatric cases through DTG policy/guideline development. PEPFAR PNG contributed to the updates in the national Care & Treatment Guidelines, HIV Testing Guidelines, and the launching of the SGBV Guidelines. The Care and Treatment Guidelines were updated in November 2021 to include pediatric DTG 10mg. PEPFAR PNG will support the NDoH to roll out the guidelines into PEPFAR-supported sites in ROP22 and to support the MPRs. Updates include support for PrEP implementation through the PrEP Feasibility Assessment, increasing Test & Start and SDART, and strengthening DSDM including 6+MMD. PNG completed the TLD transition but gains are fragile. In ROP22, PEPFAR PNG will continue to monitor and provide TA to ensure there is adequate procurement and stock of ART. In ROP21, PEPFAR PNG also successfully advocated for the inclusion of 10mg pDTG to address pediatric/CLHIV cases and will monitor its procurement as well as improve the reporting and monitoring systems to ensure treatment initiation and continuation in ROP22.

PHILIPPINES

PEPFAR Philippines will aim to advance several policies in ROP22, including an effort to support policy changes to include task shifting towards community provision of PrEP. PEPFAR Philippines will also provide support to streamline the rHIVda accreditation process to facilitate more rapid expansion with clearer catchment areas and SDART scale up.

TAJIKISTAN

Tajikistan will aim to remove policy barriers for “Methadone Home Take dose”. Based on WHO Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring (July 2021), Tajikistan updated its HIV treatment guidelines. The changes made in

the Tajikistan HIV treatment guidelines had some positive implications for some MPRs scale up, including >95% linkage to treatment, transition to TLD, and MMD implementation. The new guidelines says that PLHIV with signs and symptoms suggesting TB, except for central nervous system disease (meningitis) can start ART while rapidly test for TB with close follow-up within seven days to initiate TB treatment if TB is confirmed. The new Tajikistan treatment guidelines now recommend DTG for pregnant and breastfeeding women and adolescent girls.

THAILAND

There were several national guidelines and protocols launched during ROP21 including:

1. October 2020: Thai national HIV treatment guidelines recommended TLD as preferred first-line regimen. TLD was registered in the national essential drug list in July 2021. Due to limited stock, NHSO and SSS has prioritized TLD to newly diagnosed PLHIV and pregnant women from January 2022 to May 2022. Full transition to cover all populations of PLHIV will start in June 2022. The government anticipated more than 80% TLD transition to eligible PLHIV in December 2022.
2. August 2021: Thailand MOPH Curriculum for HIV and STD Services in Community to provide a standards-based training needs for community workers to learn and practice. It is required for all community staff to achieve proficiency and competency as part of the CBO certification program
3. July-August 2021: Thai FDA approved two HIV self-test kits and developed self-test guidelines for both assisted and unassisted options for users to select according to preference. In ROP22, Thailand plans to implement self-testing in index testing modalities to increase the index partners' acceptance rates.
4. October 2021: Thailand PrEP guidelines endorsed and included all new WHO PrEP guidelines. The changes of PrEP guidelines could support scale up of PrEP_new and enhance same-day PrEP at KPLHS sites and reduce non-necessarily laboratory costs on kidney function tests.
5. October 2021: the “Thai national differentiated ART service delivery (DSD) guidelines” was published and recommended a variety of client-centered DSD services including MMD 6 following the 2017 Thai national HIV treatment guidelines recommendation for ART dispensing 3-6 months to stable PLHIV, fast track ART refill, ART delivery via post, decentralized ART delivery in health centers, telehealth, etc.
6. December 2021: MOPH disseminated the national SDART manual to all public hospitals in Thailand. The manual described benefits of SDART, examples of SDART flow, and experiences from hospitals and CBOs implementing SDART. MOPH also conducted SDART training to >300 HCWs in 4 regions to expand the concept of SDART to non-PEPFAR supported sites. In ROP22, PEPFAR Thailand will continue to increase coverage of SDART initiation in PEPFAR-supported sites. MOPH will conduct coaching at sites with late ART initiation including PLHIV presented with opportunistic infections (OIs) that are not contraindicated to delay ART initiation. IHRI and TRCARC have been

hubs to initiate SDART in Bangkok for clients from KPLHS sites before referring PLHIV to long term ART in health facilities. This activity will be continued in ROP22.

7. May to June 2022: MOPH will publish the TB/HIV Guidelines and Treatment Literacy manual and tools. The TB/HIV guidelines recommend a new TPT algorithm for PLHIV and promote the use of 3HP (INH + rifapentine) and 1 HP as preferred TPT regimen.

PEPFAR Thailand developed the Safe and Ethical Index Testing Guidelines for CHWs in KPLHS. All CHW counselors and care and support workers were trained to implement Safe and Ethical Index Testing.

PEPFAR Thailand will maintain current capacity building support and work with MOPH to mobilize support for index testing including training of ethical and safe index testing to government facilities and monitoring IPV prevalence. Thailand monitors index testing through MOPH web-based platform and PEPFAR Thailand will help to strengthen the use of index testing real time data report, which will inform gaps and actions needed. Supportive supervision and monitoring meetings will be maintained to discuss challenges and identify corrective actions.

The 12 countries within the **Asia Region** have made substantial progress with many of the MPR requirements since the 2019 regionalization, but gaps still remain. The table below indicates the status for each MPR across the 12 countries in the region.

Asia Regional PEPFAR Minimum Program Requirements (MPR) table

	Test&Start w/immediate >95% linkage	Increased host resources expended	ART and VL literacy activities	COI Practices	TPT scale-up	DNO and 100% access to VL	PrEP	Scale-up CBS/UIC	Index and HIVST scale-up	M/M monitoring & reporting	TLD transition	DSD/6MMD	Progress toward local prime	HIV S&D
Cambodia	National	National	National	National	National	National	Partial	Preparing	National	Partial	National	National	Achieved	Partial
Thailand	National	National	Partial	National	Partial	National	Partial	National	Partial	National	Partial +	Partial +	Partial +	Partial +
Burma	Partial	Partial	Partial +	Partial	Partial	Partial	Partial	Preparing	Partial	Partial	Partial	National	Partial	Adopted
India	Partial +	National	National	Partial +	National	Partial +	Partial	Preparing	Partial +	National	National	Partial +	Partial +	National
Kyrgyzstan	National	Partial	National	National	National	National	Partial +	National	Partial +	National	National	National	Partial	Adopted
Tajikistan	National	Partial	Partial +	Partial	National	Partial	Partial	National	Partial +	National	National	Partial +	Partial	Partial
Nepal	Partial +	Partial +	National	Partial +	National	Partial +	Partial +	National	National	National	National	Partial	Partial	Partial +
Indonesia	Partial	National	Partial	Partial +	Partial	Partial	Preparing	Preparing	Partial	Partial +	Partial	Partial	Partial	Partial
Kazakhstan	Partial	National	Partial	Partial +	National	Partial +	Partial +	National	Partial +	National	Partial	Partial	Partial	Partial
Laos	Partial	Partial	Partial	National	National	National	Partial	Partial	Partial	Partial	National	Partial	Partial	Partial
PNG	Partial	Partial	Partial	Partial?	National	Partial	None	Partial	Partial	Partial	National	Partial	None	Partial?
Philippines	Partial	National	Partial	Partial?	Preparing	Preparing	Partial +	National	Preparing	Partial	Partial +	Partial?	None	Preparing

National	Scaled with fidelity to all regions/sites
Partial	Implemented in select regions/sites (+: Implemented w/fidelity in all PEPFAR regions)
Preparing	Actively preparing for national rollout (e.g., training, SOPs, drug registration in progress)
Adopted	Policy adopted nationally, but not actively rolling out
None	Policy not yet adopted, advocacy-level

Index testing is being scaled up throughout the region. As the focus shifts towards implementation fidelity⁵, PEPFAR recognizes that importance of providing index testing in accordance with internationally recognized standards to ensure the provision of safe and ethical services to all clients. All PEPFAR-supported sites conducting index testing must adhere to PEPFAR's Guidance on Implementing Safe and Ethical Index Testing (SEIT)⁶, as well as meet WHO's 5Cs minimum standards (consent, counseling, confidentiality, correct test results, and connection to appropriate HIV prevention and treatment services). In alignment with the PEPFAR Guidance, ROP22 activities will support efforts to ensure informed patient consent; awareness and protection of patient rights; intimate partner violence screening; and monitoring and reporting of adverse events⁷ along with remediation plans. All PEPFAR-supported sites are expected to meet the minimum standards described above through routine monitoring (e.g., the SIMS, CLM, other program monitoring activities). As one example, PEPFAR Tajikistan will implement continuous quality assurance for its index testing services, including monitoring adherence to the guiding principles of confidentiality and voluntary participation (e.g., non-coercive).

PEPFAR teams will respond to and immediately investigate any allegations of unethical behavior, misconduct, or adverse event related to the provision of index testing services. As part of this effort, PEPFAR will continue collaborating with civil society partners, government leaders, PEPFAR implementing partners and key population members themselves to ensure all voices are heard, remediation actions are conducted in a timely manner, and the safety and ethical treatment of clients remains a central focus. India, for example, has a patient charter and feedback is incorporated into their index testing systems. Countries such as Laos and Thailand will implement supportive supervision and mentoring to ensure an understanding of, and compliance with, the aforementioned PEPFAR guidance. Cambodia has incorporated safe and ethical index testing into the Partner Notification, Tracing and Testing (PNTT) and VCCT programs and has incorporated the assessment findings into the national training program and field visits. Several countries will hold fresher index trainings (e.g., Laos), with an emphasis on safe and ethical ways to increase elicitation and communicate testing choices to index clients. In India, staff are trained on minimum standard assessment checklists and participate in refresher trainings every six months. PEPFAR PNG will focus on strengthening safe and ethical index testing through a peer-driven case finding approach for KPs in NCD.

⁵ According to PEPFAR, fidelity "indicates that all key elements of the intervention are in place and standards of success and quality are adhered to at all times." Available at: <https://www.state.gov/wp-content/uploads/2019/08/PEPFAR-Fiscal-Year-2019-Country-Operational-Plan-Guidance.pdf>

⁶ Available at: <https://www.pepfarsolutions.org/resourcesandtools-2/2020/7/10/pepfar-guidance-on-implementing-safe-and-ethical-index-testing-services>

⁷ An adverse event is defined as an incident that results in harm to the client or others as a result of their participation in index testing services. Harm includes any intended or unintended cause of physical, economic, emotional or psychosocial injury or hurt from one person to another, a person to themselves, or an institution to a person, occurring before, during or after index testing services.

While minimum standards are in place for implementing safe and ethical index testing services, there are potential threats to these safeguards. In ROP22, PEPFAR PNG will support the roll-out of the new HIV Testing Guidelines which will ensure increased quality of index testing in PEPFAR-supported facilities as well as providing TA to donors, government partners, and other stakeholders to ensure this case finding strategy can be implemented with the highest ethical and confidentiality standards. However, PEPFAR PNG remains cautious of intensive focus on reaching index testing targets as women and KPs face an increased risk of violence, thus requiring high-quality and full confidential services of which some facilities are not physically able to accommodate. PEPFAR PNG will continue to implement index testing, including for KPs, high-risk individuals, and for pregnant women to prevent MTCT. PEPFAR PNG will also increase partnership with CSOs including the KP Advocacy Consortium to increase the quality and coverage of KP-friendly index testing for key populations, utilizing data and findings from previous index and KP-friendliness assessments in ROP22. In Philippines, 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 index testing among key populations in particular.

In addition to adherence to PEPFAR’s Guidance on Implementing Safe and Ethical Index Testing, the region is moving forward with a more differentiated and person-centered that allows for more tailored and self-determined options to reach individuals exposed to HIV through sex or needle sharing (as well as others in high-risk networks). For example, HIV self-testing, which has high levels of acceptability among key populations, will be offered as a partner notification option in several countries (Thailand, Laos). Tajikistan will promote online self-elicitation and partner notification approaches. Thailand, India, and Burma will integrate SNS opportunities into its index testing cascade. Lao will use peer-to-peer virtual coaching on index testing for case-based surveillance in to PSNUs to increase uptake.

One of the WHO 5Cs is “connection to appropriate HIV prevention and treatment services.” The ARP recognizes that not all index testing results in case finding; therefore, the region is committed to a “testing for prevention” approach that includes linkage to prevention services (e.g., PrEP), particularly for high-risk individuals to help them stay negative. As one example, Laos includes linkage to PrEP among discordant partners of index testing. The need for more prevention cascades (e.g., expanding from index testing cascades) was acknowledged and discussed within the region during the pre-ROP planning meetings and other stakeholder engagements.

4.5.3 Decisions made on ROP22 program direction based on ROP20 performance and POART findings

BURMA

PEPFAR Burma is working closely with the Interim Coordinating Mechanism to implement the Interim HIV Action Plan with all key stakeholders and community and technical partners. Burma continues to invest in safe and ethical Index Testing - as well as introduce additional testing modalities. Based on assessments of COP21, the program will diversify HIV testing modalities, expand eligible PrEP populations and geographies, ensure immediate ART initiation by working closely with local NAP and introduce innovative Harm Reduction practices including PrEP for PWID, women-only services and community-based Buprenorphine.

As a priority, Burma is working toward ensuring treatment continuity by working closely with GHSC-PSM and major donors - also providing services to PLHIV from the national cohort as needed given the disruptions at public sector clinics. Burma is continuously monitoring program and partner progress toward achievements and holds regular meetings to analyze programmatic data. PEPFAR Burma will regularly monitor and review the evolving situations and operational challenges to make necessary program adjustments by exploring feasible implementation approaches while ensuring PEPFAR strategic directions. Toward this goal, Burma is investing in Community-led Monitoring (CLM) with a local group Pyi Gyi Khin - as well as the National Community Network Consortium with UNAIDS - to establish a sustainable CLM structure in the country to improve quality of services for those at risk for and living with HIV.

CAMBODIA

A review of COP21 and COP20 performance conducted during the quarterly POART process identified successes and areas of improvement that have informed Cambodia's COP22 strategic direction. PEPFAR Cambodia plans to institutionalize existing successful approaches and improve the quality of existing services. A cross-cutting priority will be to support policies and systems that are equitable, reduce stigma and promote human rights. In order to meet the 95 goals by 2025, PEPFAR Cambodia will focus on increasing PrEP uptake and continuation through improving KP- friendly care; same-day and rapid ART initiation; continuing MMD scale-up including 6-month dispensing and expanding 3-MMD for children, adolescents, and adults; and improving access to viral load testing. Additional priorities are to improve index partner elicitation and testing, expand the use of self-testing and virtual outreach, better use recency testing, and use granular and timely data of the master patient index to guide our programs interventions.

INDIA

Testing was impacted by COVID-19, and when the pandemic restrictions subsided, PEPFAR India and partners expanded case finding strategies through granular analysis and surge plans in districts with large testing gaps. Additionally, assessment of causes of treatment interruption led to new person-centered strategies for service delivery including family-centric programming.

INDONESIA

In 2021, PEPFAR's analysis of the National Health Insurance or Jaminan Kesehatan National (JKN) claims data found that 78% of HIV services for JKN members were delivered in hospitals, while most of those cases (around 80%) with no comorbidities or complications were treated in outpatient departments. These stable patients can be treated at Primary Health Care (PHC) facilities as HIV services are included in the essential services that PHC facilities are mandated to deliver by the Indonesian Medical Council. PEPFAR will:

- initiate the rollout of a back referral mechanism under the JKN scheme to encourage stable PLHIV to receive care at PHC centers; and,
- conduct a supply-side survey to ensure that PHCs have the capacity to handle comprehensive HIV care for patients the hospital would send to reduce service disruption.

Viral load test coverage remains considerably low. As of December 2021, the VL suppression rate in Indonesia was at 14%. In response, PEPFAR Indonesia will:

- support the GOI to design a strategy to scale up VL testing coverage that identifies an alternative sustainable financing scheme, including domestic funding;
- continue to provide targeted technical assistance that improves data collection, analysis, and utilization efforts at the site, district, provincial and national levels;
- support the Jakarta and Greater Jakarta PHOs and the MOH to coordinate, implement and monitor programming for 95-95-95 goals. Continue technical assistance efforts for HRH system strengthening, including operationalization of district clinical mentorship teams and the provision of assistance that strengthens evidence-based practice; and;
- continue to build the organizational, programmatic, financial and technical capacities of CSOs and community associations to design, implement, monitor, and manage HIV interventions. The program will focus training and coaching on organizational planning and management skills needed to operate an organization that meets governance, financial, and technical standards, and improve partners' capacity to serve as local, national, and regional leaders in HIV programming.

Community-led monitoring efforts will be strengthened and expanded to ensure the provision of person-centered care across the HIV cascade in partnership with GF. Moreover, PEPFAR Indonesia plans to enhance collaboration with the GF in the three priority areas:

- (1) improve the treatment continuity by supporting TA to Greater Jakarta in GF priority sites, including analysis of the Test & Start data, participate in regular coordination meetings between health facilities and CSOs on the Lost & Link program to ensure continuity of treatment of their patients in non-PEPFAR health facilities. PEPFAR Indonesia will collaborate with the GF to expand the initiation of 4-month buffer stock at

the site level. PEPFAR will also partner with the GF team on ongoing advocacy and support for policy updates for TLD transition to all PLHIV;

(2) provide technical assistance at the district level to strengthen the clinical mentoring system in Jakarta and to adopt the system in 13 districts; and,

(3) work closely with the GF to deploy the SIHA 2.0 upgrade. In addition, PEPFAR Indonesia will work closely with the GF PRs to utilize quarterly data analysis of SIHA 2.0 for programmatic improvement in the 13 priority districts.

KAZAKHSTAN

PEPFAR Kazakhstan will scale up MSM activities as a result of COP 21 activity. Since GFATM was implementing HIV prevention activities among MSM in East Kazakhstan oblast, PEPFAR Kazakhstan negotiated deduplication of activities. Additional training on partner notifications and IPV prevention was conducted by IPs. Online modes of communication were scaled up to respond to growing COVID cases. Self-testing is scaled up and will include both facility and community self-testing. In addition, PEPFAR in Kazakhstan will integrate HIVST with PrEP and support “return to care”. In the care and treatment areas, PEPFAR will support routinization of U=U and demand creation along with revision of client-oriented approaches in care cascades based on people’s personal profiles and extend the nurse-led project nationally. PEPFAR will support participation of local labs in EQA/PT programs; GSM will scale up to more sites. PEPFAR will prioritize expansion of PrEP, including community PrEP. The program will focus on building an integrated electronic data platform for the country that will encompass the multiple HMIS platforms currently in use and increase data visibility along the cascade. Use of case-based surveillance and recency testing will also be prioritized. Continued engagement with the GF and institutionalization of the CLM will be prioritized.

KYRGYZ REPUBLIC

Based on the assessment of program performance reflected in COP20 and Q1 COP21 findings, PEPFAR Kyrgyz Republic the following priorities were identified: expansion of all relevant testing modalities, including scale-up of HIV-ST among most-at-risk populations and integration of ST with PrEP, and support “return to care”. In care and treatment, PEPFAR will support routinization of U=U and demand creation along with revision of client-oriented approaches in care cascades and extension of a nurse-led project nationally. PEPFAR plans to ensure local laboratory participation in EQA/PT programs; supports accreditation on ISO 15189 and GSM will scale up nationally. The Kyrgyz Republic PEPFAR team prioritizes expanding PrEP, including community PrEP, while focusing on increased availability and quality of MAT provision activities. The program will support development of an integrated electronic data platform for the country that will encompass the multiple HMIS platforms currently in use and

increase data visibility along the cascade. Use of case-based surveillance and recency testing will also be prioritized. Engagement with Global Fund and institutionalization of CLM will be prioritized. PEPFAR Kyrgyz Republic will explore private sector and financing opportunities, building on Kyrgyz Republic's significant track record with social contracting.

LAOS

Based on the program performance data from ROP20 and Q1 ROP21 and in consultation with stakeholders, PEPFAR Laos identified additional program priorities:

Strengthening linkage from VCT to ART sites: In FY2021, 79% of HIV positive clients from VCT sites registered in DHIS2-ART-Tracker systems based on patient matching analysis. Individuals who were diagnosed at VCT sites located in the ART sites had a high ART linkage of 88%, while only 55% of those who were diagnosed at VCT sites located outside of ART sites were linked to treatment. Gaps in DHIS2 data quality affecting patient ID matching process include incomplete and incorrect format of ART ID in DHIS2-VCT System and missing patient records from PLHIV not completing the referral process from VCT to ART sites. In order to close this gap, in ROP22, PEPFAR will strengthen the referral flow and improve data quality from VCT to ART sites. Laos will promote QI and coaching at VCT, ART, and POC ART sites.

Implementation of a digital application to facilitate VL services, reminders and list of clients with VL appointments: Prior to FY21, VLC was sustained at over 89% but began to decline to <80% due to key systemic and technical challenges including testing interruptions and delays while transitioning from centralized testing to POC VL decentralization, gaps in human capacity, process, and Issues with data transfer from TB labs to the HIV system. In ROP22, we will improve VLC using available Xpert machines for VL testing to cover all POC ART sites, coordinate with NCLE and TB program to utilize Xpert machines used for covid testing in all provinces to increase VLC, continue to closely monitor QI coaching activity, strengthen collaboration between TB and HIV care providers to support improvement of VLC, and continue to support the implementation of the newly developed Digital Application called VLAO to facilitate VL services, reminders and list of clients with VL appointments.

NEPAL

To ensure HIV services are provided in a standardized quality assured manner and service recipients and community actively engaged to inform ensure service quality as well as accountabilities, in ROP22 community led monitoring (CLM) will be implemented through CSO and KP led organizations. In ROP21 CLM implementation has been initiated by establishing a national process for CLM implementation by 1) forming a national task team constituting GON, KP and PLHIV networks, UNAIDS, PEPFAR, Global Fund and AIDS care foundation, 2) holding multiple consultations with KP and PLHIV community to inform the CLM process,

areas of priorities and selection of three KP and PLHIV representatives to lead and oversee the CLM planning and implementation processes; 3) leveraging additional resources from Global Fund for CLM implementation in geographies not addressed by PEPFAR; 4) developing a consolidated work plan to cover two years of CLM activity; 5) by developing training packages and standard operating procedures. In ROP22, CLM will be implemented in accordance with PEPFAR guidance and primarily through KP and PLHIV CSO to monitor HIV service providing outlets at public facility and community level. Availability of KP competent comprehensive services and KP specific commodities as well as provision of HIV services in accessible and stigma free manner will be among the indicators to be monitored.

PAPUA NEW GUINEA

During ROP21, PEPFAR PNG reached 100 percent of treatment targets for the first time and surpassed several other targets in testing and gender-based violence. Index testing and VL testing coverage have significantly increased but have not yet reached targets. Previous data shows treatment interruption continues to be a challenge, but with improved reporting systems and tracking of clients, PEPFAR PNG expects improvements in ROP22.

PHILIPPINES

Additional program priorities center on areas of policy and health systems strengthening including supply chain management and surveillance. In the policy arena, PEPFAR Philippines will work to accelerate DOH adoption of the new HIV Testing guidelines so that more newly diagnosed PLHIV can begin treatment.

TAJIKISTAN

Based on the assessment of program performance during FY21 and Q1FY22, PEPFAR Tajikistan identified the following strategic priorities for ROP22 implementation period:

Prevention

- Tajikistan will expand PrEP coverage by 50% (in comparison to the planned targets for ROP21) and will increase PrEP coverage among KPs by 84%
- The program will support better integration of in-demand services into MAT services, including HTS, TB screening and medicines dispensation, PrEP, and viral hepatitis screening and treatment to offer more comprehensive and holistic MAT services.

Case finding and linkage to treatment

- Tajikistan PEPFAR will focus on more successful case finding modalities in the preceding period, including index testing, VCT, and SNS. About 40% of all HTS_POS are expected to be found via index testing, 50% via SMS modality and the rest via VCT. In Tajikistan, HIV self-testing will be integrated with key prevention services including PrEP. Nurses in facilities and peer navigators at the community level will play an integral role to ensure high linkage to treatment. At least, 95% of new HIV positive will get tested for recent infection and case surveillance will identify areas and sub-groups of population with active ongoing HIV transmission to inform recommendations for prevention programs. PEPFAR Tajikistan will use the program data to identify areas and populations with poor treatment outcomes and will adjust programs accordingly.

THAILAND

In FY2021, the Thailand national HIV cascade showed improvement in both PLHIV and KP for the 1st and 2nd 95. The 1st 95 increased from 94% in FY2020 to 100% in FY2021 among estimated PLHIV and 78% to 82% among KPs. The second 95 improved slightly from 84% in FY2020 to 86% in FY2021 for all populations and from 81% to 87% among KPs. 30% of PLHIV not receiving ART were older adults aged >45 years who were aware of their HIV status but not receiving ART. About 30% of PLHIV were aging cohorts >50 years and about 50% will be aging to elderly PLHIV in the next 5 years. Recency surveillance implemented in Bangkok in FY2021 also showed that males have a higher number of recent infections, and recent infection rates were highest among young men. Recency has been implemented in sites where approval was received by the local ethical review committee. The other sites will be transferred under MOPH surveillance protocol and will be implemented as above site. Index testing continues to remain a challenge in both community and facility settings. In FY2022 and 2023, Thailand's program will be prioritizing the efficient implementation of index testing by working on factors that continue to lead to low acceptance and contact testing rates.

For treatment, trends in SDART and rapid ART (initiation by 7 days) have increased among both PLHIV and KP from FY2020 to FY2022. In FY2022 Q1, 64% of newly diagnosed PLHIV and HIV-infected KP received SDART and 82% initiated ART by 7 days.

To improve HIV services in health care facilities (HCF), Thailand will use the findings from CLM implementation in ROP21, during which time Thailand completed CLM data collection at one pilot health care facility site in the northern region run by the CLM committee. There are seven key services that PLHIV and the CLM committee found to be critical challenges and that needs to be improved. These challenges included: (1) improving MMD 2-3 months to be MMD 6 months, (2) scaling-up the promotion of U=U from the current 50% because U=U is a key strategy to reduce stigma and discrimination, (3) supporting at least 80% of index clients to plan to bring in their partners to receive index testing services, (4) increasing provision of PrEP/PEP information to the 25% of HIV negative clients in VCT clinics who did not receive offers for

PrEP /PEP, (5) reducing the waiting time at HIV prevention services, (6) reducing congestion of patients at HIV clinics in the hospitals, and (7) providing TB prevention information to PLHIV.

MMD in FY2021 showed that overall MMD for more than 3 months was higher than 90% amongst PLHIV, including KPs. KPs accounted for 14% of Tx_curr in PEPFAR supported health facilities. MMD 6 and MMD more than 3 months increased, particularly during COVID-19 lock down in Q3/Q4, 2021. MMD more than 3 months were not different across age groups except all children 10-14 years had MMD 13-24 weeks as the number of children in the data were small. MMD in KPLHS sites in Chiang Mai, Chiang Rai and Songkla is low.

VL testing coverage remains a challenge at PEPFAR supported sites. Overall, 83% of eligible clients for VL testing accessing VL testing services and the VL testing gaps are still in Bangkok and Chiang Mai. The decreasing trend VLC among all PLHIV reduced from 86% to 85% in FY2020 to 84% in FY2021 respectively while VLC among KP has slightly decreased from 75% to 73% in FY2021. The 3rd 95 showed a reduction from 85% to 84% for all populations and 75% to 73% for KPs. Young and adult men had a lower percent retention and VL suppression compared to women.

In terms of prevention, in FY2022 Q1, PrEP uptake increased 46%. Key activities contributing to PrEP initiation via KPLHS include utilizing Facebook live on a series of PrEP campaigns, promoting the community-based same day PrEP services, and working collaboratively with facility-based settings to provide PrEP services under the NHSO scheme. Among these newly PrEP initiated clients, the majority (88%) were MSM/MSW – mainly between the ages of 20-29 - while TG/TGSW accounted for 10%. The proportionally largest increases in PrEP uptake against PrEP target was among TGSW (increased from 17 to 34, 100% of its target), FSW (from 21 to 32, 52% of target), and MSM (from 968 to 1,380, 43% of target) respectively. In FY2021, the proportional increase in NHSO funding for PrEP drugs increased significantly, which accounted for 4% of all PrEP clients in FY2021 Q1 and 7% by the end of FY2022 Q1. KPLHS in Thailand continues to support PrEP access and contribute to more than two-thirds of PrEP users in Thailand.

In ROP22, PEPFAR Thailand has collaboratively worked with the UNAIDS and DAS on CHW certification and CBO accreditation systems. PEPFAR Thailand will build capacity of HIV coordinators at hospitals and HIV M&E officers at OPDC regional offices on DQA/DQI to ensure the quality of HIV data.

PEPFAR Thailand's CLM is an accountability mechanism for HIV responses at different levels, led and implemented by local community-led organizations of people living with HIV, networks of key populations, other affected groups, and other community entities. These groups, most of which access HIV health services, monitor and provide direct feedback regarding service quality in a routine and systematic manner that translates into action and change. The Thailand CLM approach is based on a people-centered approach because it puts communities, their needs, and their voices at the center of the HIV response using quantitative and qualitative indicators.

Thailand CLM initiatives monitor a wide range of HIV service provision issues that are associated with availability, accessibility, acceptability, awareness, appropriateness, equity, effectiveness, and quality of HIV service delivery. Focus areas of service provision include HIV prevention, treatment, and S&D. It is important that beneficiary populations are leading or directly involved in the monitoring of services designed for them.

4. How are Implementing Partners managed to ensure alignment with PEPFAR program strategy and to improve partner performance in an ongoing and timely manner?

Burma is continuously monitoring program and partner progress toward achievements and holds regular meetings to analyze programmatic data. Evolving situations and operational challenges will be regularly monitored and reviewed to make necessary program adjustments by exploring feasible implementation approaches while ensuring PEPFAR strategic directions.

PEPFAR **Cambodia** monitors partner performance and ensures alignment with PEPFAR strategy through quarterly coordination meetings and regular site supervision. The meetings, also joined by key stakeholders, are designed to review progress against PEPFAR Cambodia and national benchmarks and identify performance-related bottlenecks and realistic solutions. In addition, staff members in charge of specific program areas meet more frequently with partners to review progress and monitor activities in the field.

In **India**, IPs ensure alignment with PEPFAR program strategy through granular site analysis, community-led monitoring, and real time data analysis for impact. PEPFAR works with partners and stakeholders on a regular basis to ensure alignment and coordination with the GOI and GF partners.

Indonesia will continue to provide targeted technical assistance that improves data collection, analysis, and utilization efforts at the site, district, provincial, and national levels. The program will also support the Jakarta and Greater Jakarta PHOs and the MOH to coordinate, implement and monitor programming for 95-95-95 goal. Continue technical assistance efforts for HRH system strengthening, including operationalization of district clinical mentorship teams and the provision of assistance that strengthens evidence-based practice. The program will also continue to build the organizational, programmatic, financial and technical capacities of CSOs and community associations to design, implement, monitor, and manage HIV interventions. Training and coaching will focus on organizational planning and management skills needed to operate an organization that meets governance, financial, and technical standards, and improved partners capacity to serve as local, national, and regional leaders in HIV programming.

In **Laos**, ROP 22 development 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. PEPFAR Laos held meetings attended by a range of key stakeholders, including MOH, CSOs, GF, UNAIDS, WHO, CHAI, WB, and AHF. The teams reviewed progress, activities, and complementarity across all development partners. PEPFAR teams discussed in detail the development of ROP22 plans, to ensure alignment and inclusive planning, and to obtain preliminary commitments of PEPFAR implementing partners and development partners to ambitious PEPFAR targets and goals. PEPFAR Laos continues maintaining regular basis communication with implementing partners (IP) to ensure the alignment of endorsed ROP22 strategic priorities into IP's implementation plans; and work closely with IPs to monitor the implementation progress and address emerging challenges.

PEPFAR **Tajikistan** has monthly coordination meetings with its partners. These meetings are intended to identify performance related issues, gaps in coordination among partners and develop workable solutions for identified issues.

PEPFAR **Kazakhstan** has weekly meetings with IPs to discuss program updates. The program has daily communication with IPs, which provide monthly and quarterly reports, and corrective action plans are reviewed on a quarterly basis. Three SIMS visits were conducted in PSNUs. A joint CDC/USAID and IP visit was conducted in one PSNU; and one more is planned in June 2022. KSCDID conducts granular site management meetings with PEPFAR, AIDS Centers, and CBOs for data review and discussion together with facility and community partners.

At the end of March 2022, the **Kyrgyz Republic** RAC conducted a 5-day planning meeting to develop its work plan for the CDC cooperative agreement. All activities are in alignment with the PEPFAR program strategy. GSM, MER indicator, and non-custom indicator reporting will be provided to the PEPFAR team. The Kyrgyz Republic RAC will develop an Evaluation and Performance Measurement Plan to track their performance in an ongoing and timely manner. ICAP reviews and reports monthly key performance indicators to see target achievements and address underperformance in a timely manner.

PNG provides weekly, monthly, and quarterly technical guidance to IPs, including the core HIV program as well as CLM. The program collects and monitors monthly high-frequency reporting data, quarterly MER data, and receives weekly and quarterly information that is utilized to course correct as needed and to provide recommendations for program improvement and focus.

The **Philippines** receives weekly program implementation updates from its field mechanism and convenes bi-weekly meetings to discuss progress and emerging concerns. The process also allows for stock-taking of shifts in the monthly high-frequency reporting and MER data and identification of action steps as necessary. An interagency mechanism has already been established to discuss areas of convergence once all agencies are operating on the ground.

PEPFAR **Thailand** is closely engaged with its partners through weekly, monthly and quarterly meetings, and often daily check-ins tailored to partner needs to provide updates, guidance, feedback and joint planning for continued program implementation. Monthly review of program progress occurs on a regular basis in order to make any required adjustments to ongoing

programs. In the upcoming year, PEPFAR Thailand will conduct all stakeholder meetings regularly to discuss sustainability and transition plans for KPLHS and HCF sites.

5. Describe the community-led monitoring plans and program, including focus on key populations, and how teams will ensure findings are utilized to drive program improvement.

Burma is investing in Community-led Monitoring with a local group Pyi Gyi Khin - as well as the National Community Network Consortium with UNAIDS to establish a sustainable CLM structure in the country to improve quality of services for those at risk for and living with HIV.

Cambodia does not implement CLM but provides above-site TA to the National program, CSOs, and KP networks for nationwide roll-out of the Patient Feedback System (PSF) and Community Scorecard systems and capacity building of PLHIV and KP Networks to enhance their participation in QA/QI discussion forums at community, provincial and national levels.

PEPFAR **India**-supported CLM activities are led and implemented by local community organizations of PLHIV, networks of KPs, other affected groups, or other community entities. India will use a structured platform and rigorously trained peer monitors to collect and analyze qualitative and quantitative data on HIV service delivery systematically and routinely. Through the CLM process, CSOs and KP groups will be supported in enhancing their technical capacity to gather, analyze, secure, use, and own data. The data collected complement local and national monitoring and provide essential information to fill critical gaps in the decision-making process that leads to evidence-informed action to improve services. CLM provides a platform for strengthening relationships with other partners in the HIV and AIDS response around a shared understanding and response to service enablers and barriers.

In collaboration with the GF in **Indonesia**, CLM efforts will be strengthened and expanded to ensure the provision of person-centered care across the HIV cascade. PEPFAR will continue to strengthen community-led monitoring efforts, which fortify community involvement in programming and strengthen the implementation of community-led response supporting treatment acceleration. The CLM data also feeds into Strategic Information, used for monitoring and programmatic improvement, and strengthens community advocacy to national and sub-national stakeholders for the provision of, and equal access to differentiated/person-centered HIV services delivery. It also puts communities at the center of the whole programming process, making the programs more accessible and improving uptake for HIV treatment.

In ROP22, PEPFAR **Kazakhstan** will use an existing mechanism to competitively award a local HIV-related CSO to implement CLM at the PSNU level to monitor access and quality of facility and community HIV services. CLM data will be collected and analyzed on a regular basis and shared with local and national stakeholders. CLM will also monitor quality and accessibility

improvements resulting from programmatic recommendations from CLM data. A digital health tool for monitoring access and quality of services developed under PEPFAR previous programs will be implemented for CLM.

In **Kyrgyz Republic**, CLM implementation has started; the CLM tool was designed by a group of KP experts, including PWID, LGBT, and PLHIV representatives. The same group of independent local KP experts is responsible for conducting CLM visits, and analyzing and presenting the findings to key stakeholders for improving service provision by the PEPFAR program. The tool has also been discussed with the major PEPFAR partners to ensure it reflects the current services provided and was revised to address all comments received from the CLM POCs from ISMEs at USAID and CDC HQ. Six field visits in Bishkek and Chui oblast started in ROP21, concentrating on EpiC sub-partner NGO sites. CLM will expand to Osh and Chui Oblast in ROP22, where 10 site visits will be conducted at both NGO sites and government facilities. Results from CLM will be presented safely by community members to the PEPFAR team on a quarterly basis through a presentation followed by a constructive discussion in an environment that will foster honest and genuine discussion of results, including of negative outcomes. There will be follow-up on the response/action plans to address identified issues. PEPFAR will ensure that CLM findings are triangulated with other PEPFAR data sources, including MER results and SIMS scores, and that data are used to foster site-level improvements and as part of PEPFAR's partner management approach.

CLM is an integral component to help increase service quality for KPs and victims of GBV. The PEPFAR **Laos** CLM plan evolved during FY22 as the CBM tool originally developed with GF's support was not approved by stakeholders. Building on the PEPFAR partner's existing CLM tool, PEPFAR adopted it in the Laos context with extensive consultation with community-based supporters and peer mobilizers of key populations, MSM and TG network representatives and all local CSOs working on HIV/AIDS. The tool was approved by the CLM task force and CHAS and translated into Lao and is ready for implementation in FY22. As required by the PLL, PEPFAR Laos allocated ROP22 resources to implement the community led monitoring led by KP. Challenges to establishing CLM in Laos include the very limited number and capacity of local CSOs that can take on this task locally. Additionally, activities outlined in CLM guidance have never been conducted in the country, so existing KP CSOs have no experience in conducting CLM. Therefore, during ROP22, PEPFAR plans to build the KP CSO's capacity to implement CLM in three provinces. PEPFAR will also invest in building a structure for active KP participation in HIV programming by reinvigorating the CLM task force and instituting a stakeholder committee, which will discuss findings identified by the KP CSO to improve the HIV program services.

During ROP21 in **Nepal**, a national process for CLM implementation was established by: 1) forming a national task team constituting GON, KP and PLHIV networks, UNAIDS, PEPFAR,

GF and AIDS care foundation; 2) holding multiple consultations with KP and PLHIV community to inform the CLM process, areas of priorities and selection of three KP and PLHIV representatives to lead and oversee the CLM planning and implementation processes; 3) leveraging additional resources from GF for CLM implementation in geographies not addressed by PEPFAR; 4) developing a consolidated work plan to cover two years of CLM activity; and 5) developing training packages and standard operating procedures. In ROP22, CLM will be implemented in accordance with PEPFAR guidance and primarily through KP and PLHIV CSOs to monitor HIV service providing outlets at public facility and community level. Availability of KP-competent comprehensive services and KP-specific commodities as well as provision of HIV services in an accessible and stigma-free manner will be among the indicators to be monitored.

PEPFAR PNG will continue its investment in CLM in ROP22, implementing recommendations and integrating CLM into the TA package provided to PEPFAR-supported sites. As a part of KP and locally led strategic integration, the consolidated CLM model among GF, DFAT, UNAIDS, and USAID is expected to improve the quality of services for vulnerable populations and KPs. The three primary areas of focus for CLM are institutional strengthening, quality improvement, and reducing stigma and discrimination by enhancing the efforts of core HIV activities through PEPFAR PNG's close partnership with UNAIDS and the KP Consortium. In ROP22, PEPFAR will focus on institutionalizing CLM with an emphasis on sustainability.

ROP22 CLM implementation of the **Philippines** will sustain efforts towards the achievement of the country's CLM vision of establishing an online system to collect CLM data composed of service delivery, investment, policy, and stigma and discrimination monitoring modules. ROP22 CLM activities will specifically support the capacity-building of the consortium to manage the CLM platform and the development of a CLM communication plan to translate the CLM data into action. A local community partner will receive a sub-award from the yet to be determined implementing partner to conduct the various identified PEPFAR activities.

In **Tajikistan**, CLM will be implemented through CSO and KP led organizations in PEPFAR sites in Dushanbe City, Sughd Oblast and District of Republican Subordination (DRS). During ROP21, a national process for CLM implementation by: 1) conducting consultation meeting with the key stakeholders representatives of CCM, Ministry of health, KP and PLHIV CBOs, UNAIDS and GF; 2) holding multiple additional separate consultations meetings with KP and PLHIV community and the AIDS Centers to inform the CLM process, areas of priorities and selection of two KP and PLHIV led CBOs to implement the CLM in Tajikistan PEPFAR SNU's; 3) advocating for leveraging additional GF resources for CLM implementation in geographies not addressed by PEPFAR; 4) and developing a CLM scorecard. In ROP22, CLM will be implemented in accordance with PEPFAR guidance by selected KP and PLHIV CBOs to monitor HIV services at public facilities and at the community level. It is anticipated that this cycle will be routine rather than one-off and will focus on barriers and enablers of client access

to PEPFAR services (both clinical and community-based), producing action-oriented recommendations on how HIV services can be improved.

In **Thailand**, CLM implementation will be conducted by either TPN+ (the national network of people living with HIV), or provincial-level CSO-led CLM committees. CLM committees are comprised of members drawn from local community-based organizations and other civil society groups, networks of key populations (KP-CSOs), groups of people living with HIV (PLHIV), and other affected groups or other community entities. TPN+ and the CLM committee(s) will perform all aspects of CLM, including (1) assessing local context; (2) engaging decision makers and service providers and building buy-in for the CLM approach; (3) designing the CLM activity and tools use; (4) conducting data collection and analysis, presenting findings, and designing corrective action plans based on the findings; (5) engaging policy makers and advocating for changes in policies and practices; and, finally, (6) provincial CLM committees will monitor the implementation of corrective actions and identify impacts and barriers and will repeat steps 4-6 over time.

In ROP21, Thailand has continued to promote and build PLHIV and KP-led CLM activities and planned to help refine CLM methods and support implementation scale-up continuing into ROP22. Thailand-CLM's goal is to develop a shared understanding of the enablers and barriers to HIV prevention, treatment, care and support continuity in a manner that is community-driven and collaborative, productive, respectful, and solutions-oriented. Thailand will work with CLM implementers to ensure TPN+ and CLM committees coordinate with stakeholders to streamline CLM approaches and ensure that CLM results are publicly accessible. Thailand will support a routinized process of sharing data through provincial AIDS networks and national M&E platforms, as well as the development and follow up of corrective & collaborative action plans to improve service outcomes. For CLM sustainability, CLM data will be used publicly and be part of data in the national monitoring platform, along with PLHIV stigma index and crisis response systems that are led by community-based organizations.

In ROP22, Thailand will continue to expand CLM in the northern and eastern region and initiate CLM in another four regions. Online data collection tools will be used by PLHIV network in some of these areas to simplify the monitoring processes. We will work with the DAS to integrate information from CLM to the national monitoring platform to promote high-level data use (e.g., planning of national strategic direction).

PEPFAR-supported sites will conduct community-led monitoring and assisted navigation aided by CBOs, and timely receipt of results will be emphasized through U=U messaging. PEPFAR Thailand will promote the 10:10:10 targets, advocate for non-criminalization policies for KPs and include the TG health package in universal health coverage. Thailand will also continue to support the expansion of the KPLHS model to increase HIV friendly service coverage for KPs.

4.6 Commodities

In the Asia Region, 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 procurement of ARVs and VL reagents are supported through varying mechanisms. PEPFAR **Burma** works closely with the Global Fund and GHSC-PSM to ensure a continuous commodities supply. Burma will also procure HIV self-test kits in 2023. In Burma, GHSC-PSM will focus on FAST activities, ART optimization, MMD scale-up and the PrEP commodities forecast, while managing and maintaining the eLMIS system. **Indonesia** performed a commodity gap analysis that revealed a sufficient national budget to cover treatment and testing targets, implying no anticipated future shortage of HIV commodities. Indonesia will focus on ensuring adequate supplies are procured and available at the national and sub-national levels, particularly in Jakarta and Greater Jakarta, to support the expanding national HIV program. In ROP22, **Kazakhstan** will procure their own ARVs entirely through host government resources, along with GFATM and PEPFAR helping to procure a limited amount of HIV saliva-based tests, condoms and lubricants to cover program needs. TLD has been registered and will be purchased in 2023. **Kyrgyz Republic** has no concerns related to stock-outs or projected funding gaps for ARVs, TLD, or PrEP, as the Kyrgyz national government budget award is enough to cover all country needs. In **Laos**, PEPFAR will continue to procure the HIV self-kit (OraQuick) for MSM and TG for the KP program to increase case finding in the community. In Lao, better coordination of commodity planning is required moving forward, due to the impact of COVID19, longer custom clearance process, and travel restrictions that stock outs last year. At provincial level in LAO, PEPFAR will also continue to support CHAS and PCCAs to quarterly coordinate procurement and quantification for PrEP stock and other supply chain issues for KP programming. In **Nepal**, the national government is responsible for ARV, HIV rapid test kit commodities and essential medicines, while Global Fund also support procurement of ARV, rapid HIV test kits including HIV self-test and viral load test reagents to ensure no such commodity needs remain unsupported. PEPFAR/Nepal will work collaboratively with GON and Global Fund to ensure all needed HIV commodities for ROP22 target implementation are adequately quantified, timely procured, and sufficiently stocked to mitigate any negative impacts of unforeseen supply chain disruptions, seen during waves of COVID-19 pandemic globally as well as in the country, and to ensure services are implemented seamlessly. In the **Philippines**, the DOH currently funds almost 100 percent of ART procurement and is expected to remain the primary funding source for drug procurement. In ROP22, PEPFAR Philippines will work closely with the Department of Health to improve domestic procurement processes for these critical medicines and commodities by addressing supply chain bottlenecks. The national government of **PNG** is committed to procuring ARVs for PLHIV. In ROP22, PNG has allocated funds to procure PrEP drugs. Through the ARPA Emergency Commodity Fund, PEPFAR PNG will also procure HIV RTKs in fiscal year 2023. In **Tajikistan**, GFATM will fully provide the country needs for ART and VL tests, while the host government will procure HIV tests for HIV testing of pregnant women. Also, PEPFAR will procure a limited amount of HIV saliva-based tests, condoms, and lubricants to cover program needs in Tajikistan.

For prevention commodities, Thailand has collaborated with NHSO and the GF in providing support for PrEP, condoms and lubricant, rapid test kits and HIV self-test kits. In ROP21, KPLHS sites had transferred 70% of PrEP users, originally having received PrEP drugs from the Princess PrEP program to the universal health coverage scheme from NHSO.

In ROP21, there were PrEP shortages due to the discontinuation of the Princess PrEP donation program and limitation of PrEP drugs under the NHSO scheme. PEPFAR Thailand has collaborated closely with the GF to procure PrEP drugs to support all KPLHS sites while setting up a collaborative PrEP transition plan from Princess PrEP donation program to NHSO. As a result, the PrEP shortage was resolved in March 2021. In ROP22, there are no concerns about PrEP drug and supply chains due to unlimited PrEP drugs and allowing reimbursement of pre-laboratory costs for new and continuing PrEP users. Similar to condoms and lubricant, NHSO will provide THB 100m to procure condoms and lubricant for all populations in Thailand, while sharing logistics costs with GF. The GF continues to support rapid test kits, self-test kits, and VL cartridges. Therefore, KPLHS sites could have buffer kits to provide services before reimbursement comes back from NHSO.

In terms of ARV drug stock and supply, Thailand procures their own ARVs entirely through host government resources. The Thai national HIV treatment guidelines 2020/2021 recommends TLD as the preferred first-line regimen. As of April 2022, uptake of TLD among PLHIV in Thailand was low (4%). National AIDS program will provide TLD in NAP system to cover all populations of PLHIV starting in June 2022. The government planned to transition TLD to more than 80% of PLHIV in December 2022. In April 2022, TLE drug stockouts were reported in some hospitals due to delays in Government Pharmaceutical Organization (GPO) TLE600 drug production and delayed TLD procurement processes and imports from India. PEPFAR Thailand has worked with the Thai government, Thai AIDS Society, NHSO, SSO, and GPO to recommend ARV regimens for the national program, and estimate the number of TLE and TLD drugs using PEPFAR Thailand TLD forecasting tool. PEPFAR Thailand proposed to the NHSO ARV procurement committee to procure more drugs to mitigate risks of ARV stock outs during the transition period in FY2022. NHSO plans to procure Thai GPO-produced TLD that will be available in September 2022 and limit the number of TLD drugs procured from Indian companies to only the actual required amount during June to September 2022. In FY23, NHSO and SSS will plan to procure TLD from locally produced Thai GPO, mitigating risk for ARV stock out.

To mitigate any effects of the COVID 19 pandemic on supply change management, Thailand will work closely with the GF on the C-19-RM which will continue to support COVID-19 mitigation until the end of FY2023.

4.7 Collaboration, Integration and Monitoring

BURMA

[REDACTED] Burma analyzes High Frequency Reporting, quarterly reporting, and leads implementation science with the use of biometric scanning, on linkage to treatment and PrEP evaluation. This analysis is incorporated into program implementation and considerations in funding shifts. Due to the coup and Covid-19, Burma partners have had to work to integrate services and adapt to a challenging implementing environment. Burma has shifted to invest in KP-led and CSO-led services design and implementation and quality monitoring through CLM in five high-burden states and regions.

Burma has implemented a privacy-protected biometric iris scanning system at the site level that allows partners to see a client's true cascade while divorcing personal data from biometric data. Burma plans a detailed individual-level PrEP cohort analysis to understand cycling on PrEP and use the evidence to advocate for ED PrEP. At the national level, NAP had previously developed a plan to set up a Master Patient Index (MPI) as unique identifiers and integrate it with relevant information systems across the full cascade of HIV services at all public and private facilities. Efforts and investment on expanding the use of MPI and integrating it as the unique identifiers at the national level have been paused by major donors including PEPFAR since the beginning of the political crisis.[REDACTED]

PEPFAR Burma will support improving the integration of the following key *health system interventions*:

1. Capacity building and strengthening of KP/community networks and CSOs to be able to deliver critical sustainable community-led HIV responses and KP-friendly and competent services
2. Strengthening of HIV and VL diagnostic network laboratory capacity to improve coverage and the quality of HIV and VL testing in collaboration with key stakeholders
3. Supply chain strengthening for HIV commodities

Above-site activities for ROP22 in Burma are mapped to key barriers and measurable outcomes related to maintaining progress toward epidemic control and monitored in an ongoing manner using SMART benchmarks (see Section 5.0 for key barriers in Burma and PEPFAR investment).

CAMBODIA

Cambodia is an above-site only program focused on maintaining epidemic control. During ROP22, Cambodia will continue to monitor above-site activities through tracking indicators developed jointly with the national government and other key stakeholders. These activities are designed to address key systems barriers (detailed in Appendix C) and will impact broader sustainability goals, which are tracked through the biennial SID process.

In Cambodia, PEPFAR is supporting the government to align and harmonize databases through optimizing the use of existing unique key identifiers for PLHIV and KP. The alignment of unique identifiers is part of the Master Patient Index roadmap for scale-up.

INDIA

PEPFAR **India** works closely with all partners to strengthen cross-technical collaborations and implementation across agencies and with external stakeholders, including GF and the GOI. Cross collaboration and cross-learning is part of the work partners do in the field with GF partners to ensure broader impact. In doing so, teams ensure that above-site programs are mapped to key barriers and are monitored.

INDONESIA

PEPFAR in **Indonesia** plays an essential convening role in aligning MOH, the GF, and USG priorities surrounding TLD transition, legacy commodity management, and stock-out mitigation for essential HIV and TB commodities. This includes leveraging resources to support programming across agencies and stakeholders.

PEPFAR Indonesia will support the national and sub-national governments to ensure supported site-level programs have a reliable supply of commodities and lab services. The program will maintain close relationships with counterparts at the MOH to ensure the program is agile and adaptive to updated recommendations, PEPFAR targets and MOH goals. The programming addresses key barriers and measurable outcomes related to reaching epidemic control in Indonesia.

Across the HIV cascade, continuous quality improvement will be emphasized and fostered through: (a) district-level face-to-face and virtual clinical mentorship systems; (b) digital applications for service consultation and coordination between implementers and between providers and clients; (c) data-informed decision making through monthly data review and verification processes, and via the new national patient records system (SIHA 2.0 Upgrade); and (d) intensive community-led monitoring and feedback mechanisms.

Cross-technical collaboration and implementation across agencies and stakeholders will also be strengthened by providing responsive technical assistance to the MOH and GF implementing partners; integrated programming efforts in PEPFAR-supported geographic areas; integrated community-led monitoring; and peer-to-peer learning and sharing through the national HIV technical working group.

Indonesia will strengthen data collection by community partners and stakeholders to obtain feedback from end-user beneficiaries on current HIV service delivery and will provide TA on data analysis to improve the clinical cascade in all facilities in 13 districts. PEPFAR will continue to strengthen CLM efforts, data from which is used to monitor and improve programs, and which reinforces community advocacy to national and sub-national stakeholders for the provision of and equal access to differentiated/person-centered HIV services delivery. It also puts communities at the center of the whole programming process, making the programs more accessible and improving uptake for HIV treatment.

KAZAKHSTAN

PEPFAR **Kazakhstan** will continue to coordinate with and support a range of stakeholders to ensure sustained impact including host country government agencies MOH and KSCDID, GF, UNAIDS, and civil society including PLHIV and KP networks. For Kyrgyz Republic, these include MOH and RAC GF, GF/UNDP, UNAIDS, UNFPA, GIZ, and civil society. Coordination for Kazakhstan takes place through several platforms, the primary one of which is the CCM, which includes PEPFAR members, and HIV working groups.

PEPFAR will maintain active involvement in all HIV strategy development, sustainability, CLM, and technical initiatives in ROP22. In both countries, PEPFAR, UNAIDS, and GF work closely on implementation and coordination of various strategic activities, i.e., recency testing and index testing, self-testing, PrEP, and laboratory EQA activities in both countries; and in Kyrgyz Republic support also includes MAT, social contracting, and financial sustainability, including a costing analysis, and results-based financing.

PEPFAR **Kazakhstan** will continue strengthening IP management and monitoring through a technical working group with KSCDID and UNAIDS that is responsible for monitoring and evaluation of HIV epidemic response.

Kazakhstan will continue focusing on person-centered case management and adherence support through its nurse-led project and community-based interventions. In ROP22, the focus will be on routinization of U=U messaging for both countries; scaling up SDART in Kazakhstan and revision of person-centered approaches in service delivery, and scaling up CB-ART.

KYRGYZ REPUBLIC

In Kyrgyz Republic, PEPFAR coordinates through the CCM, health DPCCs and HIV working groups. Through regular consultations and site visits with IPs, PEPFAR **Kyrgyz Republic** will ensure granular management and monitoring of program interventions across the cascade to facilitate course correction. Community partners will continue using DHIS2 to track cascade data at the granular level and may provide TA to RAC in moving to this platform if the government expresses interest in ROP22. PEPFAR and partners will use dashboards, apps, and other electronic health information systems to monitor the HIV clinical cascade at national and subnational (oblast) levels and strengthen systems, data utilization, and feedback to providers to improve case finding, track PLHIV, and provide linkage to facility and community services.

In Kyrgyz Republic, PEPFAR will also maintain active involvement in implementation of the National Health strategy “Healthy person-Prosperous country.” In both countries, PEPFAR will support an HRH exercise examining host country government capacity relevant to social contracting. This exercise will be done to meet the latest GF requirement to move to performance-based payments and harmonization of payments between sectors.

Like Kazakhstan, Kyrgyz Republic will continue SIMS and DQA visits to ensure engagement and oversight at the service delivery level and continue to support CLM to ensure quality of services at both facility and community levels. Kyrgyz Republic's focus for ROP22 is institutionalizing the CLM model.

Kyrgyz Republic will work to institutionalize the nurse-led SUPPORT4HEALTH project nationwide in Kyrgyz Republic. Facility models of care (SUPPORT4HEALTH, HERE4YOU), have improved linkage to care and ART adherence in collaboration with community-level case management. 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 Kyrgyz Republic, PEPFAR-supported programs will be encouraged to actively use CLM feedback to improve services and to be responsive to the specific needs of each sub-population. CLM findings will help clarify challenges and enablers for PLHIV to help providers to tailor interventions for the specific context. Results from CLM will be presented safely by community members to the in-country PEPFAR team on a quarterly basis, who will then share these findings with IPs.

Kyrgyz Republic has highly functioning CBS systems and uses unique identifiers. The AIDS and Narcology services 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.

LAOS

In **Laos**, PEPFAR continues to strengthen DHIS2 for national HIV program monitoring. Unique identifiers are used across all sites and programs in health program monitoring, including in the HIV program. PEPFAR will also continue to assess UIC used in DHIS2 and provide TA to improve the quality of unique identifier systems.

In ROP21, PEPFAR initiated development of a data analysis platform to assess linkage between the Voluntary Counseling & Testing event and ART tracker databases. The recency dashboard has also been visualized through this system with daily, real-time results on recent infections since ROP21 Q2. In ROP22, PEPFAR will continue to support development of a national online web-based case surveillance and program monitoring, data analysis, automatic data exchange, and real-time HIV dashboard for other key program indicators, reports and visualizations. Technical staff and health care workers will be trained to strengthen data quality and use for program monitoring and quality improvement.

While the challenge of HIV care and treatment in Lao PDR is increased coverage, the strategy to expand treatment availability and access is very important. This means increasing ART and decentralized ART point-of-care (POC) sites to ensure quicker access to and continuity of treatment. CHAS established POC ART sites to increase ART accessibility to cover all provinces

in Laos, facilitate ART refills in provincial areas, and reduce transportation time. There are currently seven POC ART sites with plans to expand and cover all provinces in the following years.

To address the key barrier of stigma and discrimination against PLHIV and KP, especially TG, PEPFAR will also support the GOL's initiative to regularly conduct the Stigma and Discrimination Survey at health facilities.

NEPAL

Nepal has strong collaboration and coordination with the national HIV program, the Global Fund, WHO, AHF, UNAIDS, and CSOs such as PLHIV networks and KP networks in the country. USAID/Nepal is also co-chair of the GF CCM, which has enabled PEPFAR to ensure resource alignment and synergy of investments among PEPFAR, GF, and GON.

As a result of strong collaboration among all stakeholders, Nepal rationalized areas of investment by target population, geography, and sites, as well as aligning investments in priority HIV commodities. Under the leadership of the national HIV program, stakeholders meet regularly to share their plans and performance, and to jointly monitor progress toward HIV epidemic control. PEPFAR has successfully worked with stakeholders for CLM to be implemented as a national program by leveraging additional resources from GF and developing a comprehensive joint work plan and monitoring mechanism.

In ROP22, Nepal will continue to capitalize on the strong collaboration among stakeholders to regularly review and monitor progress to sustained HIV epidemic control and identify opportunities for integration and efficiencies. Nepal will continue supporting the national HIV program and the national public health laboratory to coordinate stakeholders, update policies and guidelines, implement strategies and standards, and jointly monitor and supervise program progress.

Through regular consultations with PLHIV and service recipients as well as through site visits, Nepal will ensure granular management and monitoring of program interventions across the cascade and course-correct whenever the need arises. PEPFAR will support implementation of one national HIV information system and its integration with eLMIS and HMIS platforms to facilitate triangulation of data, comprehensively monitor progress, provide timely feedback, and inform the decision-making processes.

PAPUA NEW GUINEA

In **PNG**, through discussions on resource pooling and strategic planning, USAID is working on a joint strategic plan including the HIV National Strategy to ensure maximum coverage of high-quality HIV services nationally. PEPFAR will partner with new local organizations for HIV programming. In ROP21, USAID increased its support from four to six sub-awardees, including

the KP Consortium, with plans to include additional CSOs to improve back-to-care and treatment retention, service continuity, and program quality.

The program will focus on improving VL coverage through implementation of VL testing strategy and will operationalize findings after the DNO exercise with GF and World Vision. PEPFAR will demonstrate QA/QI models in NCD and test them in other provinces to develop a model to scale up to other provinces, which builds the capacity of the PHA to manage the HIV program. PEPFAR will strengthen and improve the efficiency of health information systems to track and manage HIV cases in the NCD and other provinces, while improving the KP reporting and cascade of KPs along the HIV continuum.

PEPFAR PNG will continue to provide direct TA to UNAIDS and the KP Consortium to ensure that high-quality work plan strategies are implemented and to identify recommendations to be adopted into HIV programming at PEPFAR-supported sites. PEPFAR PNG will support three models within CLM including the following: 1) a virtual space model where individuals can submit recommendations and issues for the KP Consortium to continuously monitor HIV service quality; 2) a community model where exit interviews will inform a scorecard for facilities with recommendations for improvement; and 3) a health facility model to develop recommendations for facilities that can be adopted by PEPFAR and non-PEPFAR sites. PEPFAR PNG will work with UNAIDS, GF, and DFAT to develop a joint reporting structure to ease the reporting burden on the KP Consortium and ensure accountability among donors that recommendations from the KP Consortium will be adopted and implemented as well as to strategize for its inclusion at the provincial and national level to help inform decision-making for government-supported HIV programming.

In ROP22, PEPFAR will continue working with the KP Consortium to implement recommendations identified under the CLM activity initiated in ROP21 to improve HIV service quality for vulnerable populations and KPs. Building upon CLM's three primary focus areas – institutional strengthening, quality improvement, and reducing stigma and discrimination – the program will continue to partner with UNAIDS and the KP Consortium to institutionalize CLM into PNG's HIV rubicon with an emphasis on sustainability.

PEPFAR will provide above-site TA to the NDoH and provincial health authorities, including facilities, to manage pediatric cases. The program will continue to support mSupply efforts with the NDoH and collaborate with GF to migrate to mSupply, an open-sourced software. PEPFAR will provide mentorship to NDoH to implement and drive QA/QI work in PNG to institutionalize the approved NDoH policy. The program will also work to ensure decriminalization or decrease in punitive measures against sex workers, especially female sex workers, build on the work of HWW or collaborating with other partners.

In PNG, PEPFAR provided TA to update client intake forms and booklets, including NUIC, as a standard practice to improve client tracking across clinics and services. This has improved the ability to track silent-transfer clients in PEPFAR SNU. In ROP22, PEPFAR will continue to

provide TA to strengthen and institutionalize use of NUICs, including digital and integrated systems, such as mSupply and updates to the HIV Patient Database (HPDB).

PHILIPPINES

The **Philippines** will work in ROP22 to further align and integrate program activities with those being supported by GF and UNAIDS, as well as the Armed Forces of the Philippines. PEPFAR will participate in Joint Programmatic Reviews with GF and establish a technical assistance tracking and monitoring system to be used for regular alignment processes across stakeholders.

PEPFAR will conduct regular quarterly data reviews with DOH, GF, UNAIDS, WHO, other partners and relevant stakeholders to foster greater coordination, collaboration and sharing of best practices and lessons learned in country.

TAJIKISTAN

PEPFAR **Tajikistan** closely collaborates with the MOH, GF, WHO, 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. PEPFAR strengthens 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 Tajikistan, the PEPFAR team provided input for the National AIDS Program and National HIV Monitoring Plan 2021-2025 and the country's application for the GF HIV grant for 2021-2023. PEPFAR Tajikistan and its local and international partners work closely on implementation and coordination of various strategic activities, including case-finding, prevention for KPs, including PrEP, patient retention, recency testing, and index testing, HIV self-testing, and BBS implementation.

Through regular consultations and site visits with IPs, PEPFAR Tajikistan will ensure granular site management and monitoring of program interventions across the cascade and will facilitate course correction within shorter time periods. The country program and partners will continue using the MOH electronic HIV case management system maintained by local AIDS centers 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.

Tajikistan will promote further integration of HIV services. PEPFAR-supported MAT sites will provide a range of other services, such as HIV testing including self-testing, ARV dispensation, blood collection for VL testing, TB screening and TB medication dispensation, PrEP services and medication dispensation, as well as viral hepatitis screening and treatment. ART clinics also provide TB screening and prevention treatment, and dispense TB treatment medication.

In Tajikistan, the facility models of care, such as SUPPORT4HEALTH, in close collaboration with community-level case management, have improved linkage to care and ART adherence. The SUPPORT4HEALTH project focuses on patients newly initiated or restarted on ART and those with an unsuppressed VL. Under this initiative, nurses provide structured and systematized home and community visits and phone calls to remind clients about upcoming scheduled visits to facilities or to re-engage clients after a missed visit. The Community Health Center, a safe alternative model of HIV services for KPs facing stigma and discrimination at facility HIV service sites, will provide a comprehensive package of services to KPs, including online and in-person counseling, testing for HIV, referrals to other services, linkage to treatment, and PrEP counseling and referrals and/or distribution.

Implementation of CLM will start in ROP21. Programs supported by PEPFAR Tajikistan will be encouraged to use CLM feedback to improve services and tailor them to the specific needs of each sub-population. Tajikistan CLM findings will help clarify barriers and enablers for PLHIV to help providers to continuously refine interventions for the specific context and population. Results from CLM will be presented by community members to the in-country interagency PEPFAR team on a quarterly basis in an environment that will foster honest and genuine discussion of results, including negative outcomes. PEPFAR USG staff will share these findings with IPs on a quarterly basis.

The country program in Tajikistan mapped all above-site activities to appropriate SID elements and identified key systems barriers. A detailed description, period of implementation, ROP22 baseline and benchmark as well as indicator to measure an ongoing progress towards achieving planned benchmark have been included in Table 6 for each above-site activity suggested for Tajikistan.

THAILAND

For Stigma and Discrimination (S&D), through several meetings co-convened by GPN+, NGO Delegation, UNAIDS PCB, UNAIDS, UNDP, UN Women and GF ATM in FY 2020-2021, Thailand has developed the national Multisectoral and Costed Action Plan to Eliminate All Forms of HIV-related Stigma and Discrimination for FY2021-2025.

This costed action plan is comprised of four accelerated strategies which apply the principle of reducing inequality of PLHIV and KPs through a person-centered approach. The plan aims to provide access to people living with HIV and the key affected populations to a self-stigma reduction programs, gender-equitable information, and community crisis response support to protect their rights.

Of the total estimated budget for implementing the action plan in 2021-2023, only 31% of resources are available and the majority is from external funding sources. PEPFAR Thailand is requested to take part in national S&D efforts and strategy by providing technical support, program monitoring, and QI to expand S&D program interventions in community and health facilities. The national S&D strategy will guide all stakeholders to collaborate on the national

efforts. UNAIDS Thailand received additional funding from CDC HQ through a central mechanism known as the Global Ending Stigma and Discrimination initiative.

The 2022 CoAg funding will be used to accelerate community action and as a catalyst for scaling-up by the Global Fund Investment. On March 18, 2022 UNAIDS convened a meeting with key partners of S&D programs in health care settings (facility and community) to follow-up on progress of proposals and workplans for funding. DAS, MOPH, the Foundation of AIDS Rights (FAR) (dealing with HIV related human rights and law), and IHRI presented their work plans and proposed activities for funding.

The national action plan will be used as a framework for S&D implementation in the country. This will be done with the existing national coordination mechanism which has FAR as secretariat for the human rights working group to promote the local government and civil society organization leadership working on the implementation. For multilateral stakeholder meetings and collaboration, UNAIDS will be the main convener. PEPFAR Thailand has ongoing activities and will contribute to the national multisectoral action plan, along with multilateral and bilateral stakeholders, implementers, government, and communities. PEPFAR Thailand can be a co-convener or co-facilitator and provide TA support for implementing S&D reduction in health care and community settings. PEPFAR Thailand has identified several critical cross cutting priorities that merit continued focus and enhanced efforts moving into ROP22. Focusing on data, Thailand will establish a data warehouse to strengthen the national HIV data hub, enhance data quality and accessibility, strengthen web-based surveillance in KPs, and promote the use of CLM data for program improvement. PEPFAR Thailand will intensify efforts across the cascade through the provincial ending AIDS networks, including focus on the KP layered prevention package to ensure a full range of tailored prevention services, strengthening linkages between community and facility-based services, and again reinforcing the use of community led monitoring data.

PEPFAR Thailand will support Thailand (MOPH) to build a self-sustained M&E program by developing SOP for regular data review, training new staff and CHWs and strengthen digital platform (HIV Info Hub) to regularly update program indicator for self-monitoring. PEPFAR will integrate HIV, TB, hepatitis, STIs, and NCDs in the existing HIV services package and promote using telehealth as part of differentiated service delivery to promote people-centered approach. We will strengthen linkages between CBOs and health facilities under the provincial ending AIDS network to ensure sites/provinces are able to sustain HIV impact.

In Thailand, HIV treatment and care services will be strengthened through continuous quality improvement (CQI) for optimizing voluntary counseling and testing (VCT)/provider-initiated testing and counseling (PITC), linkage to SDART, DSD, VL coverage, coaching, HIV Disease Specific Certification (DSC) and provincial network strategy to help local governments promote community-health facility collaboration and networks for sustainable implementation. PEPFAR Thailand and its partners will provide training and SOP/guidelines/job aides to update knowledge and support of key PEPFAR minimum program requirements (MPRs). Thailand will improve the quality of services by strengthening the delivery of KP-led and gender-affirming services.

PEPFAR Thailand will support a routinized process of sharing and using data through provincial AIDS networks and national M&E platforms for local ownership of HIV programs, as well as the development and follow up of corrective & collaborative action plans to improve service outcomes. Thailand has a highly functioning HIV case-based surveillance (CBS) systems and uses unique identifiers.

4.8 Targets by population

Table 4.8.1 ART Targets by Prioritization for Epidemic Control							
Prioritization	Country	Total PLHIV	Expected current on ART (FY22) TX_CURR	Additional patients required for 80% ART coverage	Targets current on ART (FY 23) TX_CURR	Newly Initiated (FY 23) TX_NEW	ART Coverage (FY23)
Attained	Kazakhstan	7,451	5,380	581	6,138	867	82%
Centrally Supported	Thailand	12,549	2,033	8,006			
Scale Up: Aggressive	Burma		11,682		12,036	2,028	
	India	582,965	450,881	15,491	454,215	60,376	78%
	Indonesia		8,701		9,047	511	0%
	Kyrgyzstan	7,556	5,206	839	5,667	524	75%
	Laos	14,154	7,375	3,948	8,821	1,290	62%
	Nepal		18,630		21,193	1,900	
	Philippines		20,654		32,134	3,755	
	Tajikistan	8,648	7,287	-	7,787	606	90%
Scale-Up: Saturation	Thailand	85,661	20,187	48,342	16,154	1,694	19%
	India	54,856	29,914	13,971	32,839	2,930	60%
	Papua New Guinea		6,097		6,907	355	
Sustained	Thailand	101,984	18,067	63,520	20,378	781	20%
	Indonesia		31,904		33,356	2,151	
	Thailand	26,988	7,412	14,178	4,176	331	15%

Table 4.8.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Indicator	Target Population by SNU1	Population Size Estimate (National level data)	Disease Burden* (National level data)	FY23 Target
KP_PREV	Burma			27,699
	FSW (no SNU data available)	75,000	6,225	7,367
	MSM (no SNU data available)	268,000	23,584	10,052
	PWID (no SNU data available)	93,000	32,457	10,008
	TG			272
	India			76,014
	FSW (no SNU data available)	868,000	13,541	43,399
	MSM (no SNU data available)	357,000	9,603	14,034
	People in prisons and other enclosed settings* (no SNU data available)	21,94,364	46,082	215
	PWID (no SNU data available)	177,000	11,080	15,894
	TG (no SNU data available)	70,000	2,198	2,472
	Indonesia			15,021
	MSM (no SNU data available)	502,986	92,046	15,021
	Laos			4,976
	MSM (no SNU data available)	59,966	3,298	4,324
	TG (no SNU data available)	4,600		652
	Nepal			12,373
	FSW (no SNU data available)	49,018	1,078	4,826
	MSM (no SNU data available)	60,333	2,896	5,482
	TG	21460	ND	2,065
	Philippines			35,000
	MSM (no SNU data available)	898,600	53,916	28,000
	TG			7,000
	Tajikistan			1,500
	PWID (no SNU data available)	22,200	2,686	1,500
	Thailand			33,631
	MSM (no SNU data available)	795,189	74,702	31,365
	TG	83,806	3,932	2,266
	TOTAL			206,214
	PP_PREV	Nepal (no SNU data available)	800,618	2,402
Prevention Intervention Total				214,473

Table 4.8.4 Targets for OVC and Linkages to HIV Services					
SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY23 Target) OVC_SERV Comprehensive	Target # of OVC (FY23 Target) OVC_SERV Preventative	Target # of active OVC (FY23 Target) OVC_SERV DREAMS	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY23 Target) OVC*
India	530,000	39,719	0	0	39,455
TOTAL	530,000	39,719	0	0	39455

4.9 Cervical Cancer Program Plans

India is experiencing a rapid health transition with a rising burden of non-communicable diseases (NCDs). The Government of India has been implementing the National Programme for Prevention and Control of Cancer up to the district level under the National Health Mission, providing cytology-based screening for early detection of cervical cancer. The coverage so far has been poor and limited to the tertiary centers and the private sector. Only 30% of 336,777 women aged 30-49 report cervical cancer screening at all times (Source: National Family Health Survey (NFHS)-4).

In the state of Andhra Pradesh, PEPFAR India will focus on health promotion for 60,000 WLHIV between ages 25-50 through behavior change, with involvement of community and civil society. The program will build capacity of front-line workers (ANMs / ASHA workers) for population-based screening by VIA and strengthen referral and linkage to care pathways.

In addition, PEPFAR India will build capacity of medical officers and target 40,000 WLHIV registered at the 40 ARTC and strengthen mechanisms for patient referral to the 12 Medical College hospitals in the state for cytology-based screening according to quality-based standards. PEPFAR, as a technical advisor to India’s MOH, will advocate for integration and absorption of cervical cancer screening and treatment services for WLHIV into the national cancer programs through a strategic framework to achieve the 90-70-90 WHO 2030 global strategy goals.

4.10 Viral Load and Early Infant Diagnosis Optimization

BURMA

[REDACTED]

CAMBODIA

Cambodia has renewed its contract with the Abbott company under the current GF grant 2021-2023. In March 2021, the newest VL platform machine, Alinity m, was installed at the NCHADS lab. Alinity m can detect and quantitate Human Immunodeficiency Virus type 1 (HIV-1) RNA using plasma, serum, and dried blood spot (DBS), and ensure differences in viral loads are true differences and an undetectable result is truly un-transmittable. In addition, we will optimize VL services and diagnostic optimize network through the PEPFAR/CDC Regional Lab Project (Laboratory of Community Practice, LabCoP).

INDIA

PEPFAR **India** will continue to address systemic issues affecting VL scale-up and ensure access to VL testing through differentiated models to close remaining gaps in low VL testing coverage among pregnant and breastfeeding women (PBFW), non-suppressed population, low VL testing coverage and suppression among infants, children, adolescents, and low EID at 2 months. PEPFAR India will work collaboratively with the MOH and other stakeholders to conduct a comprehensive step wise DNO to increase access to testing and network efficiencies based on dual sample type and right mix of POCT and lab-based testing. PEPFAR India will develop and implement a strategically tiered and functional national diagnostic network that leverages Government of India's incredible investments in rapid expansion of molecular technology/platforms during COVID-19 pandemic to increase the testing capacity in public sector and meet the third 95 coverage targets.

INDONESIA

PEPFAR **Indonesia** will continue to expand viral load specimen transport systems across Jakarta and Greater Jakarta; closely monitor viral load supplies at site levels and work to increase viral load test kit allotments for Jakarta and Greater Jakarta by refining forecasting assumptions and leveraging the private sector and local government for additional viral load testing commodities and/or subsidized viral load testing fees.

Site-level clinical assistance will support the use of viral load test results to optimize treatment outcomes and manage suspected treatment failure for patients requiring second and third-line ARV regimens. PEPFAR will work closely with HIV treatment facilities including virtual or face-to-face review meetings with clinical mentors to review patients with high viral loads and discuss appropriate interventions. PEPFAR will support sites to enhance adherence counseling for clients with viral load results above 200 copies per milliliter. Technical support on enhanced adherence counseling will include tool development, webcasts, on-site TA, and an adherence

reminder system for patients. All tools will be actively shared to support viral load testing acceleration across the national program.

KAZAKHSTAN

PEPFAR **Kazakhstan** has been making substantial efforts. Based on CDC laboratory assessment, GFATM purchased and installed 16 PCR machines in all regions. PEPFAR Kazakhstan will continue EQA for proficiency testing for VL and VL literacy in all regions of the country. PEPFAR Kazakhstan supported the capacity building of local lab specialists to perform VL testing in newly established VL testing facilities. The program closely works with treatment sites to assure coverage with VL testing and achieving VLS through constant mentoring and supportive supervision of clinical and community staff in counselling and adherence support for PLHIV along with patient notification through electronic messenger services. The PEPFAR team sees continuous positive trends in VLC and VLS in PEPFAR sites. In ROP22, PEPFAR Kazakhstan will continue ongoing activities with special focus on quality and sustainability of viral load testing including supply chain for VL testing and centralized procurement of VL tests.

KYRGYZ REPUBLIC

PEPFAR **Kyrgyz Republic** made substantial efforts to ensure the availability of efficient and impactful best practices in viral load coverage (VLC) and viral load suppression (VLS). The National Strategic Plan on VL Scaling Up was developed and implemented. Country accepted hybrid type (partly decentralized) of VL services strategy. VL Services were established on regional (oblast) level, increased number of VL testing laboratories nation-wide. Legislative documents, regulating VL services (clinical protocols and national testing algorithm) were developed, approved and implemented by MOH. These changes were supported by infrastructural strengthening via Global Fund. Infrastructure strengthening includes establishing and launching PCR lab facilities, equipped with GX machines and reagents for VL and EID. PEPFAR-supported capacity building of local lab specialists to perform VL/EID testing in newly established VL testing facilities. PEPFAR closely works with treatment sites to assure coverage with VL testing and achieving VLS through constant mentoring and supportive supervision of clinical staff in counselling and adherence support for PLHIV along with patient notification through electronic messenger services. Granular Site Management (GSM) for continuous quality improvement (CQI) implementation to PEPFAR sites proved itself as an effective tool in achievement of PEPFAR MER indicators, including VLC and VLS. We see continuous positive trend in VLC and VLS in PEPFAR sites. In COP22 PEPFAR Kyrgyz Republic will continue ongoing activities with special focus on quality assurance of the VL testing. We will support above site activities including VL laboratory accreditation and routine participation of VL labs in

EQA/PT programs.

LAOS

PEPFAR **Laos** continues to support HIV VL optimization and decentralization has been adopted through the collaboration between the HIV and TB programs by integrating HIV VL testing with existing GeneXpert devices for TB testing. The program was fully implemented in July 2021 in 12 laboratories in 10 provinces. In ROP22, PEPFAR will continue to monitor HIV VL testing performance by supporting the implementation of VL EQA and IQC program in collaboration with Thai NIH and NCLE. PEPFAR will provide technical assistance to support implementation of a VL laboratory service application (VLAOs) to facilitate communication between HIV clinics and laboratories for VL request, specimen tracing, VL result reporting and generating a VL reminder list. PEPFAR will also continue supporting technology transfer for establishment of the Laos HIV VL QA program.

NEPAL

In ROP 22, PEPFAR **Nepal** will continue its support for the national public health laboratory to strengthen the national laboratory system for viral load testing. So far, diagnostic network optimization for VL/EID is done. VL testing site and sample transport is mapped out and will continue monitoring its implementation and support revising it if need be. There is at least one VL machine in each province with back-up sites mapped. PEPFAR Nepal has provided HR support to testing sites with high sample follow to reduce sample backlogs and facilitate timely analysis and result return. Feasibility assessment of use of COVID-19 PCR machines at provincial labs for HIV VL testing is completed. One of the COVID-19 machines is currently being used for HIV VL testing. As a result of these continuous supports, VL testing coverage has continued to improve; in PEPFAR supported sites VL testing coverage has increased to 84%. In ROP22, PEPFAR will work with the government of Nepal, Global Fund and VL testing laboratories to strengthen laboratory systems for VL sample collection/transportation, VL test reagent quantification and procurement, preventive maintenance of VL machines, training and mentoring of laboratory personnel to ensure quality of VL laboratory services include timely return of test results to ART sites for clinical decision making.

PAPUA NEW GUINEA

Papua New Guinea (PNG) will continue to work with GF and other stakeholders and support the 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 VLISM to streamline national level VL and EID testing data reporting. In ROP22, PEPFAR PNG will continue to strengthen support around EID and pediatric case detection to ensure adequate ARV coverage and programming. Through utilizing HIV RTKs, PEPFAR PNG will also support multiplex and STI testing for syphilis.

PHILIPPINES

PEPFAR in the **Philippines** will continue to support the final phase of diagnostic network optimization (DNO) exercise as well as operationalizing the recommendations from the completed DNO in ROP22. Support will be provided for the expansion of viral load testing access and coverage via point-of-care (POC) or near-POC testing platforms to PLHIV in all PEPFAR supported regions.

TAJIKISTAN

In **Tajikistan**, the effectiveness of ART is assessed through routine VL monitoring with results available at six, 12 months after initiation of ART, and yearly thereafter if virologically suppressed. Non-suppressed clients are eligible for targeted VL measurement at 3 months interval.

THAILAND

Thailand offers universal health insurance coverage and has a strong laboratory infrastructure of 92 VL testing facilities using 100+ automated machines with testing capacity to conduct >1,000,000 VL tests/year. In ROP22, PEPFAR Thailand will work to optimize the MOPH VL network strategic plan to leverage access to high-quality VL testing and improve coverage.

For TB and HIV diagnosis integration, GF has supported Thailand to develop the TB/HIV integration guidelines regularly and funded MOPH to diagnose all TB or HIV clients to adhere to the following protocol: all TB clients will receive counseling and testing for HIV, while every HIV client will receive TB screening and x-ray for TB infection. For prisoner clients, MOPH will have a mobile TB/HIV integration team at the provincial level to provide TB screening, portable x-ray and HIV testing annually.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

BURMA

PEPFAR **Burma** identified critical key systems gaps or barriers to achieving sustained epidemic control through analysis of the SID, MER, SIMS, a rapid HIV assessment in 2021, and through continuous discussions with key stakeholders in the Interim Coordination Mechanism. Burma

proposed Table 6 activities with benchmarks and outcomes for ROP22. The key identified gaps or barriers for Burma include:

1. [REDACTED] Inadequate capacity and service availability to deliver **person-centered differentiated services, especially for KPs** especially at public facilities;
2. Limited availability of and ability to use **reliable epidemiologic and programmatic data**, including strategic information for KPs;
3. Inconsistent delivery of **quality HIV services** across HIV care continuum; and,
4. [REDACTED]

In ROP22, PEPFAR Burma proposes the following to address the above key system barriers:

[REDACTED] The program will build CSO, KP and peer networks, and NGO service providers to implement HIV interventions in response to humanitarian crisis and MPRs with fidelity. Capacity building TA will prioritize successful new initiatives in 5 PEPFAR priority states and regions including PrEP scale up, HIVST rollout, and expansion of Index Testing into non-PEPFAR sites. With above-site TA, a locally-led laboratory workforce will be set up through introduction of Quality Corps to help address issues related to laboratory QA/QI.

Person-centered differentiated services, especially for key populations: Above site TA will: strengthen PLHIV and FSW/MSN/TGW networks to enhance outreach prevention activities; support drug user network to deliver person-centered harm reduction services and MAT; bolster KP-competent services that includes KP and peer navigation for active case management, treatment adherence support, stigma and discrimination reduction, improvement of young KP mental health literacy, psychosocial services provision and linkages. Expanding Health Care Worker Sensitization to the NGO sector as KP-friendly service providers as well as PrEP scale up TA and PrEP DSD aim to reach more KPs and at-risk populations.

Data availability and use: PEPFAR Burma will support national data collection and analysis, HIV surveillance elements, program mapping, monitoring and analysis, and collaborating with the GF and stakeholders on the PWID BBS. TA on organizational M&E and data use capacity and research/scientific knowledge and skills for CSOs, PLHIV and KP community networks will inform context-specific, data-driven strategies.

Quality HIV services including laboratory services: Above-site activities will improve the quality of HIV testing, ART, MAT and viral load services through capacity building activities and Service Quality Management System expansion for ART and MAT services. Quality HTS will be achieved through SOPs, M&E guide and training curricula for optimized HTS modalities, standardized training that includes trained KP testers for community-based screening and strengthening QA/QI measures at POC HTS and CBS sites using Rapid HIV Testing Continuous Quality Improvement (RT-CQI) initiatives. PEPFAR will optimize NGO and private sector VL testing services through DNO exercise, improved VL sample networking, strengthened NGO/outsourced labs' VL testing capacity with TA on QA/QI measures and VL EQAS.

Supply chain, human resources, and management of electronic logistic management systems (eLMIS): Through GHSC-PSM, PEPFAR will focus on Forecasting and Supply Planning (FASP) activities, ART optimization, MMD scale-up and the PrEP commodities forecast. GHSC-PSM will manage and maintain the eLMIS system for HIV commodities, promote sustainable data collection through eLMIS development, data usage, dashboard development, and support partners to acquire eLMIS/dashboard capabilities. Burma will also coordinate with key stakeholders to ensure continued ARV supply in country and provide capacity development on supply chain management.

CAMBODIA

For ROP22, PEPFAR **Cambodia** identified major systems barriers through the SID and continuous stakeholder engagement. The challenges that emerged as salient themes across the program include lack of managerial and technical capacity among national and provincial level staff and civil society in the areas of budgeting and financial management, quality monitoring and improvement, optimized treatment, laboratory systems, information systems and case-based surveillance. In addition, lack of data on program costs, an underdeveloped private market, and legal and policy constraints were identified as barriers. Table 6 activities are designed to address these barriers as well as weaknesses noted in the SID in the areas of Domestic Resource Mobilization, Private Sector Engagement, Civil Society Engagement, Service Delivery, Laboratory, and Epidemiological and Health Data. These elements were found to need improvement in the 2021 SID as well as in previous rounds.

As part of its cross-cutting approach to technical assistance, Cambodia's Table 6 activities will strengthen existing government systems with a focus on building country ownership and increasing sustainability. Indicators and benchmarks have been established in close collaboration with government and are aligned with Global Fund and UNAIDS targets. Several activities will support the country's overall digital health strategy, with a focus on increasing interoperability of existing data systems, improving efficiency of operations, and increasing access to timely program data to inform decision-making. These include the Master Patient Index, a consolidated HIV database, which will be piloted in ROP21 and scaled in ROP22; digital outreach approaches for prevention and case finding; and a monitoring and evaluation system and dashboard to track progress of implementing the policy (SCN213) on sustainable financing for HIV. Table 6 interventions will help Cambodia reach 95-95-95 targets by building the country's capacity to deliver high-quality clinical services at facility and community levels, maintain quality laboratory and surveillance systems, and be able to plan and fund HIV activities at provincial and national levels.

INDIA

In determining the program for ROP22, **PEPFAR India** consulted with key stakeholders including the Government of India, communities, and multilateral organizations including GF partners and reviewed the findings of the SID along with other granular assessments in assessing the key system barriers (KSB). The KSB identified specific areas of focus in prevention (PrEP), strategic mix of case finding (with the need to scale up index testing, SNS and self-testing), expansion of person-centered integrated service delivery, applying lessons learned during COVID, including expansion of viral load access by utilizing the results of the prior diagnostic network optimization (DNO) exercises. Finally, there will be an ongoing above site focus on the expansion of integrated data systems and real time epidemic monitoring, and sustainable financing for optimal utilization and leveraging of resources.

Table 6 investments leverage systems investments by the host country government and other donor investments in three key ways: (1) closing the first 95 gap through a mix of comprehensive prevention and testing, with ongoing technical support for GOI one stop centers; (2) person-centered service delivery across the prevention to treatment cascade, including expanded viral load access, scaling proven, evidence-based strategies to decrease treatment interruption; and, (3) working with the GOI on the expanded focus on in strategic information, and cascade and epidemic monitoring towards 95-95-95 goals, including data quality and community led monitoring.

PEPFAR India will continue to focus on quality improvement and quality assurance in the areas of HIV prevention, testing, treatment and adherence. The SIMS visits will be conducted regularly to maintain the gains and ensure maintenance of standards of care of practice.

The timelines and benchmarks were developed to support monitoring of progress on these investments. The GOI has prioritized digital health investments through ongoing investments in the SOCH platform. PEPFAR India will continue to partner with the GOI in this important priority to realize real time data for impact to strategically address program needs. The focus on quality improvement and assurance will lead to institutional systems strengthening with the long-term vision of sustainability across all the PEPFAR geographies.

INDONESIA

In ROP22, PEPFAR Indonesia will continue to focus on the gaps identified. This includes increasing the number and proportion of primary care providers that accept referral mechanisms, and distributing ARVs and logistics (cartridge and consumables) for VL tests (per the JKN guidelines) after one year of dissemination and advocacy. PEPFAR will also support the national government in building capacity to increase PLHIV accessibility to health care facilities. PEPFAR also aims to provide recommendations on the improvement of the essential commodities disbursement system and cost to provide timely delivery to PLHIV by sub-national Governments and on the implementation of telemedicine for those who receive multi-month dispensing of HIV medication. These objectives are to be achieved through the Dissemination and advocacy of the

technical guideline of HIV care under the JKN scheme to subnational Governments and other implementing partners of the HIV program in Indonesia. The advocacy will focus on four main features: access to HIV services under JKN, essential benefits package for HIV, referral mechanism, logistics of antiretroviral (ARV), and viral load testing.

The availability of KP-friendly service provision to deliver a person-centered approach in Indonesia's primary health care setting is still limited. PEPFAR's above site TA intends to strengthen KP and PLHIV networks at national and subnational levels to continue their meaningful engagement with sub-district health facilities, DHO, PHO and MOH to improve their HIV services. For health care providers, PEPFAR will expand the clinical mentoring in the area of Stigma & Discrimination Intervention to public and private health facilities sectors to provide KP-friendly services. PEPFAR Indonesia will also assist community-led advocacy efforts that actively target and engage Indonesia's National Technical Expert Panel to expand evidence-based, person-centered HIV interventions.

In ROP22, PEPFAR Indonesia will collaborate with the Global Fund and other key stakeholders to implement 2022 KP mapping and IBBS for Key Populations and disseminate findings for program planning. PEPFAR Indonesia will also improve the capacity of sub-national governments and CSOs in the data used to enhance program monitoring and program adaptation using evidence-based approaches. Over the programmatic period, community-based partners will regularly access and use programmatic data to strengthen person-centered HIV interventions.

KAZAKHSTAN

PEPFAR Kazakhstan will continue to deliver person-centered services; significantly increase PrEP coverage for the highest risk KPs; revise the national HIV testing algorithm and HIV clinical protocols to reduce time from diagnosis to treatment; increase linkage to and optimize ART; implement Granular Site Management in all 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 service beneficiaries at PEPFAR sites with subsequent correction and advocacy actions; and, support CBO participation in HIV epidemic response decision making activities.

The Kazakhstan SID 2021 has shown improvements in domains such as technical and allocative efficiencies, market openness, national health system, service delivery, policies, and governance since SID 2019. The GOK still needs to involve civil society in decision-making activities, especially in national health financing, implementation of the policies for civil society domestic funding as well as officially recognizing the role of community-based workers. The data for decision making, data quality assurance, and data review for quality issues are still elements of vulnerabilities with low scores. PEPFAR Kazakhstan suggests that the GOK can benefit from cost-effectiveness or efficiency studies and lowering unit costs by reducing fragmentation (e.g.,

pooled procurement, resource pooling, etc). The responsibility matrix demonstrates that there is minimal domestic funding for HIV-related community-based organizations.

The main system barriers included the lack of participation of civil society in the national HIV response. PEPFAR Kazakhstan plans to address by seconding an advisor to KSCDID. The barriers related to the quality of services and data will be addressed by developing CQI instruments. PEPFAR Kazakhstan will also help revise the policies that require updating to respond to the epidemic control changes such as revisions in the testing algorithm and SDART protocols. The system barriers were discussed and agreed upon with the GOK and GF.

Kazakhstan's Table 6 investments represent the priorities of partner country government and other donor investments. PEPFAR Kazakhstan defined timelines, benchmarks, and outcomes to address key systems barriers and Table 6 investments. PEPFAR Kazakhstan will continue implementing key person-centered policies and practices. In terms of Digital Health Investments, PEPFAR Kazakhstan has designed and implemented web-based EHCMS. Kazakhstan's Table 6 focuses on ensuring the quality of newly developed EHCMS.

KYRGYZ REPUBLIC

PEPFAR Kyrgyz Republic will continue to deliver client-centered services; significantly increase PrEP coverage to 60% of the highest risk KPs including community-based PrEP; 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 tools development and further expansion of the online client feedback platform expansion; implement CLM to address concerns and needs of service beneficiaries at PEPFAR sites with necessary adjustments and advocacy actions; introduce Buprenorphine as a second choice at MAT programs; and, expand and improve the quality of low-threshold, integrated MAT/ART/PrEP programs nationwide. In ROP22, the PEPFAR Kyrgyz team will also waive formal registration requirements for PWID to enroll in MAT, train HCWs on revisions of MAT clinical protocol, and implement a communication strategy to create demand for MAT in an effort to improve adherence and treatment continuity of patients in MAT.

Though Kyrgyzstan did not conduct a formal SID for ROP21, the program conducted an internal assessment using the SID tool for ROP22 in FY22 that identified several SID elements as sustainability vulnerabilities with lower scores. These included: Private sector engagement (PSE), Domestic Resource Mobilization, and HRH. As a result, the PEPFAR Kyrgyz Republic team will prioritize all of areas and will continue strengthening essential elements as Service Delivery and Epidemiological and Health data in ROP22.

In addition to the SID, the PEPFAR Kyrgyz team used the MER, SIMS, and other sources, to identify barriers to achieving sustained epidemic control. Close consultation with MOH, GF PRs, IPs, and CSOs/KPs to address gaps and to avoid duplications of TA by other stakeholders in

FY22 resulted in the proposed Table 6 activities with benchmarks and outcomes. Indicated below are some of the identified key barriers in Kyrgyz Republic: The partner country government does not fully monitor, manage, or finance the HIV response and has not diversified its HIV financing models, leading to an inability to leverage the skills of private sector actors for the national HIV response. Additionally, the Kyrgyz national HIV strategic plan does not explicitly address the private sector's role, beyond engagement with private pharmacies for HIV self-testing and use of private labs for sample transportation (paid for by GF). There are no private-public partnerships in HIV and uncertain sustainability of current CBO service delivery models. Limited availability of and ability to use reliable epidemiologic and programmatic data, including KP data, at subnational (oblast) level persist as challenges. Stigma and discrimination toward KPs remain key barriers for HIV services in Kyrgyz Republic.

Private sector engagement: As a first step in increasing PSE, a national health private sector landscape assessment will be conducted in FY22; the results will guide TA provision to the partner government to develop a strategic and legislative framework for private sector engagement in the HIV response. The PEPFAR Kyrgyz team will also continue promotion and rollout of innovative financing solutions for CSO sustainability, building from the ongoing landscape analysis in FY22 by the EpiC project.

For domestic resource mobilization, PEPFAR Kyrgyz Republic will further strengthen the State Social Contracting mechanism through support of CSO HIV service standards development and tariffication of the services, which will feed into support of financing of CSO HIV services through the Mandatory Health Insurance Fund (MHIF). The program will support the GF HRH exercise relevant to Social Contracting staff. The PEPFAR Kyrgyz team plans to increase community local partners capacity to become USG local partners, and to support certification and licensing of CSOs to build a legislative basis for differentiated service delivery (community-based testing, confirmatory, ART and PrEP).

PEPFAR Kyrgyz Republic, along with partners such as UNAIDS, will build capacity of local sub-regional/oblast level health workers to routinely utilize reliable epidemiological and programmatic data, including KP data. Local epidemiologists and M&E staff will be trained on SPECTRUM to conduct this exercise independently. PEPFAR Kyrgyz Republic will support development/finalization and implementation of the Action plan to address key findings of HIV Stigma Index report.

PEPFAR Kyrgyz Republic has developed timelines, benchmarks, and outcomes adequately defined to support monitoring of progress towards addressing key system barriers and Table 6 investments. Digital health investments 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. To improve data for decision making, PEPFAR in the Kyrgyz Republic will work to improve client-centric monitoring and management and provide TA to HIV services to introduce LIMS in RAC. The Kyrgyz team will support HIV CBS activities to monitor trends in high-risk populations; to

build capacity and institutionalize data use at the national and sub-national levels through remote and on-site workshops for Republican and Oblast level staff; to strengthen the RNC management capacity of EMR; implement a QR-code-assisted based patient registration and methadone dispensing system countrywide; integrate recency testing into the routine case-finding processes; and, introduce DHIS2.

In Kyrgyz Republic, PEPFAR investments align with the geographic disease burden, concentrated in 4 SNUs where PEPFAR works. These SNUs account for 81% of all PLHIV. The Kyrgyz Republic PEPFAR program will work aggressively to achieve and sustain UNAIDS 95-95-95 goals among KP groups in priority locations, closing the remaining gaps towards epidemic control. The program 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.

LAOS

Among the areas assessed during SID consultation in 2021, one of the lowest SID scores was civil society engagement, specifically Civil Society and Accountability for HIV/AIDS and Government Channels and Opportunities for Civil Society Engagement, which declined from 2019 SID assessment. Therefore, during ROP22, one of the key Table 6 system investments will focus on building KP/PLHIV CSO capacity through the CLM initiative to: 1) evaluate the PEPFAR-supported HIV service deliveries in the areas of prevention and treatment, testing including index testing and IPV, and stigma and discrimination; and, 2) establish a formal mechanism for KP/PLHIV CSOs to regularly communicate their issues (including stigma and discrimination) that hinders their access to essential HIV services and their continuation of treatment.

During the SID assessment in 2021, the Management and Monitoring of Laboratory Services, and Viral load infrastructure decreased since the 2019 SID. The risk of misdiagnosis will increase as Laos expands and decentralizes the access to HIV testing. The EQA programs will be a priority to improve accuracy and reliability of the test result.

In ROP22, PEPFAR will continue to strengthen national EQA program for HIV testing to support all VCT sites as well as for recency and VL EQA to cover all ART and POC ART testing sites. PEPFAR will also further improve Lab Information System (LIS) to collect data and utilize information to support quality of HIV service including expansion of Viral Load Assistant and Ordering System (VLAOs application) to all ART and POC ART sites to help generate VL reminder report. Building public health staff and local CBO capacity to use epidemiological and program monitoring data from surveillance and DHIS2 system will be continued to increase M&E skills and effective data utilization for program planning and improvement of quality of services.

NEPAL

Nepal used a comprehensive assessment of system level investment needs to determine and prioritize investment areas for ROP22. The recent SID exercise completed in November 2021 helped inform the program priorities. In addition, the PEPFAR Nepal team reviewed prior year system level investments, MER, and SIMS data to inform status of major system level issues and barriers hampering progress. The team also consulted stakeholders to identify their prioritized system level investments to avoid duplication of efforts. Hence, for ROP22 PEPFAR/Nepal has prioritized to address the following barriers and planned interventions accordingly:

1. One of the barriers PEPFAR/Nepal will work to address is **lack of standardized robust systems to capture HIV program data and capacity limitations to use programmatic data** (including KP data) to inform decision making at national and subnational levels. Currently PEPFAR Nepal supports the national HIV program in developing and rolling out One National HIV Information System (ONHIS) and training HIV service delivery sites on the system use. In ROP22, PEPFAR Nepal will continue supporting complete rollout of ONHIS, maintain the system and use data generated from the system to inform decision making. In addition, integration and interoperability of ONHIS with HMIS and eLMIS will be supported to facilitate better data triangulation and monitor progress toward HIV epidemic control.
2. There remains a **delay in adopting differentiated service delivery and implementation of multi-month ART dispensing** to stable ART service recipients. While this is an important intervention to ensure treatment continuity, VL suppression, and management of advanced HIV diseases, the delay is mainly due to lack of sufficient financial resources to secure ARVs in a timely fashion to avoid stockouts while implementing MMD. There is also limited experience with MMD interventions. In ROP21, PEPFAR Nepal is providing TA on HIV commodities security and has procured sufficient stocks of TLD to replenish the national ARV buffer stock. The program continues to advocate with the national HIV program and stakeholders, including PLHIV networks, to launch the implementation of MMD in the country with an aim to initiate MMD in the remaining quarters of FY22. In ROP22, PEPFAR Nepal will continue providing system level TA support needed to ensure MMD is implemented at all supported ART sites and city clinics.
3. Nepal's HIV program has shown good progress toward HIV epidemic control and ensuring sustainability of the epi-control is the main area of focus. However, **limited domestic financial resources for the HIV response remains a gap to be addressed**. In ROP21 PEPFAR Nepal is providing TA to build capacity of CSOs and facilitate increased domestic resource allocation by the GON and access to state funding by CSOs. To this end, PEPFAR supported development of advocacy tools. In ROP22, TA support will focus on adoption and use of advocacy tools for domestic resource mobilization and supporting GON in developing and implementation of the national HIV program sustainability plan so that the host

government quantifies the need to sustainably finance the national program and increase its resources allocation and expenditure.

4. **Viral load testing coverage is lagging due to system level and site level reasons.** Currently PopVLS is at 59%. In ROP22, PEPFAR Nepal will support the national laboratory program to continue improving its system for VL testing services, implement its standards, and optimize its processes. PEPFAR will work with the national program and the GF to make VL testing services accessible, to ensure sufficient VL reagents, and to ensure VL machines continue to operate optimally. PEPFAR will support efforts to make VL services accessible to all eligible PLHIV on ART as well as provide training and HR support to ensure VL testing laboratories have adequately trained human power to run VL testing and timely produce test results.
5. **Civil society engagement in Nepal remains critical to achieving sustainability.** In ROP22 PEPFAR Nepal will continue building CSO capacity to actively participate in the overall HIV service quality monitoring and improvements. CSO will lead implementation of Community Led Monitoring and use findings from CLM to inform and advocate for improvements and accountability.

PAPUA NEW GUINEA

PNG is one of few countries in the PEPFAR Asia Pacific Region with increasing HIV infections and still continues to face significant challenges in delivering basic health services. PEPFAR PNG's program, although small, has traction to continue providing technical expertise in health informatics, treatment guidelines, and laboratory systems strengthening for HIV VL testing. PEPFAR PNG also recognizes the HRH capacity gaps in country and will continue working with partners and the NDoH to ensure there is adequate coverage of key HIV positions through advocacy and planning, and additionally through providing TA support through implementing partners.

Activities proposed in Table 6 for ROP22 are a continuation from ROP21 and account for investments made by the GoPNG and other development partners. Table 6 investments are aligned with NDOH strategic direction and in collaboration with other donors/partners to optimize impact. PEPFAR PNG has defined appropriate timelines, benchmarks and outcomes to address key systems barriers as defined in Table 6. Outcomes aimed at addressing key systems barriers are outlined in table 6 have strategic benchmarks and realistic timelines, in consultation with other partners and NDOH. At this time, PEPFAR PNG will not be exploring Digital Health Investments.

PEPFAR PNG contributed directly to the updates in HIV guidelines to increase the national HIV program's ability to disseminate and increase the effectiveness of the HIV response as one indication of improved health systems. PEPFAR PNG has invested in Health Information Strengthening, care and treatment guidelines development, and VL testing expansion. PEPFAR

PNG's investments in care and treatment guidelines have resulted in ART optimization at the national level. PEPFAR was also instrumental in ensuring PNG's guidelines were updated and pDTG 10mg introduced for CLHIV <20kg. Additionally, PEPFAR investments in VL has resulted in the formulation of the viral load algorithm and roll-out which has been hampered by COVID; however, testing is available through GeneXpert platform in non-PEPFAR sites in all provinces.

In Health Information Strengthening, PEPFAR has invested in updating the surveillance system to capture KP data and ANC with EID testing data as well which has been adopted by NDoH and is currently rolled out. PEPFAR's investment in HPDB has seen a dramatic improvement to align with client uptake books, improved functionality, and expansion. Currently at 43 HPDB sites covering about 60% of PLHIV on ART, GF has committed to expanding HPDB to 125 sites covering >90% of PLHIV on ART. PEPFAR PNG will continue to provide TA and ride on HPDB expansion to support integration of HIV databases (HPDB, VLISM, surveillance and mSupply) into a data hub.

These strategic investments with PEPFAR's limited budget have filled critical gaps and have been catalytic to donor programming to achieve epidemic control under the leadership of NDoH. NDoH has embraced PEPFAR's investments but has a continued need for additional capacity building to sustain gains.

PEPFAR PNG utilized the SID-lite conducted in 2021 to identify the elements requiring the most attention and that also correlated with existing program activities and PEPFAR investments to have an increased strategic focus for ROP22 addressing the increasing national HIV infections through the introduction of PrEP and increased testing for women and children to prevent PMTCT and manage CLHIV cases. PEPFAR PNG will increase focus on HIV services for KPs as well as supporting community organizations to lead and influence the quality of the HIV program in the NCD and nationally. Through results from the SID, MER, national estimates, and assessments of the current national HIV program, PEPFAR PNG identified the following as key system gaps or barriers in PNG:

Service Delivery: Despite the finalization of a number of HIV-related guidelines through ROP 21 (e.g., three-test HIV algorithm guidelines and SGBV Clinical Guidelines, among others), the Government of PNG (GoPNG) still requires additional TA to operationalize the guidelines. Additional resources for training are needed to implement innovative DSD models and ensure delivery of high-quality services. Programmatic improvements are required to implement findings from an LTFU analysis and ensure delivery of high-quality services for PLHIV. In ROP22, PEPFAR PNG will work with the NDoH and partners to ensure dissemination and implementation of key policy guidelines are adopted by PHA's and sustained CQI activities will be integrated to improve quality of care for PLHIV and improve retention.

Laboratory: The national-level shift in focus and resources to COVID-19 caused a significant drop in VL testing coverage. VL machines in PNG are not being utilized to their full potential. In

ROP22, PEPFAR PNG will improve VL testing coverage and sustain VL suppression by working closely with the NDoH and Global Fund to implement recommendations from the DNO conducted in ROP21. Additional TA will be provided to optimize utilization of current VL machines in PNG.

Civil Society Engagement: CSOs are not being sufficiently resourced and utilized to support the GoPNG's HIV priorities and they have insufficient technical, operational, and management capacity to transition to receive USG funding. In ROP22, PEPFAR PNG will leverage recommendations from CLM activities conducted in ROP21 to improve CSO ownership of the HIV response. PEPFAR PNG will build on recommendations from an Organizational Capacity Assessment (OCA) planned in ROP21 and will work with key development partners to strengthen CSOs' management, operational and financial capacities.

Commodity Security and Supply Chain: The NDoH requires additional TA to increase their capacity to conduct accurate forecasting for ART and commodities in order to plan for sufficient budgetary allocation. In ROP22, PEPFAR PNG will provide TA to the NDoH to forecast more accurately budgetary and commodity needs and strengthen supply chain activities.

Epidemiological and Health Data: PNG does not have an integrated, updated, and responsive SI data system that accurately reflects epidemiological changes at the provincial level. In ROP22, PEPFAR PNG will strengthen the HIV surveillance system, HPDB and establish a HIV data hub linked to the PNG eNHIS. PEPFAR will provide TA to strategic PHA's to utilize improved Health Information systems to inform strategic programming to address critical gaps.

PHILIPPINES

Performance to date as reflected by MER indicators, findings from the SID-Lite that the country team undertook, and the broad consultation across stakeholders guided the the identification of critical ROP22 program support. MER data shows that the Philippines continues to contend with high treatment interruption and low viral load suppression due to low testing coverage. The SID-Lite highlights gaps in laboratory optimization, procurement and supply chain, as well as the monitoring of investments at the municipal level. Meanwhile, the Department of Health's Epidemiology Bureau explicitly requested for assistance in further strengthening the country's case-based surveillance particularly in relation to the new testing modalities introduced by PEPFAR. These were all taken into account in determining the support to be provided by the Philippine PEPFAR program for ROP22.

Strategic Information and Surveillance Systems Investments: The country's case-based surveillance system is currently migrating to its new platform the One HIV/AIDS, and STI Information System (OHASIS). Support will be provided towards integrating data capture and tracking for testing including modalities to be scaled up by PEPFAR (i.e., index testing, network testing approaches) and PrEP. PEPFAR Philippines assistance will also include TA support for

the next iteration of the IHBSS with additional sites proposed for PWID and FSW populations along with HIV surveillance proposed for AFP. Enhancements to IHBSS will incorporate novel population size estimation methods including social networking apps. Furthermore, recent infection surveillance due to begin in FY23 will further bolster a more targeted and efficient programming and response.

Although the Philippines has a robust case-based surveillance system that tracks patients across the HIV care cascade key gaps exist that require further support. The Philippines relies on antibody-based serologic testing that has no capacity to detect acute HIV infection (AHI), missing critical opportunities to maximize the benefits of treatment. To build capacity to diagnose and intervene during AHI, the program will build on work started in FY22 and introduce AHI screening via a pilot study in selected supported sites with existing infrastructure to conduct the test. Additionally, the availability of epi data specific to the military population is limited. This surveillance activity aims to increase the understanding of the epidemic in the military context through characterizing cases identified within a larger military surveillance system, which will leverage other non-PEPFAR DOD supported health investments.

Procurement and Supply Chain: While the Philippines has an established supply chain management system, procurement inefficiencies continue to be a major challenge. The country currently has limited national suppliers of HIV medicines and commodities, which offer pricing far above the competitive global rates. As a result, the PEPFAR program will work to develop a pooled procurement framework to allow the Philippines Government to access more competitive pricing.

Sustainable Financing of the HIV response: Domestic spending on the HIV program and associated medicines/commodities occurs primarily at the national level. As part of the Philippine Government's increased devolution of financial responsibility and program management to local government units (LGU), PEPFAR will build LGU capacity to effectively budget for and manage HIV service provision.

Continuous Quality Improvement: PEPFAR Philippines will support national CQI efforts through partnership with the DOH at national and regional levels, including the Centers for Health Development, supporting the development, enhancement and implementation of a national QI/QM plan and strategy, with mentoring of DOH staff to use data to drive improvement, partner with regional networks to reduce stigma and the utilization of a virtual learning platform with facility and community providers to build capacity for medical case management, complex medical management of advanced HIV disease, mental health, and gender-affirming care.

Strengthening Laboratory Systems to achieve 95-95-95:

PEPFAR Philippines will continue to advocate for and develop tools and resources to streamline the rHIVda accreditation process; facilitate its expansion; and support rapid SDART scale up. The results of the DNO assessment, anticipated in late FY22, will inform programmatic

interventions to optimize the current testing platform to improve access and uptake of routine VL testing and timely receipt of results for patients. This will promote improved treatment adherence and increase early detection of treatment failure.

TAJIKISTAN

In ROP22, PEPFAR Tajikistan prioritized key system barriers to help improve progress across the continuum of HIV services from prevention and to viral load suppression for PLHIV. For example, in Tajikistan, a key system barrier is “Legal, policy or regulatory constraint”, which does not allow the implementation of methadone take-home doses and introduction of Buprenorphine as an alternative to methadone limits MAT coverage. To improve MAT coverage, the Tajikistan PEPFAR team, jointly with IPs, suggested an above-site activity intended to remove this barrier to greater MAT coverage.

Through the SID, MER, SIMS, and other sources, the PEPFAR Tajikistan team identified barriers to achieving sustained epidemic control and in close consultation with MOH, GF PRs, IPs, and CSOs/KPs and proposed Table 6 above-site activities with baseline, benchmarks, and measurable indicators to remove identified barriers. These barriers guided the continued ROP22 program in Tajikistan and are listed further below.

The PEPFAR Tajikistan team adequately defined timelines, benchmarks, and outcomes for each proposed above-site activity to support monitoring of progress towards addressing key system barriers identified in Table 6. To determine and prioritize investment areas for ROP22, the Tajikistan PEPFAR team used a comprehensive assessment of system level investment needs which are mentioned in the Table 6. The PEPFAR team also reviewed prior year system level investments, MER and SIMS data to inform status of major system level issues and barriers hampering progress. During the stakeholder’s meeting and separate consultation, we have also identified their prioritized system level investments to avoid duplication of efforts. In addition, we have used the findings from the conducted first “light” version of SID in FY22 as one of the sources of information. Hence, for ROP22 PEPFAR Tajikistan has prioritized to address the following barriers and planned interventions accordingly:

1. **Stigma and discrimination** remain one of the persisting challenges hampering progress towards HIV epidemic control efforts in Tajikistan. To address this barrier, PEPFAR Tajikistan in ROP22 is planning to support country on implementation of the Action plan intended to address key findings from HIV Stigma Index and the Global partnership to eliminate all forms of HIV related stigma and discrimination;
2. **Limited domestic financial resources for the HIV response** in Tajikistan remains a gap toward HIV epidemic control and ensuring sustainability of the epi-control to be addressed in ROP22. In ROP21 PEPFAR Tajikistan is providing TA to the MOH on social contracting and developing initial plans for social contracting for community-led organization to support the cascade of HIV services for KPs and PLHIV. In ROP22, TA support will focus on

enhancing advocacy efforts for increasing domestic resource mobilization and supporting capacity building activities for local CBOs to apply and implement social contracting funds;

3. **Civil society engagement** was also another area of sustainability element found in need of support to ensure sustainability. In ROP22 PEPFAR Tajikistan will continue building CBOs capacity to actively participate in the overall HIV service quality monitoring and improvements. CBO will lead implementation of Community Led Monitoring and use findings from CLM to inform and advocate for improvements of quality of HIV services and accountability;
4. One of the barriers in Tajikistan is **limited implementation of PrEP due to low awareness and demand generation for PrEP as well as MAT** due to policy constraints to implement methadone take-home doses and introduce Buprenorphine as alternative to methadone. To address this barrier PEPFAR Tajikistan will support technical working groups (TWG) to promote methadone take-home doses and introduction Buprenorphine as alternative to methadone;
5. **Tajikistan does not have technical expertise to establish and implement recency surveillance.** To address this barrier PEPFAR Tajikistan will support key specialists in applying HIV Avidity (Recency testing), support conducting HIV Avidity (Recency) Testing in the country for all newly diagnosed HIV individuals aged 15 years and older, data analysis from recency testing to monitor epidemic trends and inform public health response to better target program resources; and
6. Tajikistan **has limited technical expertise to establish and implement case surveillance.** PEPFAR Tajikistan will support establishing HIV case surveillance system to capture and report continuous individual-level demographic, clinical, and behavioral data on all unique PLHIV diagnosed with HIV and to use this data to monitor epidemiological trends, identify geographic areas and subpopulations with higher-than-expected new diagnoses and/or gaps in the clinical cascade, and inform targeted and timely public health response to achieve or maintain epidemic control.

Tajikistan does not have funds to conduct drug resistance surveillance thus it is a challenge to monitor early emergence of DTG resistance. PEPFAR in Tajikistan proposed to establish a system for implementation of the Cyclical Acquired Drug Resistance Patient Monitoring (CADRE) among virally non-suppressed HIV patients on dolutegravir-based regimens in Tajikistan.

THAILAND

Through the HIV/AIDS Sustainability Index and Dashboard (SID), Monitoring, Evaluation, and Reporting (MER), Site Improvement through Monitoring System (SIMS), and other sources, PEPFAR Thailand 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 MOPH to address gaps and to avoid TA duplications with other stakeholders in FY23. Indicated below are the 2 most commonly identified key system gaps or barriers:

- 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. Fidelity in implementation to scale many of the MPRs: index testing, DSD including MMD, SDART, TPT, TLD, especially tailored to KP needs, remains a challenge.
- Unclear structure to conduct quality management/quality improvement as specified and documented in the National Strategic Plan to End AIDS 2017-2030 and supported by the National Health Accreditation Institute (HAI). There is a need for a clear structure, dedicated focal points, and domestic funds to conduct QI at the sub-national level in high HIV burden areas.

Monitoring the process and outcomes of these PEPFAR supported interventions will be undertaken by strengthening site-level continuous QI across the HIV cascade and nationally by measuring progress towards 95-95-95. The national HIV Info Hub is a PEPFAR supported data system that serves as a data repository for various existing data streams. It is also used to manage, visualize, and monitor national HIV epidemic trends, investments, and program response. The system was established 2018 and in ROP22 PEPFAR Thailand will provide support to upgrade and advance data analysis of national and sub-national indicators. New indicators (e.g., PrEP, index testing, MMD, CLM, TLD transition) will be included to monitor the PEPFAR intervention package at site, sub-national and national level to allow the country to continue to self-monitor PEPFAR and national program investments. The data warehouse plan developed in ROP21 will be implemented in ROP22 to increase efficiency in data management, governance, security and data sharing capacity.

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 will be addressed continuously to ensure improved access and uptake of routine VL testing and timely receipt of results for patients to improve adherence and increase early detection of treatment failure.

Strengthening KP CSO sustainability remains high on the list of priorities. PEPFAR Thailand will continue to roll out CHW and CSO certification and accreditation as well as advocate for an appropriate social contracting mechanism to increase potential resources for CSOs. Certification

and accreditation for community health workers and their organizations is required for CBOs to access domestic funding. The first-ever certified CHWs for HIV services were announced in ROP21. However, provincial roll out is delayed and affects the ability of CBOs to access multi-year funding rather than annual contract renewals. The consequence is a 3-month funding gap every year.

PEPFAR Thailand will enhance the tracking of KPs receiving continuous prevention packages to better understand service utilization and practices for sustainability purposes. Finally, PEPFAR Thailand will conduct innovative capacity building through telehealth, ECHO, and digital tools for HIV diagnosis, treatment and care improvement.

For CSO sustainability, the first issue is domestic funding. NHSO is the main domestic health financier for HIV services and grants prevention and they fund \$6.7m annually and will continue to support KP-CBOs to increase access to this fund. In ROP22, to better ensure consistent funding flows to CBOs, NHSO has changed the current social contracting mechanism from project contract based (where CBOs have to resubmit and re-sign contracts annually) to a monthly basis. To be a node of HIV services under NHSO healthcare provider's system, NHSO will reimburse HIV services on a monthly basis based on the performance of reach, recruit and test. In addition, NHSO will allow all CBOs to access HIV positive retention funds (600THB/Case/Year) which originally only the PLHIV network group could access.

To diversify funding, PEPFAR Thailand has supported a social enterprise business model, including a specific business enterprise linked to one of our CBOs in ROP21. This activity aims to demonstrate feasibility to other CBOs and will be built upon and disseminated to others through the regional technical learning and sharing platform as resources allow.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

In ROP21, the ARP distributed assets model has been difficult to achieve for several main reasons: 1) country-level staffing shortages, 2) PARCU and PCO staffing shortages; 3) lack of dedicated regional level of effort (LOE) explicitly designated for key “distributed assets” positions; and 4) increased OGAC processes and requirements that have not been tied to additional resources or staffing. These issues have been compounded by additional demands of the prolonged COVID-19 situation (task shifting; TA trips canceled/postponed), the civil unrest in Burma, and the starting of three new agency offices in the Philippines.

The PARCU itself is composed of three members: the Asia Region PEPFAR Coordinator, one CDC representative and one USAID representative. The Asia Region PEPFAR Coordination Office (PCO) supports the PARCU and provides regional operational support. By the end of FY22 Q3, the PCO plans to hire an FTE FSN Deputy PEPFAR Coordinator. The ARP PCO includes the Deputy PEPFAR Coordinator (1.0 FTE), regional Strategic Information Advisor

(.25 FTE), and the Administrative Assistant (1.0 FTE). In ROP22, the PARCU budget will continue to cover salaries for the PEPFAR Coordinator position, the Deputy PEPFAR Coordinator position, two agency representatives (each devoting .30 LOE to PARCU/.70 LOE to country support for a total 100% ARP support per advisor), an administrative assistant, and .25 of a USAID SI advisor position. As a note, CDC HQ traditionally has always provided 1-2 HQ PHA advisors that are allocated 100% during COP/ROP season to PARCU. Other costs also include ICASS, Embassy office operating costs, regional TA travel (for PARCU and country teams), technical exchanges, and routine meeting costs. To be optimally responsive to the region and to OGAC, and to operate effectively as one Operating Unit, ROP22 PARCU/PCO staffing contingencies will support any potential PEPFAR Coordinator coverage requirements, ROP23 support, and gap/surge needs. In ROP22, the PARCU budget will also provide \$3.25 million for the region's unifying collaborations that intend to enhance sharing of knowledge, resources, best practices, and tools. For ROP22, CDC and USAID have both proposed unifying collaboration activities that build upon their ROP21 activities.

The Philippines is slowly emerging from what is considered the most severe COVID-19 outbreak in the Southeast Asia region. As a result, **PEPFAR Philippines** program was delayed in launching activities including establishment of three new agency PEPFAR programs (DOD, CDC, and HRSA). Prior to ROP21, USAID was the only agency in-country launching activities in ROP20. HHS agencies (CDC, HRSA) signed a Memorandum of Understanding with the Government of the Philippines in May 2022 that will allow them to implement planned activities. During ROP21, PEPFAR will accelerate the start of program delivery providing critical support to the burgeoning HIV epidemic in the country. Recruitment of staff is ongoing and there are no plans to request additional staff in ROP21. In support of PEPFAR's continued transition of HIV services to local partners, OGAC has approved one additional Locally Employed Staff (LES) to be added to USAID staffing in Kyrgyz Republic and Indonesia; these positions will be recruited in ROP 22.

USAID's PEPFAR funding for cost-of-doing-business (CODB) includes resources to provide targeted support to partners to meet rigorous PEPFAR results and expenditure reporting requirements, as well as USAID award compliance guidelines. USAID's CODB ensures adequate staffing to design, award, and effectively manage implementing mechanisms as well as anticipated surge support requirements when necessary. Failure to approve the requested level could lead to inadequate oversight and reporting delays.

The USAID staffing pattern in **Thailand** remains unchanged from that proposed in ROP21. USAID has made steady progress in filling vacant positions and anticipates only two remaining vacant positions at the start of ROP22. The requested USAID CODB for ROP22 is decreased to reduce travel budget and delay hiring of two positions to maximize the funds available to KPLHS sites in this fiscal year to support stability in a transition to NHSO funding. In ROP22, CDC **Thailand**'s CODB budget has been reduced from the ROP21 level partly due to savings in staffing costs and ICASS along with reductions to professional development and non-ICASS

cost categories to apply toward implementing partner activities. After conducting an internal staffing review, some roles are being modified to complement implementing partner technical and management needs for successful programming. In addition, there will be no new position requests in FY23 for CDC.

HIV Prevalence (%)	India		0.22		NA		NA		NA		NA		NA		NA
HIV Prevalence (%)	Indonesia		0.2		0.03		0.03		0.11		0.15		0.21		0.36
HIV Prevalence (%)	Kazakhstan		0.3		n/d		n/d	0.03	0.03	0.03	0.03	0.25	0.25	0.25	0.25
HIV Prevalence (%)	Kyrgyz Republic	-	0.14		1%		2%	-	4%	-	6%	-	15%	-	35%
HIV Prevalence (%)	Laos		0.22		0.02%		0.02%		0.10%		0.13%		0.31%		0.47%
HIV Prevalence (%)	Nepal		0.13		0.01		0.01		0.02		0.02		0.14		0.26
HIV Prevalence (%)	Papua New Guinea		0.89		NA				1.1		0.68		1.1		0.68
HIV Prevalence (%)	Philippines		0.2		NA				<0.1		0.2				
HIV Prevalence (%)	Tajikistan		0.2		0.1		0.1		0.2		0.2		0.2		0.2
HIV Prevalence (%)	Thailand		0.079		0.0002		0.0002		0.0019		0.0037		0.0085		0.0125
AIDS Deaths (per year)	Burma	7,700		ND		ND		ND		ND		ND		ND	
AIDS Deaths (per year)	Cambodia	1,166		26		27		51		49		580		433	
AIDS Deaths (per year)	India	31940		NA		NA		NA		NA		NA		NA	
AIDS Deaths (per year)	Indonesia	25,842		1,127		1,182		281		374		8,188		14,690	
AIDS Deaths (per year)	Kazakhstan	152		8		10		0		1		41		92	
AIDS Deaths	Kyrgyz	94		2		4		0		1		9		78	

nal, double)														
Orphans (maternal, paternal, double)	Kazakhstan	23,410		N/A		N/A		N/A		N/A		N/A		N/A
Orphans (maternal, paternal, double)	Kyrgyz Republic	NA		N/A		N/A		N/A		N/A		N/A		N/A
Orphans (maternal, paternal, double)	Laos	NA		N/A		N/A		N/A		N/A		N/A		N/A
Orphans (maternal, paternal, double)	Nepal	NA		N/A		N/A		N/A		N/A		N/A		N/A
Orphans (maternal, paternal, double)	Papua New Guinea	9,300		N/A		N/A		N/A		N/A		N/A		N/A
Orphans (maternal, paternal, double)	Philippines	ND		ND		ND		ND		ND		ND		ND
Orphans (maternal, paternal, double)	Tajikistan	ND		ND		ND		ND		ND		ND		ND
Orphans (maternal, paternal, double)	Thailand	ND		ND		ND		ND		ND		ND		ND
Notified	Burma	105,380		ND		ND		ND		ND		ND		ND

s that are HIV infected															
% of TB cases that are HIV infected	Tajikistan	118	2.9%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
% of TB cases that are HIV infected	Thailand	ND													
% of Males Circumcised	Burma	NA	NA			NA	NA			NA	NA			NA	NA
% of Males Circumcised	Cambodia	N/A	N/A			NA	NA			NA	NA			NA	NA
% of Males Circumcised	India	NA	NA			NA	NA			NA	NA			NA	NA
% of Males Circumcised	Indonesia	105,257,965	76.50%			13,701,000	40%			20,633,930	89%			70,923,035	89%
% of Males Circumcised	Kazakhstan	NA	NA			NA	NA			NA	NA			NA	NA
% of Males Circumcised	Kyrgyz Republic	NA	NA			NA	NA			NA	NA			NA	NA
% of Males Circumcised	Laos	NA	NA			NA	NA			NA	NA			NA	NA
% of Males Circumcised	Nepal	NA	NA			NA	NA			NA	NA			NA	NA

Estimated Population Size of FSW	Indonesia	277,624													
Estimated Population Size of FSW	Kazakhstan	20,250													
Estimated Population Size of FSW	Kyrgyz Republic	7,100													
Estimated Population Size of FSW	Laos	16,386													
Estimated Population Size of FSW	Nepal	49,018													
Estimated Population Size of FSW	Papua New Guinea	16,100													
Estimated Population Size of FSW (2020)	Philippines	87,500													
Estimated Population Size of FSW	Tajikistan	17,500													
Estimated Population Size of FSW	Thailand	47,231													
FSW HIV Prev	Burma	6,225	8.3					NA	3.1			NA	6.8		

of Priority Populations Prevalence (specify)	New Guinea																		
Estimated Size of Priority Populations Prevalence (specify)	Philippines	N/A	N/A																
Priority Populations HIV Prevalence (labour migrants)	Tajikistan	4	0.4%																
Priority Populations HIV Prevalence (labour migrants)	Thailand	ND	ND																
Data source	Burma	# PLHIV-Data source: UNAIDS 2020 AIDS Databook Myanmar; % of Males Circumcised-Data source: N/A; % of Pregnant Women with at least one ANC visit -Data source: UNICEF: State of the World's Children 2021; % of TB cases that are HIV infected-Data source: WHO: TB Country Profile 2021; AIDS Deaths (per year)-Data source: UNAIDS 2020 AIDS Databook Myanmar; Annual births-Data source: UNICEF: State of the World's Children 2021; Estimated Population Size of FSW-Data source: FSW BBS 2019; Estimated Population Size of MSM*-Data source: MSM BBS 2019; Estimated Population Size of PWID-Data source: PWID BBS 2017; Estimated Size of Priority Populations (specify)-Data source: N/A; Estimated Size of Priority Populations Prevalence (specify)-Data source: N/A; FSW HIV Prevalence-Data source: FSW BBS 2019 and HSS 2020; HIV Prevalence (%)*-Data source: AEM estimates Apr 2019; UNAIDS 2019 estimates; Age and disaggregation available for Adult Females 15+ and Adult Males 15+.; Incidence Rate (Yr)-Data source: UNAIDS 2020 AIDS Databook Myanmar; MSM HIV Prevalence-Data source: MSM BBS 2019; New Infections (Yr)-Data source: UNAIDS 2020 AIDS Databook Myanmar; Notified TB cases (2020)-Data source: WHO: TB Country Profile 2021; Orphans (maternal, paternal, double)-Data source: N/A; Pregnant women needing ARVs-Data source: UNAIDS Factsheet Myanmar 2019; PWID HIV Prevalence-Data source: PWID BBS 2017; Total Population (2020)-Data source: Union Population Projections based on Census 2014, The Department of Population, Myanmar																	

Data source	Cambodia	# PLHIV-Data source: Preliminary HIV estimates 2022, AEM spectrum; % of Males Circumcised-Data source: N/A; % of Pregnant Women with at least one ANC visit -Data source: National PMTCT report 2020; % of TB cases that are HIV infected-Data source: CENAT Report, 2021; AIDS Deaths (per year)-Data source: Preliminary HIV estimates 2022, AEM spectrum; Annual births-Data source: General Population Census of the Kingdom of Cambodia 2019; Estimated Population Size of FSW-Data source: Preliminary HIV estimates 2022, AEM spectrum; Estimated Population Size of MSM*-Data source: Preliminary HIV estimates 2022, AEM spectrum; Estimated Population Size of PWID-Data source: HIV estimates 2021, AEM spectrum; Estimated Size of Priority Populations (TG)-Data source: Preliminary HIV estimates 2022, AEM spectrum; Estimated Size of Priority Populations Prevalence (TG)-Data source: Preliminary HIV estimates 2022, AEM spectrum; FSW HIV Prevalence-Data source: Preliminary HIV estimates 2022, AEM spectrum; HIV Prevalence (%)-Data source: HIV estimates 2021, AEM spectrum; Incidence Rate (Yr)-Data source: HIV estimates 2021, AEM spectrum; MSM HIV Prevalence-Data source: Preliminary HIV estimates 2022, AEM spectrum; New Infections (Yr)-Data source: Preliminary HIV estimates 2022, AEM spectrum; Notified TB cases (Yr)-Data source: CENAT Report, 2021; Orphans (maternal, paternal, double)-Data source: UNAIDS Cambodia Factsheet, 2018; Pregnant women needing ARVs-Data source: Preliminary HIV estimates 2022, AEM spectrum; PWID HIV Prevalence-Data source: PWID IBBS 2017; Total Population-Data source: General Population Census of the Kingdom of Cambodia 2019
Data source	India	Total Population: Data source - US Census Data 2017;HIV Prevalence (%): Data source - India HIV estimates 2020, Technical Brief, NACO, ICMR-NIMS, MoHFW;AIDS Deaths : Data source - National AIDS Control Organization (2021). Sankalak: Status of National AIDS Response (Third edition, 2021). New Delhi: NACO, Ministry of Health and Family Welfare, Government of India.;(per year): Data source - N/A;# PLHIV: Data source - National AIDS Control Organization (2021). Sankalak: Status of National AIDS Response (Third edition, 2021). New Delhi: NACO, Ministry of Health and Family Welfare, Government of India.;Incidence Rate (Yr): Data source - India HIV estimates 2020, Technical Brief, NACO, ICMR-NIMS, MoHFW;New Infections (Yr): Data source - National AIDS Control Organization (2021). Sankalak: Status of National AIDS Response (Third edition, 2021). New Delhi: NACO, Ministry of Health and Family Welfare, Government of India.;Annual births: Data source - HMIS, STATISTICS DIVISION MINISTRY OF HEALTH & FAMILY WELFARE GOVERNMENT OF INDIA 2019-20;% of Pregnant Women with at least one ANC visit : Data source - India National Family Health Survey (NFHS-4), 2016 ;Pregnant women needing ARVs: Data source - India HIV estimates 2020, NACO, ICMR-NIMS, MoHFW;Orphans (maternal, paternal, double): Data source - Estimated Children orphaned by HIV/AIDS (2014), SOWC, UNICEF 2016;Notified TB cases (Yr): Data source - https://tbcindia.gov.in/WriteReadData/IndiaTBReport2022/TBAnnauReport2022.pdf ;% of TB cases that are HIV infected: Data source - https://www.downtoearth.org.in/news/health/hiv-associated-tuberculosis-on-the-rise-india-tb-report-66938#:~:text=it%20is%20the%20third%2Dhighest,rate%20of%203.4%20per%20cent. ;% of Males Circumcised: Data source - N/A;Estimated Population Size of MSM*: Data source - National AIDS Control Organization (2021). Sankalak: Status of National AIDS Response (Third edition, 2021). New Delhi: NACO, Ministry of Health and Family Welfare, Government of India.;MSM HIV Prevalence: Data source - National AIDS Control Organization (2021). Sankalak: Status of National AIDS Response (Third edition, 2021). New Delhi: NACO, Ministry of Health and Family Welfare, Government of India.;Estimated Population Size of FSW: Data source - National AIDS Control Organization (2021). Sankalak: Status of National AIDS Response (Third edition, 2021). New Delhi: NACO, Ministry of Health and Family Welfare, Government of India.;FSW HIV Prevalence: Data source - National AIDS Control Organization (2021). Sankalak: Status of National AIDS Response (Third edition, 2021). New Delhi: NACO, Ministry of Health and Family Welfare, Government of India.;Estimated Population Size of PWID: Data source - National AIDS Control Organization (2021). Sankalak: Status of National AIDS Response (Third edition, 2021). New Delhi: NACO, Ministry of Health and Family Welfare, Government of India.;PWID HIV Prevalence: Data source - National AIDS Control Organization (2021). Sankalak: Status of National AIDS Response (Third edition, 2021). New Delhi: NACO, Ministry of Health and Family Welfare, Government of India.;Estimated Size of Priority Populations (specify) TG: Data source - National AIDS Control Organization (2021). Sankalak: Status of National AIDS Response (Third edition, 2021). New Delhi: NACO, Ministry of Health and Family Welfare, Government of India.;Estimated Size of Priority Populations Prevalence (specify): Data source - N/A
Data source	Indonesia	# PLHIV-Data source: Spectrum, Ministry of Health, 2021; % of Males Circumcised-Data source: Indonesia Population Projection for Year 2021, Result of SUPAS 2015, Indonesia Bureau of Statistics; % of Pregnant Women with at least one ANC visit -Data source: Ministry of Health, 2021; % of TB cases that are HIV infected-Data source: Global TB Report 2021; AIDS Deaths (per year)-Data source: Spectrum, Ministry of Health, 2021; Annual births-Data source: Indonesia Population Projection for Year 2021, Result of SUPAS 2015, Indonesia Bureau of Statistics; Estimated Population Size of FSW-Data source: Technical Report "Size Estimates of Population at Risk of HIV Infection in Indonesia 2020", Ministry of Health; Estimated Population Size of MSM*-Data source: Technical Report "Size Estimates of Population at Risk of HIV Infection in Indonesia 2020", Ministry of Health; Estimated Population Size of PWID-Data source: Technical Report "Size Estimates of Population at Risk of HIV Infection in Indonesia 2020", Ministry of Health; Estimated Size of Priority Populations (specify)-Data source: Technical Report "Size Estimates of Population at Risk of HIV Infection in Indonesia 2020", Ministry of Health; Estimated Size of Priority Populations Prevalence (specify)-Data source: MoH 2021, AEM 2021 based on Integrated Biological and Behavioral Survey 2018-2019; FSW HIV Prevalence-Data source: MoH 2021, AEM 2021 based on Integrated Biological and Behavioral Survey 2018-2019; HIV Prevalence (%)-Data source: N/A; Incidence Rate (Yr)-Data source: Spectrum, Ministry of Health, 2021; MSM HIV Prevalence-Data source: MoH 2021, AEM 2021 based on Integrated Biological and Behavioral Survey 2018-2019; New Infections (Yr)-Data source: Spectrum, Ministry of Health, 2021; Notified TB cases (Yr)-Data source: Global TB Report 2021; Orphans (maternal, paternal, double)-Data source: N/A; Pregnant women needing ARVs-Data source: SIHA, Ministry of Health 2021; PWID HIV Prevalence-Data source: MoH 2021, AEM

		2021 based on Integrated Biological and Behavioral Survey 2018-2019; Total Population-Data source: Indonesia Population Projection for Year 2021, Result of SUPAS 2015, Indonesia Bureau of Statistics
Data source	Kazakhstan	# PLHIV-Data source: 2021 Spectrum file CSAVR; % of Males Circumcised-Data source: N/A; % of Pregnant Women with at least one ANC visit -Data source: https://www.eisz.kz ; % of TB cases that are HIV infected-Data source: https://plhiv.kz ; AIDS Deaths (per year)-Data source: 2021 Spectrum file CSAVR; Annual births-Data source: https://www.eisz.kz ; Estimated Population Size of FSW-Data source: Biobehavioral Study, 2023; Estimated Population Size of MSM*-Data source: Biobehavioral Study, 2021; Estimated Population Size of PWID-Data source: Biobehavioral Study, 2020; Estimated Size of Priority Populations (specify)-Data source: Biobehavioral Studies, 2018-2021; Estimated Size of Priority Populations Prevalence (specify)-Data source: Biobehavioral Studies, 2018-2022; FSW HIV Prevalence-Data source: Biobehavioral Study, 2024; HIV Prevalence (%)-Data source: 2021 Spectrum file CSAVR; Incidence Rate (Yr)-Data source: 2021 Spectrum file CSAVR; MSM HIV Prevalence-Data source: Biobehavioral Study, 2022; New Infections (Yr)-Data source: 2021 Spectrum file CSAVR; Notified TB cases (Yr)-Data source: National TB Center Register as of December 31, 2021; Orphans (maternal, paternal, double)-Data source: https://www.stat.gov.kz ; Pregnant women needing ARVs-Data source: https://plhiv.kz ; PWID HIV Prevalence-Data source: Biobehavioral Study, 2020; Total Population-Data source: https://www.stat.gov.kz
Data source	Kyrgyz Republic	% of Males Circumcised-Data source: N/A; % of Pregnant Women with at least one ANC visit -Data source: e-Health Center data, 2021; % of TB cases that are HIV infected-Data source: EHCMS, As of Jan 31, 2020; calculated % = TB that are HIV infected/ TB registered cases. 2021; AIDS Death (per yr)-Data source: Estimated # PLHIV (UNAIDS data)/Total population. Spectrum for 2020, calculated in 2021; Annual births-Data source: e-Health Center data, 2021; Estimated # PLHIV-Data source: Estimated # PLHIV (UNAIDS data)/Total population. Spectrum for 2020, calculated in 2021; Estimated Population Size of FSW-Data source: M-Vector, 2013; Estimated Population size of MSM-Data source: Methods and Results of 2016 size estimation exercise in Kyrgyz Republic: service multipliers to estimate the size of PLHIV, FSWs and MSM http://www.afew.kg/upload/files/Narrative_methods_results_KG_SE_03_01_2018.pdf ; Estimated Population Size of PWID-Data source: https://kpatlas.unaids.org/dashboard ; Estimated Size of Priority Populations (specify)-Data source: N/A; Estimated Size of Priority Populations Prevalence (specify)-Data source: N/A; FSW HIV Prev.-Data source: RAC report, IBBS 2016; HIV Prevalence (%)-Data source: Estimated # PLHIV (UNAIDS data)/Total population. Spectrum for 2020, calculated in 2021; Incidence Rate per 1000 population (Yr)-Data source: Estimated # PLHIV (UNAIDS data)/Total population. Spectrum for 2020, calculated in 2021; MSM HIV Prev.-Data source: RAC report, IBBS 2016; New Infections (Yr)-Data source: Estimated # PLHIV (UNAIDS data)/Total population. Spectrum for 2020, calculated in 2021; Notified TB Cases (Yr)-Data source: Data are not available yet for 2021. New TB in 2020; Orphans (maternal, paternal, double)-Data source: No data, 3 children are in children's organizations under the care of the state; Pregnant Women Needing (ARVs)-Data source: RAC Statistical Form #4, 2021 ; PWID HIV Prev.-Data source: RAC report. IBBS 2016; Total Population-Data source: National Statistical Committee of the Kyrgyz Republic As of January 01, 2021 (www.stat.kg)
Data source	Laos	# PLHIV-Data source: Spectrum_updated 30Mar2021, 2022; % of Males Circumcised-Data source: N/A; % of Pregnant Women with at least one ANC visit -Data source: N/A; % of TB cases that are HIV infected-Data source: N/A; AIDS Deaths (per year)-Data source: Spectrum_updated 30Mar2021, 2022; Annual births-Data source: N/A; Estimated Population Size of FSW-Data source: AEM_updated 30Mar2021, 2022; Estimated Population Size of MSM*-Data source: AEM_updated 30Mar2021, 2022; Estimated Population Size of PWID-Data source: AEM_updated 30Mar2021, 2022; Estimated Size of Priority Populations (specify)-Data source: N/A; Estimated Size of Priority Populations Prevalence (specify)-Data source: N/A; FSW HIV Prevalence-Data source: AEM_updated 30Mar2021, 2022; HIV Prevalence (%)-Data source: Spectrum_updated 30Mar2021, 2022; Incidence Rate (Yr)-Data source: Spectrum_updated 30Mar2021, 2022; MSM HIV Prevalence-Data source: AEM_updated 30Mar2021, 2022; New Infections (Yr)-Data source: N/A; Notified TB cases (Yr)-Data source: N/A; Orphans (maternal, paternal, double)-Data source: N/A; Pregnant women needing ARVs-Data source: N/A; PWID HIV Prevalence-Data source: AEM_updated 30Mar2021, 2022; Total Population-Data source: N/A
Data source	Nepal	# PLHIV-Data source: National HIV Estimates 2020; % of Males Circumcised-Data source: Not applicable.; % of Pregnant Women with at least one ANC visit -Data source: NDHS 2016; % of TB cases that are HIV infected-Data source: Tuberculosis Profile FY 2076/77 (2019/20); AIDS Deaths (per year)-Data source: National HIV Estimates 2020; Annual births-Data source: World Population Prospects 2017; Estimated Population Size of FSW-Data source: National size estimates, 2016; Estimated Population Size of MSM*-Data source: National size estimates, 2016; Estimated Population Size of PWID-Data source: National size estimates, 2016; Estimated Size of Priority Populations (Clients of FSW)-Data source: N/A; Estimated Size of Priority Populations Prevalence (Clients of FSW)-Data source: IBBS among clients of FSW (Truckers) in 22 Terai Highway districts of Nepal, 2016; FSW HIV Prevalence-Data source: IBBS, Kathmandu valley, 2017 ; IBBS, Pokhara valley, 2016 IBBS, Terai highway districts, 2018; HIV Prevalence (%)-Data source: National HIV Estimates 2020; Incidence Rate (Yr)-Data source: National HIV Estimates 2020; MSM HIV Prevalence-Data source: IBBS, Kathmandu valley, 2017 IBBS, Pokhara valley, 2017 IBBS, Terai highway districts, 2018 ; New Infections (Yr)-Data source: National HIV Estimates 2020; Notified TB cases (Yr)-Data source: Tuberculosis Profile FY 2076/77 (2019/20); Orphans (maternal,

		paternal, double)-Data source: National HIV Estimates 2020; Pregnant women needing ARVs-Data source: National HIV Estimates 2020; PWID HIV Prevalence-Data source: Nationwide IBBS among PWIDs, 2020 ; Total Population-Data source: EPP Spectrum V 5.756
Data source	Papua New Guinea	# PLHIV-Data source: National Estimates (2022); % of Males Circumcised-Data source: No Reliable Data exists; % of Pregnant Women with at least one ANC visit -Data source: Annual HIV Program Report (2018); % of TB cases that are HIV infected-Data source: WHO Global TB Report, 2020; AIDS Deaths (per year)-Data source: National Estimates (only includes 15-49); Annual births-Data source: World Bank (2020) calculated from crude birthrate and current population.; Estimated Population Size of FSW-Data source: IBBS Report (2017), only for NCD - Port Moresby, Lae, and Mt. Hagen; Estimated Population Size of MSM*-Data source: IBBS Report (2017), only for NCD, Lae, and Mt. Hagen; Estimated Population Size of PWID-Data source: No Reliable Data exists; Estimated Size of Priority Populations (specify)-Data source: No Reliable Data exists; Estimated Size of Priority Populations Prevalence (specify)-Data source: No Reliable Data exists; FSW HIV Prevalence-Data source: IBBS Report (2017), only for NCD - Port Moresby, Lae, and Mt. Hagen; HIV Prevalence (%)-Data source: Spectrum Estimates (2021). 15+ prevalence was flatly distributed across 15-24 and 25+.; Incidence Rate (Yr)-Data source: UNAIDS Estimates. Age disaggregates not available; 0.61 incidence rate is for 15-49 per 1,000 uninfected population (2020).; MSM HIV Prevalence-Data source: IBBS Report (2017), only for NCD, Lae, and Mt. Hagen; New Infections (Yr)-Data source: Spectrum Estimates (2022); Notified TB cases (Yr)-Data source: WHO Global TB Report, 2020; Orphans (maternal, paternal, double)-Data source: Most recently available data.; Pregnant women needing ARVs-Data source: Spectrum Estimates (2019); PWID HIV Prevalence-Data source: No Reliable Data exists; Total Population-Data source: World Bank (2020)
Data source	Philippines	Total Population (2021): Data source - Updated: AEM-Spectrum, May 2021;AIDS Deaths: Data source - Updated: AEM-Spectrum, May 2021;(per year): Data source - ;# PLHIV (2021): Data source - Updated: AEM-Spectrum, May 2021;Incidence Rate (2021): Data source - AEM-Spectrum, May 2021 Incidence per 1000 uninfected population HIV Prevalence (%): Data source - Updated: AEM-Spectrum, May 2021; HIV AIDS Data Hub for Asia Pacific: Philippine Country Profile. Age disaggregates not available; 0.61 incidence rate is for 15-49 per 1,000 uninfected population; New Infections (2022): Data source - AEM-Spectrum, May 2021;Annual births: Data source - Registered live births (2020), Philippine Statistics Authority;% of Pregnant Women with at least one ANC visit: Data source - NDHS, 2017; Age disaggregation in the NDHS do not match levels prescribed here <20 (91.4%); 20-34 (94%); 35-49 (94.4%);Pregnant women needing ARVs: Data source - UNAIDS 2021 Estimates; Orphans (maternal, paternal, double): Data source - ;Notified TB cases (2020): Data source - Global TB Report 2021;% of TB cases that are HIV infected: Data source - Global TB Report 2021;% of Males Circumcised: Data source - Neonatal and child male circumcision: a global review (WHO, 2010);Estimated Population Size of MSM* (2021): Data source - AEM-Spectrum, May 2021; Estimate aggregated MSM (703,300) and trans women (210,100); Note that UNAIDS Key Population Atlas estimates population to be at 680,600;MSM HIV Prevalence (2018): Data source - UNAIDS Key Population Atlas; Estimated Population Size of FSW (2021): Data source - AEM-Spectrum, May 2021; Note that UNAIDS Key Population Atlas estimates population to be at 227,400.;FSW HIV Prevalence (2015): Data source - UNAIDS Key Population Atlas; Estimated Population Size of PWID (2021): Data source - Note that AEM-Spectrum, May 2021. Note that UNAIDS Key Population Atlas estimates population to be at 10,800.;PWID HIV Prevalence (2015): Data source - UNAIDS Key Population Atlas; Estimated Size of Priority Populations (specify): Data source - ;Estimated Size of Priority Populations Prevalence (specify)
Data source	Tajikistan	# PLHIV-Data source: Spectrum files data for 2021, RAC, Tajikistan (data retrieved on March 29, 2022); % of Males Circumcised-Data source: N/A; % of Pregnant Women with at least one ANC visit -Data source: N/A; % of TB cases that are HIV infected-Data source: https://www.who.int/data/gho/data/indicators/indicators-index ; AIDS Deaths (per year)-Data source: Spectrum files data for 2021, RAC, Tajikistan (data retrieved on March 29, 2022); Annual births-Data source: N/A; Estimated Population Size of FSW-Data source: UNAIDS data, 2018, https://aidsinfo.unaids.org/ ; Estimated Population Size of MSM*-Data source: UNAIDS data, 2015, https://aidsinfo.unaids.org/ ; Estimated Population Size of PWID-Data source: UNAIDS data, 2018, https://aidsinfo.unaids.org/ ; Estimated Size of Priority Populations (labour migrants)-Data source: N/A; FSW HIV Prevalence-Data source: UNAIDS data, 2018, https://aidsinfo.unaids.org/ ; HIV Prevalence (%)-Data source: Spectrum files data for 2021, RAC, Tajikistan (data retrieved on March 29, 2022); Incidence Rate (Yr)-Data source: Spectrum files data for 2021, RAC, Tajikistan (data retrieved on March 29, 2022); MSM HIV Prevalence-Data source: UNAIDS data, 2017, https://aidsinfo.unaids.org/ ; New Infections (Yr)-Data source: Spectrum files data for 2021, RAC, Tajikistan (data retrieved on March 29, 2022); Notified TB cases (Yr)-Data source: https://www.who.int/data/gho/data/indicators/indicator-details/GHO/tuberculosis---new-and-relapse-cases ; Orphans (maternal, paternal, double)-Data source: N/A; Pregnant women needing ARVs-Data source: Spectrum files data for 2021, RAC, Tajikistan (data retrieved on March 29, 2022); Priority Populations (labour migrants) HIV Prevalence-Data source: IBBS 2020 among labor migrants; PWID HIV Prevalence-Data source: UNAIDS data, 2018, https://aidsinfo.unaids.org/ ; Total Population-Data source: National Statistics Agency, As of January 01, 2020 www.stat.tj/ru/

<p>Data source</p>	<p>Thailand</p>	<p>Total Population Data source - Ministry of interior, 2021;HIV Prevalence (%) Data source - Spectrum updated May 30 2022, 2021;AIDS Deaths (per year) Data source - Spectrum updated May 30 2022, 2021;# PLHIV Data source - Spectrum updated Mar 30 2022, 2021;Incidence Rate (Yr) Data source - Spectrum updated May 30 2022, 2021;New Infections (Yr) Data source - NA;Annual births Data source - NA;% of Pregnant Women with at least one ANC visit Data source - NA;Pregnant women needing ARVs Data source - NA;Orphans (maternal, paternal, double) Data source - NA;Notified TB cases (Yr) Data source - NA;% of TB cases that are HIV infected Data source - NA;% of Males Circumcised Data source - NA;Estimated Population Size of MSM* Data source - AEM updated Mar 30 2022, 2021;MSM HIV Prevalence Data source - AEM updated Mar 30 2022, 2021;Estimated Population Size of FSW Data source - AEM updated Mar 30 2022, 2021;FSW HIV Prevalence Data source - AEM updated Mar 30 2022, 2021;Estimated Population Size of PWID Data source - NA;PWID HIV Prevalence Data source - NA;Estimated Size of Priority Populations (specify) Data source - NA;Estimated Size of Priority Populations Prevalence (specify) Data source - NA</p>
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Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression*

	Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
		Total Population Size Estimate	HIV Prevalence	Estimated Total PLHIV		On ART	ART Coverage (%)	% Viral Suppression (as a % of on ART)	Tested for HIV	Diagnosed HIV Positive	Initiated on ART
		(#)	(%)	(#)	PLHIV diagnosed (#)	(#)			(#)	(#)	(#)
Burma	Total population	54,818,000	0.44%	240,000	204,000	184,624	91%	94%	492,836	38,881	30,061
Burma	Population <15 years	14,763,000	0.07%	10,860	-	7,927	-	-	-	-	1,076
Burma	Men 15-24 years	4,884,000	N/A	14200 (>15)	-	99690 (>15)	-	-	-	-	18313 (>15)
Burma	Men 25+ years	13,899,000	N/A	ND	-	-	-	-	-	-	-
Burma	Women 15-24 years	4,855,000	N/A	88000 (>15)	-	77007 (>15)	-	-	-	-	10674 (>15)
Burma	Women 25+ years	16,417,000	N/A	ND	-	-	-	-	-	-	-
Burma											
Burma	MSM	268,000	8%	22,517	-	-	-	-	64,870	4,652	-
Burma	FSW	75,000	12%	8,892	-	-	-	-	55,759	2,679	-
Burma	PWID	93,000	23%	21,212	-	-	-	-	47,900	11,680	-
Burma	Priority Pop (specify)	-	-	-	-	-	-	-	-	-	-
Cambodia	Total population	15,552,211	0.48%	75,373	62,561	62,561	83%	98	25,713	3,120	3,165
Cambodia	Population <15 years	4,573,793	0.05%	2,414	1,265	1,265	100%	88	762	36	48
Cambodia	Men 15-24 years	1,325,072	0.28%	3,648	3,151	3,151	100%	91	3,550	615	608
Cambodia	Men 25+ years	3,899,496	0.82%	31,894	27,148	27,148	100%	98	9,499	1,650	1,736
Cambodia	Women 15-24 years	1,348,684	0.22%	2,996	2,232	2,232	100%	90	3,431	154	145
Cambodia	Women 25+ years	4,405,166	0.78%	34,421	28,765	28,765	100%	99	8,471	665	628
Cambodia											
Cambodia	MSM	89,241	4.50%	4,016					37,963	795	793
Cambodia	FSW	51,221	2.50%	1,281					37,891	139	138
Cambodia	PWID	6,500	15.20%	988					568	1	1
Cambodia	Priority Pop (TG)	9,227	11.70%	1,080					9,058	324	324
India	Total population	1,300,120,000	0.2%	2,318,737	1,810,122	1,494,143	83	85	41,324,195	107,737	101,793

India	Population <15 years	400,000,000	0.0%	81,156	73,040	56,777	78	85	-	-	-
India	MEN >15	460,460,000	0.3%	1,210,382	885,912	733,056	83	85	-	-	-
India	WOMEN >15	439,660,000	0.2%	1,027,200	851,170	704,309	83	85	-	-	-
India											
India	MSM	357,000	2.7%	9,603	6,239	5,799	60%	-	214,000	514	457
India	FSW	868,000	1.6%	13,541	10,897	10,202	75%	-	600,100	540	486
India	PWID	177,000	6.3%	11,080	8,601	8,601	78%	-	113,000	1,017	783
India	TG	70,000	3.1%	2,198	1,745	1,642	75%	-	38,000	144	115
Indonesia	Total population	272,432,400	0.2%	540,972	387,210	152,525	39 %	50%	4,055,600	36,902	23,997
Indonesia	Population <15 years	65,969,200	0.0%	18,046					40,554	810	
Indonesia	Men 15-24 years	22,268,300	0.2%	34,153					258,991	4,940	
Indonesia	Men 25+ years	80,915,700	0.4%	294,231					985,675	19,964	
Indonesia	Women 15-24 years	21,821,700	0.1%	24,955					576,463	2,219	
Indonesia	Women 25+ years	81,457,500	0.2%	169,587					2,193,917	8,970	
Indonesia											
Indonesia	MSM	502,986	18.3%	92,272	N/A	N/A	N/A	N/A	151,919	9,597	N/A
Indonesia	FSW	277,624	2.2%	6,044	N/A	N/A	N/A	N/A	52,756	1,034	N/A
Indonesia	PWID	34,157	15.7%	5,371	N/A	N/A	N/A	N/A	7,811	223	N/A
Indonesia	Priority Pop (TG)	34,695	12.0%	4,175	N/A	N/A	N/A	N/A	11,101	381	N/A
Kazakhstan	Total population	18,879,000	0.2%	35,130	28,264	22,315	79	86	3,533,310	3,478	3,036
Kazakhstan	Population <15 years	5,522,000	0.0%	428	304	290	95	85	79,790	35	35
Kazakhstan	Men 15-24 years	1,200,000	0.0%	404	579	513	89	88	n/d	171	162
Kazakhstan	Men 25+ years	5,116,000	0.4%	20,944	16,223	12,348	76	85	n/d	2,079	1,797
Kazakhstan	Women 15-24 years	1,146,000	0.0%	388	424	376	89	86	n/d	90	87
Kazakhstan	Women 25+ years	5,894,000	0.2%	12,966	10,734	8,788	82	87	n/d	1,103	955
Kazakhstan											
Kazakhstan	MSM	62,000	2.9%	1,802	1,285	1,118	87	90	11,577	258	248
Kazakhstan	FSW	20250	1.4%	285	319	214	67	76	16,336	33	32

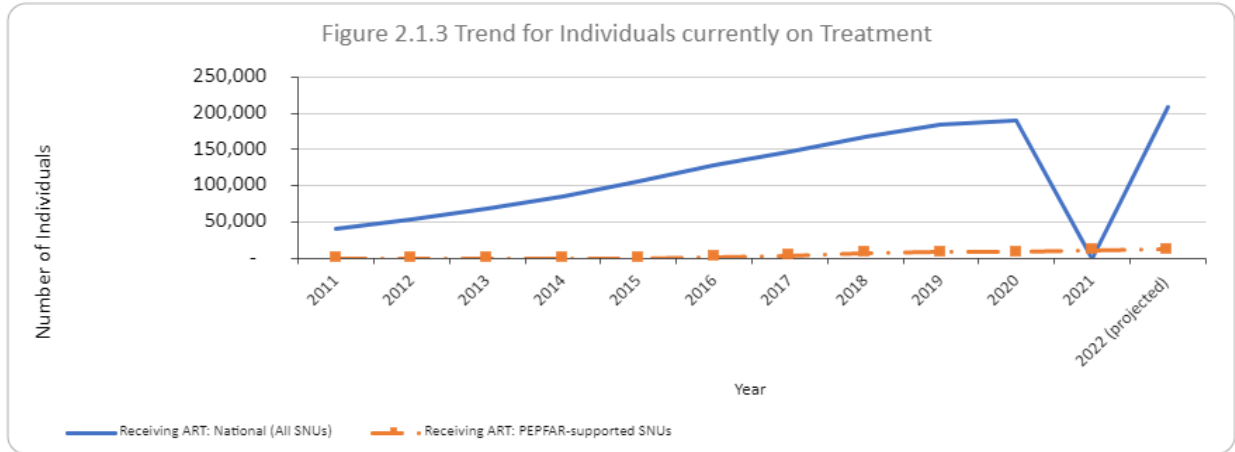
Kazakhstan	PWID	85,300	8.3%	7,080	9,655	7,123	74	86	45,202	824	704
Kazakhstan	Priority Pop (labour migrants)	167,650	6.9%	11,568	11,259	8,455	75	86	73,115	1,115	984
Kyrgyz Republic	Total population	6,636,803	0.14	9,200	7,517	5,001	67%	94%	595,143	826	754
Kyrgyz Republic	Population <15 years	2,192,067	0.01	324	219	196	89%	89%	921	31	29
Kyrgyz Republic	Men 15-24 years	520,163	0.07	341	371	325	88%	94%	NA	60	54
Kyrgyz Republic	Men 25+ years	1,651,085	0.35	5,713	3,925	2,263	58%	94%	NA	424	376
Kyrgyz Republic	Women 15-24 years	500,291	0.04	224	260	226	87%	93%	NA	33	32
Kyrgyz Republic	Women 25+ years	1,773,197	0.15	2,604	2,742	1,991	73%	95%	NA	278	263
Kyrgyz Republic											
Kyrgyz Republic	MSM	16,900	6.60%	1,447	327	248	76%	96%	NA	88	83
Kyrgyz Republic	FSW	7,100	1.97%	179	58	19	33%	89%	3,821	9	8
Kyrgyz Republic	PWID	25,000	14.3	2,452	2,024	956	47%	95%	14,162	36	31
Kyrgyz Republic	Priority Pop (prisoners)	8200			120	102	85%	87%	10,112	27	20
Laos	Total population	7,222,066	0.22%	15,971	12,143	8,826	55%	72%	110,205	1,542	1,459
Laos	Population <15 years	2,287,811		539	456	311	58%	63%	858	31	39
Laos	Men 15-24 years	700,087	0.13%	900	669	514	57%	61%	8,028	242	241
Laos	Men 25+ years	1,756,971	0.47%	8,238	5,982	4,427	54%	73%	16,219	778	712
Laos	Women 15-24 years	689,251	0.10%	682	512	327	48%	58%	36,495	160	144
Laos	Women 25+ years	1,787,946	0.31%	5,611	4,523	3,246	58%	74%	48,605	331	323
Laos											
Laos	MSM	59,966	5%	3,298	2,207	1,797	54%	68%	3,877	528	573
Laos	FSW	147	1%	147							
Laos	PWID	130	7%	130							
Laos	Priority Pop (specify)										
Nepal	Total population	29,786,486	0.13	30,300	26,441	21,995	83%	59.00%	213,179	2,313	2,070
Nepal	Population <15 years	8,324,677		1,268					2,761	83	

Papua New Guinea	FSW	16,100	14.9	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Papua New Guinea	PWID	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Papua New Guinea	Priority Pop (specify)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Philippines	Total population	111,893,600	0.2	133,800	88,964	56,385	63%	96%	360,732	12,341	8,941
Philippines	Population <15 years	33,392,000		<1,000	185	121	65%	63%		30	24
Philippines	Men 15-24 years	10,744,000	0.3	29,300	9,867	6,761	69%	95%		3,522	2,638
Philippines	Men 25+ years	28,318,500		95,600	73,855	45,974	62%	96%		8,255	5,938
Philippines	Women 15-24 years	10,169,400	<0.1	2,400	559	272	49%	91%		163	105
Philippines	Women 25+ years	29,269,700		5,900	4,430	1,716	39%	95%		371	236
Philippines											
Philippines	MSM	898,600	11.53	104,300	72,588	48,017	66%	96%		10,732	8,007
Philippines	FSW	87,500		-	-	-	-	-	-	-	-
Philippines	PWID	7,800	38.7	3,000	2,270	400	18%	85%		96	52
Philippines	Priority Pop (specify)										
Tajikistan	Total population	9,313,800	0.20%	13,598	9,579	8,326	87%	92%	909,536	922	879
Tajikistan	Population <15 years	3,191,100	0.10%	949	852	767	90%	94%		58	56
Tajikistan	Men 15-24 years	864,400	0.20%	127	276	259	94%	95%		39	38
Tajikistan	Men 25+ years	2,195,600	0.20%	6,466	4,692	3,903	83%	93%		505	477
Tajikistan	Women 15-24 years	829,700	0.20%	370	266	245	92%	93%		50	48
Tajikistan	Women 25+ years	2,233,000	0.20%	5,686	3,493	3,152	90%	95%		270	260
Tajikistan											
Tajikistan	MSM	13,400	2.30%	308	152	132	87%	90%	3,580	20	20
Tajikistan	FSW	17,500	2.90%	508	422	346	82%	94%	12,980	10	9
Tajikistan	PWID	22,200	12.10%	2,641	1,747	1,229	70%	93%	19,657	76	64
Tajikistan	Priority Pop (labour migrants)	1,000,000	0.40%		1,580	1,389	88%	89%	26,430	228	218

Thailand	Total population	66,171,439	0.8%	520,000	490,362	447,061	86%	97%	1,212,200	24,494	34,297
Thailand	Population <15 years	10,456,075	0.019%	2,000	1,499	1,499	79%	86%	20,227	117	100
Thailand	Men 15+ years	26,963,751	1.1%	300000	28,4139	256,947	90%	97%	668,045	17,735	24,407
Thailand	Women 15+ years	28,880,176	0.76%	220000	20,4724	188,615	92%	97%	523,928	6,642	9,790
Thailand											
Thailand	MSM	593,162	11.2%	66,649	48,256	42,100	63%	73%	99,944	6,771	7,122
Thailand	FSW	586	1.2%	586	ND	ND	ND	ND	ND	ND	ND

Figure 2.1.3 Trend for Individuals currently on Treatment

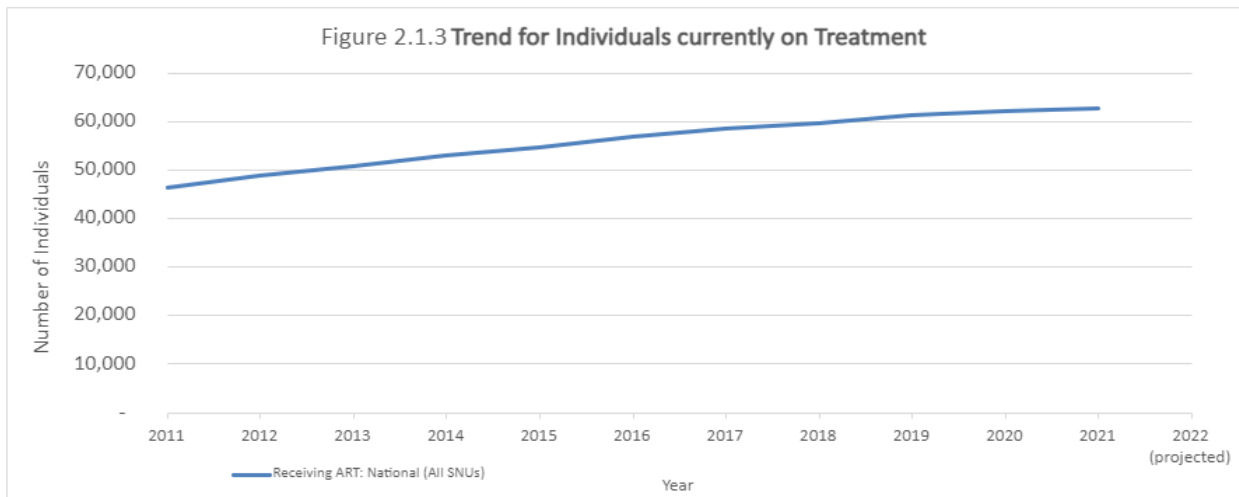
Burma



Data source notes

Annual Progress Report, National AIDS Program (2019) and Programmatic Data (2020 & 2021)

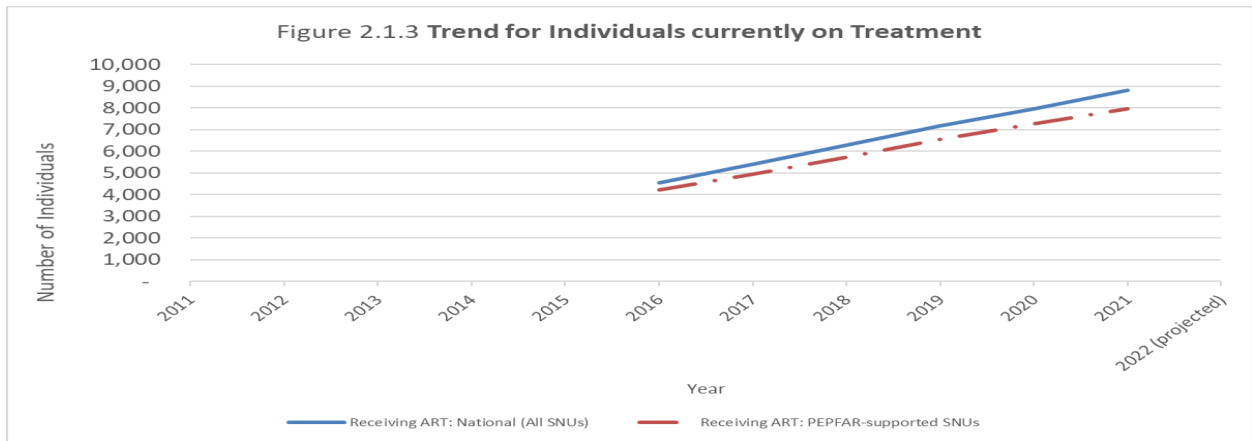
Cambodia



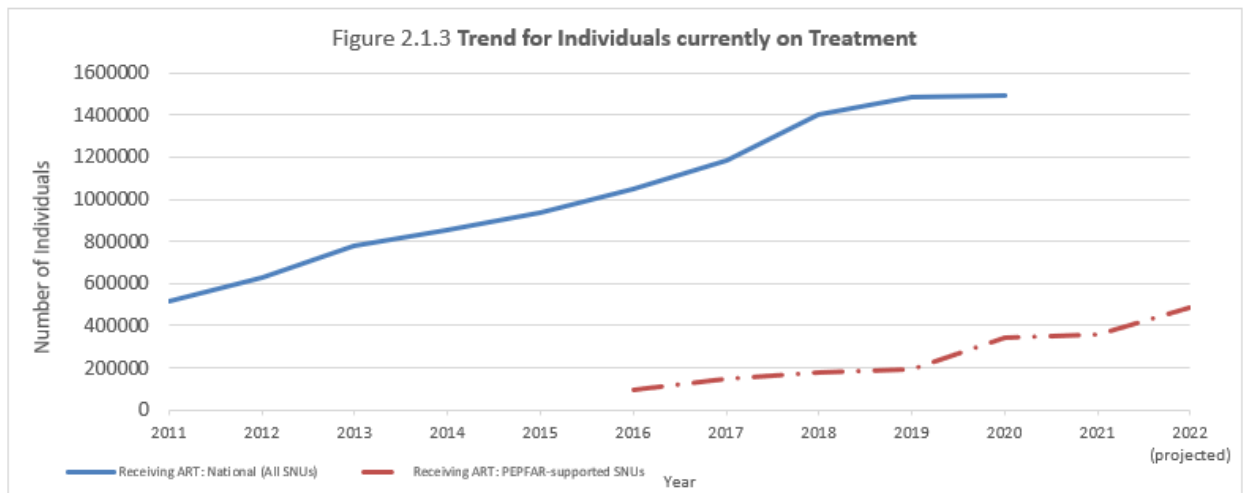
Data source notes

PEPFAR does not support site-level activities in Cambodia. The trend line reflects national data (TX_CURR at end of each calendar year of national ART reports)

Laos



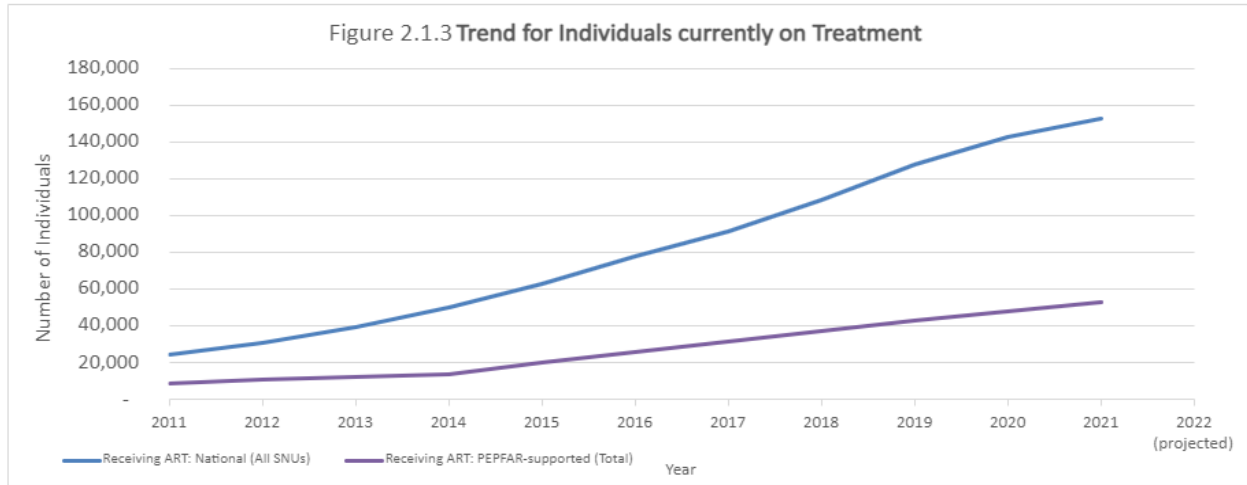
India



Data source notes

UNAIDS Data Hub 2021, PEPFAR India ROP Datapack 2022

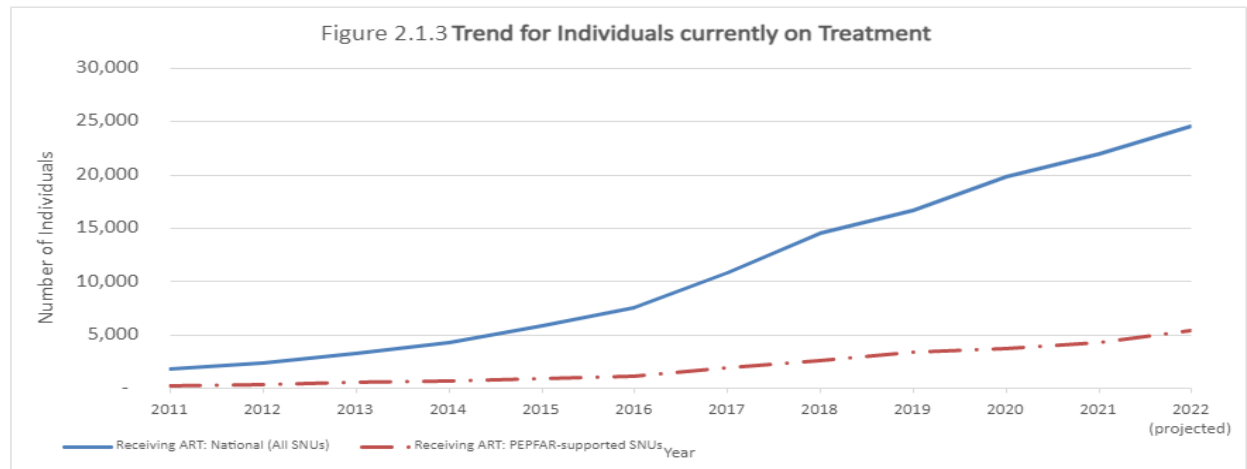
Indonesia



Data source notes

SIHA, Ministry of Health, 2022

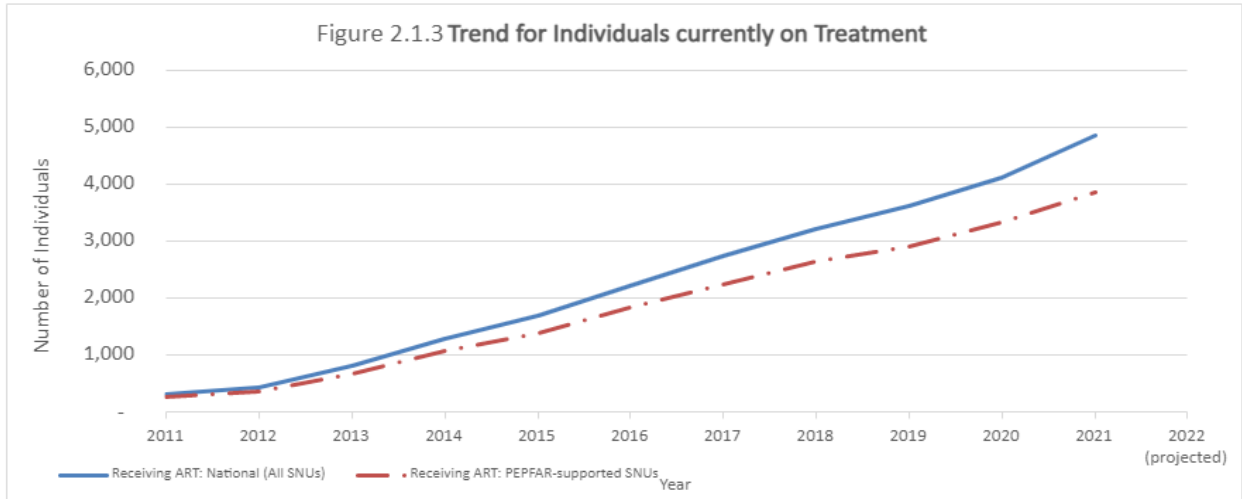
Kazakhstan



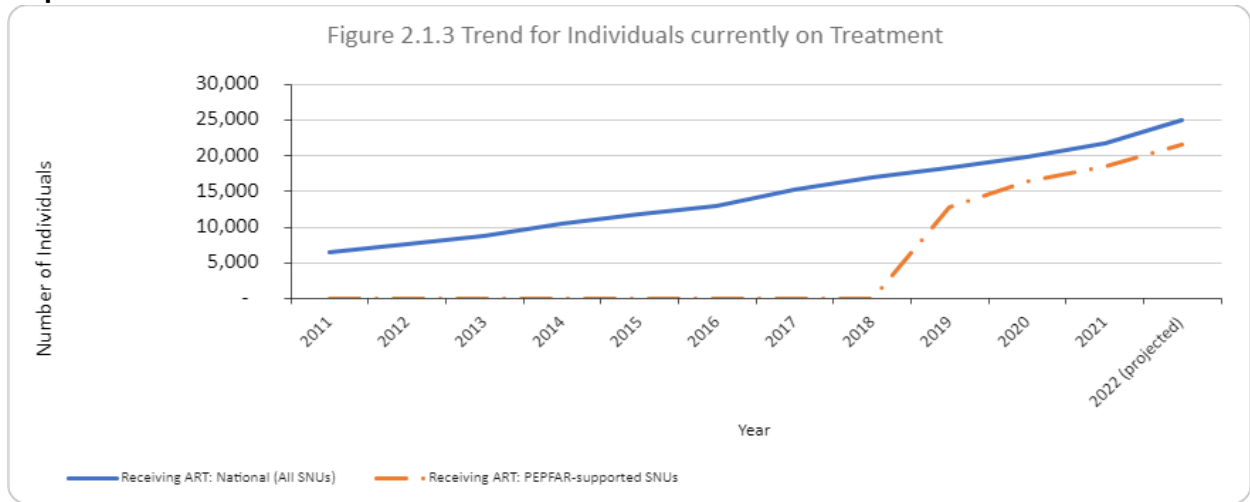
Data source notes

Ministry of Health

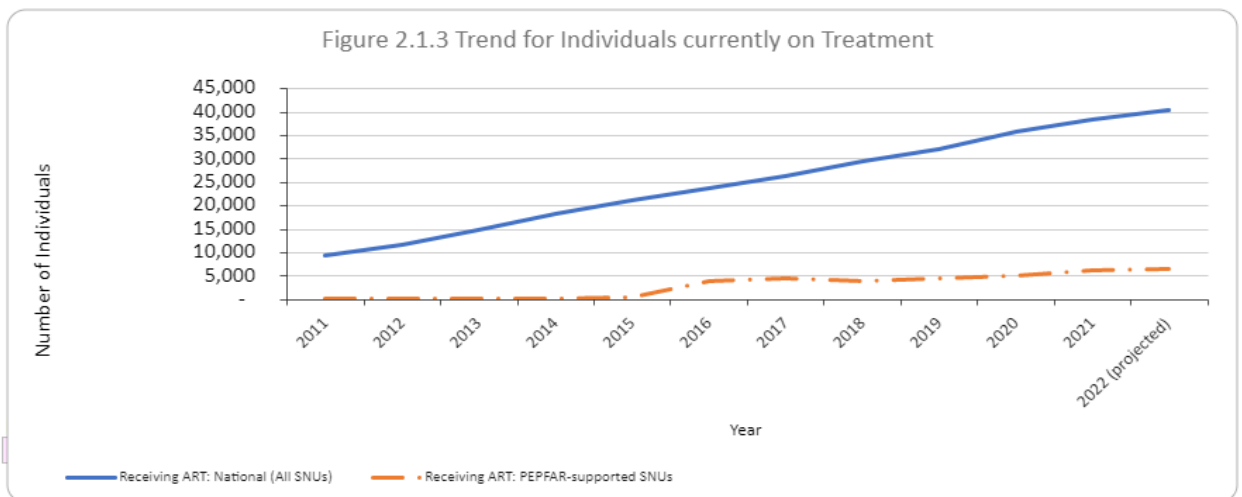
Kyrgyz Republic



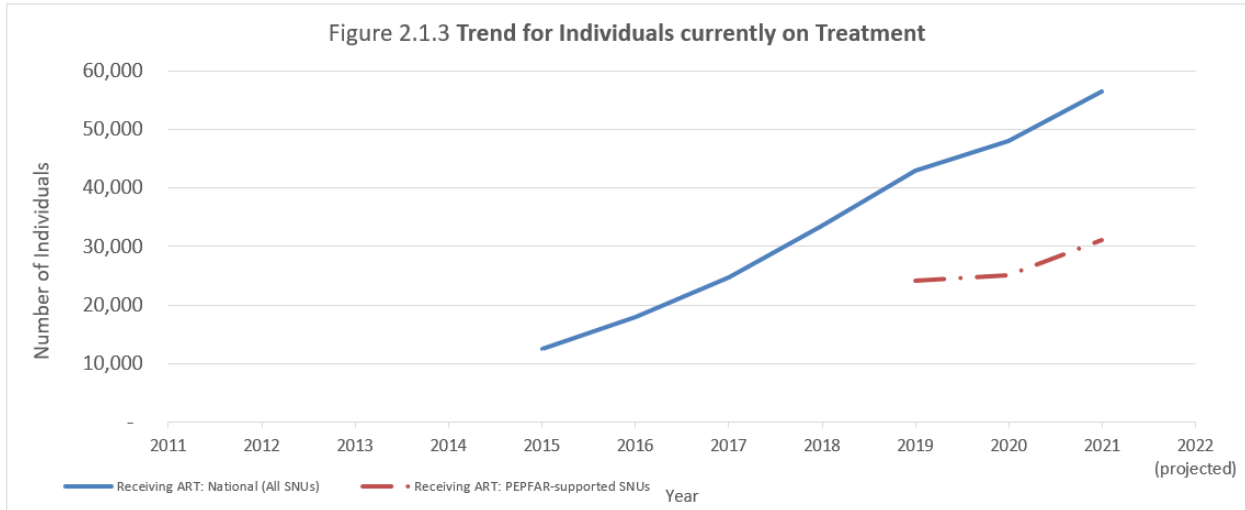
Nepal



Papua New Guinea



Philippines



Data source notes

Receiving ART: National (All SNU, 2015-2018) - <https://www.aidsdatahub.org/country-profiles/philippines>

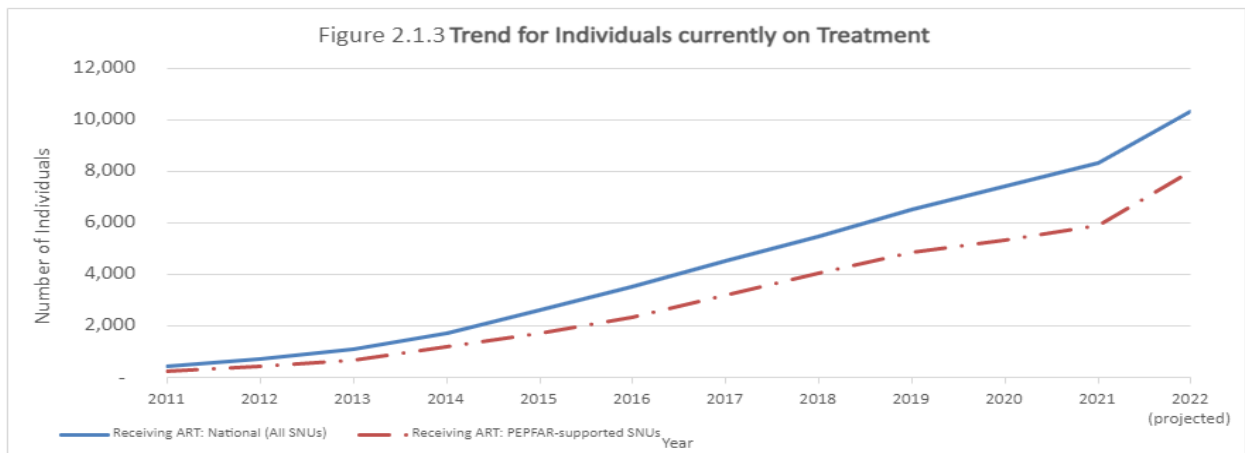
Receiving ART: National (All SNU, 2019-2021) and Receiving ART: PEPFAR supported SNU - HIV AIDS and ART Registry of the Philippines (HARP), DOH-Epidemiology Bureau

PEPFAR supported SNU include 52 sites under PEPFAR-USAID (20 of which were only added in FY22) and all sites in CDC-supported subnational regions. There are still no identified CDC sites as of April 2022.

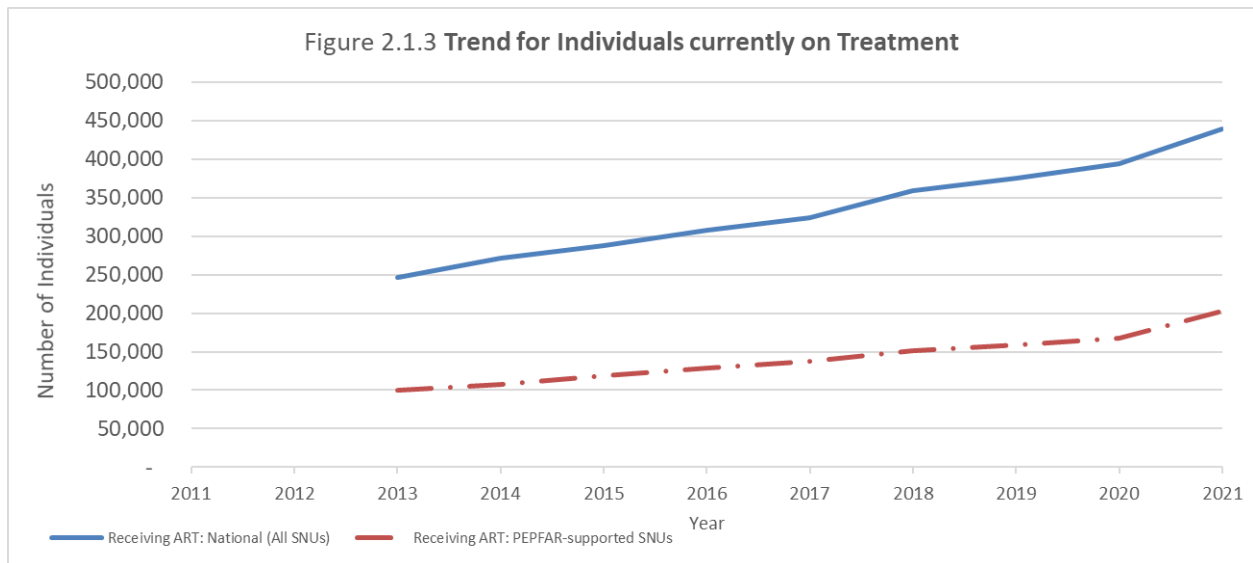
Time period covered is different for Receiving ART: National (All SNU, 2019-2021) as this followed the PEPFAR FY. Receiving ART: National (All SNU, 2015-2018) followed the CY.

Data pending from DOH-EB for National (all SNU) and PEPFAR supported SNU for 2015-2018.

Tajikistan



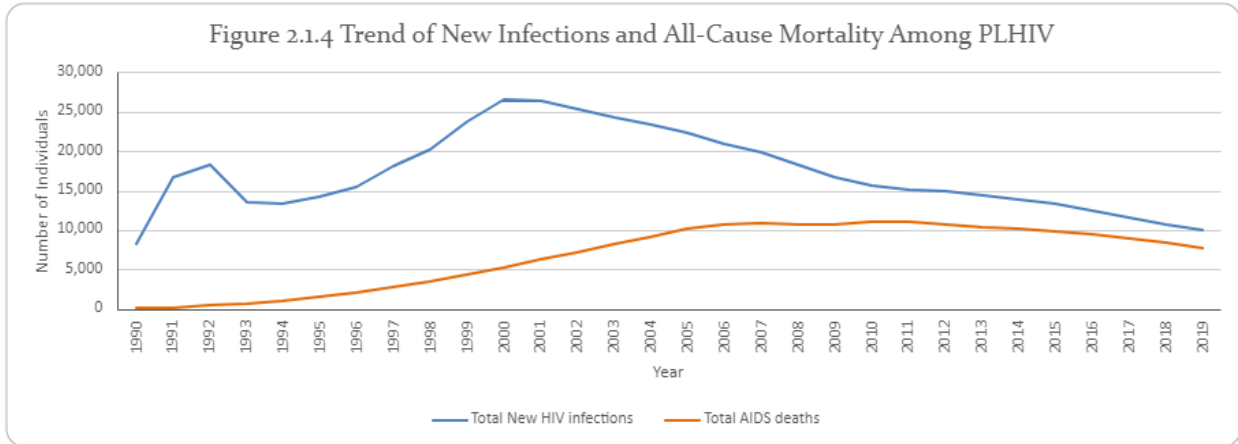
Thailand



Data source notes

National AIDS Program, 2021

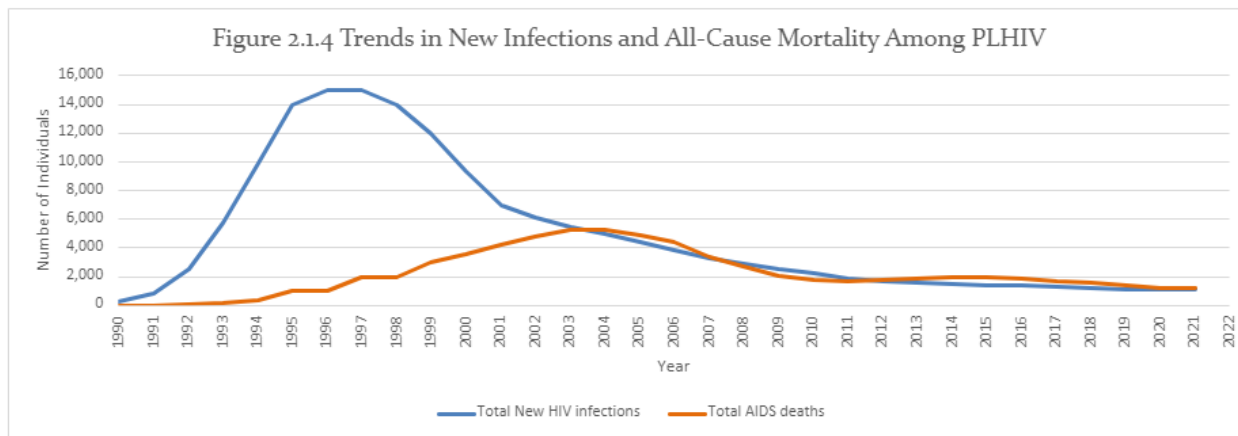
Burmaⁱ



Data source notes

Annual Progress Report, National AIDS Program (2019) and Programmatic Data (2020 & 2021)

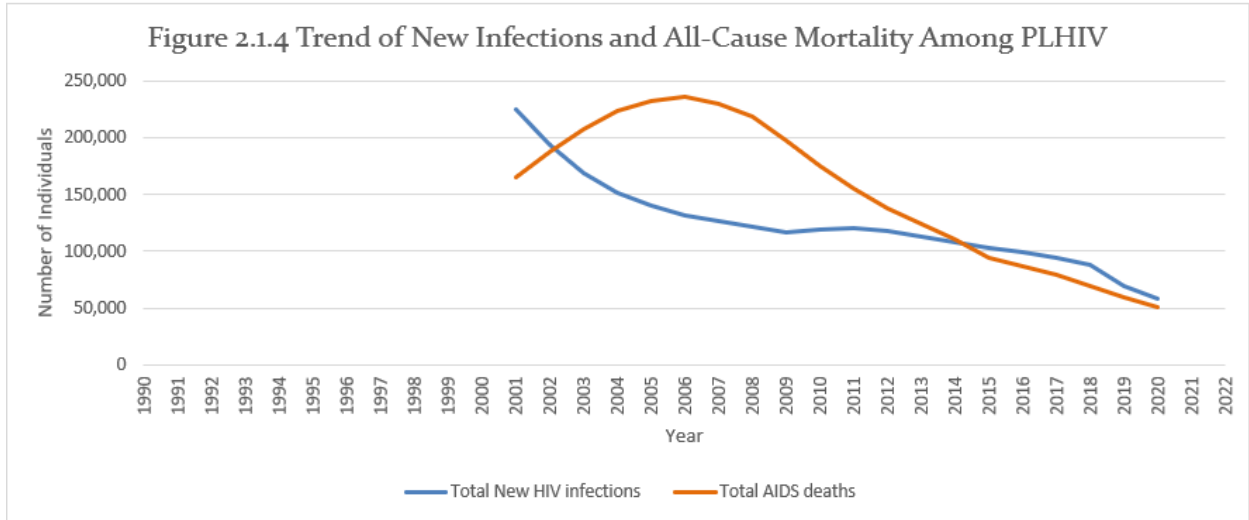
Cambodia



Data Source

Preliminary HIV estimates 2022, AEM spectrum

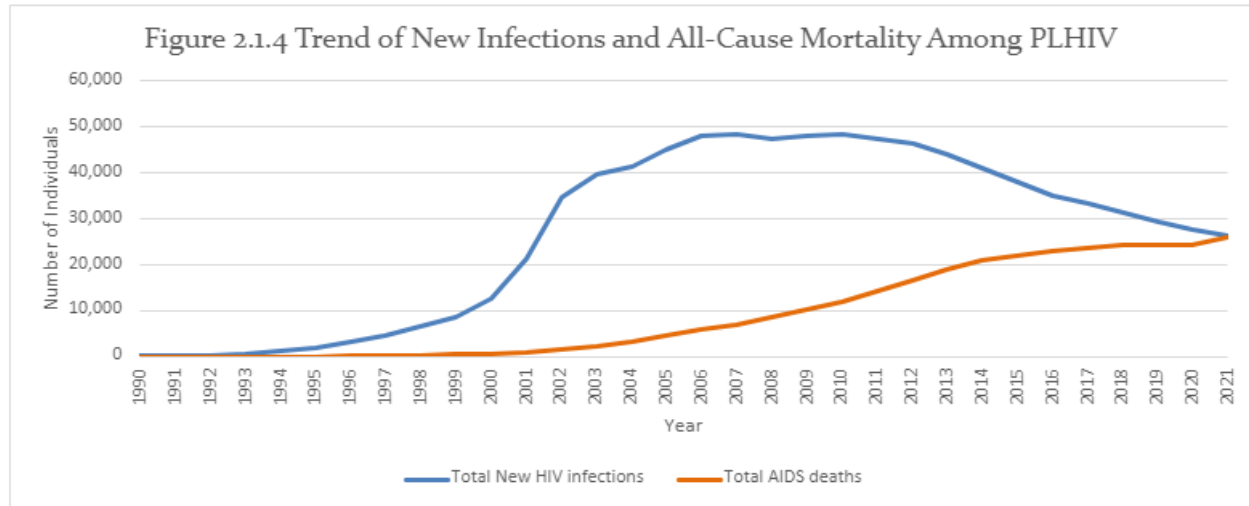
India



Data source:

UNAIDS Data Hub 2021

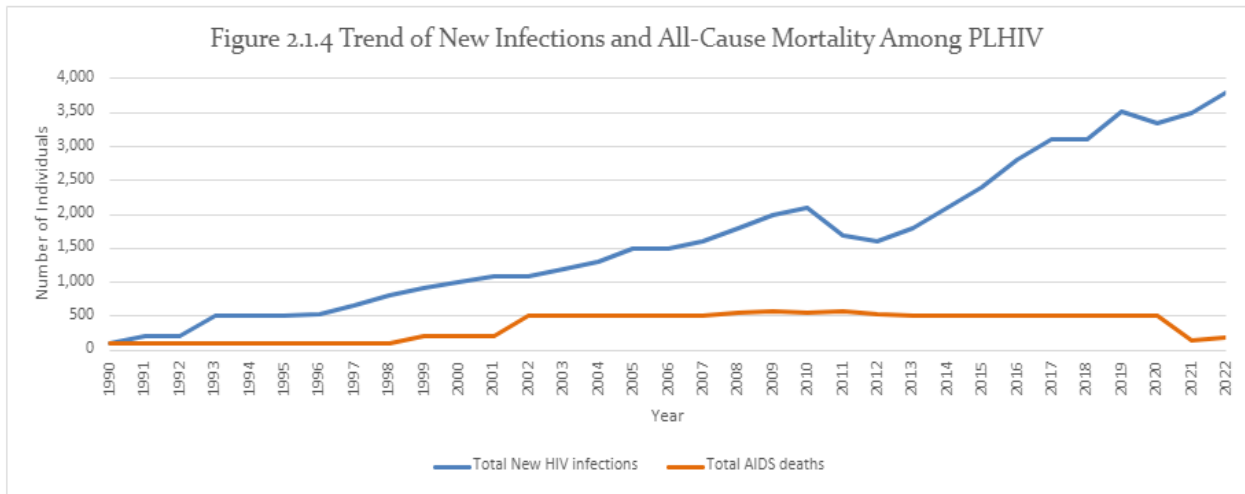
Indonesiaⁱⁱ



Data source:

Spectrum estimates 2021 (updated using program data up to 2020), Ministry of Health

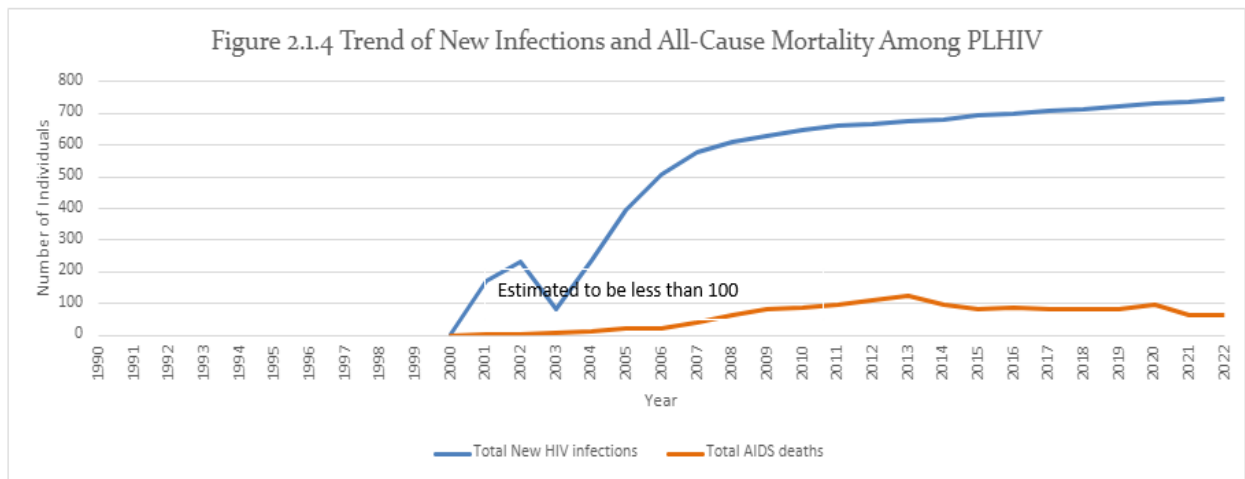
Kazakhstanⁱⁱⁱ



Data source:

UNAIDS 2021 estimates (1990-2017), Ministry of Health of Kazakhstan (2018-2021)

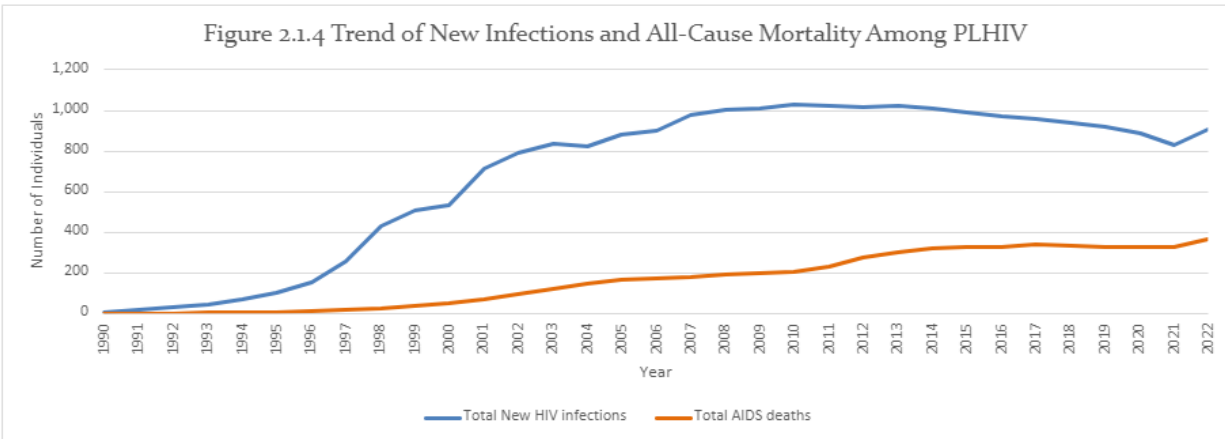
Kyrgyz Republic^{iv}



Data source:

UNAIDS 2020 estimates

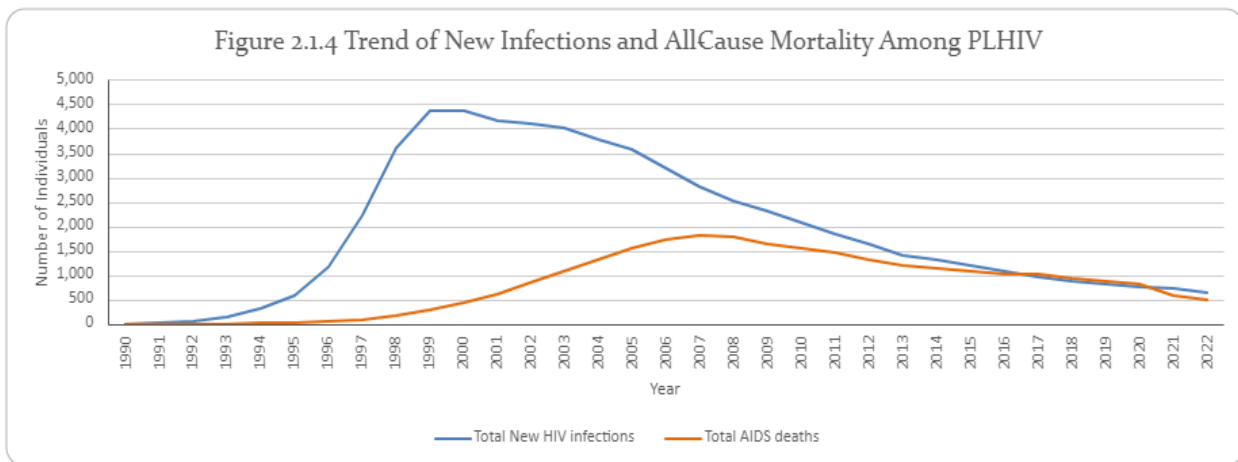
Laos



Data source:

UNAIDS 2022 estimates

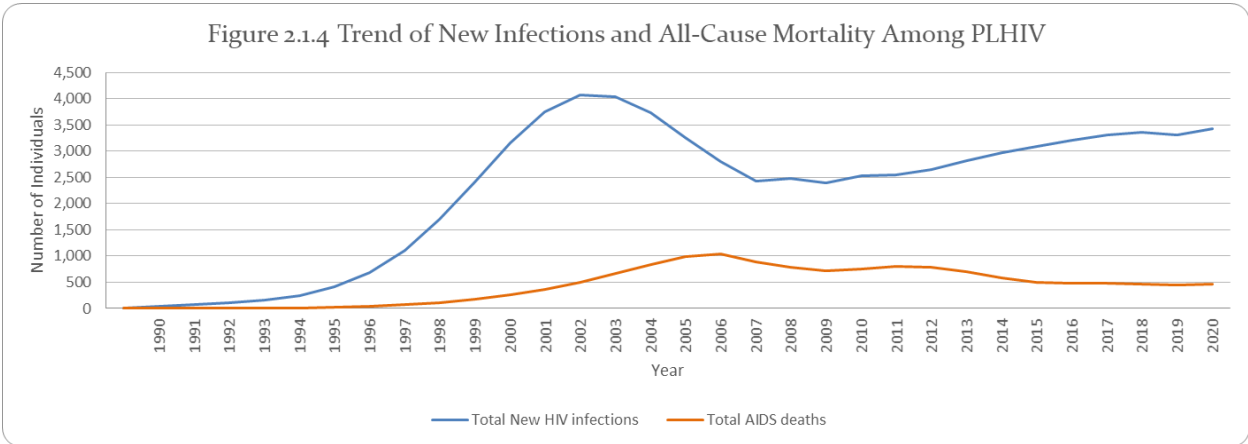
Nepal^v



Data source:

National HIV estimates 2020

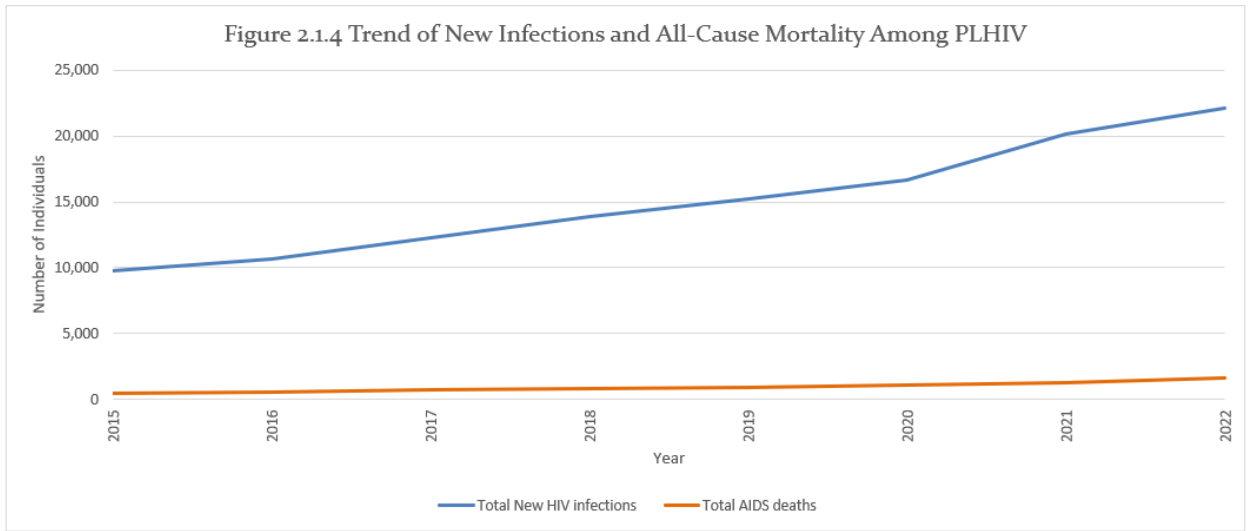
Papua New Guinea



Data source:

Spectrum estimates 2019

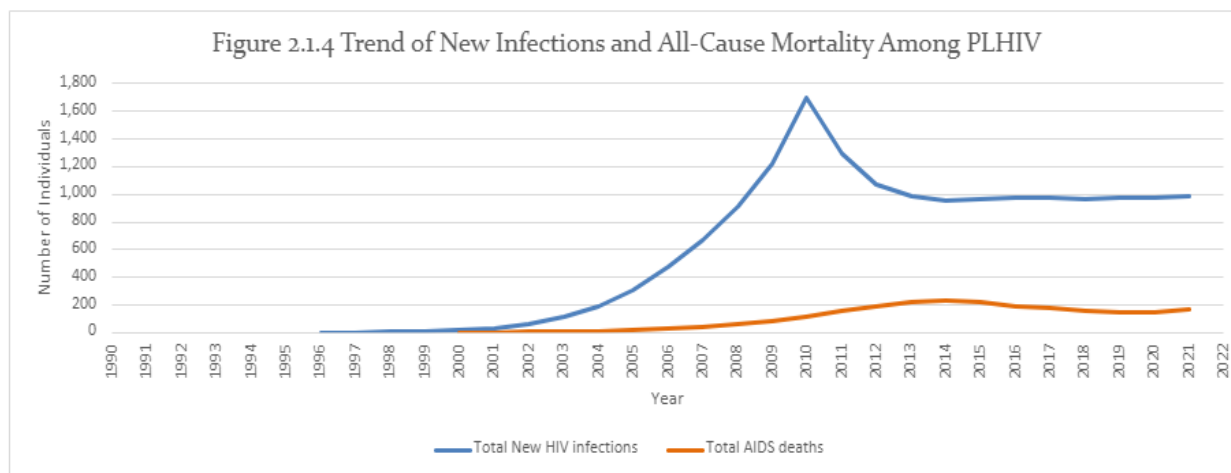
Philippines



Data source:

Spectrum estimates 2022

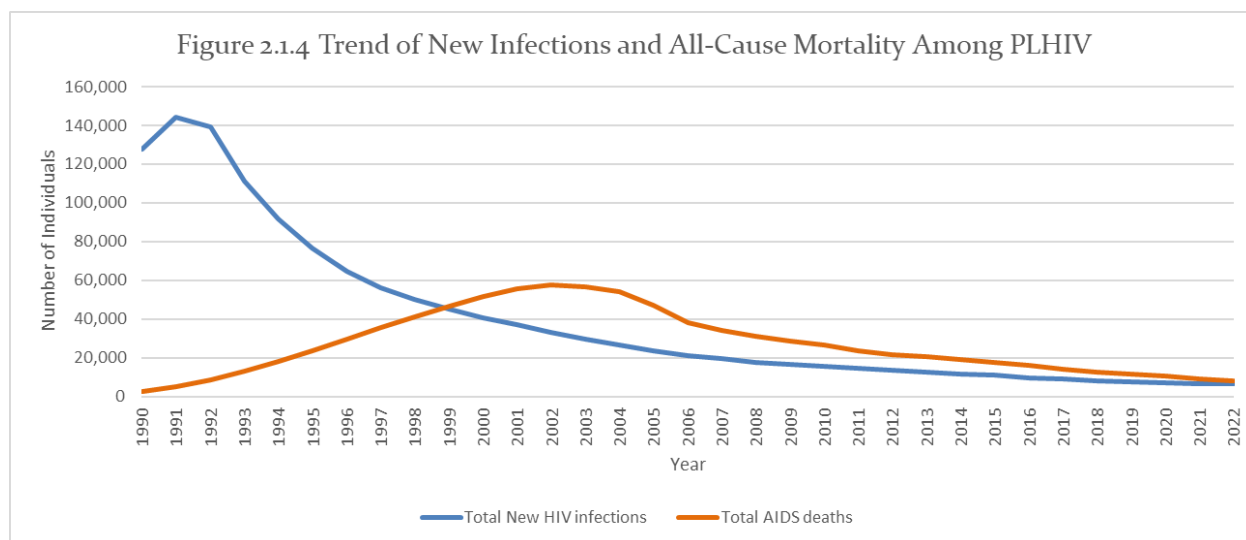
Tajikistan^{vi}



Data source:

Spectrum estimates 2021

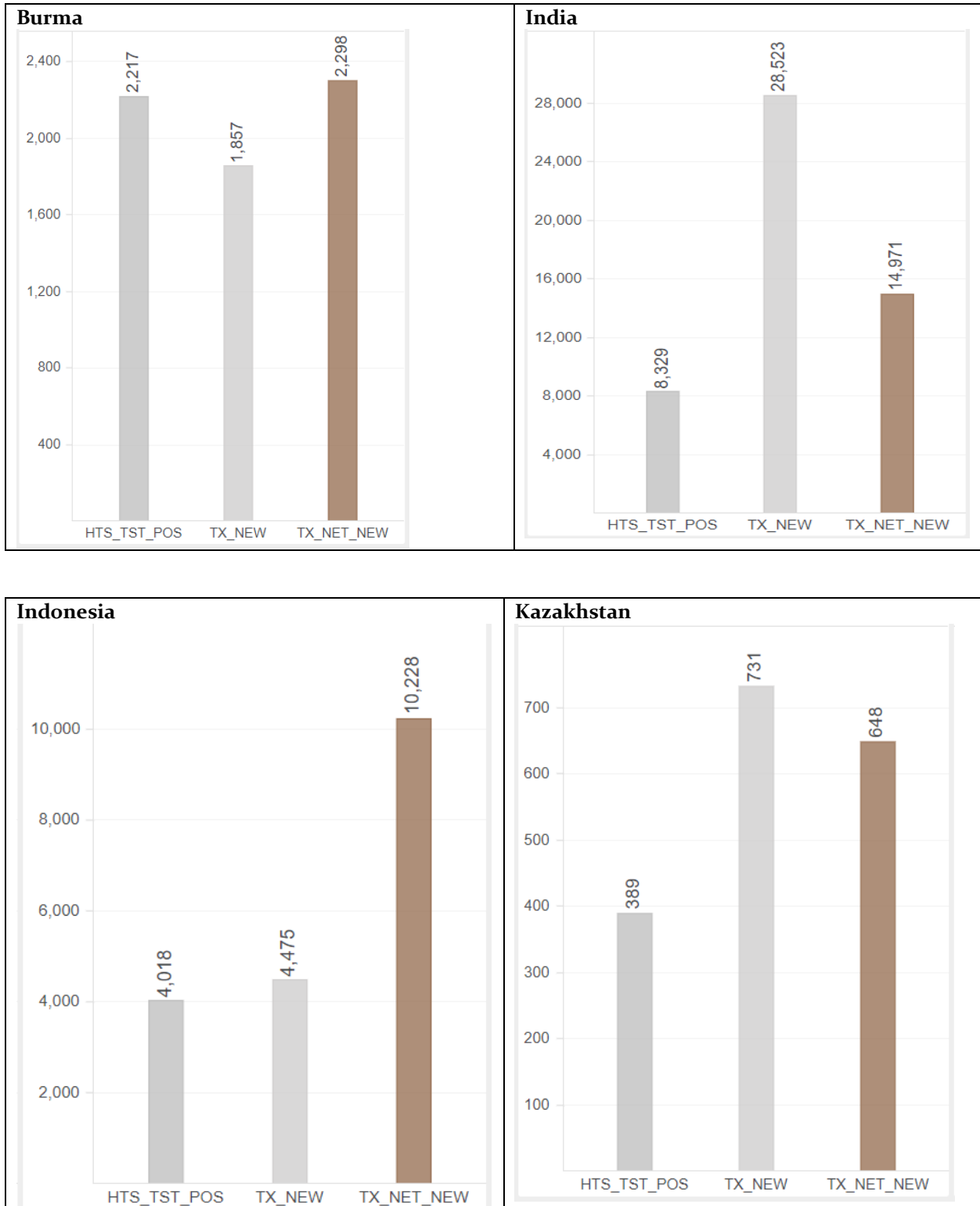
Thailand



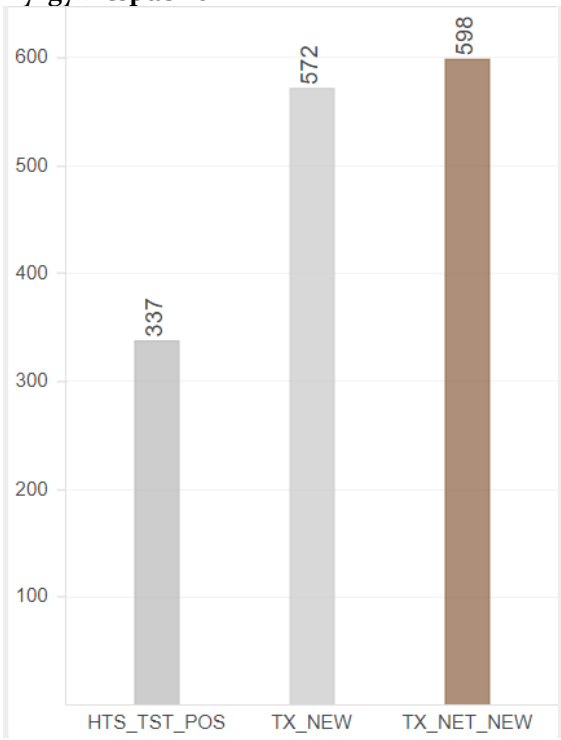
Data source:

Spectrum estimates 2022

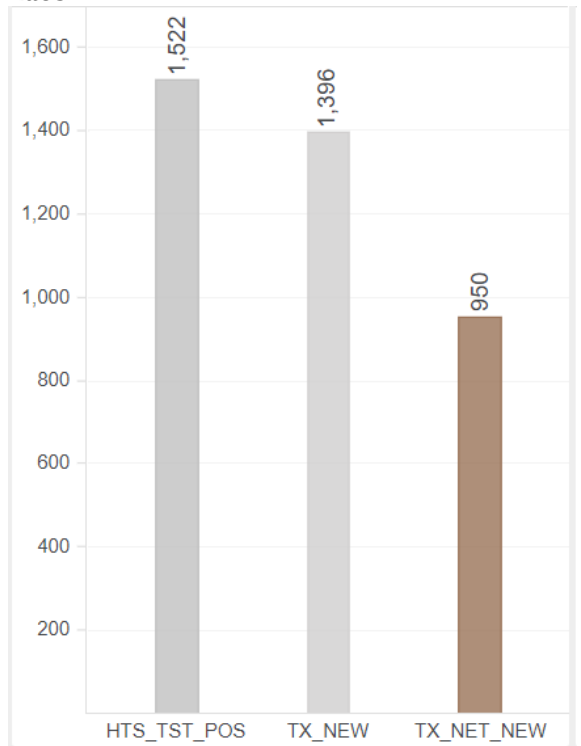
Figure 2.1.5 Assessment of ART program growth in FY21



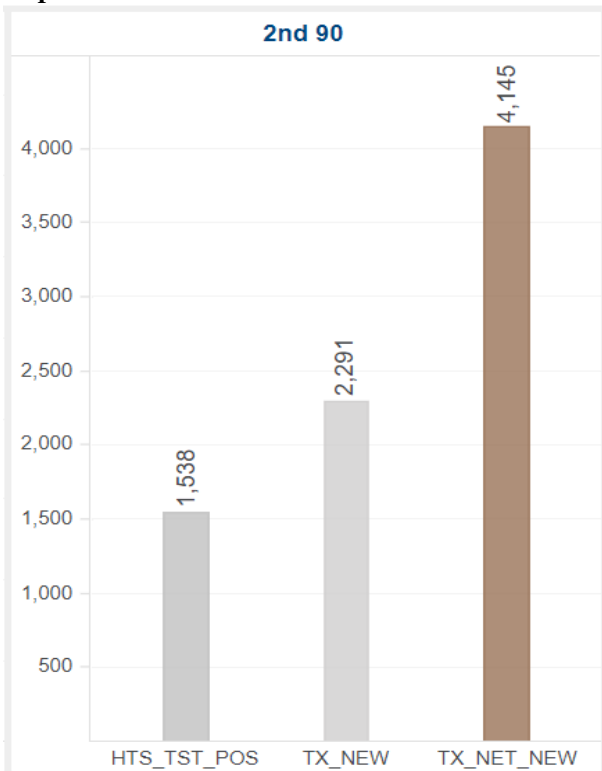
Kyrgyz Republic



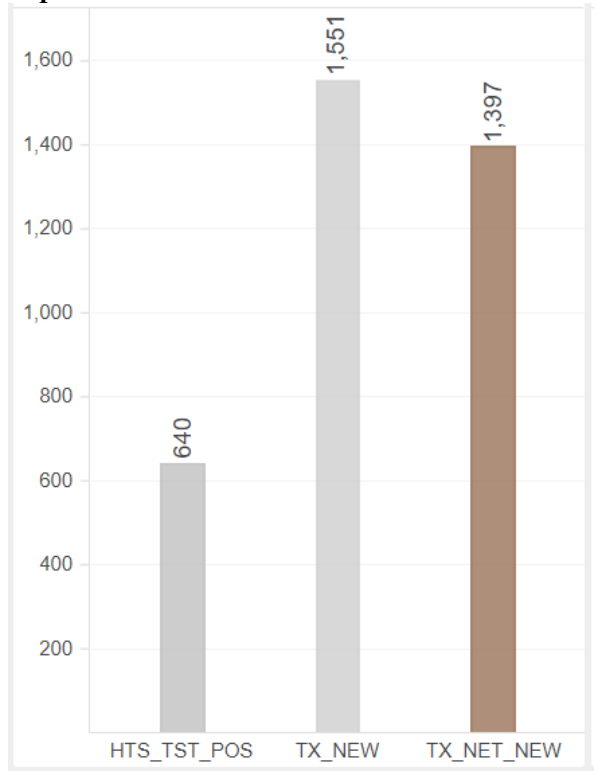
Laos



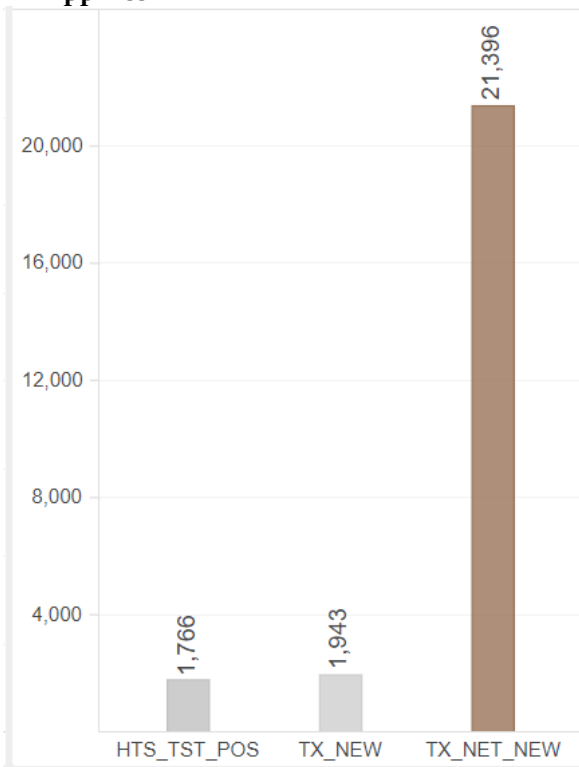
Nepal



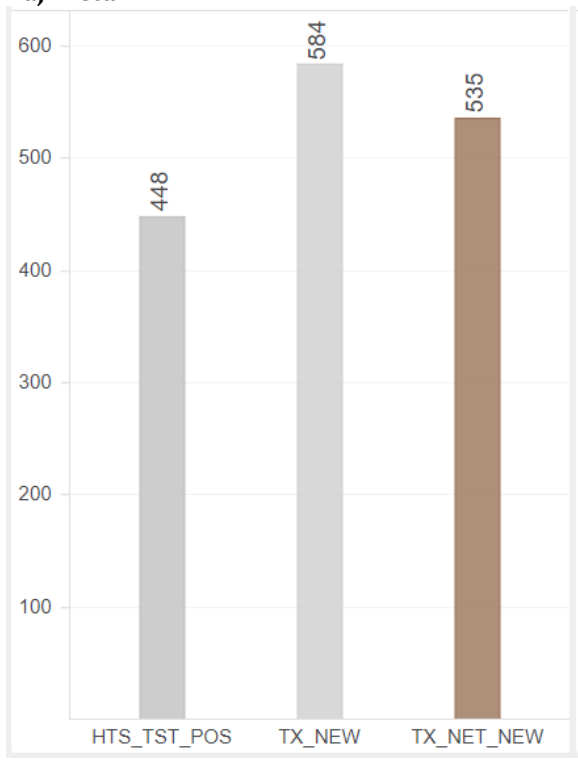
Papua New Guinea



Philippines



Tajikistan



Thailand

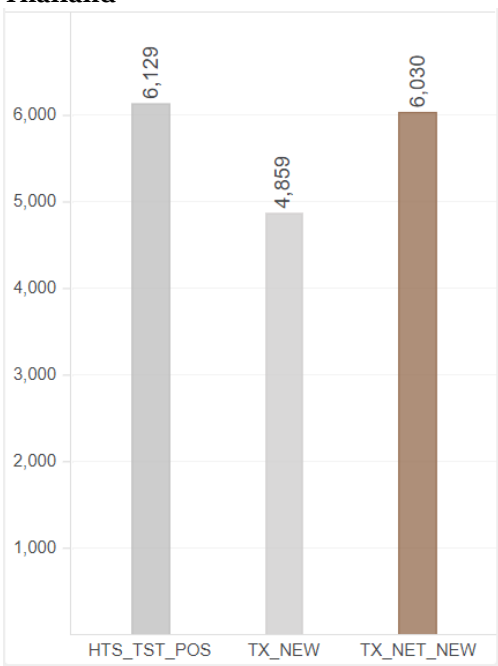
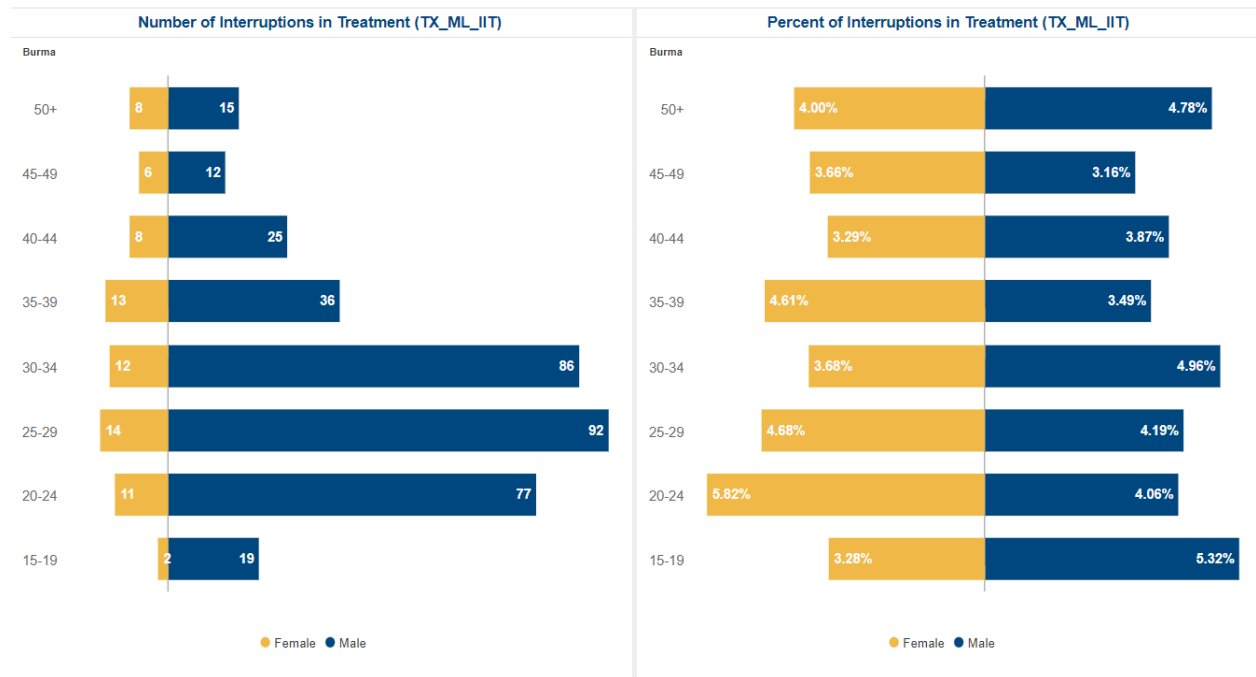
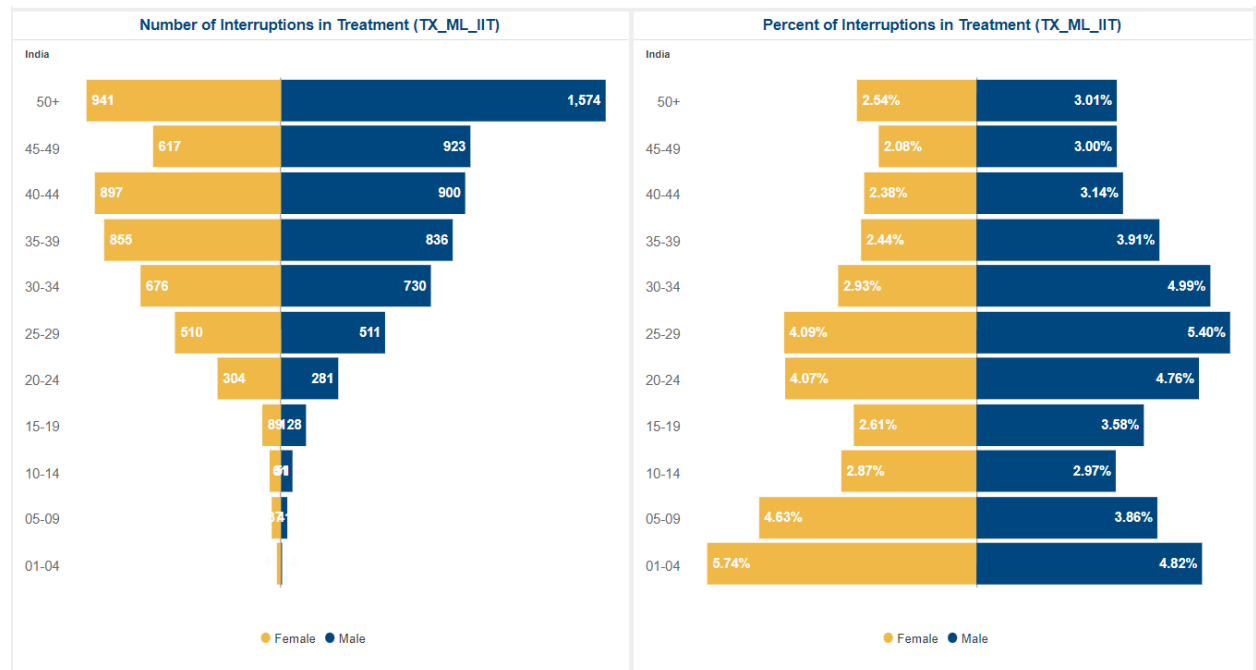


Figure 2.1.6 Clients Gained/Lost from ART by Age/Sex, FY21 Q4

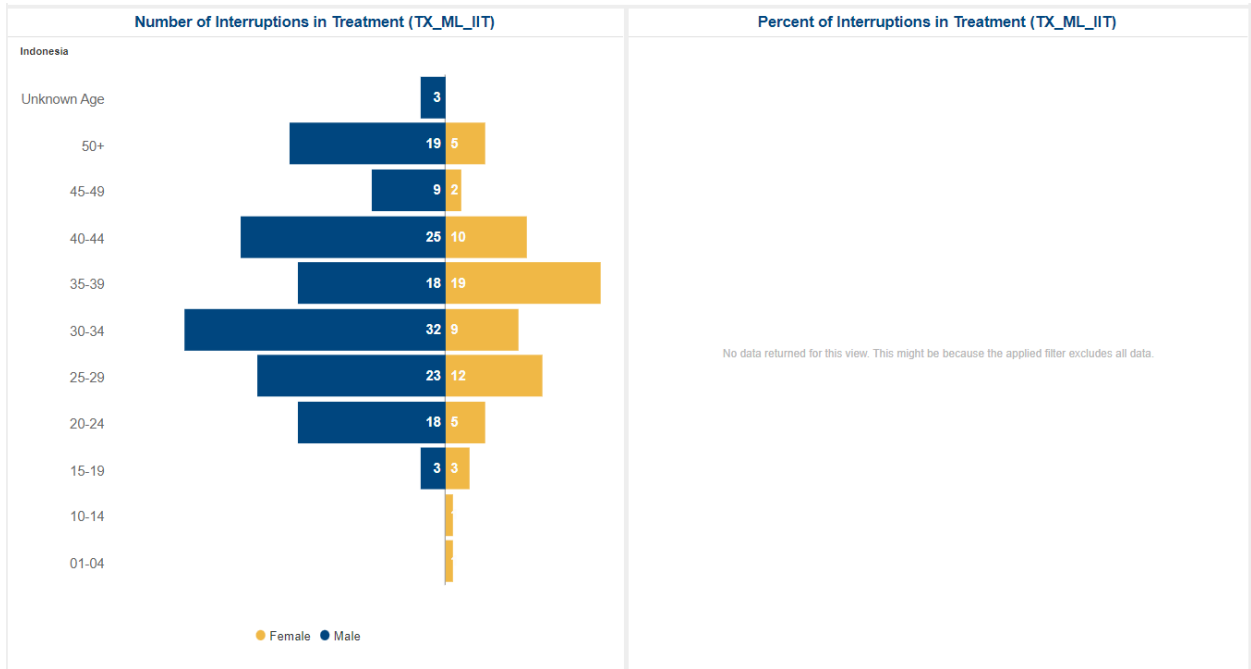
Burma



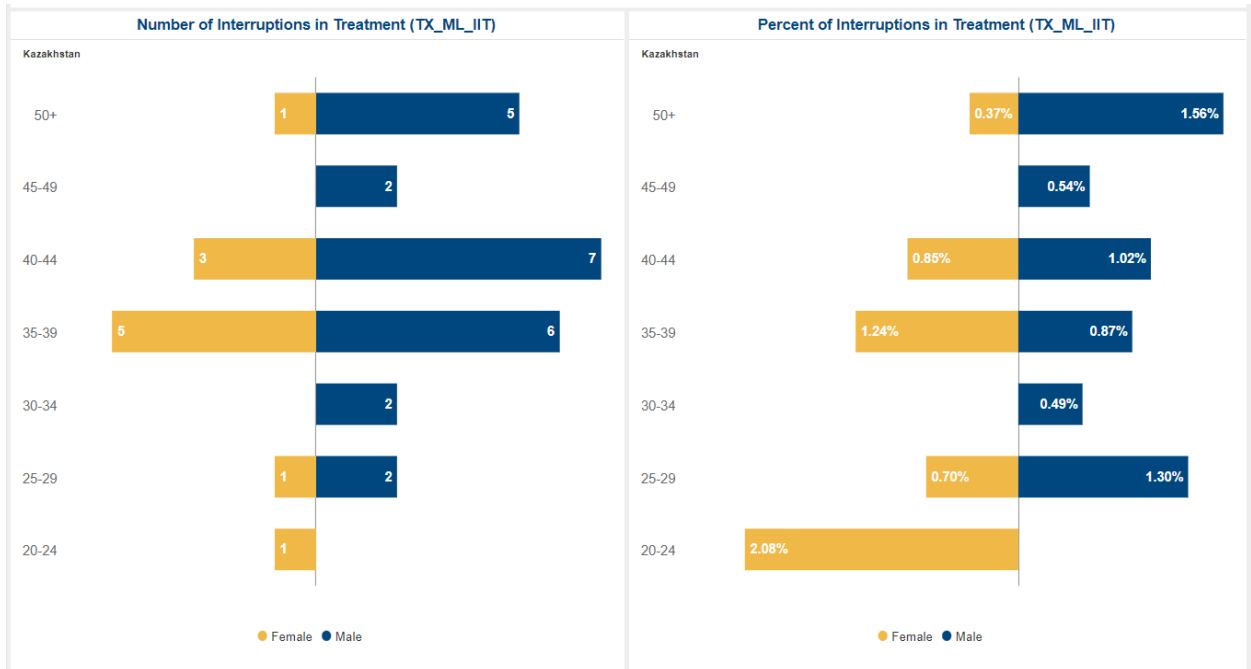
India



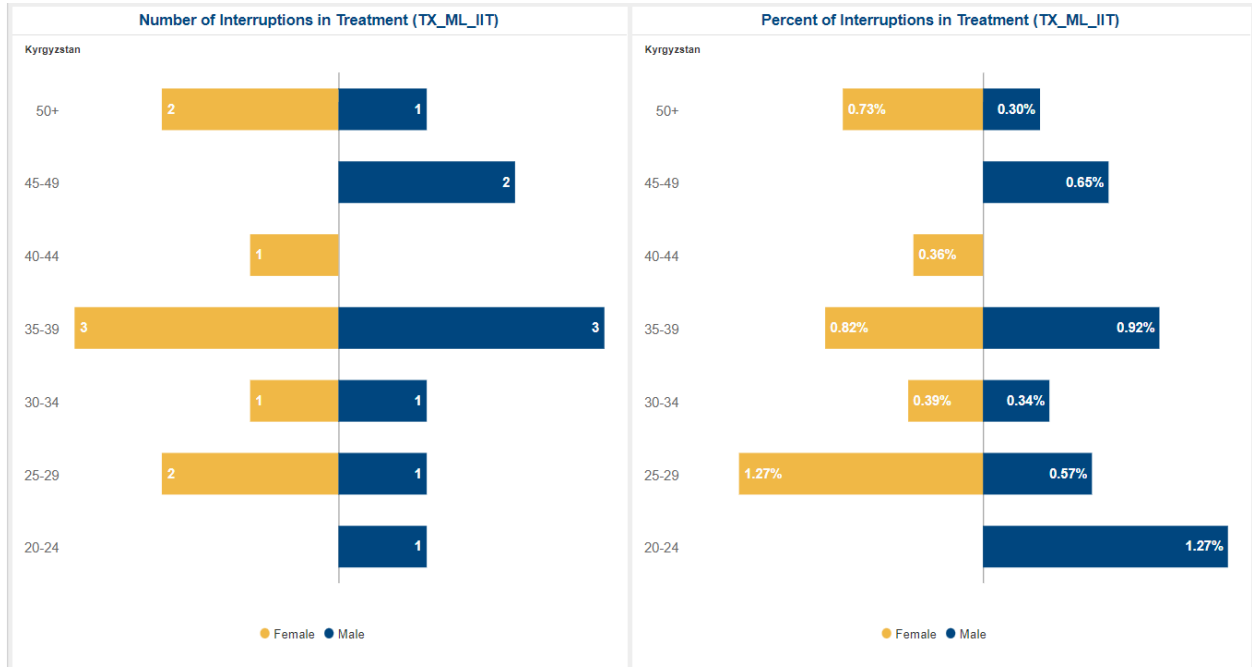
Indonesia



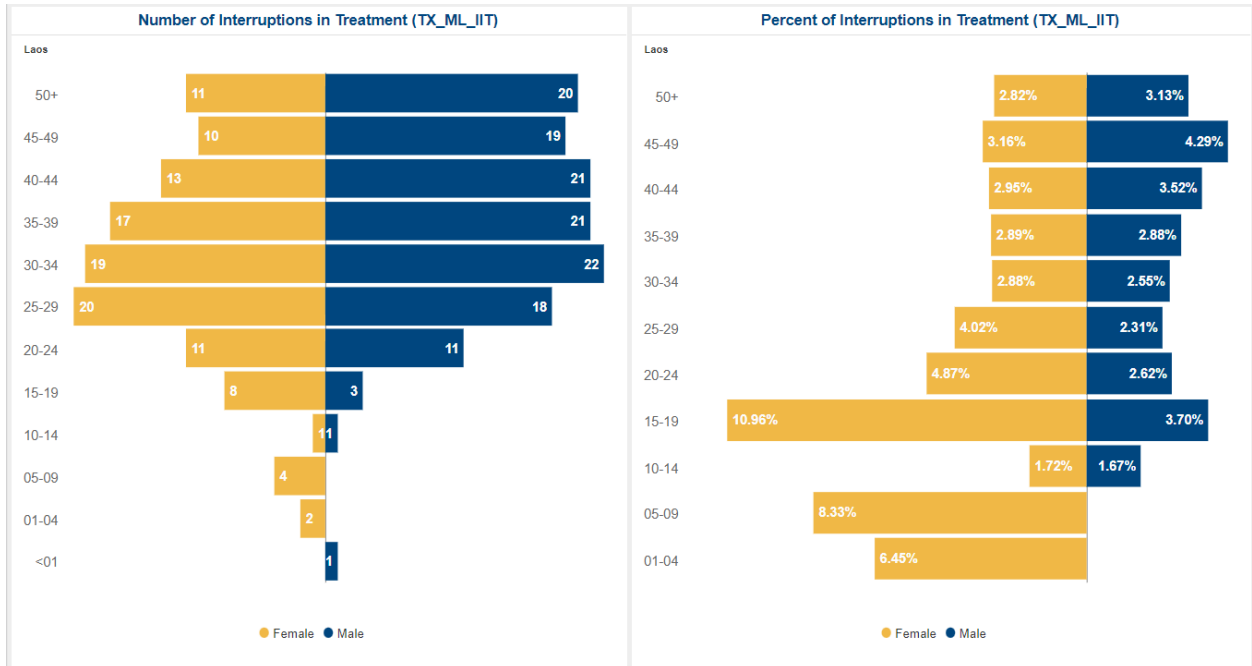
Kazakhstan



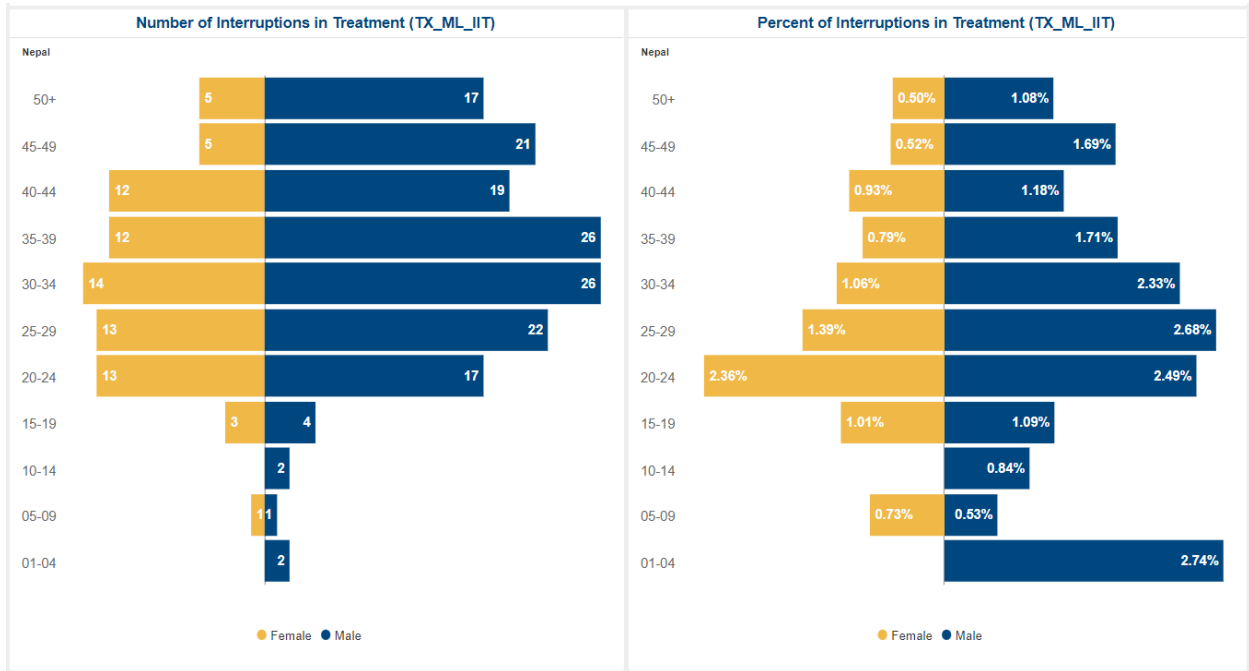
Kyrgyz Republic



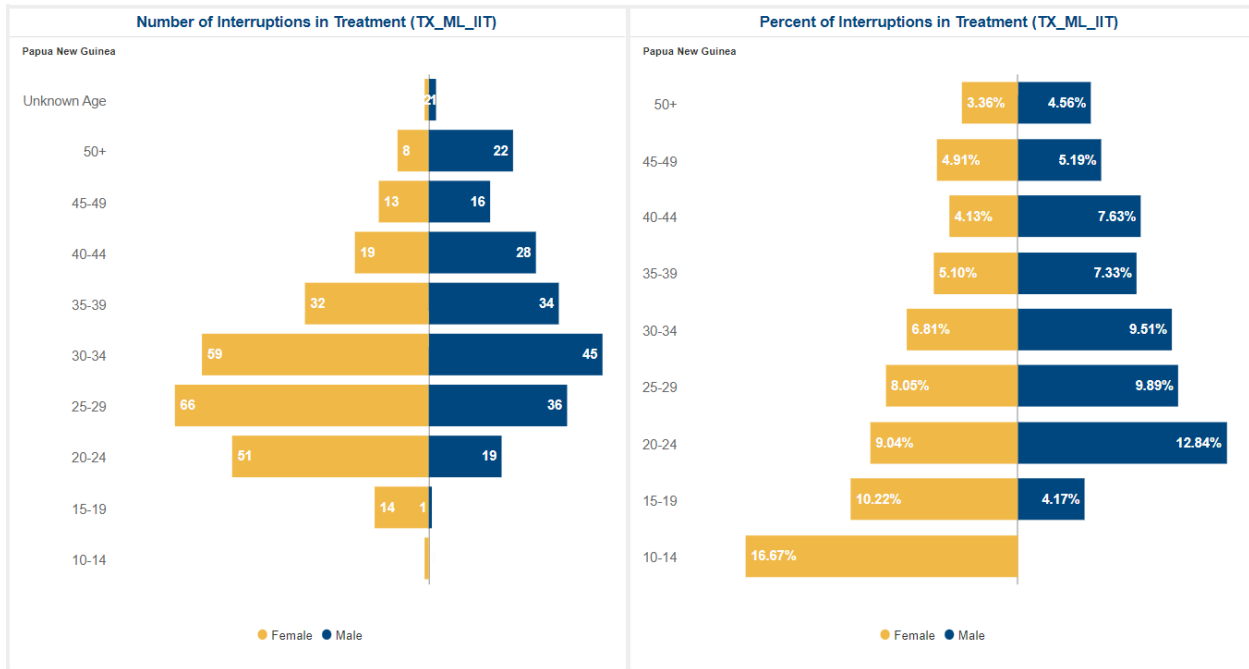
Laos



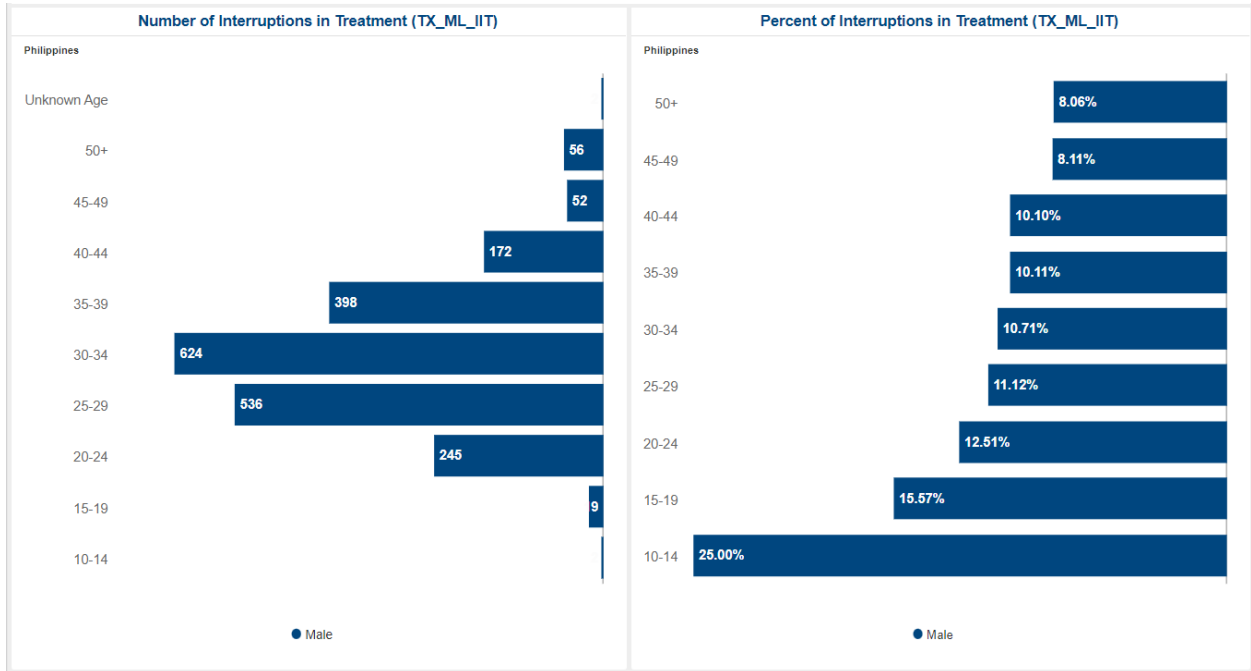
Nepal



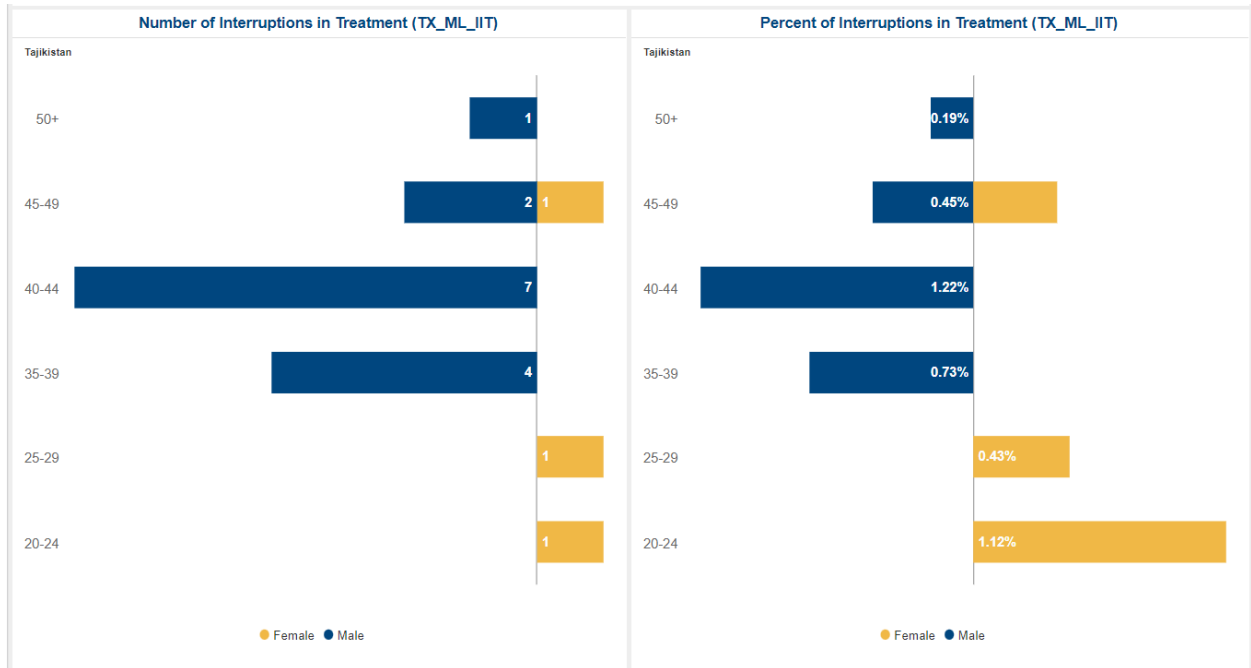
Papua New Guinea



Philippines



Tajikistan



Thailand

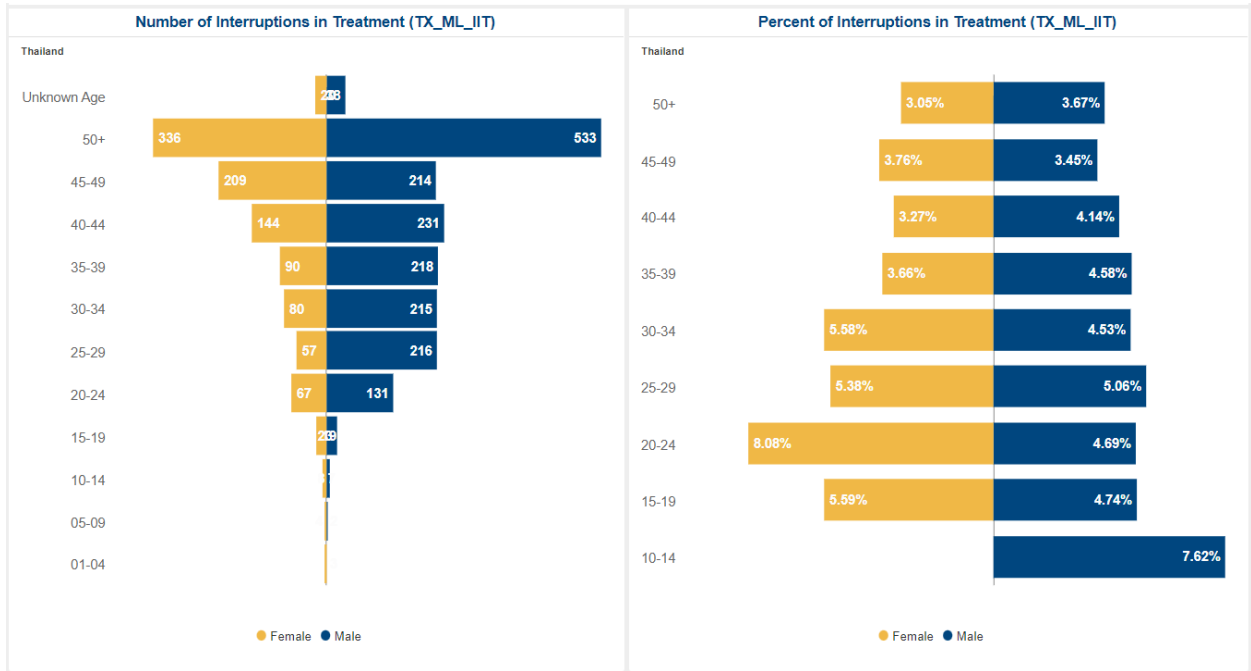
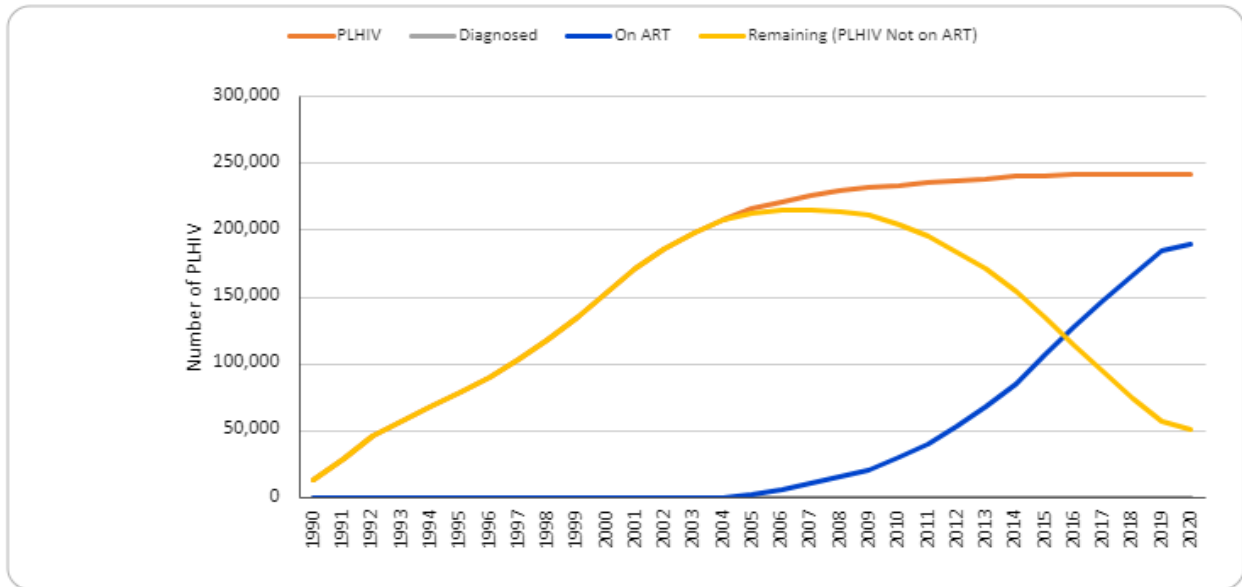
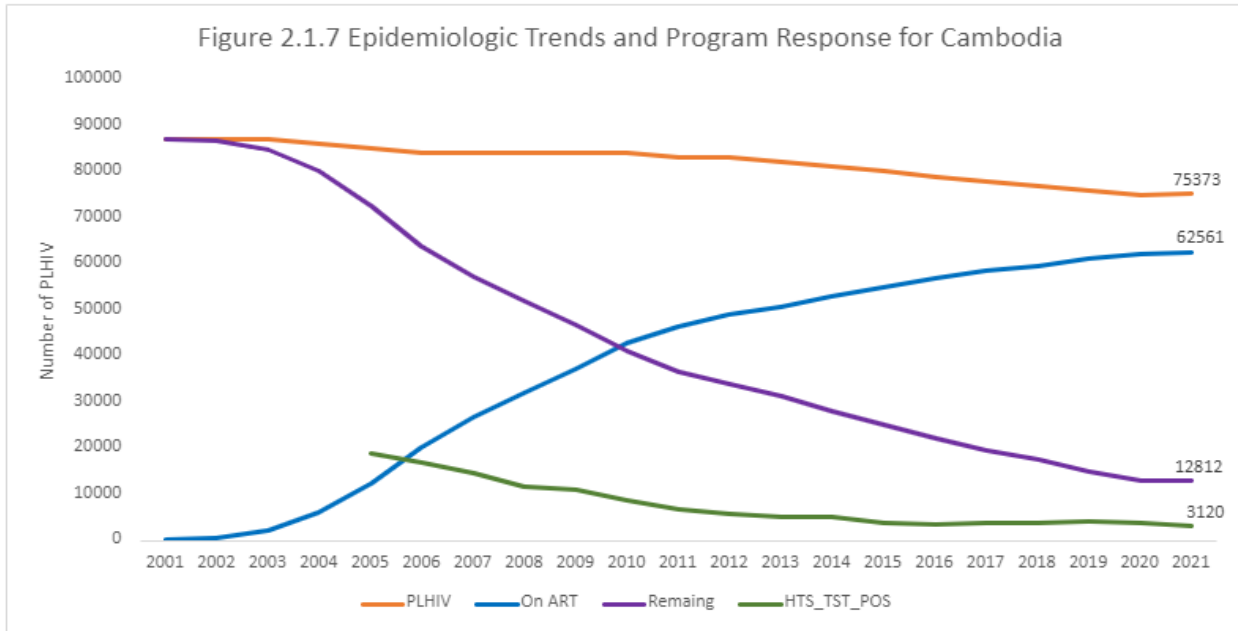


Figure 2.1.7 Epidemiologic Trends and Program Response per country

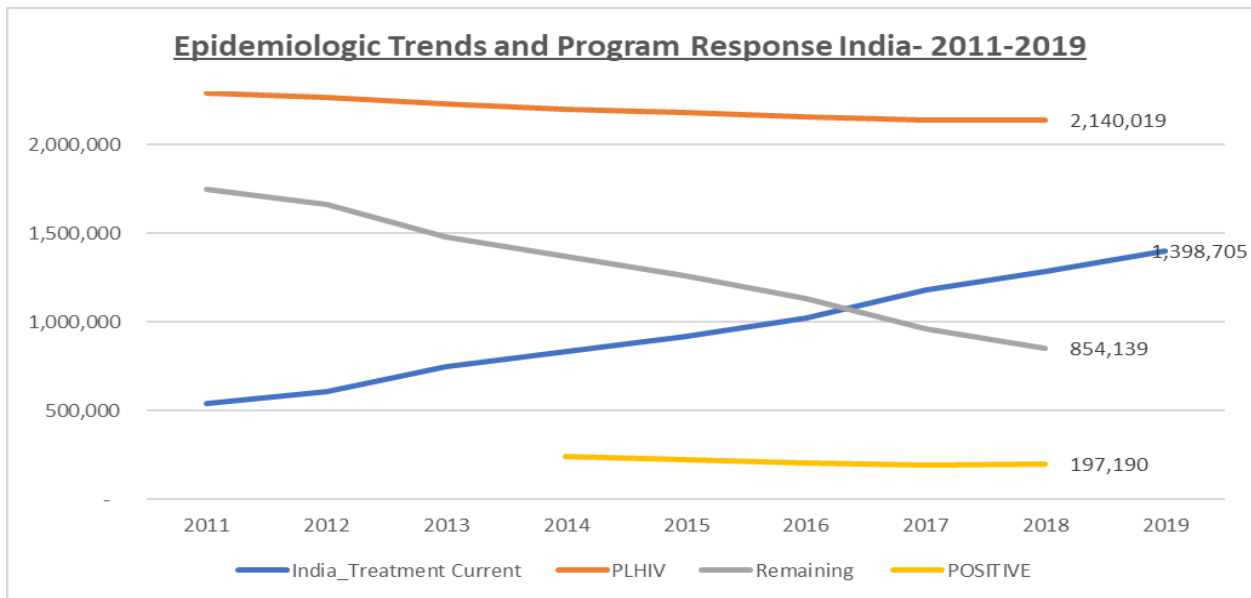
Burma



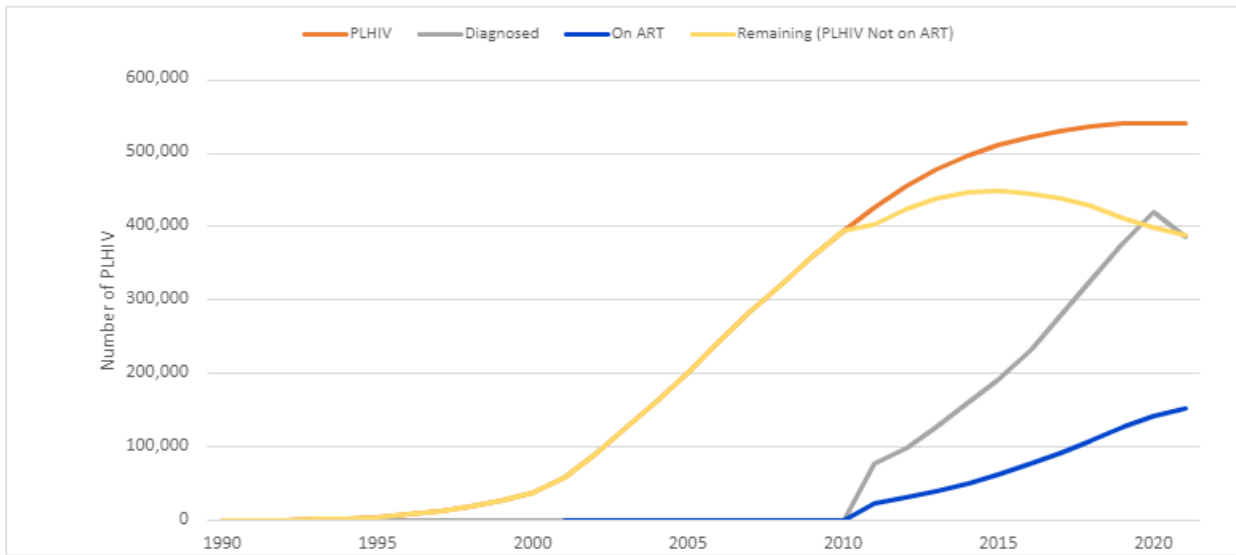
Cambodia



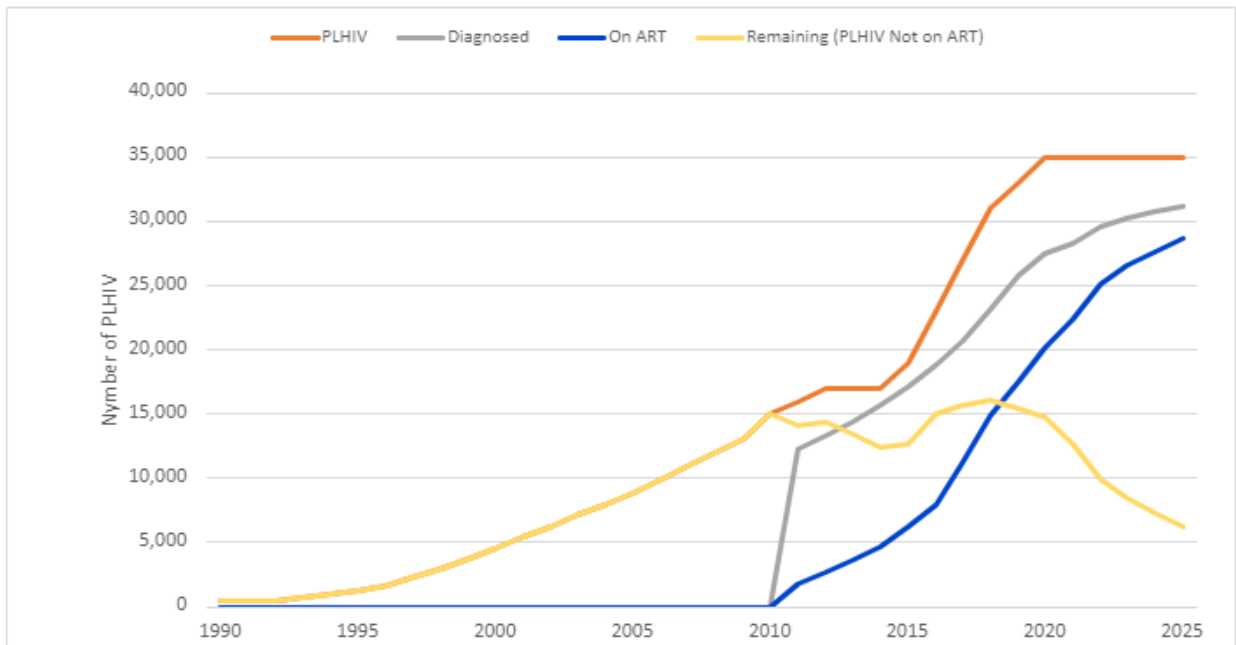
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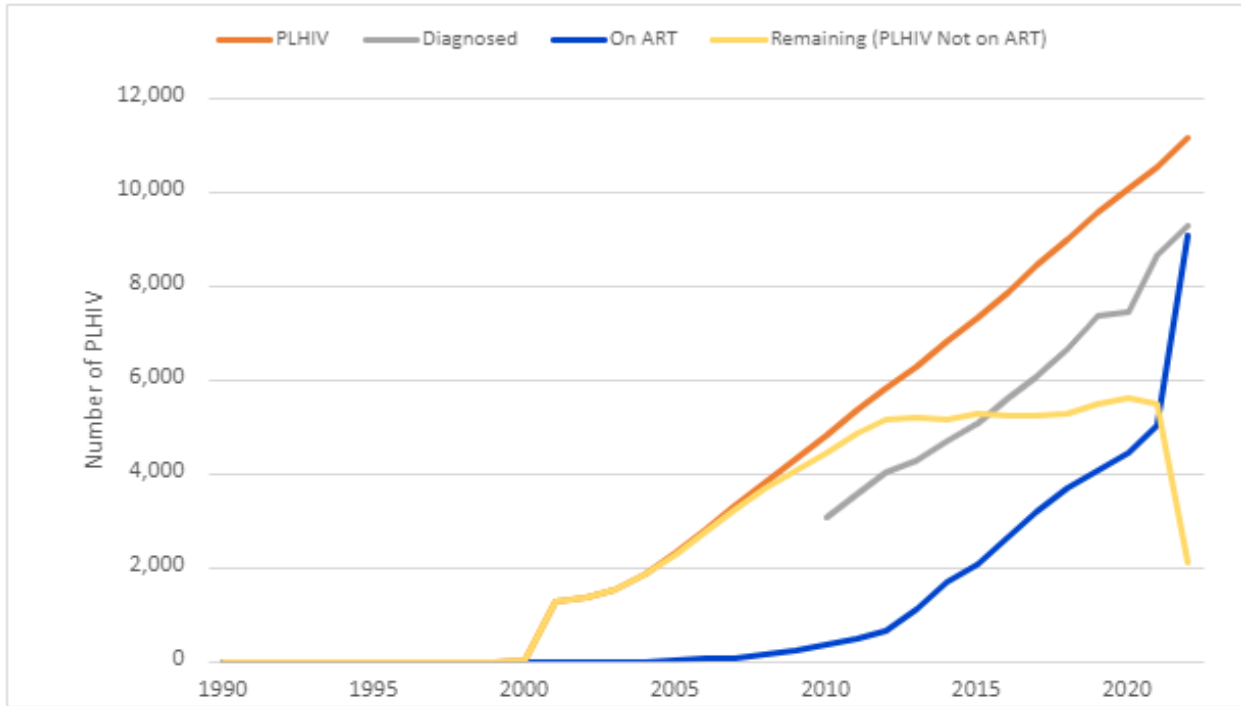
Indonesia



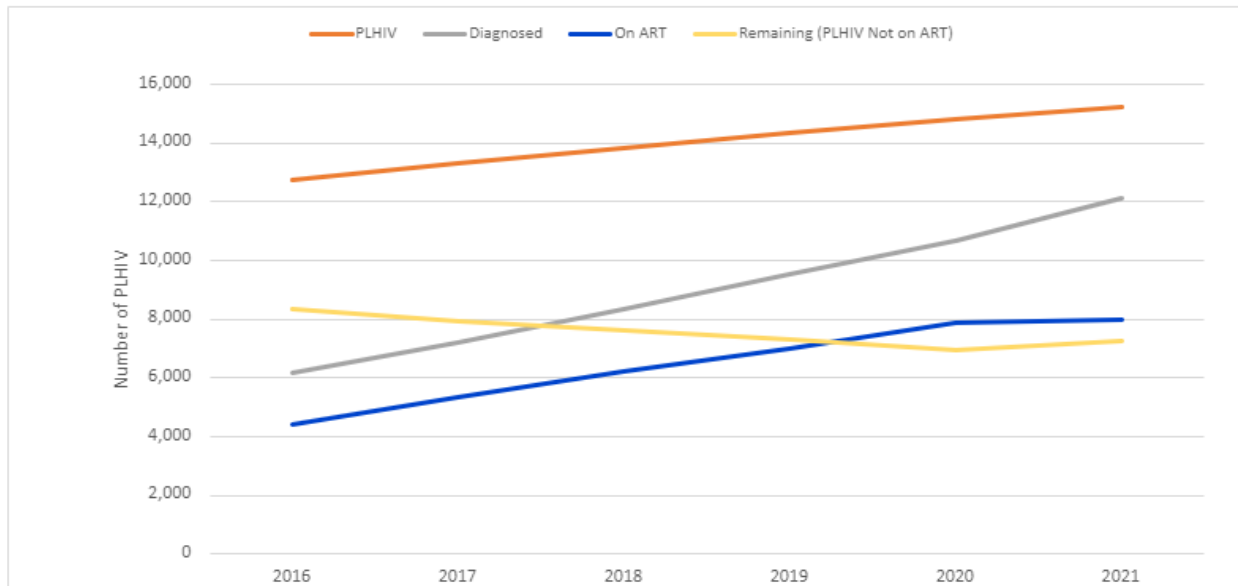
Kazakhstan



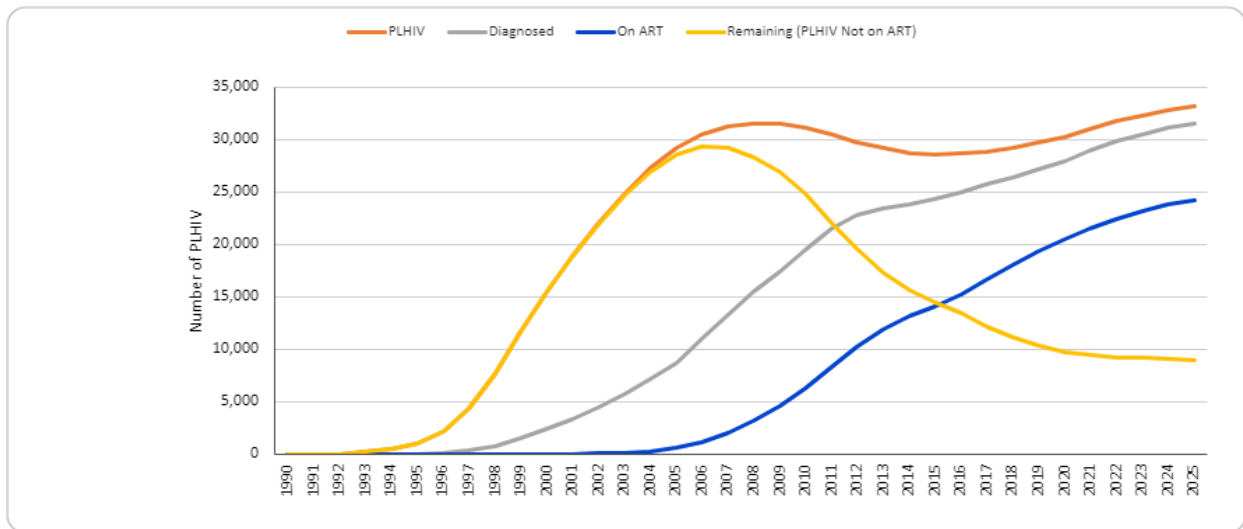
Kyrgyz Republic



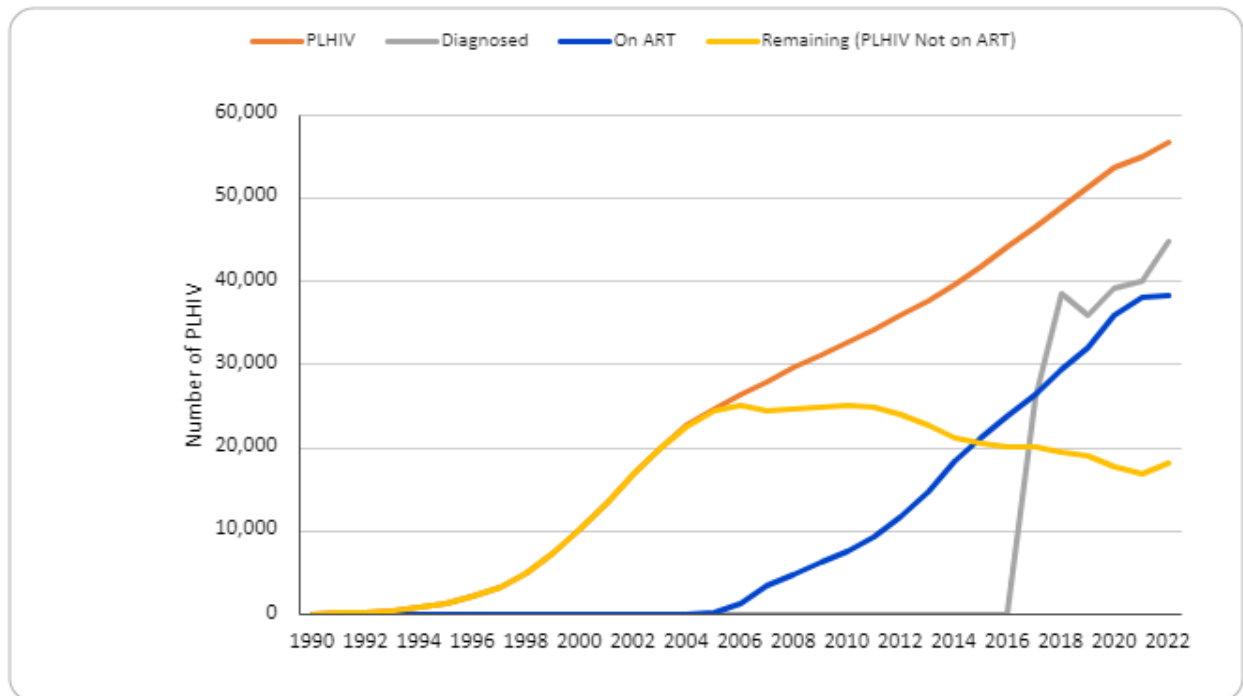
Laos



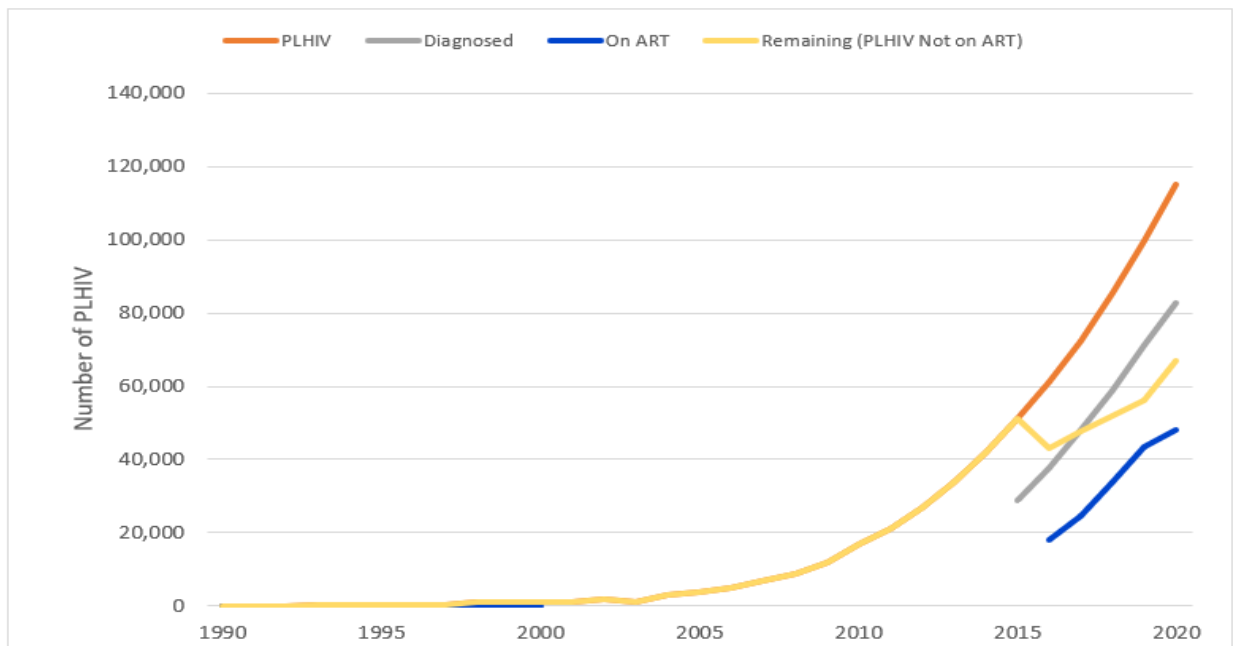
Nepal



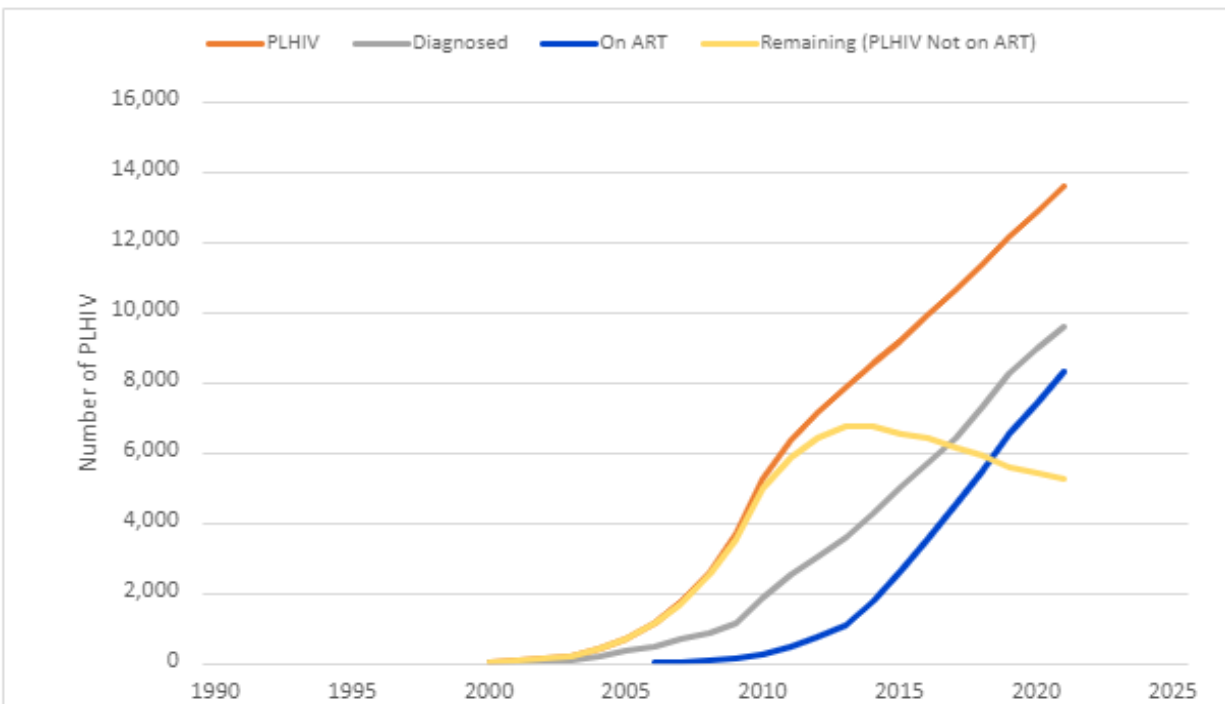
Papua New Guinea



Philippines



Tajikistan



Thailand

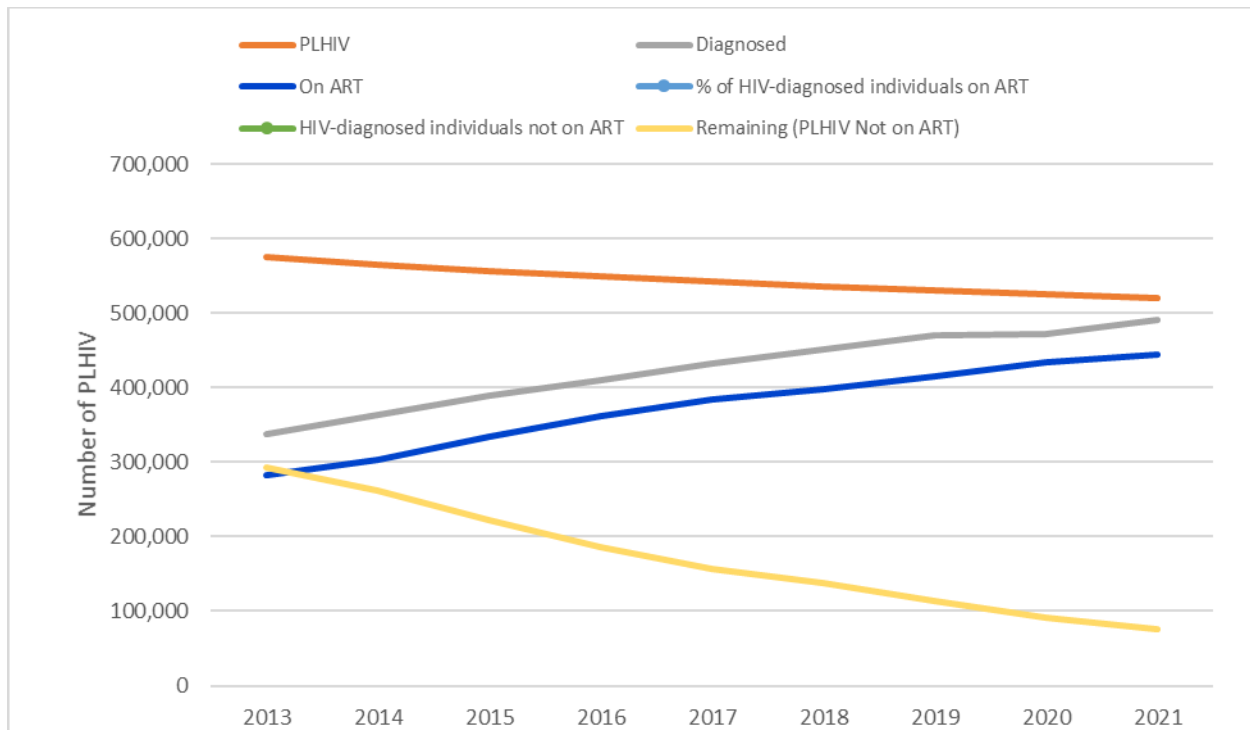
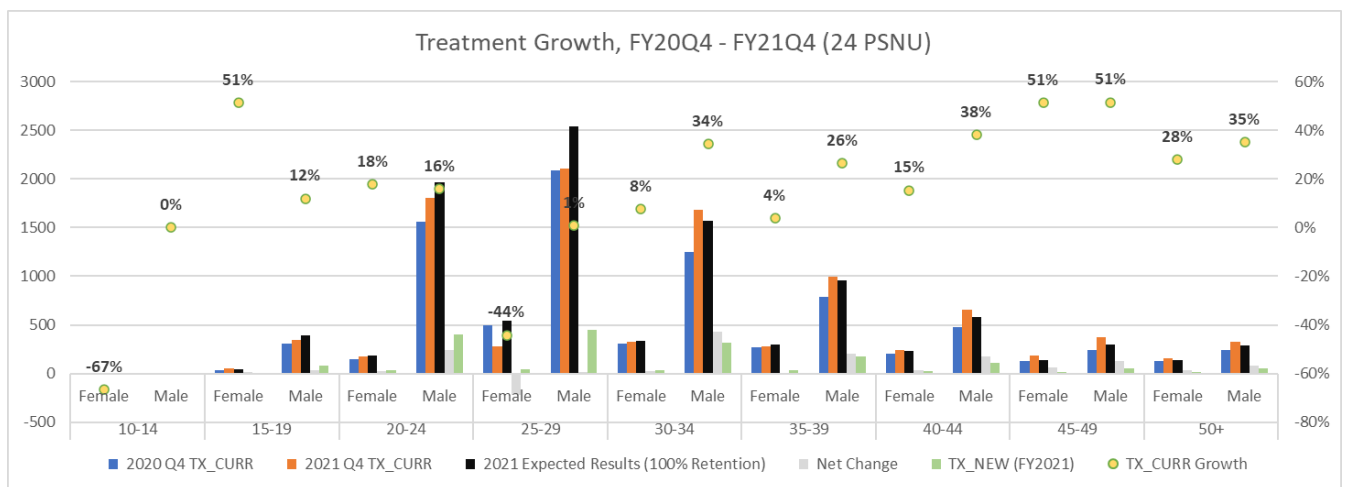
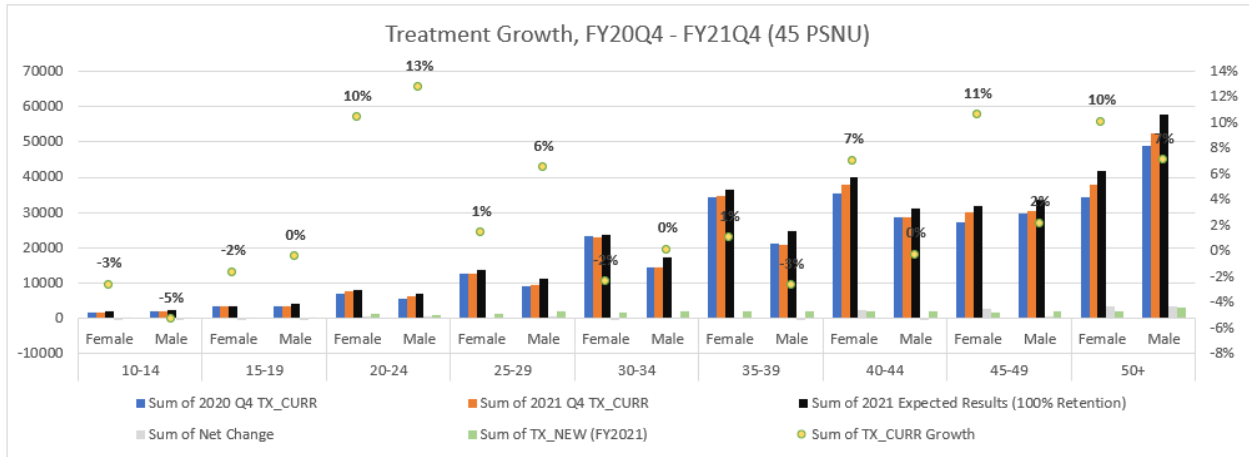


Figure 2.1.8 Net change in HIV treatment by sex and age bands 2020 Q4 to 2021 Q4

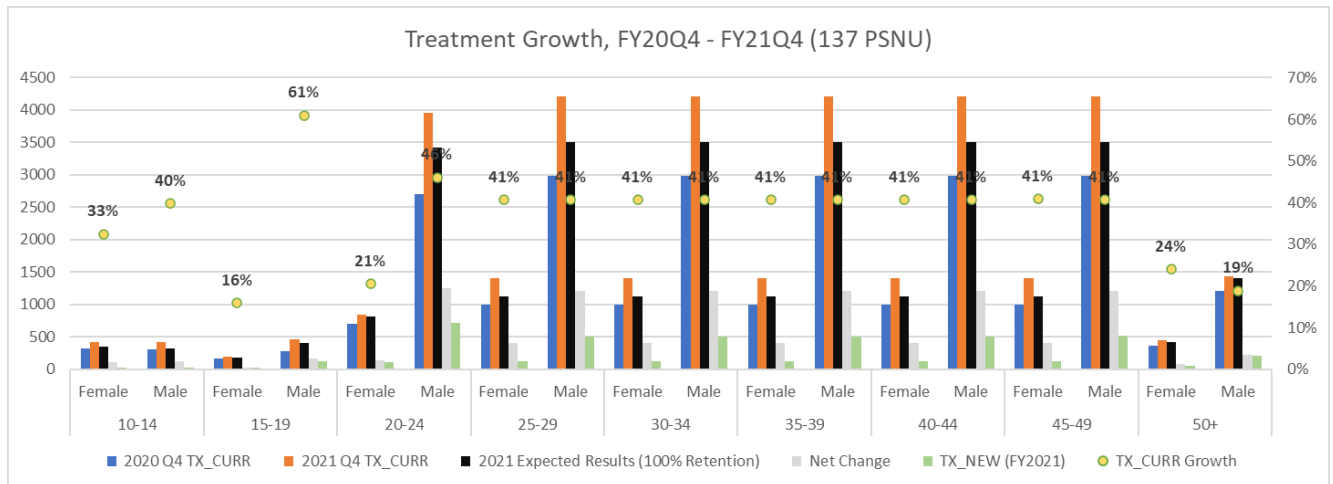
Burma



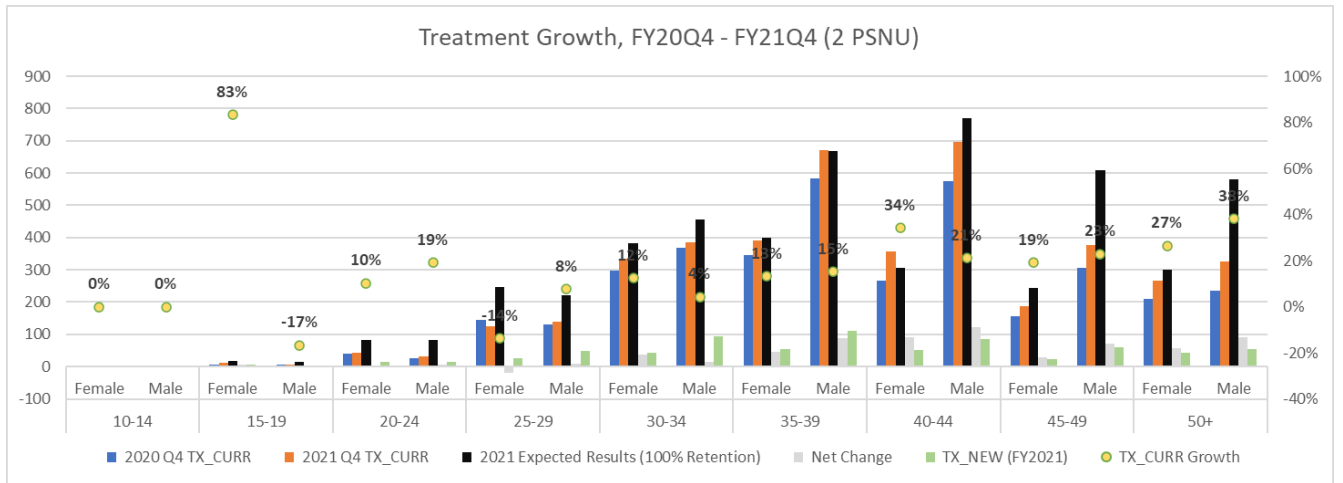
India



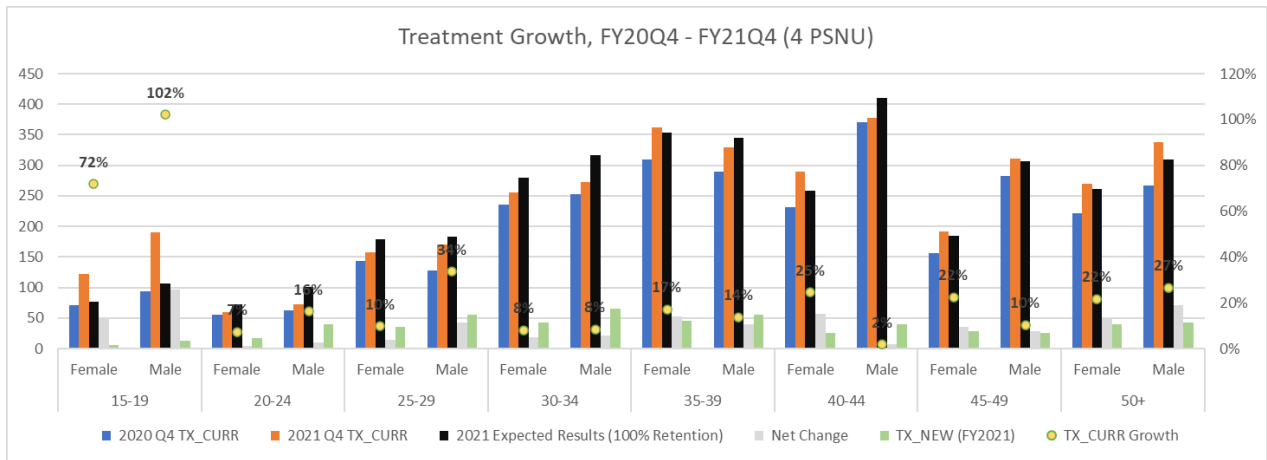
Indonesia



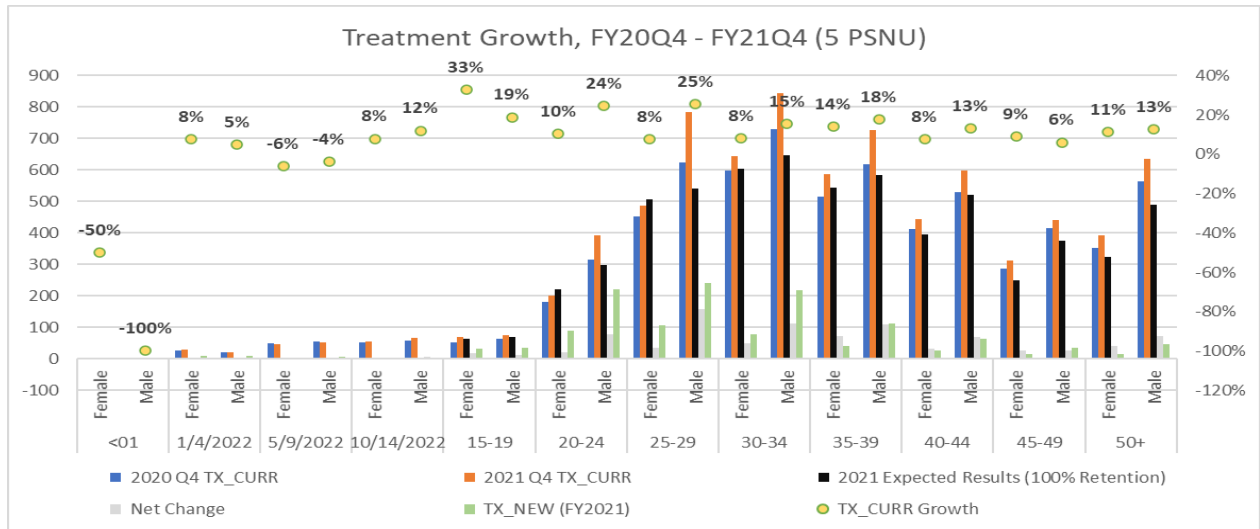
Kazakhstan



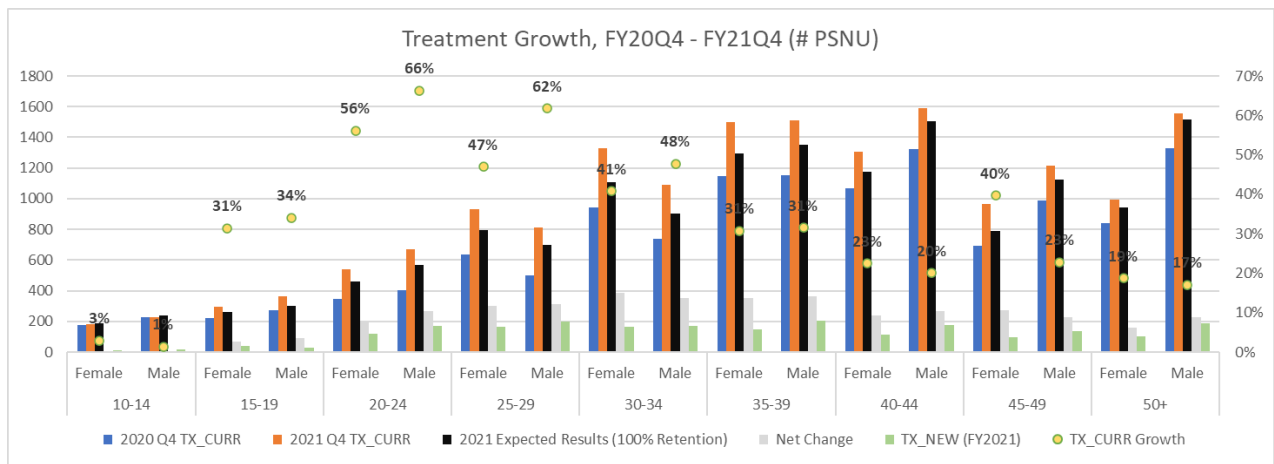
Kyrgyz Republic



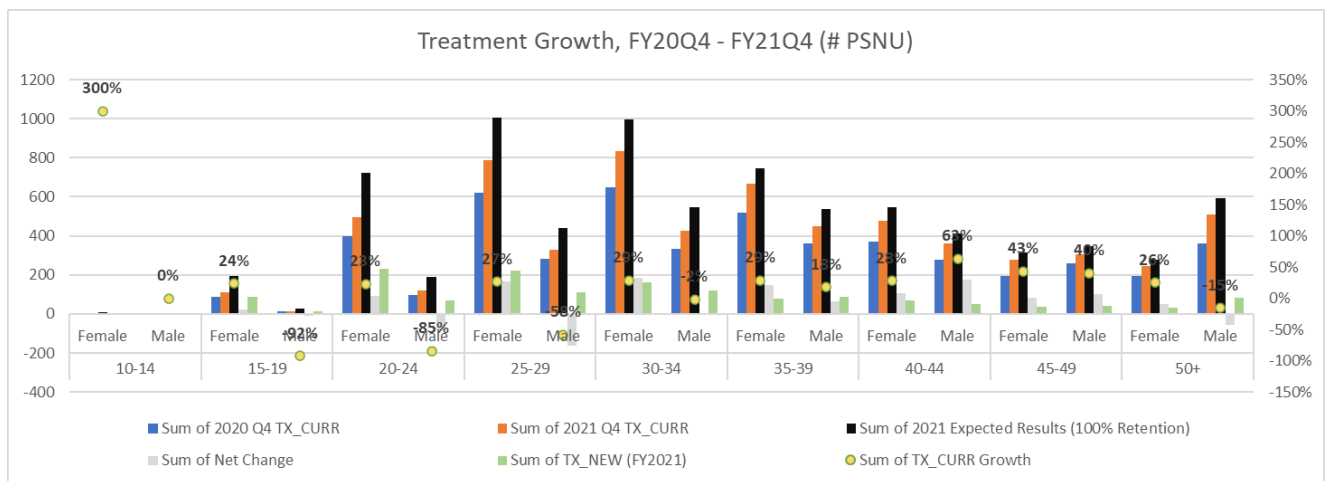
Laos



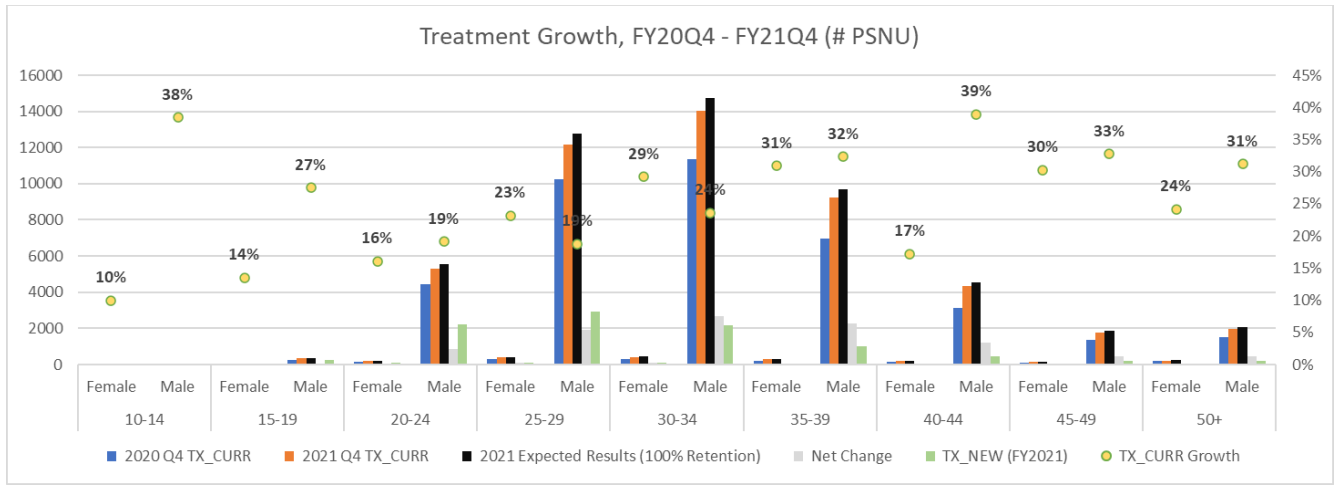
Nepal



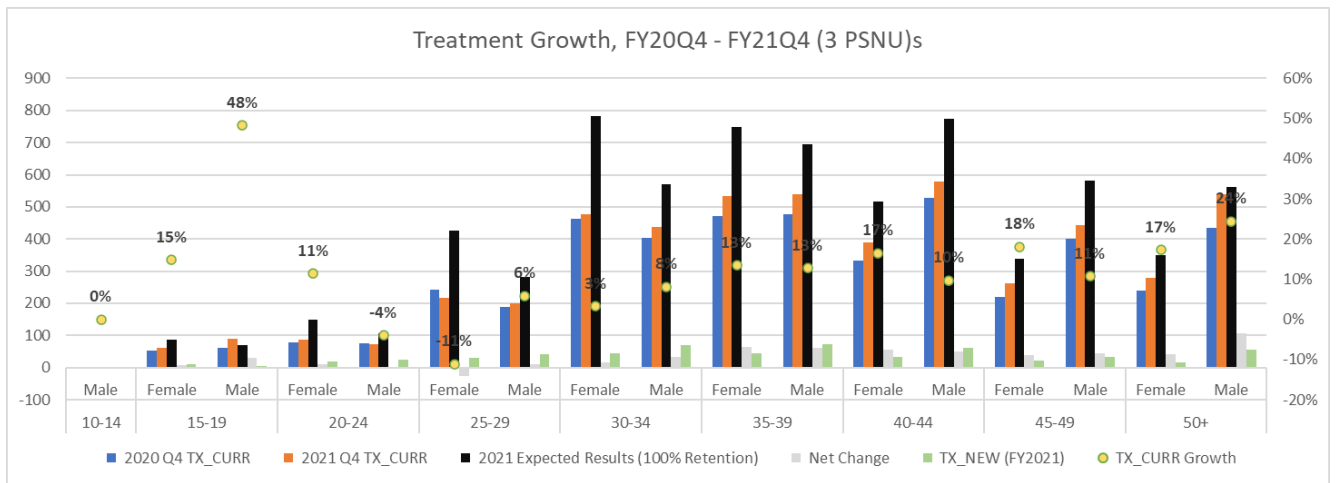
Papua New Guinea



Philippines



Tajikistan



Thailand

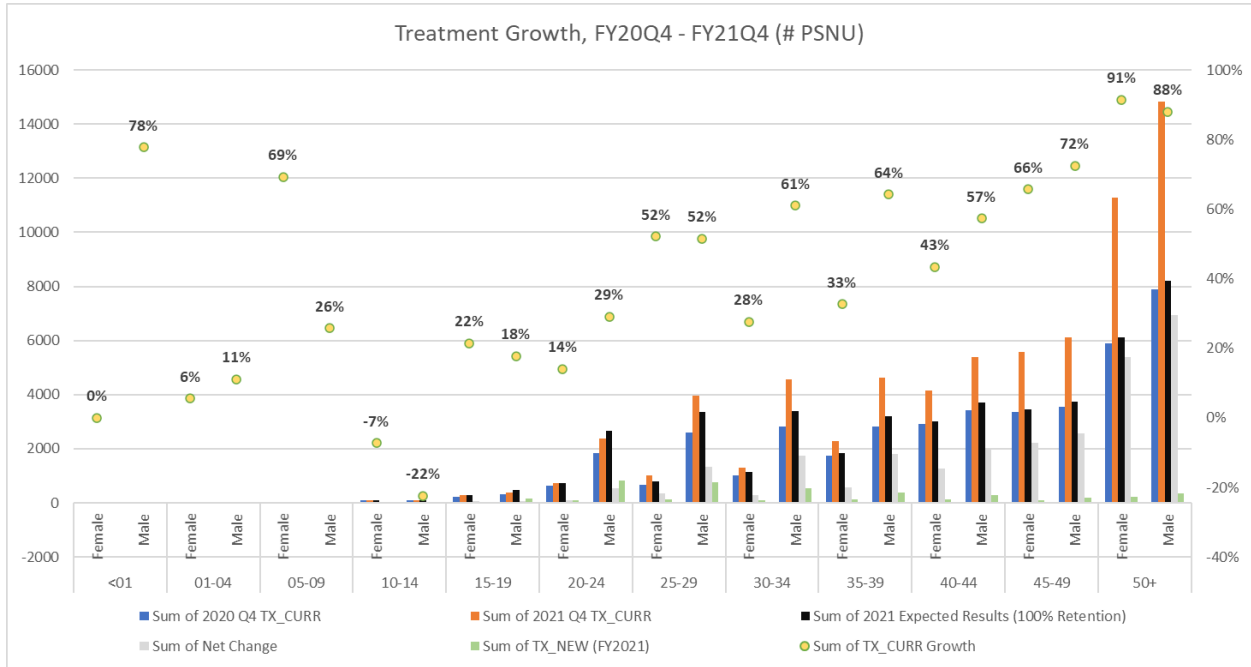


Table 2.3.1 Investment Profile for HIV programs

Burma

Table S1. Investment Profile (Budget Allocation) for HIV Programs, 2022					
	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders
	\$	%	%	%	%
Care and Treatment	\$32,402,888	31%	60%	9%	0%
<i>HIV Care and Clinical Services</i>	\$29,664,669	34%	62%	4%	0%
<i>Laboratory Services incl. Treatment Monitoring</i>	\$1,005,765	0%	100%	0%	0%
<i>Care and Treatment (Not Disaggregated)</i>	\$1,732,454	0%	6%	94%	0%
HIV Testing Services	\$4,652,695	0%	77%	22%	1%
<i>Facility-Based Testing</i>	\$2,360,298	0%	80%	20%	0%
<i>Community-Based Testing</i>	\$1,681,182	0%	100%	0%	0%
<i>HIV Testing Services (Not Disaggregated)</i>	\$611,215	0%	0%	91%	9%
Prevention	\$17,755,598	6%	57%	17%	21%
<i>Community mobilization, behavior and norms change</i>	\$5,165,139	0%	93%	7%	0%
<i>Voluntary Medical Male Circumcision</i>	\$0				
<i>Pre-Exposure Prophylaxis</i>	\$1,259,527	0%	0%	100%	0%
<i>Condom and Lubricant Programming</i>	\$1,636,338	0%	100%	0%	0%
<i>Opioid Substitution Therapy</i>	\$2,045,186	49%	51%	0%	0%
<i>Primary Prevention of HIV & Sexual Violence</i>	\$531,132	0%	100%	0%	0%
<i>Prevention (Not Disaggregated)</i>	\$7,118,276	0%	28%	19%	52%
Socio-economic (incl. OVC)	\$1,377,122	0%	95%	5%	0%
<i>Case Management</i>	\$0				
<i>Economic Strengthening</i>	\$0				
<i>Education Assistance</i>	\$0				
<i>Psychosocial Support</i>	\$988,525	0%	93%	7%	0%
<i>Legal, Human Rights, and Protection</i>	\$388,597	0%	100%	0%	0%
<i>Socio-economic (Not Disaggregated)</i>	\$0				
Above Site Programs	\$10,354,998	0%	50%	44%	6%
<i>HRH Systems</i>	\$629,636	0%	63%	37%	0%
<i>Institutional Prevention</i>	\$0				
<i>Procurement and Supply Chain Management</i>	\$2,680,282	0%	95%	5%	0%
<i>Health Mgmt Info Systems, Surveillance, and Research</i>	\$2,920,330	0%	71%	29%	0%
<i>Laboratory Systems Strengthening</i>	\$917,715	0%	3%	97%	0%
<i>Public Financial Management Strengthening</i>	\$247,817	0%	6%	94%	0%
<i>Policy, Planning, Coordination and Management of Disease Ctrl Programs</i>	\$2,925,861	0%	4%	75%	22%
<i>Laws, Regulations and Policy Environment</i>	\$0				
<i>Above Site Programs (Not Disaggregated)</i>	\$33,357	0%	100%	0%	0%
Program Management	\$16,714,494	0%	83%	17%	0%
<i>Implementation Level</i>	\$16,714,494	0%	83%	17%	0%
Total (incl. Commodities)	\$83,257,795	13%	64%	17%	5%
Commodities Only	\$32,890,431	33%	67%	0%	0%
<i>% of Total Budget</i>	<i>40%</i>				

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Cambodia

Table S1. Investment Profile (Budget Allocation) for HIV Programs, 2022

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders
	\$	%	%	%	%
Care and Treatment	\$11,116,710	31%	69%	0%	0%
HIV Care and Clinical Services	\$7,333,552	0%	100%	0%	0%
Laboratory Services incl. Treatment Monitoring	\$231,306	0%	100%	0%	0%
Care and Treatment (Not Disaggregated)	\$3,551,852	99%	1%	0%	0%
HIV Testing Services	\$997,367	0%	100%	0%	0%
Facility-Based Testing	\$411,945	0%	100%	0%	0%
Community-Based Testing	\$554,178	0%	100%	0%	0%
HIV Testing Services (Not Disaggregated)	\$31,244	0%	100%	0%	0%
Prevention	\$2,226,400	0%	100%	0%	0%
Community mobilization, behavior and norms change	\$1,292,222	0%	100%	0%	0%
Voluntary Medical Male Circumcision	\$0				
Pre-Exposure Prophylaxis	\$85,803	0%	100%	0%	0%
Condom and Lubricant Programming	\$463,223	0%	100%	0%	0%
Opioid Substitution Therapy	\$6,110	0%	100%	0%	0%
Primary Prevention of HIV & Sexual Violence	\$67,919	0%	100%	0%	0%
Prevention (Not Disaggregated)	\$311,123	0%	100%	0%	0%
Socio-economic (incl. OVC)	\$149,449	0%	100%	0%	0%
Care Management	\$0				
Economic Strengthening	\$0				
Education Assistance	\$0				
Psychosocial Support	\$0				
Legal, Human Rights, and Protection	\$149,449	0%	100%	0%	0%
Socio-economic (Not Disaggregated)	\$0				
Above Site Programs	\$7,671,035	25%	15%	60%	0%
HRV Systems	\$0				
Institutional Prevention	\$0				
Procurement and Supply Chain Management	\$228,923	0%	100%	0%	0%
Health Mgmt Info Systems, Surveillance, and Research	\$1,407,504	0%	61%	39%	0%
Laboratory Systems Strengthening	\$866,657	0%	4%	96%	0%
Public Financial Management Strengthening	\$400,000	0%	0%	100%	0%
Policy, Planning, Coordination and Management of Disease Ctrl Programs	\$2,233,895	0%	0%	100%	0%
Laws, Regulations and Policy Environment	\$0				
Above Site Programs (Not Disaggregated)	\$2,534,056	76%	0%	24%	0%
Program Management	\$4,097,239	0%	74%	26%	0%
Implementation Level	\$4,097,239	0%	74%	26%	0%
Total (incl. Commodities)	\$26,258,200	21%	58%	22%	0%
Commodities Only	\$7,173,126	0%	100%	0%	0%
% of Total Budget	27%				

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

India

Table S1. Investment Profile (Budget Allocation) for HIV Programs, 2022

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders
	\$	%	%	%	%
Care and Treatment	\$15,368,757	0%	26%	74%	0%
HIV Care and Clinical Services	\$11,096,568	0%	36%	64%	0%
Laboratory Services incl. Treatment Monitoring	\$1,195,750	0%	0%	100%	0%
Care and Treatment (Not Disaggregated)	\$3,076,439	0%	0%	100%	0%
HIV Testing Services	\$4,892,526	0%	33%	67%	0%
Facility-Based Testing	\$2,196,265	0%	54%	46%	0%
Community-Based Testing	\$512,607	0%	80%	20%	0%
HIV Testing Services (Not Disaggregated)	\$2,183,654	0%	0%	100%	0%
Prevention	\$6,280,413	0%	14%	86%	0%
Community mobilization, behavior and norms change	\$938,211	0%	33%	67%	0%
Voluntary Medical Male Circumcision	\$0				
Pre-Exposure Prophylaxis	\$160,247	0%	1%	99%	0%
Condom and Lubricant Programming	\$255,209	0%	0%	100%	0%
Opioid Substitution Therapy	\$128,865	0%	0%	100%	0%
Primary Prevention of HIV & Sexual Violence	\$123,597	0%	100%	0%	0%
Prevention (Not Disaggregated)	\$4,674,284	0%	10%	90%	0%
Socio-economic (incl. OVC)	\$6,915,893	0%	74%	26%	0%
Case Management	\$1,786,658	0%	0%	100%	0%
Economic Strengthening	\$0				
Education Assistance	\$0				
Psychosocial Support	\$4,252,428	0%	100%	0%	0%
Legal, Human Rights, and Protection	\$0				
Socio-economic (Not Disaggregated)	\$876,807	0%	100%	0%	0%
Above Site Programs	\$42,306,616	0%	94%	6%	0%
HIV Systems	\$961,669	0%	100%	0%	0%
Institutional Prevention	\$0				
Procurement and Supply Chain Management	\$0				
Health Mgmt Info Systems, Surveillance, and Research	\$1,018,885	0%	9%	91%	0%
Laboratory Systems Strengthening	\$75,000	0%	0%	100%	0%
Public Financial Management Strengthening	\$0				
Policy, Planning, Coordination and Management of Disease Ctrl Programs	\$964,680	0%	39%	61%	0%
Laws, Regulations and Policy Environment	\$85,000	0%	0%	100%	0%
Above Site Programs (Not Disaggregated)	\$39,201,382	0%	98%	2%	0%
Program Management	\$9,628,208	0%	53%	47%	0%
Implementation Level	\$9,628,208	0%	53%	47%	0%
Total (incl. Commodities)	\$85,392,413	0%	66%	34%	0%
Commodities Only	\$2,995,601	0%	98%	2%	0%
% of Total Budget	4%				

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Indonesia

Table S1. Investment Profile (Budget Allocation) for HIV Programs, 2022

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders
	\$	%	%	%	%
Care and Treatment	\$106,263,724	80%	15%	5%	0%
<i>HIV Care and Clinical Services</i>	\$16,756,501	0%	74%	26%	0%
<i>Laboratory Services incl. Treatment Monitoring</i>	\$3,076,246	0%	100%	0%	0%
<i>Care and Treatment (Not Disaggregated)</i>	\$86,430,977	98%	1%	1%	0%
HIV Testing Services	\$4,578,351	0%	87%	13%	0%
<i>Facility-Based Testing</i>	\$1,541,915	0%	100%	0%	0%
<i>Community-Based Testing</i>	\$2,429,755	0%	100%	0%	0%
<i>HIV Testing Services (Not Disaggregated)</i>	\$606,681	0%	0%	100%	0%
Prevention	\$14,126,785	15%	73%	0%	11%
<i>Community mobilization, behavior and norms change</i>	\$10,268,386	0%	90%	0%	10%
<i>Voluntary Medical Male Circumcision</i>	\$0				
<i>Pre-Exposure Prophylaxis</i>	\$474,830	0%	100%	0%	0%
<i>Condom and Lubricant Programming</i>	\$216,088	0%	100%	0%	0%
<i>Opioid Substitution Therapy</i>	\$63,601	0%	100%	0%	0%
<i>Primary Prevention of HIV & Sexual Violence</i>	\$251,490	0%	100%	0%	0%
<i>Prevention (Not Disaggregated)</i>	\$2,852,389	76%	4%	0%	20%
Socio-economic (incl. OVC)	\$5,580,384	0%	100%	0%	0%
<i>Case Management</i>	\$19,170	0%	0%	100%	0%
<i>Economic Strengthening</i>	\$0				
<i>Education Assistance</i>	\$0				
<i>Psychosocial Support</i>	\$3,966,221	0%	100%	0%	0%
<i>Legal, Human Rights, and Protection</i>	\$1,519,738	0%	100%	0%	0%
<i>Socio-economic (Not Disaggregated)</i>	\$75,255	0%	100%	0%	0%
Above Site Programs	\$15,167,038	23%	39%	34%	4%
<i>HRH Systems</i>	\$245,000	0%	0%	100%	0%
<i>Institutional Prevention</i>	\$0				
<i>Procurement and Supply Chain Management</i>	\$751,519	0%	0%	100%	0%
<i>Health Mgmt Info Systems, Surveillance, and Research</i>	\$6,627,308	0%	70%	30%	0%
<i>Laboratory Systems Strengthening</i>	\$210,405	0%	64%	36%	0%
<i>Public Financial Management Strengthening</i>	\$150,000	0%	0%	100%	0%
<i>Policy, Planning, Coordination and Management of Disease Ctrl Programs</i>	\$1,976,592	0%	55%	45%	0%
<i>Laws, Regulations and Policy Environment</i>	\$1,137,926	8%	0%	69%	23%
<i>Above Site Programs (Not Disaggregated)</i>	\$4,068,288	85%	0%	5%	10%
Program Management	\$9,503,507	0%	75%	25%	0%
<i>Implementation Level</i>	\$9,503,507	0%	75%	25%	0%
Total (incl. Commodities)	\$155,219,789	58%	31%	9%	2%
Commodities Only	\$2,276,624	0%	75%	0%	25%
<i>% of Total Budget</i>	1%				

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Kazakhstan

Table 2.3.1 Investment Profile (Expenditures) for HIV Programs

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders
	\$	%	%	%	%
Care and Treatment	\$16,625,961	98%	0%	2%	0%
HIV Care and Clinical Services	\$14,553,517	98%	0%	2%	0%
Laboratory Services incl. Treatment Monitoring	\$1,949,089	100%	0%	0%	0%
Care and Treatment (Not Disaggregated)	\$123,355	0%	0%	100%	0%
HIV Testing Services	\$2,212,424	88%	3%	9%	0%
Facility-Based Testing	\$1,772,109	97%	0%	3%	0%
Community-Based Testing	\$368,423	58%	0%	42%	0%
HIV Testing Services (Not Disaggregated)	\$71,892	0%	100%	0%	0%
Prevention	\$1,989,564	69%	29%	1%	0%
Community mobilization, behavior and norms change	\$573,665	67%	33%	0%	0%
Voluntary Medical Male Circumcision	\$0				
Pre-Exposure Prophylaxis	\$0				
Condom and Lubricant Programming	\$649,957	81%	19%	0%	0%
Opioid Substitution Therapy	\$45,074	0%	44%	56%	0%
Primary Prevention of HIV & Sexual Violence	\$5,306	100%	0%	0%	0%
Prevention (Not Disaggregated)	\$715,562	65%	35%	0%	0%
Socio-economic (incl. OVC)	\$116,131	0%	0%	100%	0%
Case Management	\$72,623	0%	0%	100%	0%
Economic Strengthening	\$0				
Education Assistance	\$0				
Psychosocial Support	\$0				
Legal, Human Rights, and Protection	\$43,508	0%	0%	100%	0%
Socio-economic (Not Disaggregated)	\$0				
Above Site Programs	\$14,091,797	98%	0%	2%	0%
HRH Systems	\$10,047,120	100%	0%	0%	0%
Institutional Prevention	\$0				
Procurement and Supply Chain Management	\$22,410	0%	0%	100%	0%
Health Mgmt Info Systems, Surveillance, and Research	\$232,242	59%	0%	41%	0%
Laboratory Systems Strengthening	\$1,455,217	97%	0%	3%	0%
Public Financial Management Strengthening	\$680	0%	0%	100%	0%
Policy, Planning, Coordination and Management of Disease Ctrl Programs	\$98,025	0%	71%	29%	0%
Laws, Regulations and Policy Environment	\$23,705	0%	0%	100%	0%
Above Site Programs (Not Disaggregated)	\$2,212,398	100%	0%	0%	0%
Program Management	\$695,260	0%	37%	63%	0%
Implementation Level	\$695,260	0%	37%	63%	0%
Total (incl. Commodities)	\$35,731,137	93%	3%	4%	0%
Commodities Only	\$20,592,188	98%	2%	0%	0%
% of Total Budget	58%				

Kyrgyz Republic

Table S1. Investment Profile (Budget Allocation) for HIV Programs, 2022

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders
	\$	%	%	%	%
Care and Treatment	\$3,045,732	4%	27%	33%	35%
HIV Care and Clinical Services	\$1,899,147	6%	43%	25%	26%
Laboratory Services incl. Treatment Monitoring	\$197,072	11%	0%	0%	89%
Care and Treatment (Not Disaggregated)	\$949,513	0%	0%	57%	43%
HIV Testing Services	\$937,842	19%	21%	38%	21%
Facility-Based Testing	\$370,620	49%	9%	33%	9%
Community-Based Testing	\$567,222	0%	29%	42%	29%
HIV Testing Services (Not Disaggregated)	\$0				
Prevention	\$2,840,538	4%	39%	19%	39%
Community mobilization, behavior and norms change	\$958,333	0%	45%	11%	44%
Voluntary Medical Male Circumcision	\$0				
Pre-Exposure Prophylaxis	\$148,716	3%	0%	97%	0%
Condom and Lubricant Programming	\$210,505	0%	0%	0%	100%
Opitoid Substitution Therapy	\$642,647	0%	46%	23%	31%
Primary Prevention of HIV & Sexual Violence	\$0				
Prevention (Not Disaggregated)	\$880,337	11%	41%	18%	30%
Socio-economic (incl. OVC)	\$555,538	0%	100%	0%	0%
Case Management	\$0				
Economic Strengthening	\$0				
Education Assistance	\$0				
Psychosocial Support	\$231,701	0%	100%	0%	0%
Legal, Human Rights, and Protection	\$323,837	0%	100%	0%	0%
Socio-economic (Not Disaggregated)	\$0				
Above Site Programs	\$1,870,452	38%	7%	36%	20%
HIV Systems	\$61,996	85%	0%	15%	0%
Institutional Prevention	\$39,977	100%	0%	0%	0%
Procurement and Supply Chain Management	\$29,216	100%	0%	0%	0%
Health Mgmt Info Systems, Surveillance, and Research	\$29,273	23%	17%	60%	0%
Laboratory Systems Strengthening	\$289,011	11%	28%	39%	22%
Public Financial Management Strengthening	\$148,959	9%	0%	91%	0%
Policy, Planning, Coordination and Management of Disease Ctrl Programs	\$354,524	27%	0%	73%	0%
Laws, Regulations and Policy Environment	\$326,369	3%	0%	2%	95%
Above Site Programs (Not Disaggregated)	\$381,127	100%	0%	0%	0%
Program Management	\$3,616,227	0%	57%	25%	19%
Implementation Level	\$3,616,227	0%	57%	25%	19%
Total (incl. Commodities)	\$12,866,329	9%	38%	27%	27%
Commodities Only	\$2,706,109	0%	53%	1%	46%
% of Total Budget	21%				

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Laos

Table S1. Investment Profile (Budget Allocation) for HIV Programs, 2022

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders
	\$	%	%	%	%
Care and Treatment	\$1,998,090	0%	78%	22%	0%
HIV Care and Clinical Services	\$707,690	0%	86%	14%	0%
Laboratory Services Incl. Treatment Monitoring	\$110,741	0%	64%	36%	0%
Care and Treatment (Not Disaggregated)	\$1,179,659	0%	74%	26%	0%
HIV Testing Services	\$178,599	0%	7%	93%	0%
Facility-Based Testing	\$42,000	0%	29%	71%	0%
Community-Based Testing	\$136,599	0%	0%	100%	0%
HIV Testing Services (Not Disaggregated)	\$0				
Prevention	\$482,750	0%	0%	100%	0%
Community mobilization, behavior and norms change	\$355,250	0%	0%	100%	0%
Voluntary Medical Male Circumcision	\$0				
Pre-Exposure Prophylaxis	\$127,500	0%	0%	100%	0%
Condom and Lubricant Programming	\$0				
Opioid Substitution Therapy	\$0				
Primary Prevention of HIV & Sexual Violence	\$0				
Prevention (Not Disaggregated)	\$0				
Socio-economic (Incl. OVC)	\$0				
Case Management	\$0				
Economic Strengthening	\$0				
Education Assistant	\$0				
Psychosocial Support	\$0				
Legal, Human Rights, and Protection	\$0				
Socio-economic (Not Disaggregated)	\$0				
Above Site Programs	\$3,264,612	1%	84%	15%	0%
HIV Systems	\$120,000	0%	0%	100%	0%
Institutional Prevention	\$0				
Procurement and Supply Chain Management	\$0				
Health Mgmt Info Systems, Surveillance, and Research	\$138,199	0%	0%	100%	0%
Laboratory Systems Strengthening	\$49,098	0%	0%	100%	0%
Public Financial Management Strengthening	\$10,000	0%	0%	100%	0%
Policy, Planning, Coordination and Management of Disease Ctrl Programs	\$158,870	13%	0%	87%	0%
Laws, Regulations and Policy Environment	\$50,000	0%	0%	100%	0%
Above Site Programs (Not Disaggregated)	\$2,738,445	0%	100%	0%	0%
Program Management	\$594,532	0%	35%	65%	0%
Implementation Level	\$594,532	0%	35%	65%	0%
Total (Incl. Commodities)	\$6,518,583	0%	69%	30%	0%
Commodities Only	\$1,235,491	46%	54%	0%	0%
% of Total Budget	19%				

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Nepal (country generated table)

	Total	<i>Domestic Gov't</i>	Global Fund	<i>PEPFAR</i>	Others
	FY 2020	%	%	%	%
Care and Treatment	\$6,830,384	38.6	31.3	29.6	0.5
HIV Testing Services	\$3,245,132	22.8	14.7	43.7	18.8
Prevention	\$3,928,814	11.5	63.9	15.5	9.1
Orphans and Vulnerable Children	\$0	0	0	0	0
Above Site Programs	\$2,045,721	23.2	56.0	15.7	5.0
Total (incl. Commodities)	\$16,050,051	26.8	38.4	27.9	6.9
commodities only	\$4,155,792	67.6	28.0	3.2	1.2
% of total budget spent on commodity	25.9	65.2	18.9	3.0	5.1

Philippines

Table S1. Investment Profile (Budget Allocation) for HIV Programs, 2022

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders
	\$	%	%	%	%
Care and Treatment	\$15,268,549	66%	3%	31%	0%
HIV Care and Clinical Services	\$4,530,526	0%	9%	91%	0%
Laboratory Services Incl. Treatment Monitoring	\$299,012	0%	27%	73%	0%
Care and Treatment (Not Disaggregated)	\$10,459,011	96%	0%	4%	0%
HIV Testing Services	\$7,404,731	58%	18%	23%	0%
Facility-Based Testing	\$406,896	0%	35%	65%	0%
Community-Based Testing	\$869,337	0%	88%	12%	0%
HIV Testing Services (Not Disaggregated)	\$6,128,498	71%	8%	22%	0%
Prevention	\$6,574,371	37%	41%	22%	0%
Community mobilization, behavior and norms change	\$1,787,480	0%	97%	3%	0%
Voluntary Medical Male Circumcision	\$0				
Pre-Exposure Prophylaxis	\$1,564,346	0%	17%	83%	0%
Condom and Lubricant Programming	\$466,619	0%	100%	0%	0%
Opitoid Substitution Therapy	\$0				
Primary Prevention of HIV & Sexual Violence	\$185,899	0%	100%	0%	0%
Prevention (Not Disaggregated)	\$2,570,027	95%	2%	4%	0%
Socio-economic (incl. OVC)	\$946,118	0%	100%	0%	0%
Care Management	\$0				
Economic Strengthening	\$0				
Education Assistance	\$0				
Psychosocial Support	\$164,277	0%	100%	0%	0%
Legal, Human Rights, and Protection	\$638,890	0%	100%	0%	0%
Socio-economic (Not Disaggregated)	\$142,951	0%	100%	0%	0%
Above Site Programs	\$4,886,796	0%	19%	81%	0%
HIV Systems	\$378,489	0%	87%	13%	0%
Institutional Prevention	\$0				
Procurement and Supply Chain Management	\$557,605	0%	5%	95%	0%
Health Mgmt Info Systems, Surveillance, and Research	\$874,912	0%	56%	44%	0%
Laboratory Systems Strengthening	\$60,000	0%	0%	100%	0%
Public Financial Management Strengthening	\$0				
Policy, Planning, Coordination and Management of Disease Ctrl Programs	\$1,498,846	0%	6%	94%	0%
Laws, Regulations and Policy Environment	\$249,444	0%	0%	100%	0%
Above Site Programs (Not Disaggregated)	\$1,267,500	0%	0%	100%	0%
Program Management	\$4,277,571	0%	27%	73%	0%
Implementation Level	\$4,277,571	0%	27%	73%	0%
Total (incl. Commodities)	\$39,378,136	43%	19%	38%	0%
Commodities Only	\$18,517,374	91%	8%	1%	0%
% of Total Budget	47%				

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Tajikistan

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders
	\$	%	%	%	%
Care and Treatment	\$2,054,181	0%	75%	25%	0%
HIV Care and Clinical Services	\$2,373,369	0%	84%	16%	0%
Laboratory Services Incl. Treatment Monitoring	\$98,762	0%	0%	100%	0%
Care and Treatment (Not Disaggregated)	\$192,050	0%	0%	100%	0%
HIV Testing Services	\$946,352	0%	24%	76%	0%
Facility-Based Testing	\$282,792	0%	64%	36%	0%
Community-Based Testing	\$653,560	0%	7%	93%	0%
HIV Testing Services (Not Disaggregated)	\$10,000	0%	0%	100%	0%
Prevention	\$2,030,051	0%	74%	26%	0%
Community mobilization, behavior and norms change	\$804,068	0%	84%	16%	0%
Voluntary Medical Male Circumcision	\$0				
Pre-Exposure Prophylaxis	\$11,290	0%	0%	100%	0%
Condom and Lubricant Programming	\$228,670	0%	100%	0%	0%
Opitoid Substitution Therapy	\$464,980	0%	89%	11%	0%
Primary Prevention of HIV & Sexual Violence	\$0				
Prevention (Not Disaggregated)	\$521,043	0%	33%	67%	0%
Socio-economic (Incl. OVC)	\$118,791	0%	100%	0%	0%
Case Management	\$0				
Economic Strengthening	\$0				
Education Assistance	\$0				
Psychosocial Support	\$0				
Legal, Human Rights, and Protection	\$118,791	0%	100%	0%	0%
Socio-economic (Not Disaggregated)	\$0				
Above Site Programs	\$759,903	0%	18%	82%	0%
HIV Systems	\$7,080	0%	0%	100%	0%
Institutional Prevention	\$0				
Procurement and Supply Chain Management	\$32,586	0%	100%	0%	0%
Health Mgmt Infb Systems, Surveillance, and Research	\$341,937	0%	33%	67%	0%
Laboratory Systems Strengthening	\$16,500	0%	0%	100%	0%
Public Financial Management Strengthening	\$66,000	0%	0%	100%	0%
Policy, Planning, Coordination and Management of Disease Ctrl Programs	\$305,800	0%	0%	100%	0%
Law, Regulations and Policy Environment	\$0				
Above Site Programs (Not Disaggregated)	\$0				
Program Management	\$3,149,456	0%	71%	29%	0%
Implementation Level	\$3,149,456	0%	72%	29%	0%
Total (Incl. Commodities)	\$9,668,734	0%	64%	36%	0%
Commodities Only	\$2,630,410	0%	98%	2%	0%
% of Total Budget	27%				

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Thailand

Table S1. Investment Profile (Budget Allocation) for HIV Program, 2022

	Total \$	Domestic Gov't %	Global Fund %	PEPFAR %	Other Funders %
Care and Treatment	\$7,492,291	0%	57%	43%	0%
<i>HIV Care and Clinical Services</i>	\$5,295,787	0%	40%	60%	0%
<i>Laboratory Services incl. Treatment Monitoring</i>	\$40,100	0%	0%	100%	0%
<i>Care and Treatment (Not Disaggregated)</i>	\$2,156,404	0%	100%	0%	0%
HIV Testing Services	\$1,867,265	0%	19%	81%	0%
<i>Facility-Based Testing</i>	\$10,418	0%	100%	0%	0%
<i>Community-Based Testing</i>	\$759,419	0%	32%	68%	0%
<i>HIV Testing Services (Not-Disaggregated)</i>	\$1,097,428	0%	9%	91%	0%
Prevention	\$9,058,008	0%	63%	37%	0%
<i>Community mobilization, behavior and norms change</i>	\$4,120,390	0%	96%	4%	0%
<i>Voluntary Medical Male Circumcision</i>	\$0				
<i>Pre-Exposure Prophylaxis</i>	\$2,171,575	0%	16%	84%	0%
<i>Condom and Lubricant Programming</i>	\$0				
<i>Opioid Substitution Therapy</i>	\$20,531	0%	100%	0%	0%
<i>Primary Prevention of HIV & Sexual Violence</i>	\$936,379	0%	100%	0%	0%
<i>Prevention (Not Disaggregated)</i>	\$1,809,133	0%	25%	75%	0%
Socio-economic (incl. OVC)	\$1,340,519	0%	88%	12%	0%
<i>Case Management</i>	\$100,300	0%	0%	100%	0%
<i>Economic Strengthening</i>	\$0				
<i>Education Assistance</i>	\$0				
<i>Psychosocial Support</i>	\$33,038	0%	100%	0%	0%
<i>Legal, Human Rights, and Protection</i>	\$1,118,059	0%	100%	0%	0%
<i>Socio-economic (Not Disaggregated)</i>	\$89,122	0%	37%	63%	0%
Above Site Programs	\$5,243,357	0%	39%	61%	0%
<i>HRH Systems</i>	\$1,007,315	0%	14%	86%	0%
<i>Institutional Prevention</i>	\$0				
<i>Procurement and Supply Chain Management</i>	\$0				
<i>Health Mgmt Info Systems, Surveillance, and Research</i>	\$2,154,335	0%	60%	40%	0%
<i>Laboratory Systems Strengthening</i>	\$344,600	0%	0%	100%	0%
<i>Public Financial Management Strengthening</i>	\$58,176	0%	0%	100%	0%
<i>Policy, Planning, Coordination and Management of</i>	\$1,568,381	13%	38%	62%	0%
<i>Laws, Regulations and Policy Environment</i>	\$0				
<i>Above Site Programs (Not Disaggregated)</i>	\$110,550	0%	0%	100%	0%
Program Management	\$3,852,682	0%	82%	18%	0%
<i>Implementation Level</i>	\$3,852,682	0%	82%	18%	0%
Total (incl. Commodities)	\$28,254,122	0%	58%	42%	0%
Commodities Only	\$3,123,518	0%	100%	0%	0%
% of Total Budget	11%				
Data Sources and Additional Comments	Funders data included where available. PEPFAR regional program				

Table 2.3.2 Investment Profile (Funding Landscape) for HIV Commodities

Burma

Table S2. Investment Profile (Budget Allocation) for HIV Commodities, 2022					
	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders
	\$	%	%	%	%
Antiretroviral Drugs	\$14,458,325	69%	31%	0%	0%
Laboratory Supplies and Reagents	\$3,122,482	0%	100%	0%	0%
CD4	\$0				
Viral Load	\$0				
Other Laboratory Supplies and Reagents	\$3,122,482	0%	100%	0%	0%
Laboratory (Not Disaggregated)	\$0				
Medicines	\$4,671,978	21%	79%	0%	0%
Essential Medicines	\$2,129,016	47%	53%	0%	0%
Tuberculosis Medicines	\$3,120	0%	100%	0%	0%
Other Medicines	\$2,539,842	0%	100%	0%	0%
Consumables	\$7,535,922	0%	100%	0%	0%
Condoms and Lubricants	\$3,710,546	0%	100%	0%	0%
Rapid Test Kits	\$3,149,859	0%	100%	0%	0%
VMMC Kits and Supplies	\$0				
Other Consumables	\$675,517	0%	100%	0%	0%
Health Equipment	\$754,152	0%	100%	0%	0%
Health Equipment	\$53,220	0%	100%	0%	0%
Service and Maintenance	\$700,932	0%	100%	0%	0%
PSM Costs	\$2,347,572	0%	100%	0%	0%
Total Commodities Only	\$32,890,431	33%	67%	0%	0%

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

India

Table S2. Investment Profile (Budget Allocation) for HIV Commodities, 2022

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders
	\$	%	%	%	%
Antiretroviral Drugs	\$0				
Laboratory Supplies and Reagents	\$60,000	0%	0%	100%	0%
CD4	\$0				
Viral Load	\$0				
Other Laboratory Supplies and Reagents	\$60,000	0%	0%	100%	0%
Laboratory (Not Disaggregated)	\$0				
Medicines	\$0				
Essential Medicines	\$0				
Tuberculosis Medicines	\$0				
Other Medicines	\$0				
Consumables	\$0				
Condoms and Lubricants	\$0				
Rapid Test Kits	\$0				
VMMC Kits and Supplies	\$0				
Other Consumables	\$0				
Health Equipment	\$40,613	0%	100%	0%	0%
Health Equipment	\$40,613	0%	100%	0%	0%
Service and Maintenance	\$0				
PSM Costs	\$2,894,988	0%	100%	0%	0%
Total Commodities Only	\$2,995,601	0%	98%	2%	0%

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Indonesia

Table S2. Investment Profile (Budget Allocation) for HIV Commodities, 2021 Budget

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders
	\$	%	%	%	%
Antiretroviral Drugs	\$44,076,760	98%	2%	0%	0%
Laboratory Supplies and Reagents	\$190,000	0%	100%	0%	0%
CD4	\$0				
Viral Load	\$0				
Other Laboratory Supplies and Reagents	\$190,000	0%	100%	0%	0%
Laboratory (Not Disaggregated)	\$0				
Medicines	\$0				
Essential Medicines	\$0				
Tuberculosis Medicines	\$0				
Other Medicines	\$0				
Consumables	\$689,227	0%	100%	0%	0%
Condoms and Lubricants	\$464,483	0%	100%	0%	0%
Rapid Test Kits	\$121,719	0%	100%	0%	0%
VMMC Kits and Supplies	\$0				
Other Consumables	\$103,025	0%	100%	0%	0%
Health Equipment	\$136,045	0%	100%	0%	0%
Health Equipment	\$136,045	0%	100%	0%	0%
Service and Maintenance	\$0				
PSM Costs	\$797,687	0%	100%	0%	0%
Total Commodities Only	\$45,889,719	96%	5%	0%	0%

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available.

Kazakhstan

Table 2.3.2. Investment Profile (Expenditures) for HIV Commodities

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders
	\$	%	%	%	%
Antiretroviral Drugs	\$14,028,076	100%	0%	0%	0%
Laboratory Supplies and Reagents	\$5,088,438	100%	0%	0%	0%
CD4	\$998,732	100%	0%	0%	0%
Viral Load	\$788,256	100%	0%	0%	0%
Other Laboratory Supplies and Reagents	\$1,408,586	100%	0%	0%	0%
Laboratory (Not Disaggregated)	\$1,892,864	99%	0%	1%	0%
Medicines	\$271,360	100%	0%	0%	0%
Essential Medicines	\$256,344	100%	0%	0%	0%
Tuberculosis Medicines	\$15,016	100%	0%	0%	0%
Other Medicines	\$0				
Consumables	\$1,153,130	65%	35%	0%	0%
Condoms and Lubricants	\$528,336	100%	0%	0%	0%
Rapid Test Kits	\$222,002	100%	0%	0%	0%
VMMC Kits and Supplies	\$0				
Other Consumables	\$402,792	0%	100%	0%	0%
Health Equipment	\$9,855	0%	100%	0%	0%
Health Equipment	\$9,855	0%	100%	0%	0%
Service and Maintenance	\$0				
PSM Costs	\$41,329	0%	100%	0%	0%
Total Commodities Only	\$20,592,188	98%	2%	0%	0%

Kyrgyz Republic

Table S2. Investment Profile (Budget Allocation) for HIV Commodities, 2022

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders
	\$	%	%	%	%
Antiretroviral Drugs	\$910,571	0%	57%	0%	43%
Laboratory Supplies and Reagents	\$196,653	0%	0%	0%	100%
CD4	\$15,000	0%	0%	0%	100%
Viral Load	\$96,850	0%	0%	0%	100%
Other Laboratory Supplies and Reagents	\$34,734	0%	0%	0%	100%
Laboratory (Not Disaggregated)	\$50,069	0%	0%	0%	100%
Medicines	\$169,445	0%	0%	0%	100%
Essential Medicines	\$0				
Tuberculosis Medicines	\$0				
Other Medicines	\$169,445	0%	0%	0%	100%
Consumables	\$797,300	0%	62%	3%	34%
Condoms and Lubricants	\$170,055	0%	0%	0%	100%
Rapid Test Kits	\$25,240	0%	0%	100%	0%
VMMC Kits and Supplies	\$0				
Other Consumables	\$602,005	0%	83%	0%	17%
Health Equipment	\$174,239	0%	100%	0%	0%
Health Equipment	\$174,239	0%	100%	0%	0%
Service and Maintenance	\$0				
PSM Costs	\$457,901	0%	51%	0%	49%
Total Commodities Only	\$2,706,109	0%	53%	1%	46%

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Laos

Table S2. Investment Profile (Budget Allocation) for HIV Commodities, 2022

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders
	\$	%	%	%	%
Antiretroviral Drugs	\$772,180	37%	63%	0%	0%
Laboratory Supplies and Reagents	\$212,613	67%	33%	0%	0%
CD4	\$21,120	100%	0%	0%	0%
Viral Load	\$191,493	63%	37%	0%	0%
Other Laboratory Supplies and Reagents	\$0				
Laboratory (Not Disaggregated)	\$0				
Medicines	\$65,532	100%	0%	0%	0%
Essential Medicines	\$0				
Tuberculosis Medicines	\$0				
Other Medicines	\$65,532	100%	0%	0%	0%
Consumables	\$91,505	86%	13%	1%	0%
Condoms and Lubricants	\$0				
Rapid Test Kits	\$91,505	86%	13%	1%	0%
VMMC Kits and Supplies	\$0				
Other Consumables	\$0				
Health Equipment	\$0				
Health Equipment	\$0				
Service and Maintenance	\$0				
PSM Costs	\$93,662	0%	100%	0%	0%
Total Commodities Only	\$1,235,491	46%	54%	0%	0%

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Nepal (country generated table)

Table 2.3.2 Investment profile (funding landscape) for HIV commodities					
	total	Domestic Gov't	Global Fund	PEPFAR	Others
	FY2020	%	%	%	%
Antiretroviral Drugs	\$2,595,030	80	14	5	
Condoms and Lubricants	\$46,702	0	100	0	0
Rapid Test Kits	\$1,177,892	63	37		
Laboratory Supplies and Reagents	\$139,978	0	91	0	9
Medicines	\$42,034	0	100	0	0
Consumables	\$154,156	0	100	0	0
Total Expenditure	\$4,155,792	68	28	3	1

Philippines

Table S2. Investment Profile (Budget Allocation) for HIV Commodities, 2022					
	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders
	\$	%	%	%	%
Antiretroviral Drugs	\$8,633,611	97%	1%	2%	0%
Laboratory Supplies and Reagents	\$1,308,800	100%	0%	0%	0%
CD4	\$0				
Viral Load	\$0				
Other Laboratory Supplies and Reagents	\$0				
Laboratory (Not Disaggregated)	\$1,308,800	100%	0%	0%	0%
Medicines	\$0				
Essential Medicines	\$0				
Tuberculosis Medicines	\$0				
Other Medicines	\$0				
Consumables	\$8,195,037	87%	13%	0%	0%
Condoms and Lubricants	\$2,781,916	87%	13%	0%	0%
Rapid Test Kits	\$5,413,121	87%	13%	0%	0%
VMMC Kits and Supplies	\$0				
Other Consumables	\$0				
Health Equipment	\$33,724	0%	100%	0%	0%
Health Equipment	\$33,724	0%	100%	0%	0%
Service and Maintenance	\$0				
PSM Costs	\$346,202	0%	92%	8%	0%
Total Commodities Only	\$18,517,374	91%	8%	1%	0%

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Tajikistan

Table S2. Investment Profile (Budget Allocation) for HIV Commodities, 2022					
	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders
	\$	%	%	%	%
Antiretroviral Drugs	\$885,979	0%	100%	0%	0%
Laboratory Supplies and Reagents	\$271,147	0%	100%	0%	0%
CD4	\$0				
Viral Load	\$0				
Other Laboratory Supplies and Reagents	\$271,147	0%	100%	0%	0%
Laboratory (Not Disaggregated)	\$0				
Medicines	\$142,423	0%	100%	0%	0%
Essential Medicines	\$142,423	0%	100%	0%	0%
Tuberculosis Medicines	\$0				
Other Medicines	\$0				
Consumables	\$706,061	0%	93%	7%	0%
Condoms and Lubricants	\$312,545	0%	100%	0%	0%
Rapid Test Kits	\$219,445	0%	78%	22%	0%
VMMC Kits and Supplies	\$0				
Other Consumables	\$174,071	0%	100%	0%	0%
Health Equipment	\$5,460	0%	100%	0%	0%
Health Equipment	\$0				
Service and Maintenance	\$5,460	0%	100%	0%	0%
PSM Costs	\$619,340	0%	100%	0%	0%
Total Commodities Only	\$2,630,410	0%	98%	2%	0%

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Thailand

Table S2. Investment Profile (Budget Allocation) for HIV Commodities, 2022

	Total \$	Domestic Gov't %	Global Fund %	PEPFAR %	Other Funders %
Antiretroviral Drugs	\$785,000	0%	100%	0%	0%
Laboratory Supplies and Reagents	\$344,322	0%	100%	0%	0%
<i>CD4</i>	\$0	0%	100%	0%	0%
<i>Viral Load</i>	\$0	0%	100%	0%	0%
<i>Other Laboratory Supplies and Reagents</i>	\$344,322	0%	100%	0%	0%
<i>Laboratory (Not Disaggregated)</i>	\$0	0%	100%	0%	0%
Medicines	\$934,677	0%	100%	0%	0%
<i>Essential Medicines</i>	\$932,596	0%	100%	0%	0%
<i>Tuberculosis Medicines</i>	\$0	0%	100%	0%	0%
<i>Other Medicines</i>	\$2,081	0%	100%	0%	0%
Consumables	\$754,934	0%	100%	0%	0%
<i>Condoms and Lubricants</i>	\$35,495	0%	100%	0%	0%
<i>Rapid Test Kits</i>	\$286,793	0%	100%	0%	0%
<i>VMMC Kits and Supplies</i>	\$0	0%	100%	0%	0%
<i>Other Consumables</i>	\$432,646	0%	100%	0%	0%
Health Equipment	\$158,520	0%	100%	0%	0%
<i>Health Equipment</i>	\$112,208	0%	100%	0%	0%
<i>Service and Maintenance</i>	\$46,312	0%	100%	0%	0%
PSM Costs	\$146,065	0%	100%	0%	0%
Total Commodities Only	\$3,123,518	0%	100%	0%	0%

Data Sources and Additional Comments

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration

Country	Funding Source	Total USG	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
		Non-PEPFAR Resources				
Burma	USAID MCH	\$ 5,000,000.00		0		
Burma	USAID TB	\$12,000,000.00	\$ 6,092,000.00	3	\$ 7,715,680	1. End the HIV and TB epidemics 2. Community led monitoring and empower TB civil society 3. Strengthen the supply chain for key commodities
Burma	USAID Malaria	\$10,000,000.00				
Cambodia	USAID MCH	\$ 3,000,000.00	\$ 2,070,000.00	2	900000	Health Quality Improvement & Health Finance
Cambodia	USAID TB	\$ 6,505,000.00	\$ 1,200,000.00	2	900000	Quality Improvement & Health Finance
Cambodia	USAID Malaria	\$10,000,000.00	-	2	900000	Quality Improvement & Health Finance
Cambodia	Family Planning	\$ 3,000,000.00	\$ 1,650,000.00	2	900000	Quality Improvement & Health Finance
India	USAID MCH	\$6,000,000				
India	USAID TB	\$10,500,000				

India	Family Planning	\$6,500,000				
India	CDC (Global Health Security)	\$6,822,526				
Indonesia	USAID MCH	\$14,500,000.00	\$ 2,300,000.00	2	800,000	To strengthen strategic information capacity at national & sub-national levels.
Indonesia	USAID TB	\$17,000,000.00	\$ 1,600,000.00	3	1,236,433	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.
Kazakhstan	USAID TB	\$ 1,380,000.00				Technical Assistance
Kyrgyz Republic	USAID MCH	\$ 750,000.00				
Kyrgyz Republic	USAID TB	\$ 6,000,000.00				
Kyrgyz Republic	CDC (Global Health Security)				\$156,250.00	ARPA
Laos	USAID MCH	\$ 6,700,000.00				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
Nepal	USAID MCH	\$13,000,000.00	\$ -	N/A	N/A	
Nepal	Family Planning	\$15,000,000.00	\$ -	N/A	N/A	
Philippines	USAID TB	\$20,000,000.00	\$ 1,500,000.00	MTaPS, ProtectHealth	\$200,000 to each IM	
Philippines	Family Planning	\$13,000,000.00	\$ 1,700,000.00	MTaPS, ProtectHealth	same as above	
Tajikistan	USAID MCH	\$ 2,000.00				
Tajikistan	USAID TB	\$ 7,000.00				
Tajikistan	USAID Nutrition	\$ 2,500.00				
Tajikistan	USAID COVID19	\$ 1,128.00		1	\$155,000	
Thailand	USAID Malaria	3,000,000	0	0	0	
Thailand	NIH	1573848	0	0	0	(1) NIAID grant to Chiang Mai University (2) Fogerty International Center grant to Prince Songkla University
Thailand	CDC (Global Health Security)	\$4,217,593 (FY22 Thailand country funds only)	0	0	0	In FY22, GHS funds are supporting activities in Thailand: - Quarantine and Migration vaccination efforts - Influenza surveillance, management and laboratory capacity building - Disease surveillance (i.e. Dengue), public health emergency response preparedness and response efforts. - Melioidosis Prevention and Control

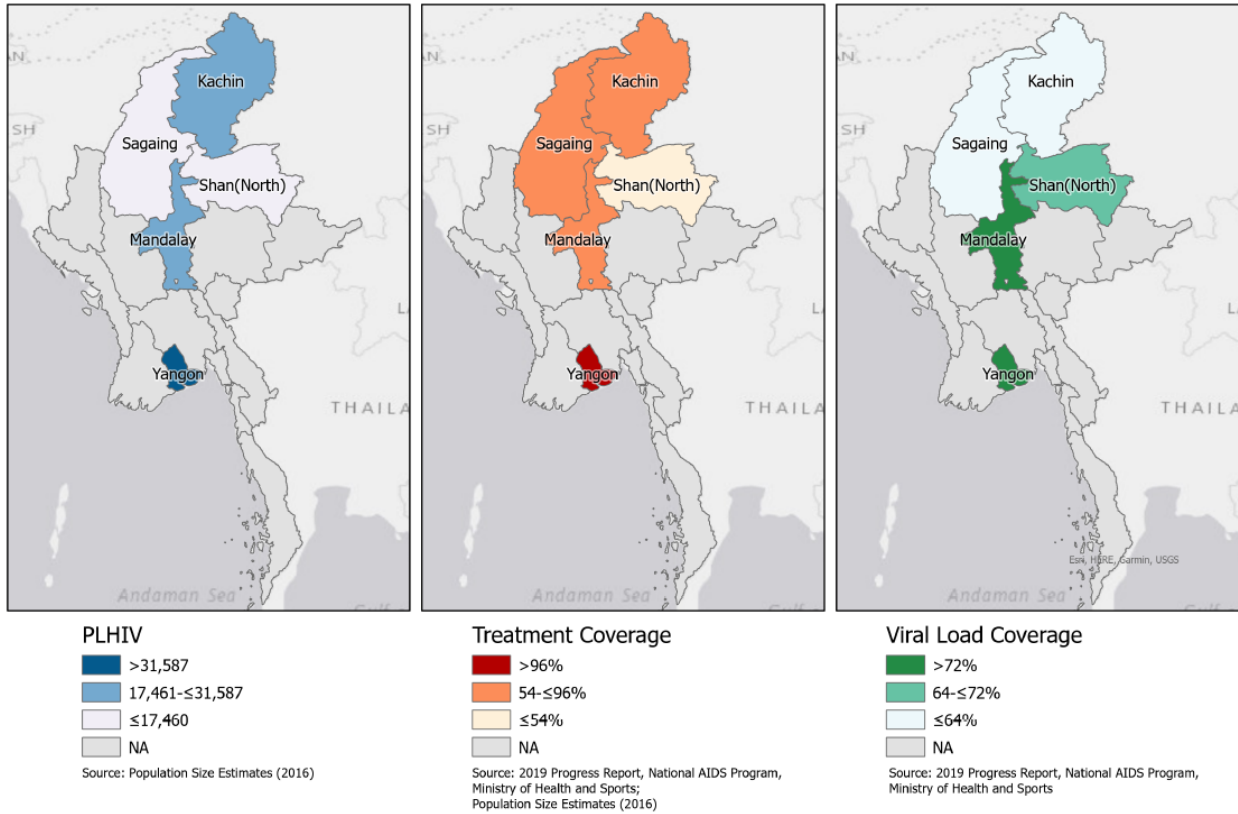
						- Public health workforce capacity building Prevalence and genetic study for important Bacterial Zoonosis disease and advancing Zoonotic detection through One Health activities.
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Figure 2.5.1: Minimum elements for display include the following: percent PLHIV by SNU, total PLHIV by SNU, coverage of total PLHIV with ART, and viral load coverage by SNU.



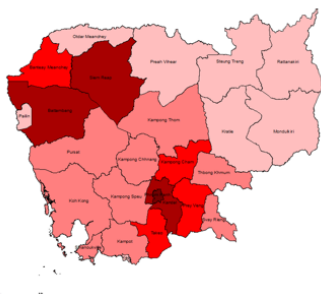
PEPFAR
U.S. President's Emergency Plan for AIDS Relief

PEPFAR Burma: People Living with HIV (PLHIV), Treatment Coverage, Viral Load Testing Coverage



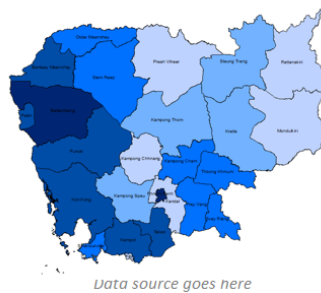
Cambodia

Figure 1: Number of PLHIV by province



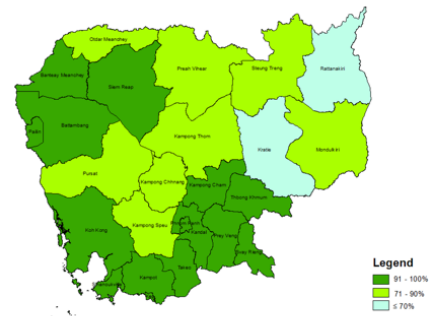
Preliminary HIV Estimates 2022, AEM Spectrum

Figure 2: Percent treatment coverage



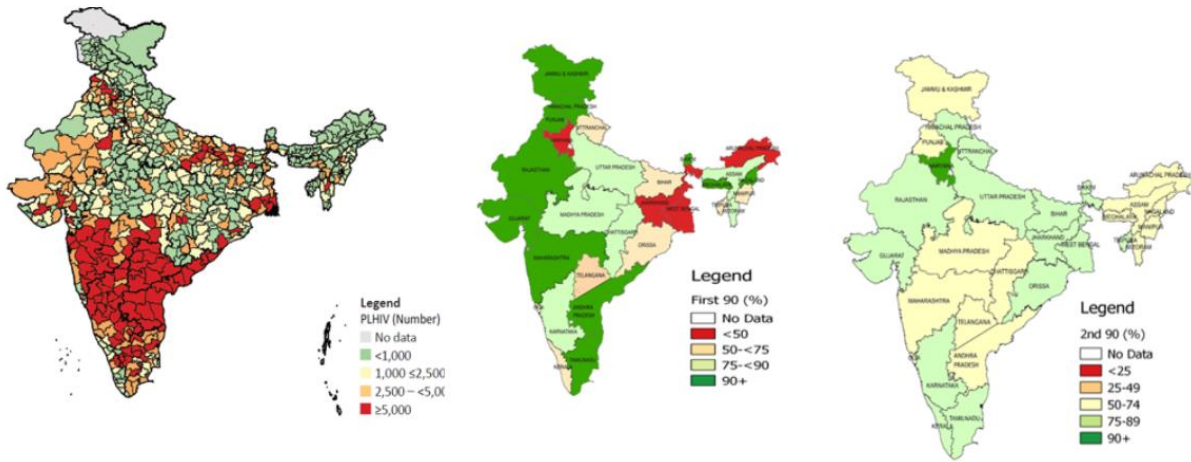
NCHADS Program ART data, 2021

Figure 3: Viral load monitoring coverage

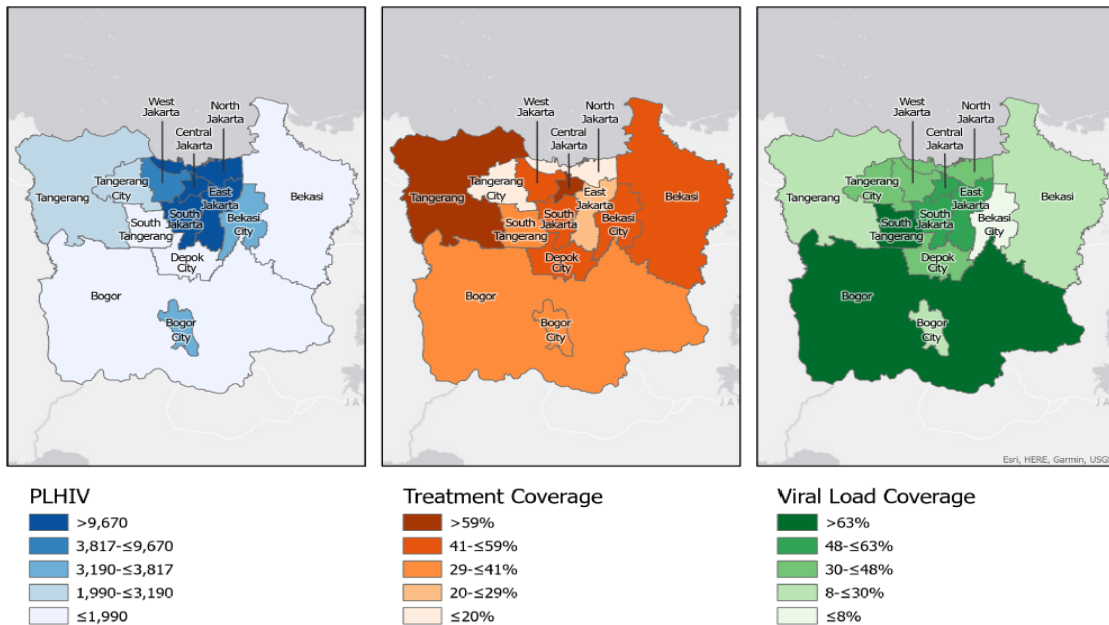


NCHADS Program ART data, 2021

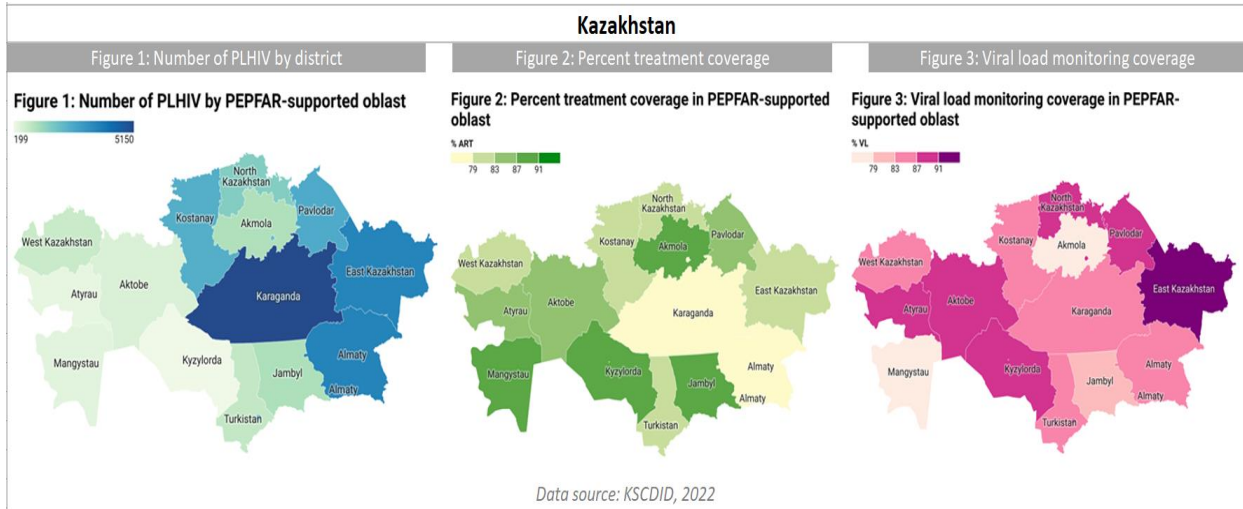
India



PEPFAR Indonesia: People Living with HIV (PLHIV), Treatment Coverage, Viral Load Testing Coverage

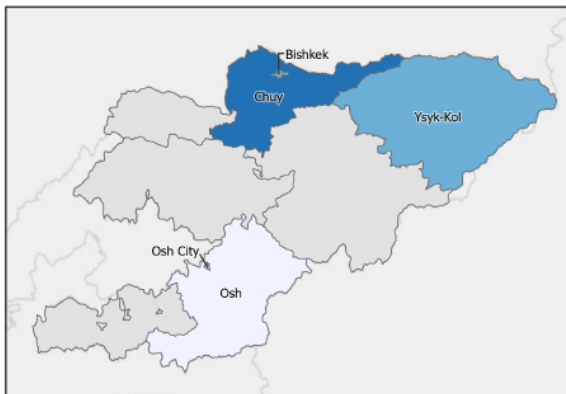


Source: Ministry of Health, National HIV/AIDS Information on System/SIHA (2021)



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

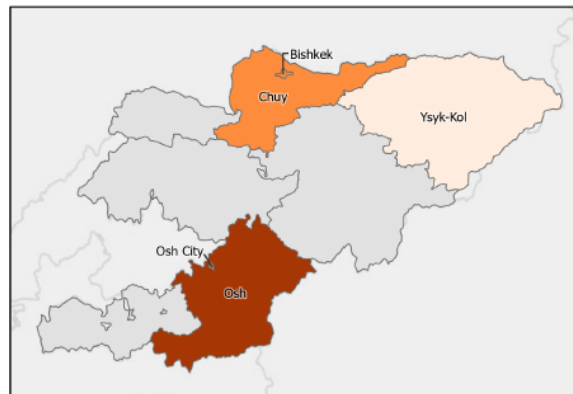
PEPFAR Kyrgyzstan: People Living with HIV (PLHIV), Treatment Coverage, Viral Load Testing Coverage



PLHIV

- >2,206
- 1,320 ≤ 2,206
- ≤ 1,320
- NA

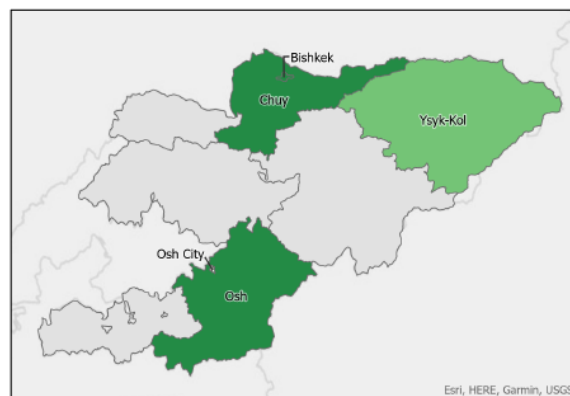
Source: UNAIDS 2021



TXCoverage

- >53%
- 7-≤53%
- ≤7%
- NA

Source: RAC 2022; UNAIDS 2021



Viral Load Coverage

- >83%
- 62-≤83%
- ≤62%
- NA

Source: RAC 2022

Esri, HERE, Garmin, USGS

Laos

Figure 1: Number of PLHIV by district

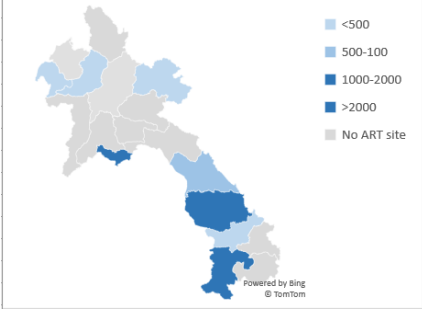


Figure 2: Percent treatment coverage

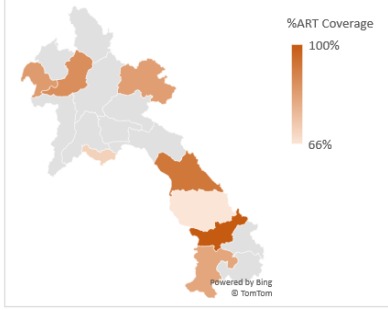
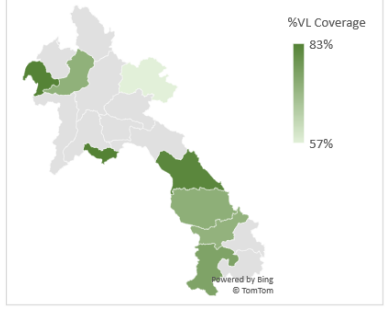


Figure 3: Viral load monitoring coverage



Nepal

Figure 1: Number of PLHIV by district

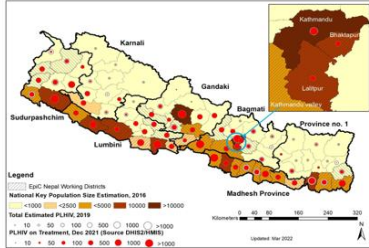


Figure 2: Percent treatment coverage

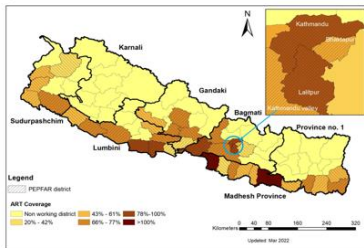
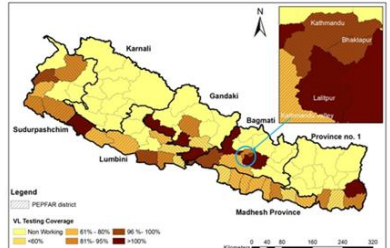
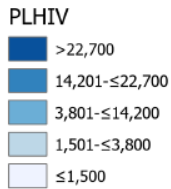
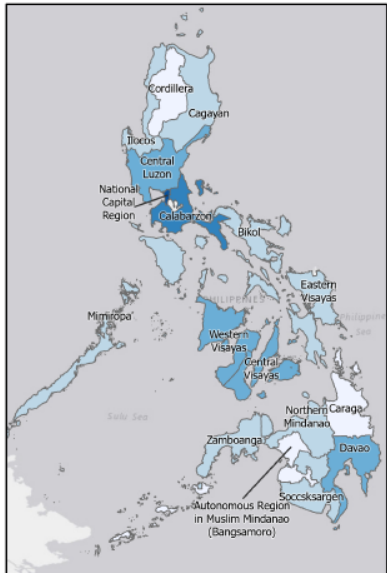


Figure 3: Viral load monitoring coverage

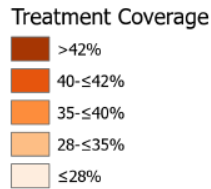
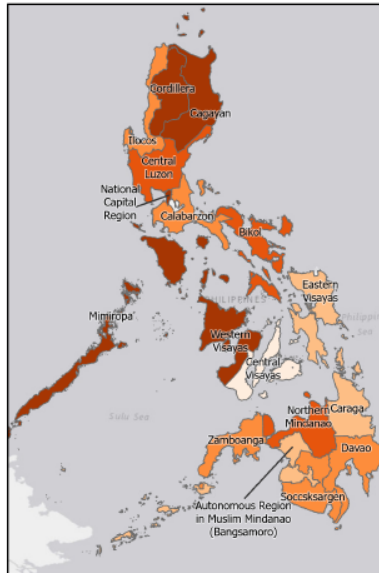




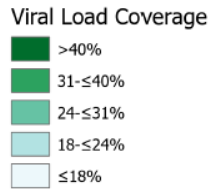
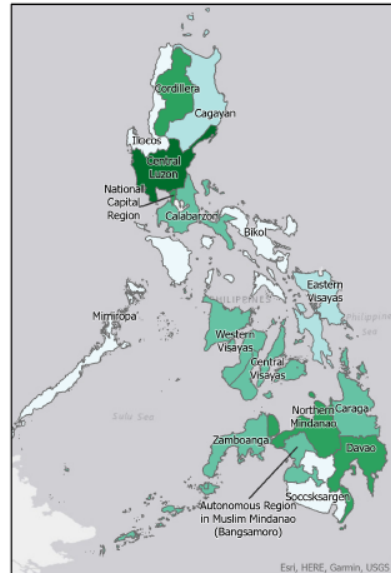
PEPFAR Philippines: People Living with HIV (PLHIV), Treatment Coverage, Viral Load Testing Coverage



Source: AEM-Spectrum (May 2021)



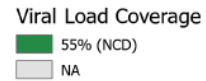
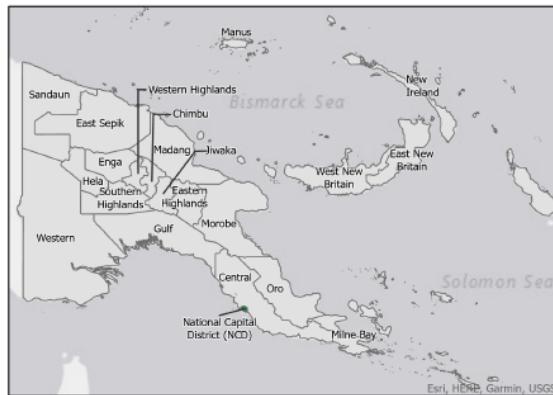
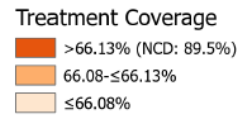
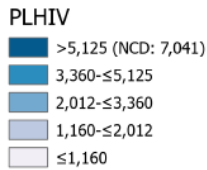
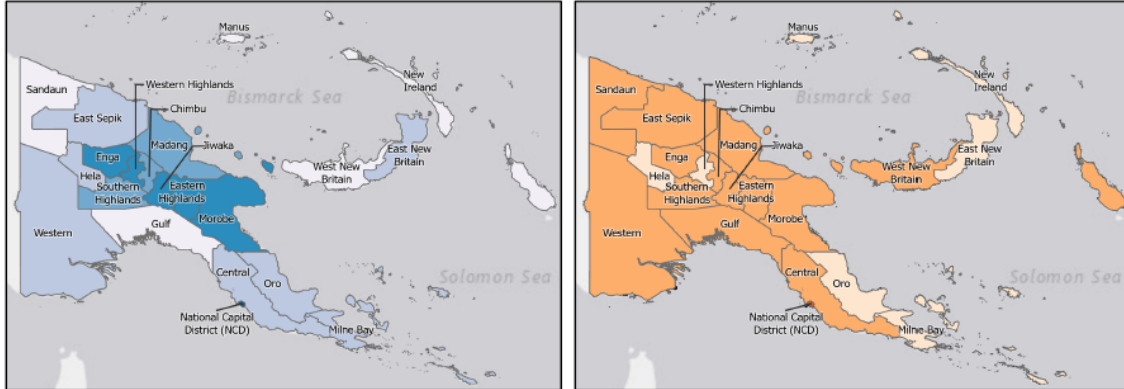
Source: AEM-Spectrum (May 2021); NDOH 2021



Source: NDOH 2021



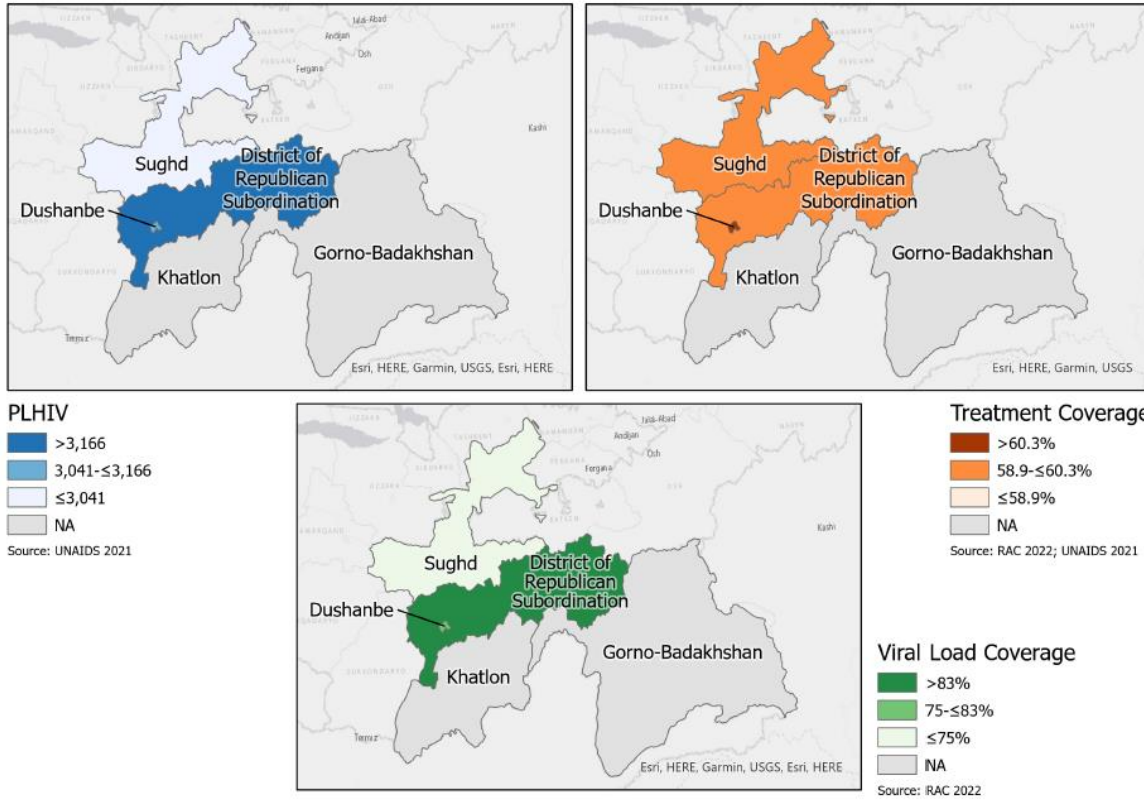
PEPFAR Papua New Guinea: People Living with HIV (PLHIV), Treatment Coverage, Viral Load Testing Coverage



Source: NDOH 2021



PEPFAR Tajikistan: People Living with HIV (PLHIV), Treatment Coverage, Viral Load Testing Coverage



Thailand

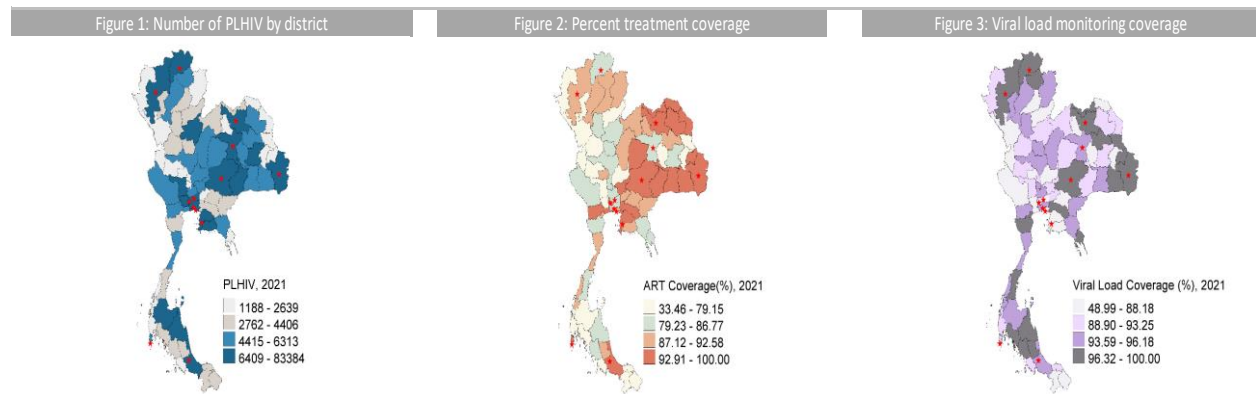
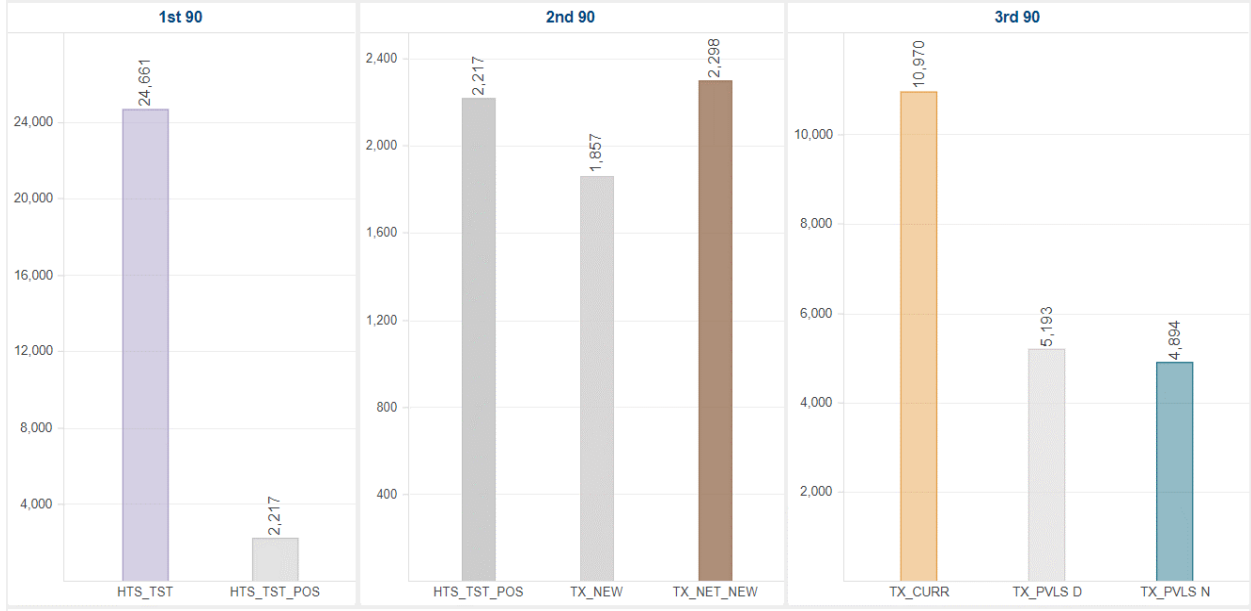


Table 3.1 Current Status of ART saturation

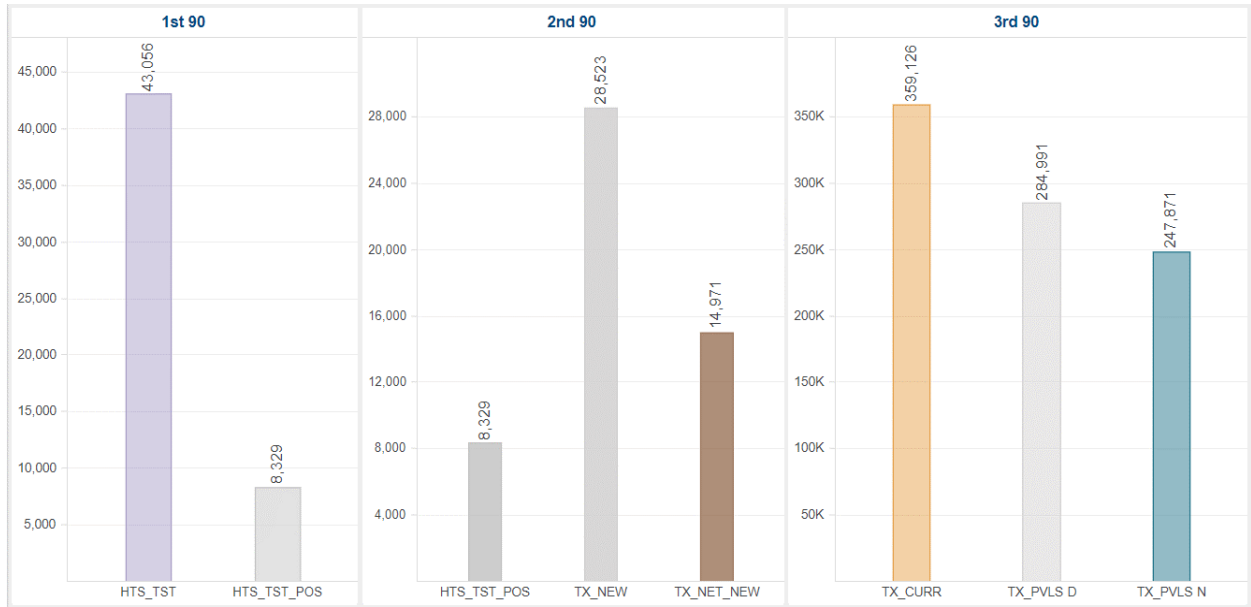
	Prioritization Area	Total PLHIV/% of all PLHIV for COP22	# Current on ART (FY21)	# of SNU COP21 (FY22)	# of SNU COP22 (FY23)
Burma	Scale-up Aggressive	N/A	10,614	28	30
Cambodia	Central support	75,373	62,561	25	25
India	Scale-up Saturation	54,853	27,806	4	3
India	Scale-up Aggressive	584,118	331,727	37	42
Indonesia	Scale-up Aggressive	387,210	8,660	8	8
Indonesia	Sustained		27,531	5	5
Kazakhstan	Sustained	7,451	4,347	2	2
Kyrgyz Republic	Scale-up Aggressive	9,637	3,768	4	4
Laos	Scale-up Aggressive	14,154	7,660	5	5
Nepal	Scale-up Aggressive	30,300	20,883	37	37
Papua New Guinea	Scale-up Saturation	7041	6444	1	1
Philippines	Scale-up Aggressive	133,800	31,181	5	5
Tajikistan	Scale-up Aggressive	8,648.00	5,205	3	3
Thailand	Scale-up Saturation	102,461	91,296	10	8
Thailand	Scale-up Aggressive	86,075	64,192	2	1
Thailand	Sustained	27,118	22,418	0	2
Thailand	Central support	31,059	29,342	2	3

Figure 4.0.1 Overview of 95/95/95 Cascade, FY21

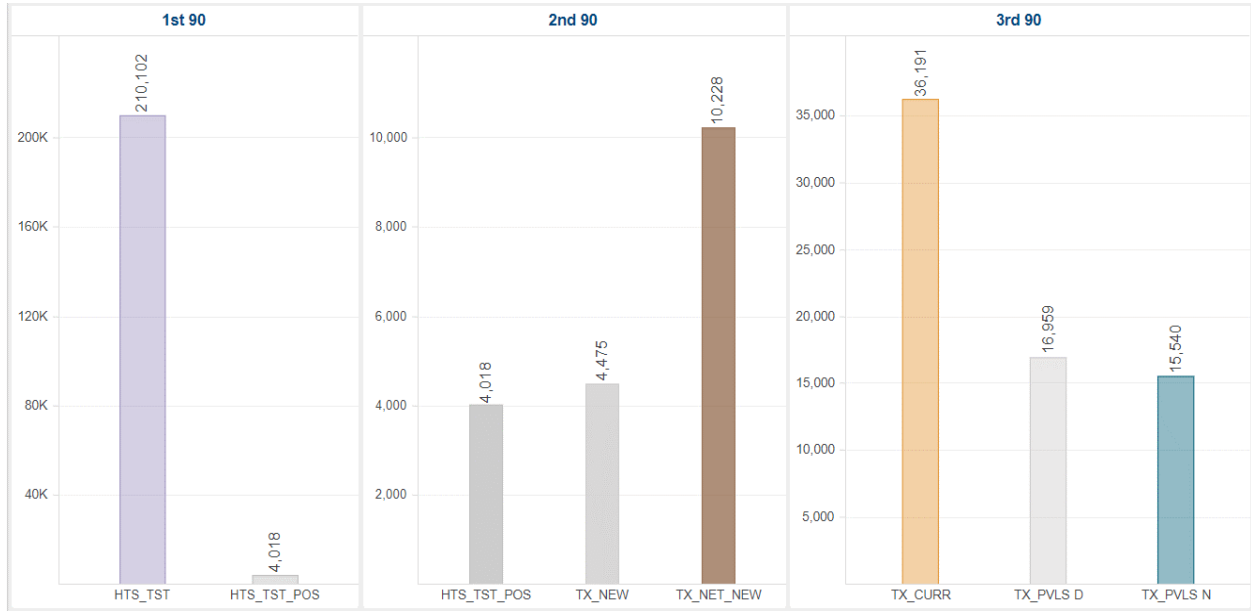
Burma



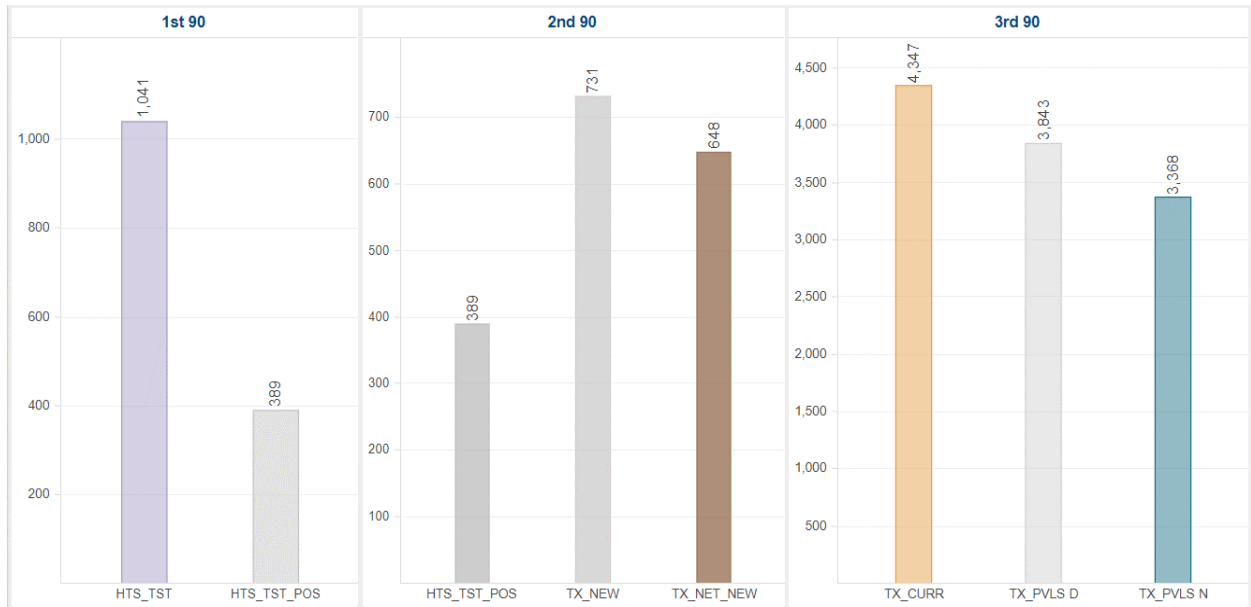
India



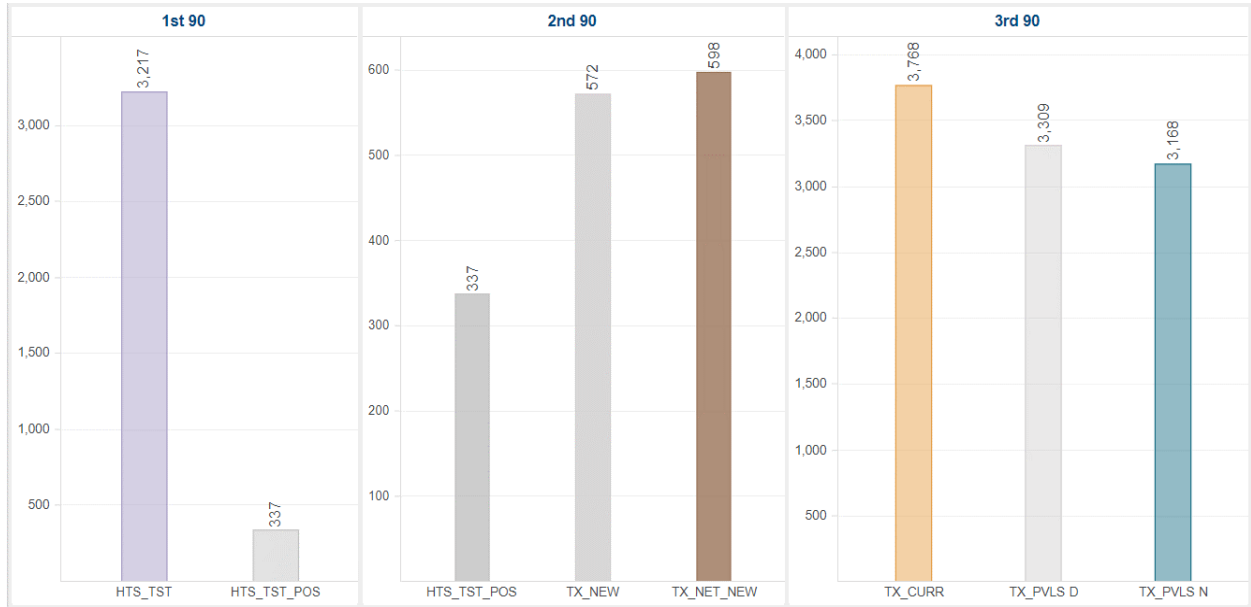
Indonesia



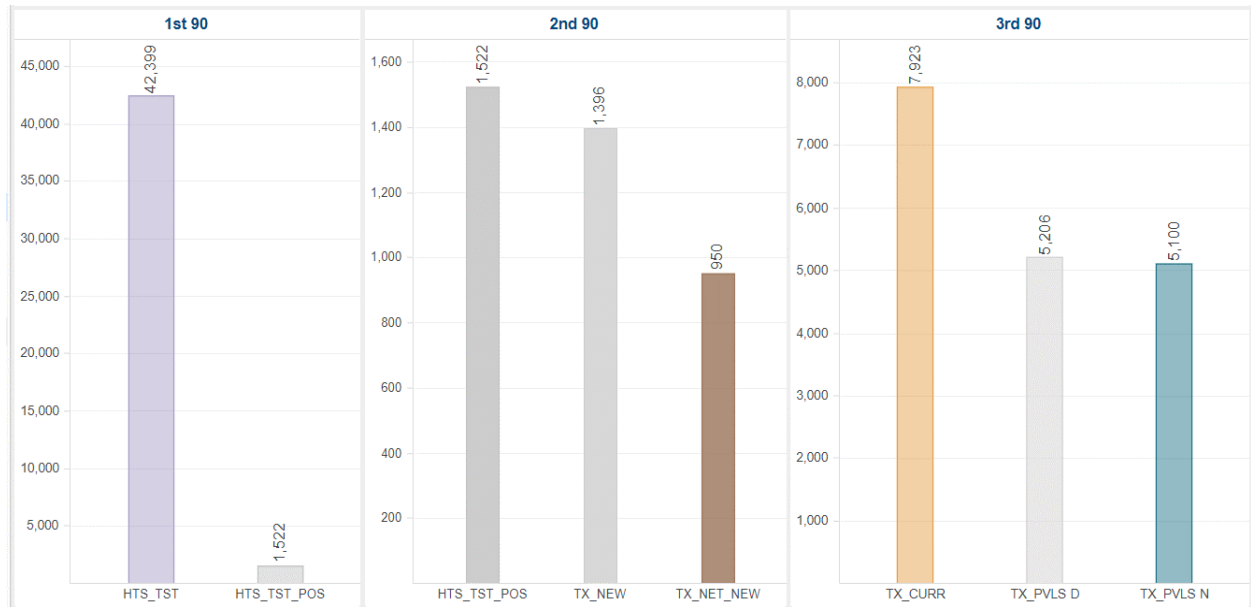
Kazakhstan



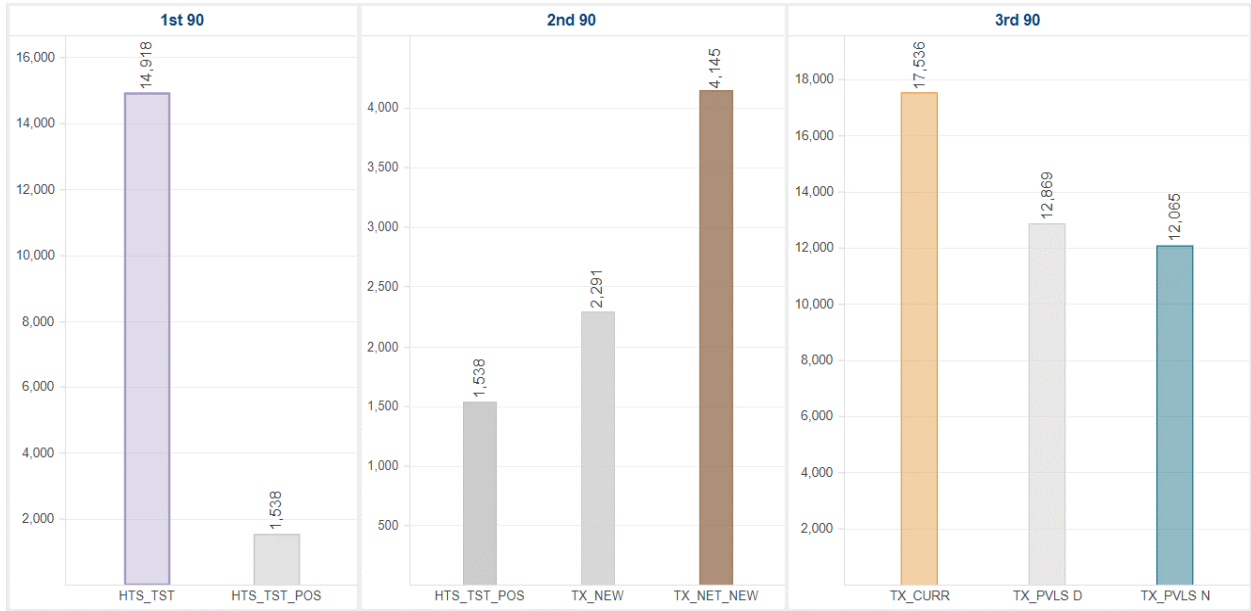
Kyrgyz Republic



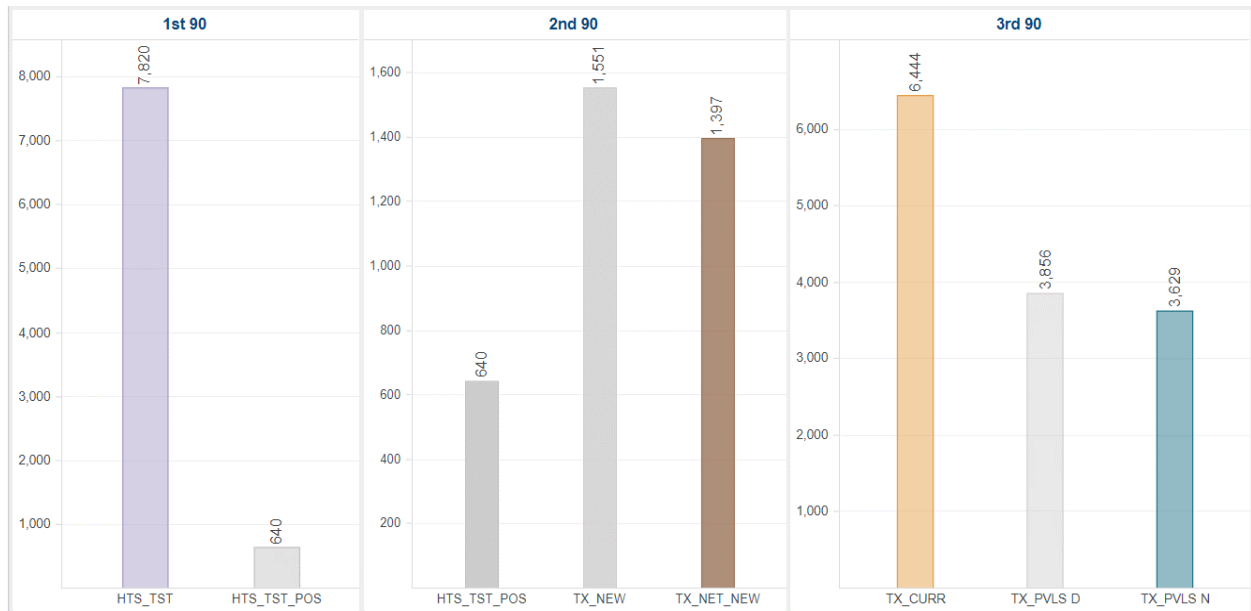
Laos



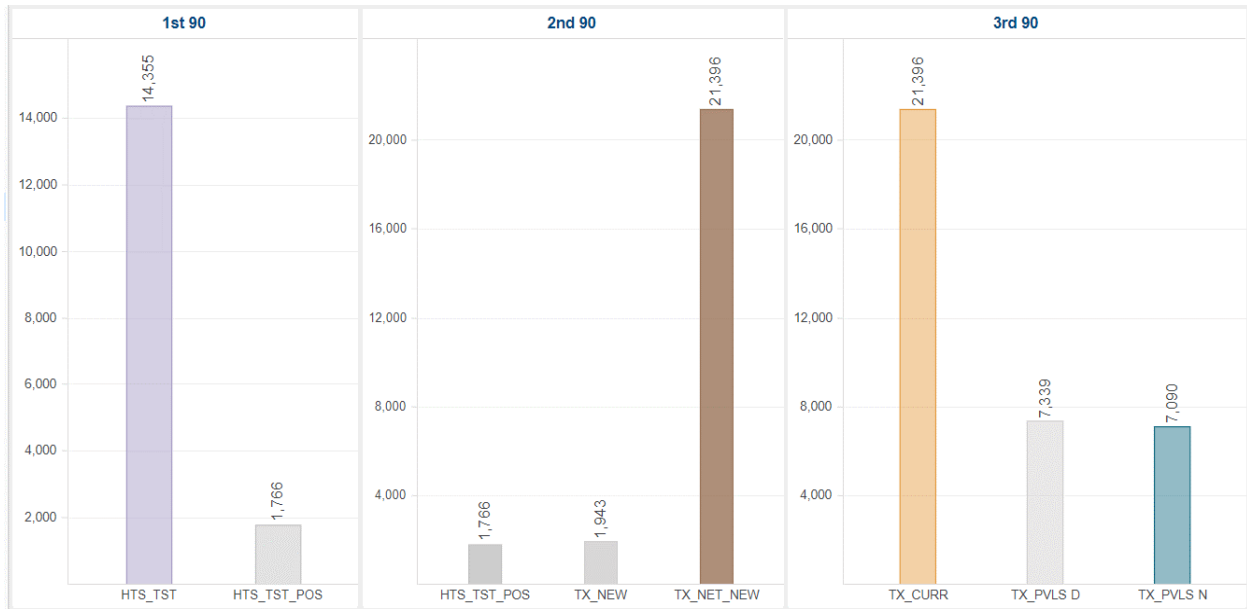
Nepal



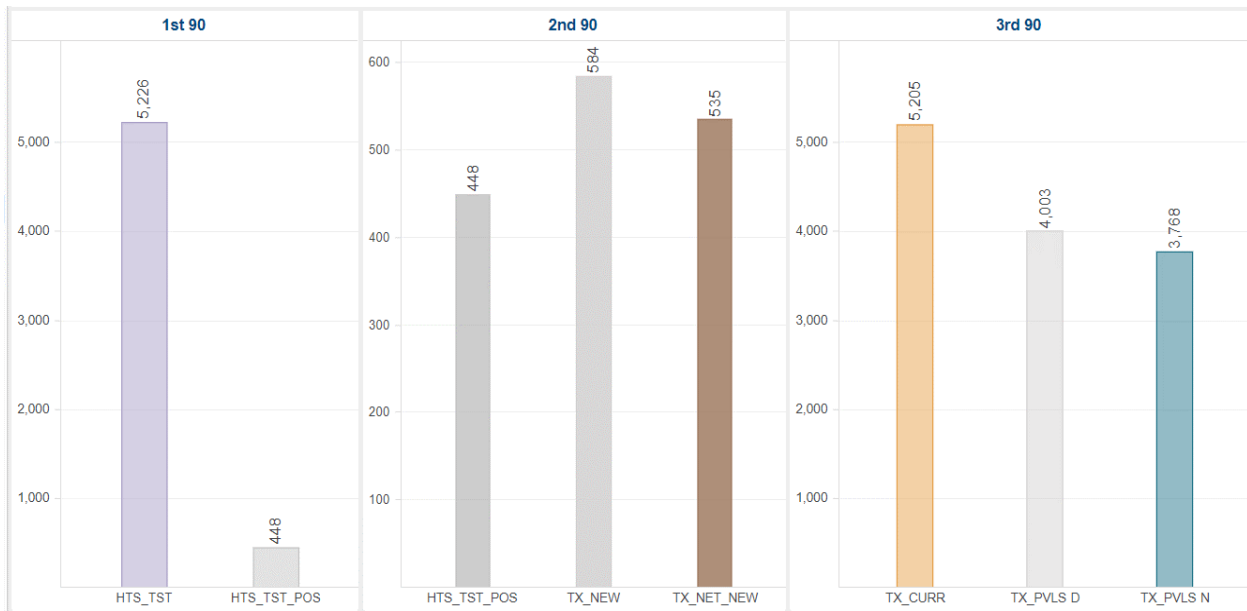
Papua New Guinea



Philippines



Tajikistan



Thailand

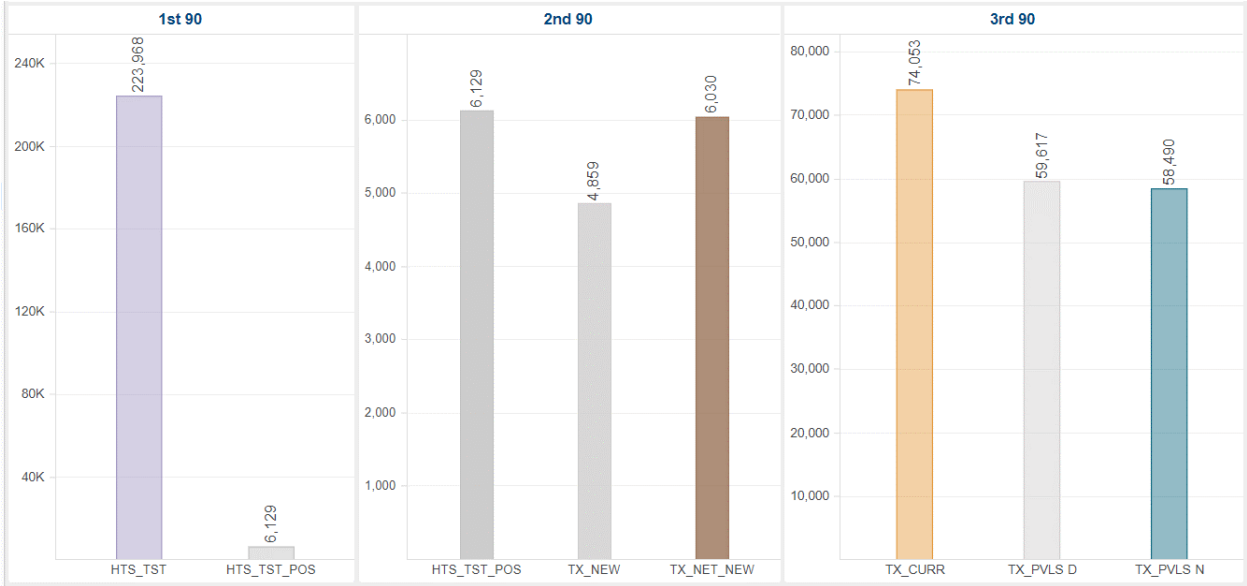
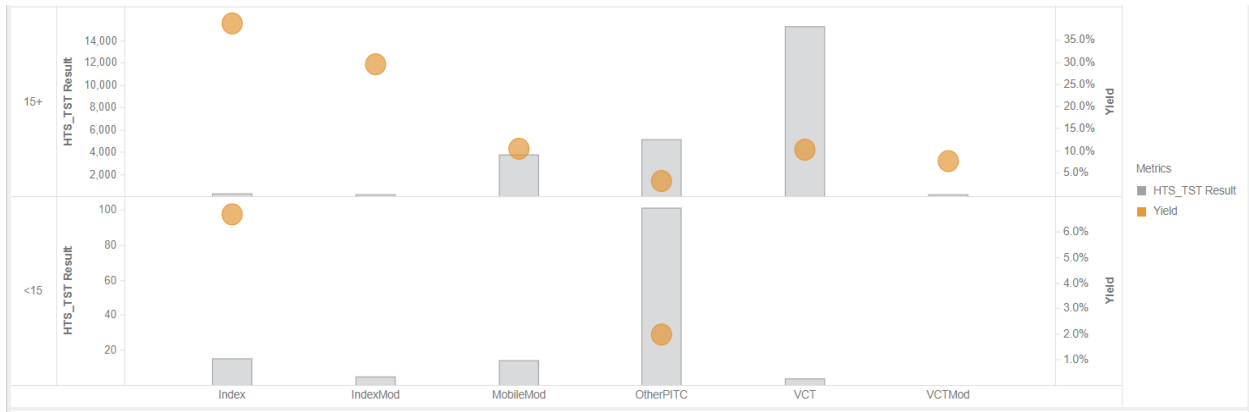
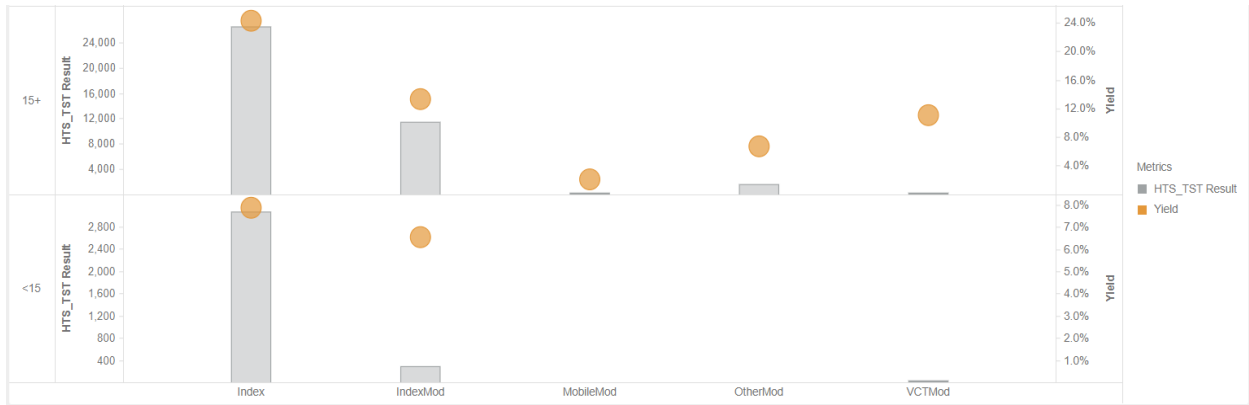


Figure 4.1.1 Testing Volume and Yield by Modality and Age/Sex, FY21

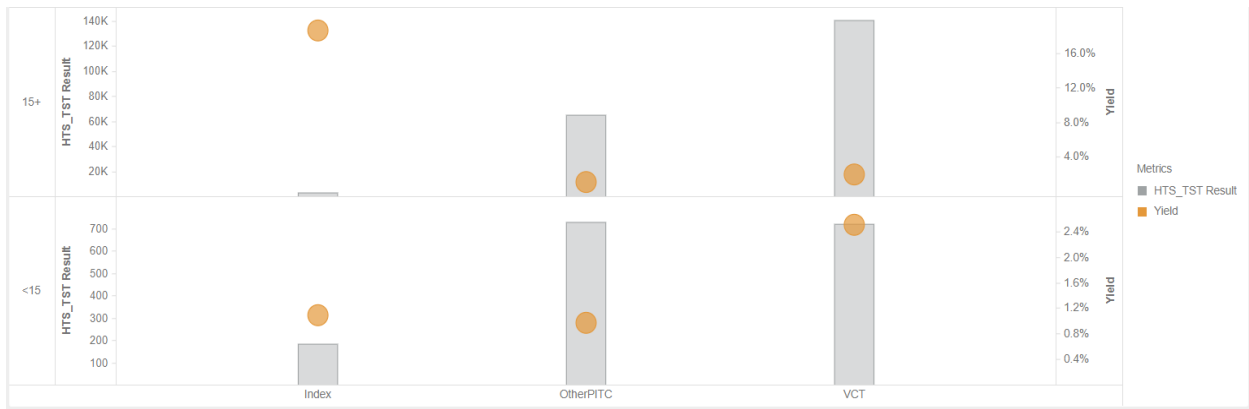
Burma



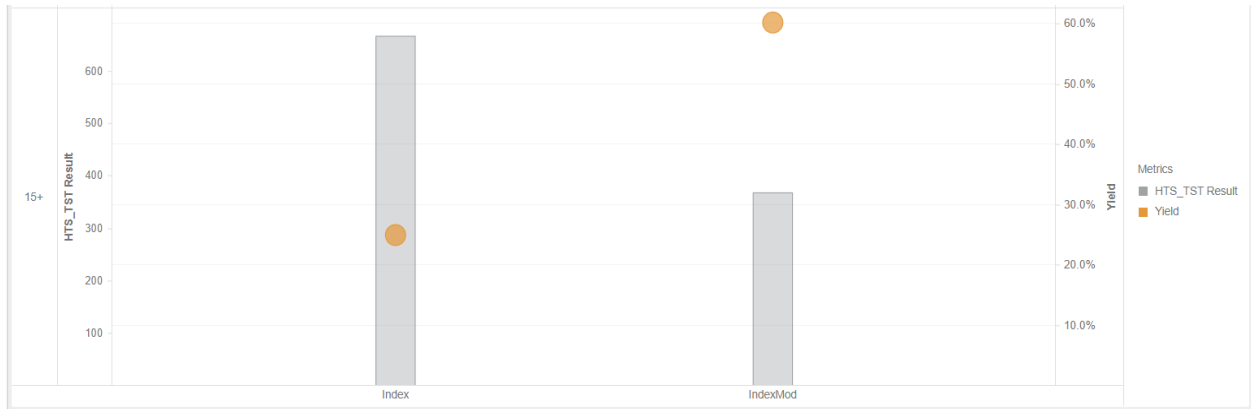
India



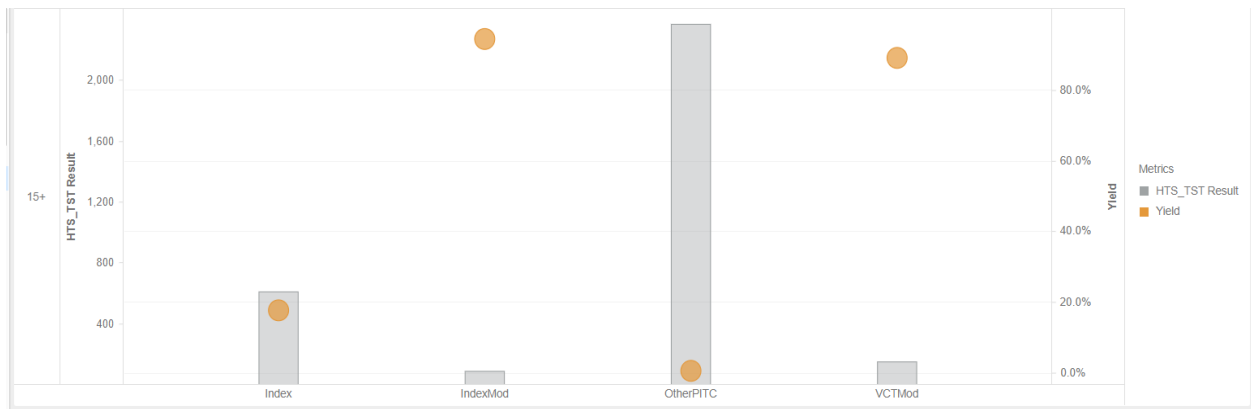
Indonesia



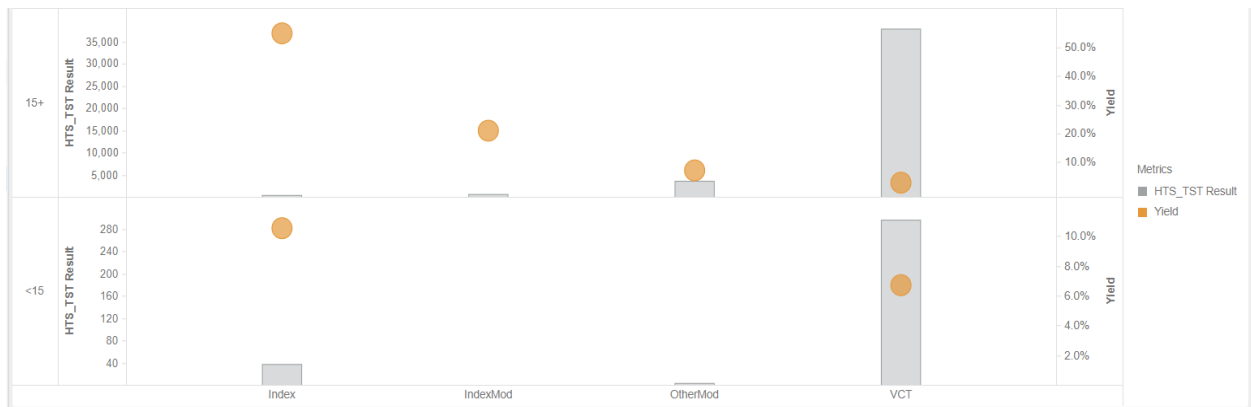
Kazakhstan



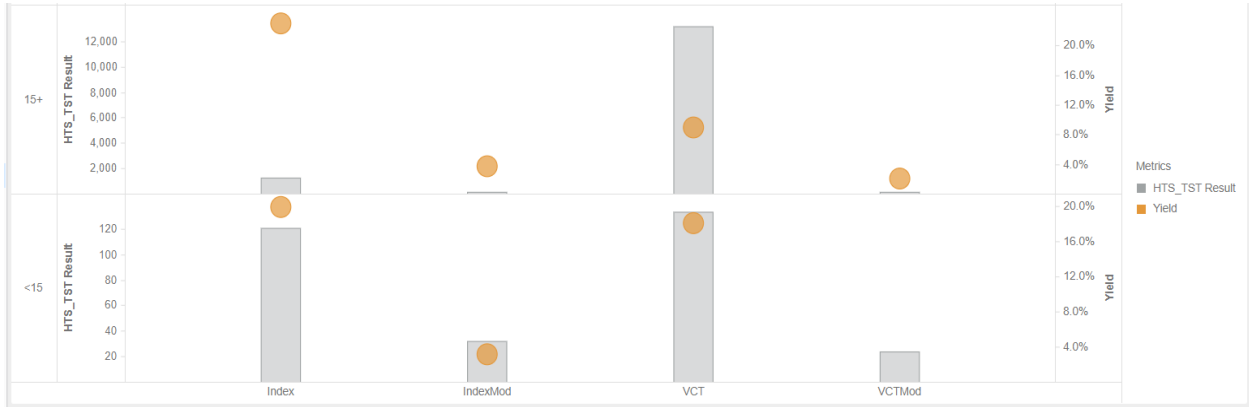
Kyrgyz Republic



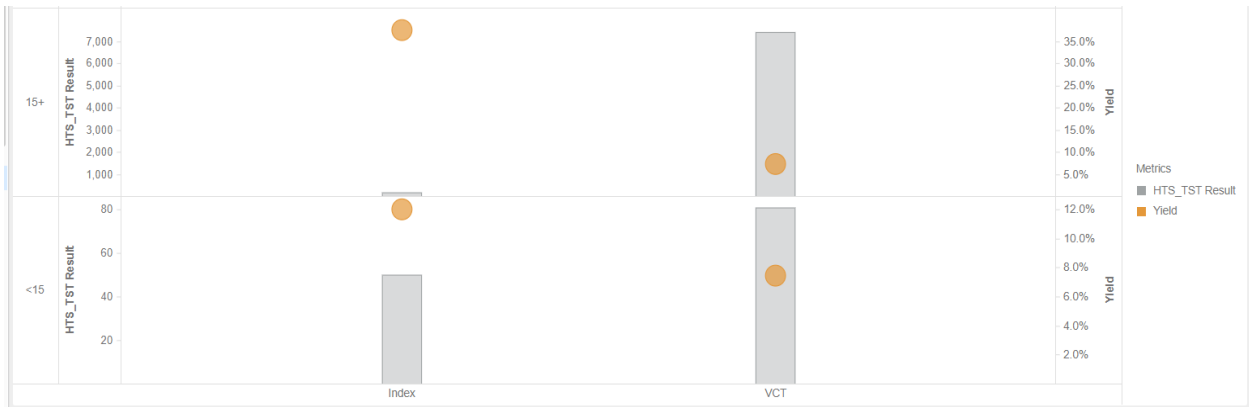
Laos



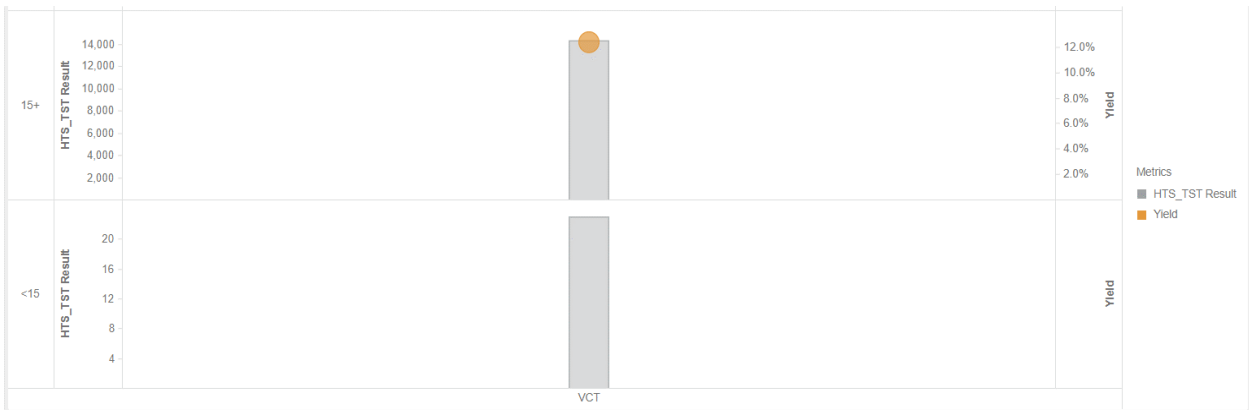
Nepal



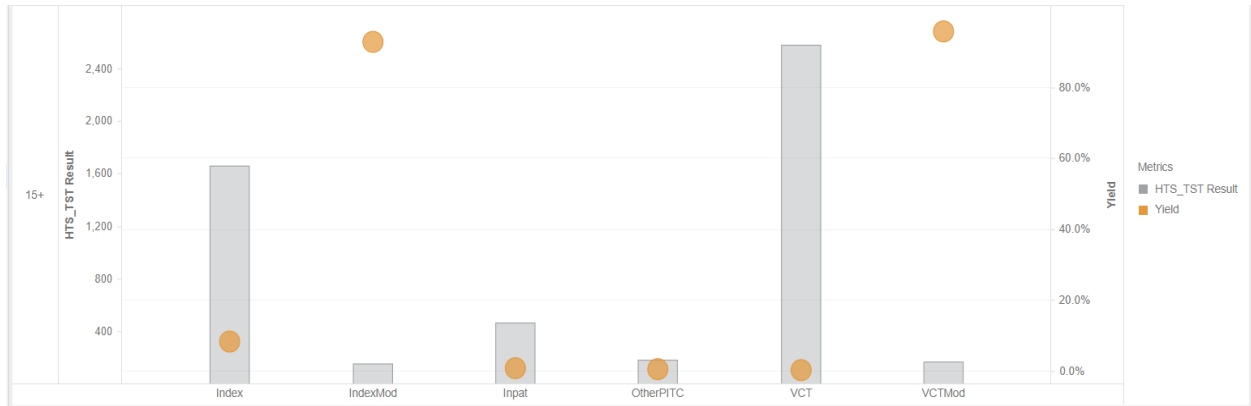
Papua New Guinea



Philippines



Tajikistan



Thailand

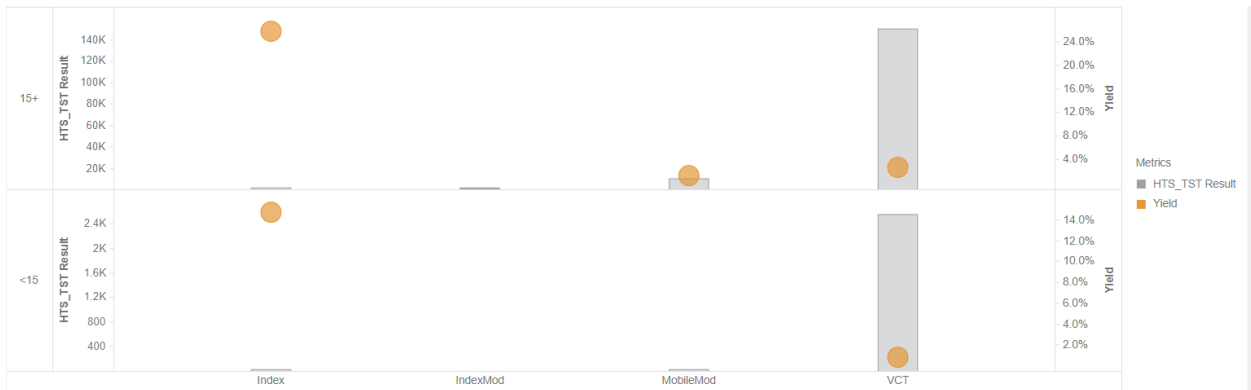
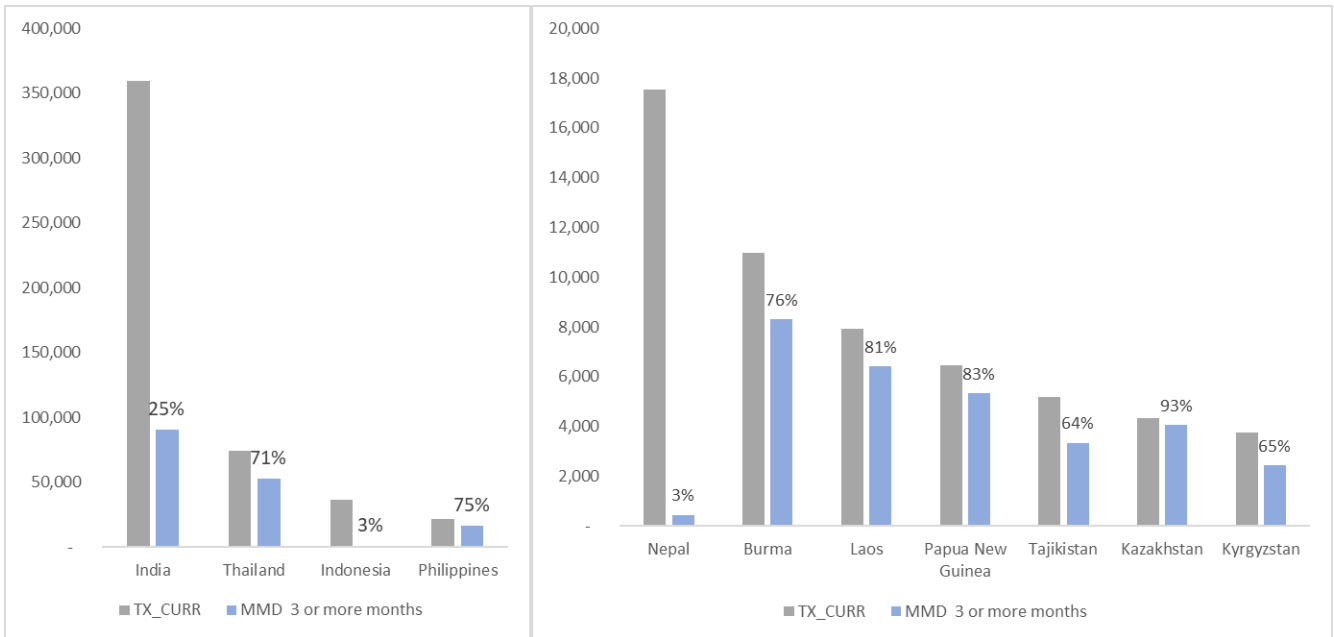
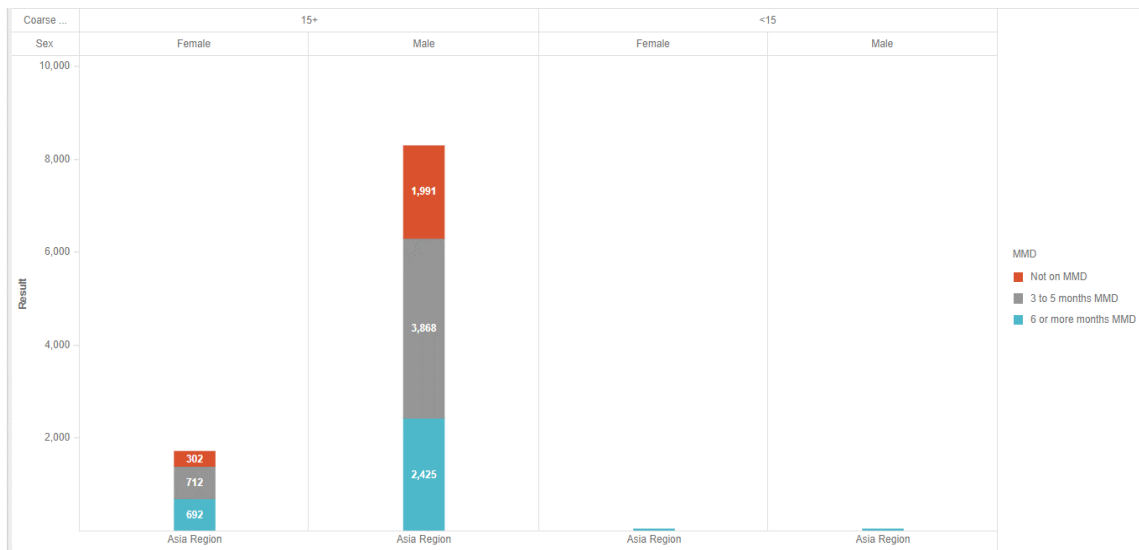


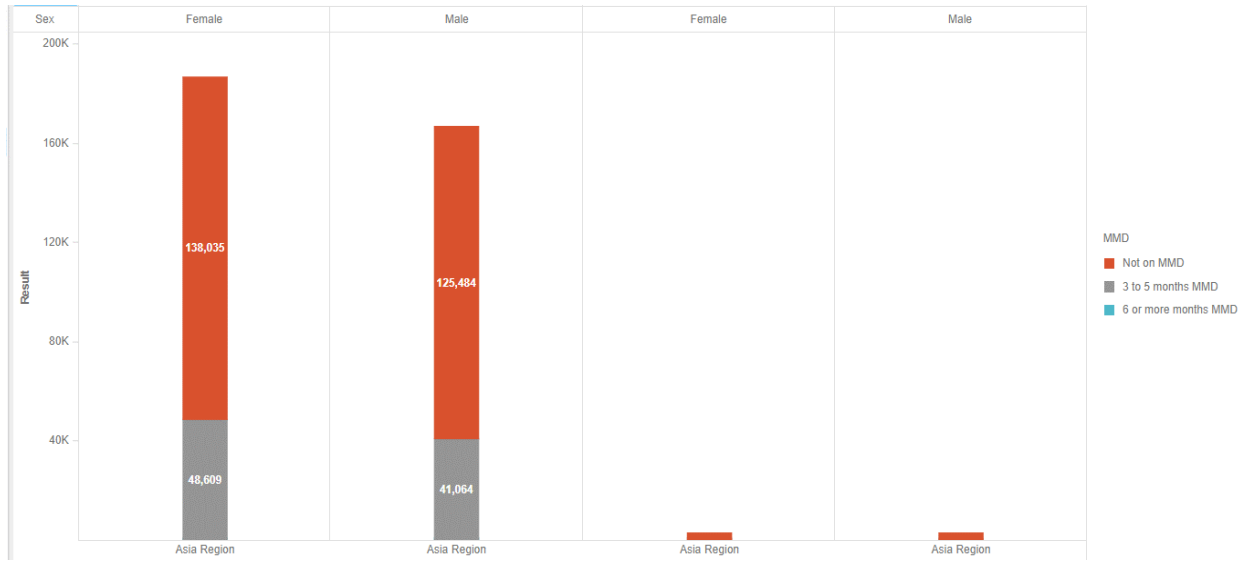
Figure 4.2.1 Number and Percent Contribution of Clients Receiving MMD by Age/Sex, FY21



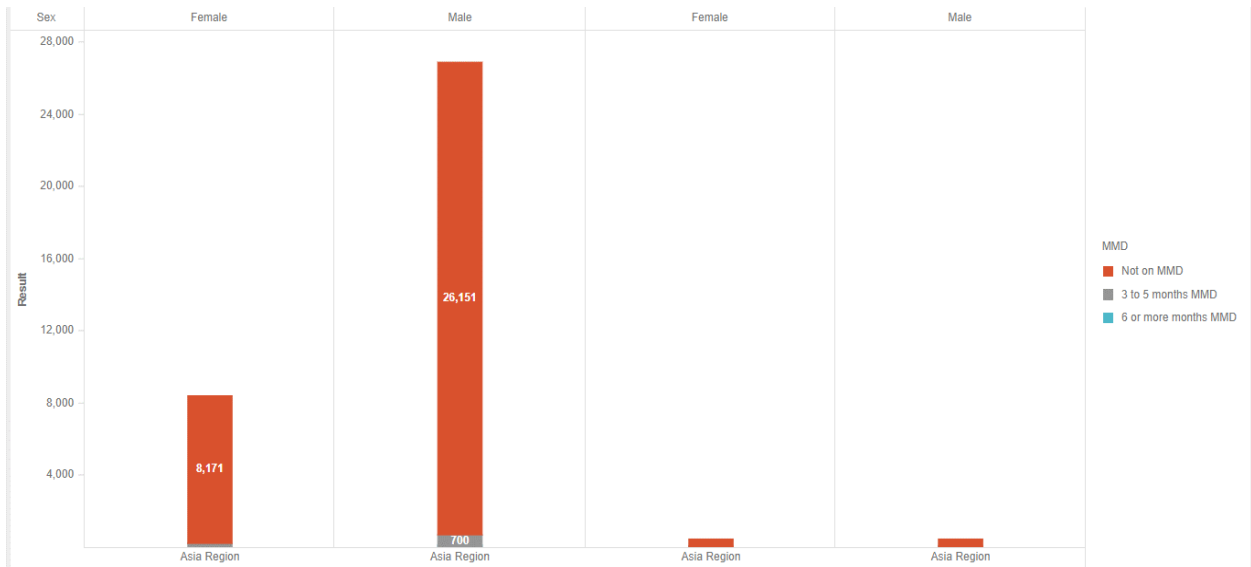
Burma



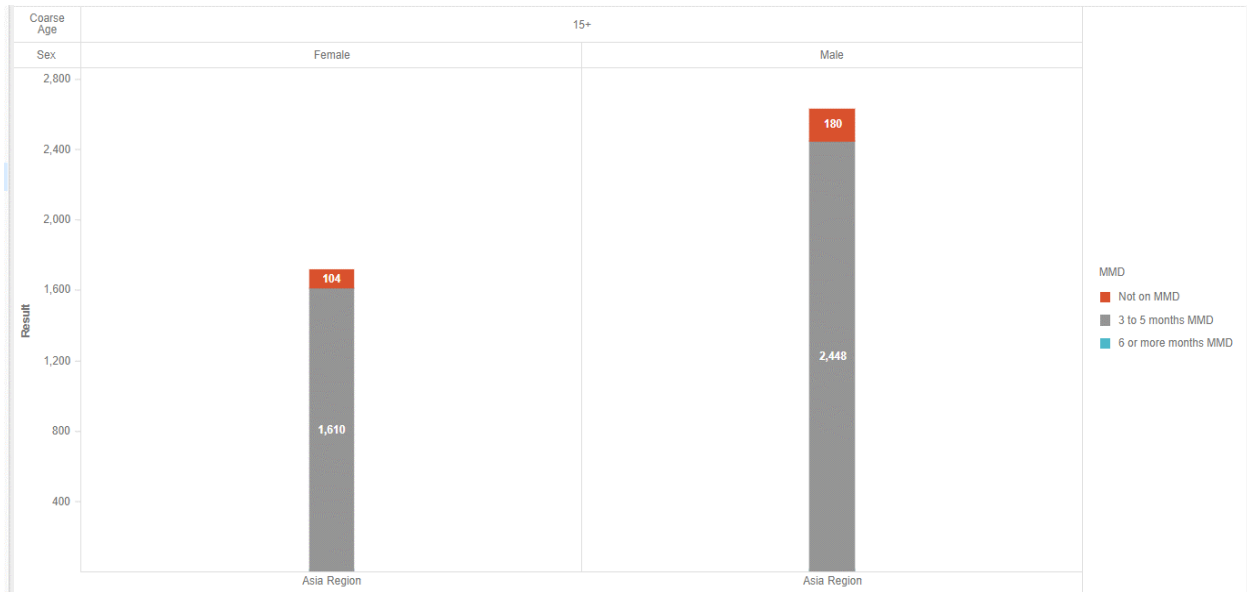
India



Indonesia



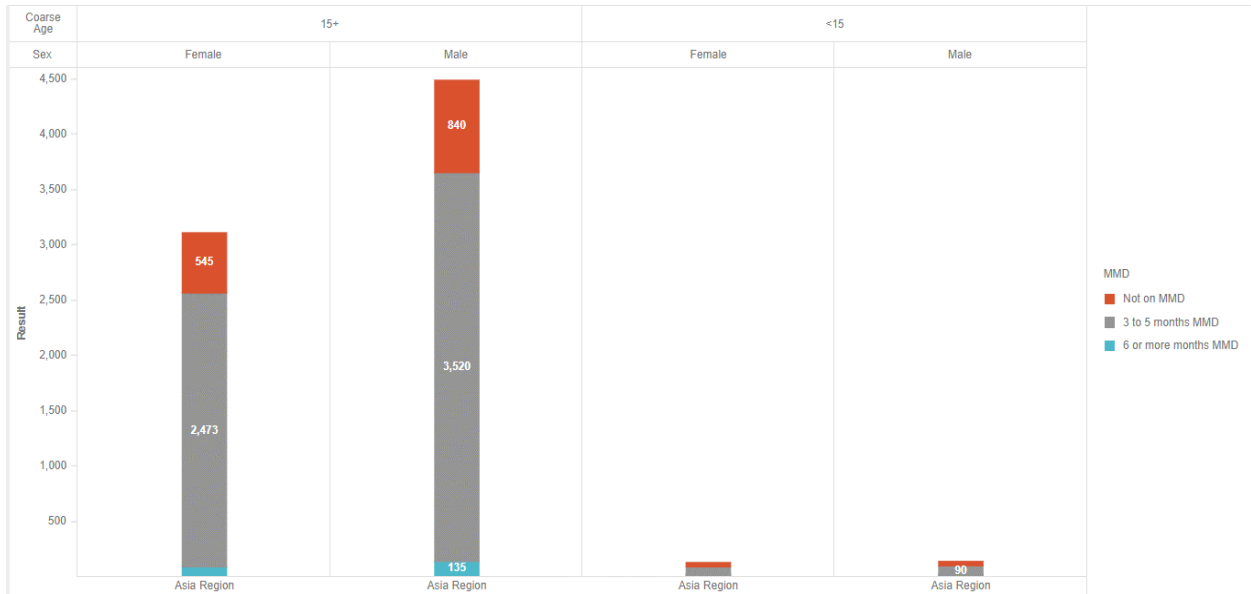
Kazakhstan



Kyrgyz Republic



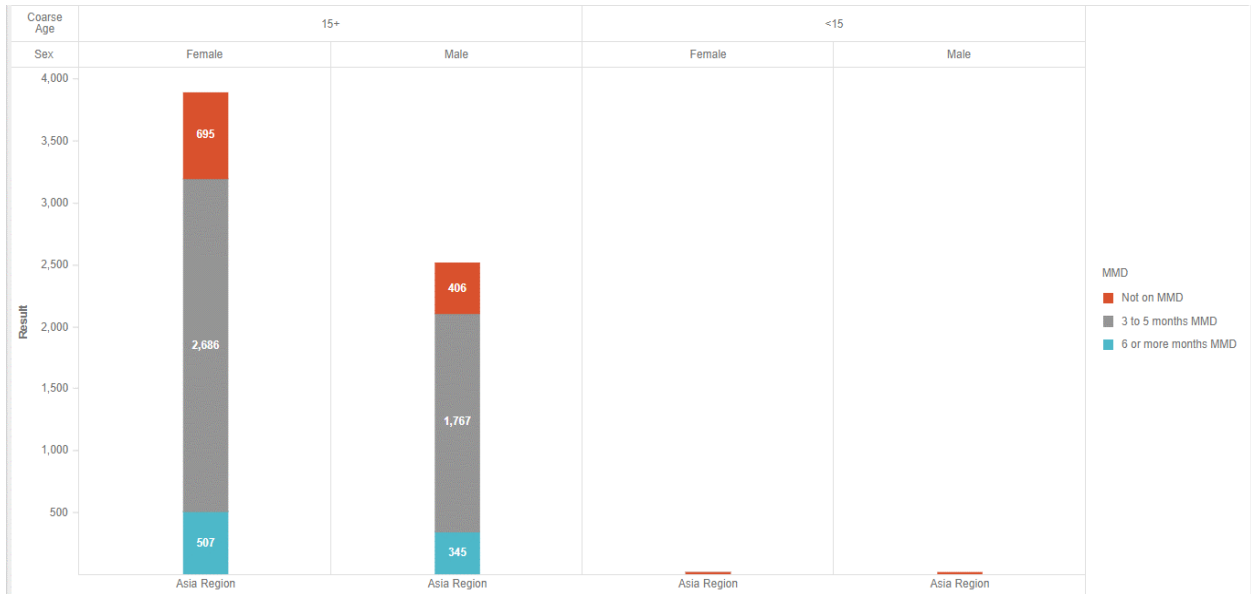
Laos



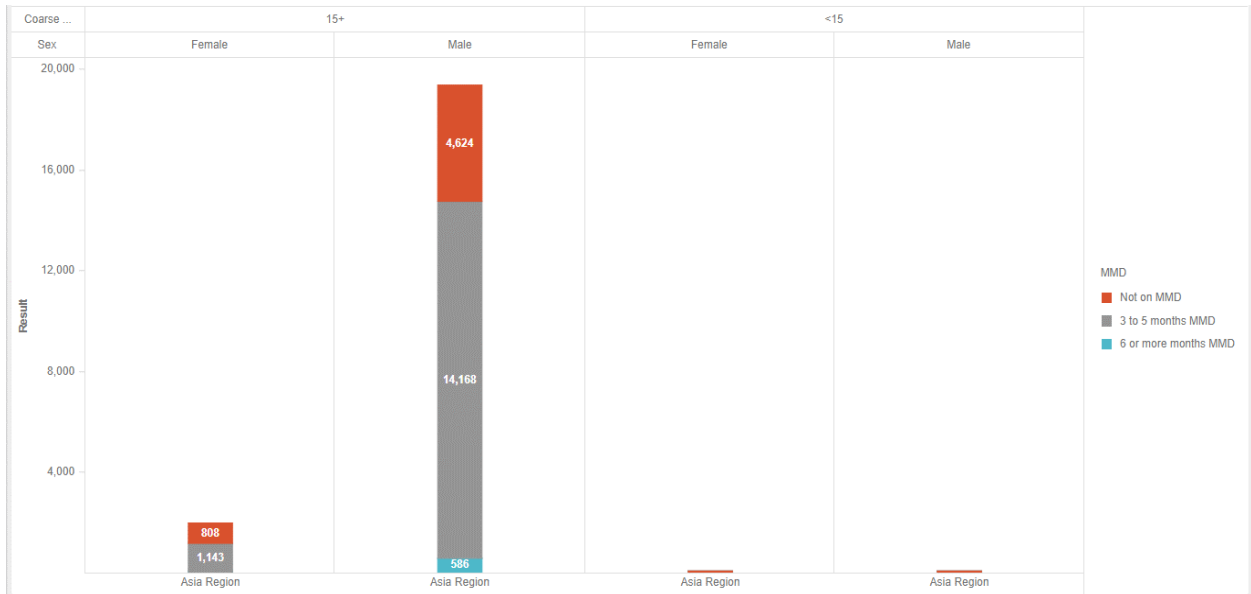
Nepal



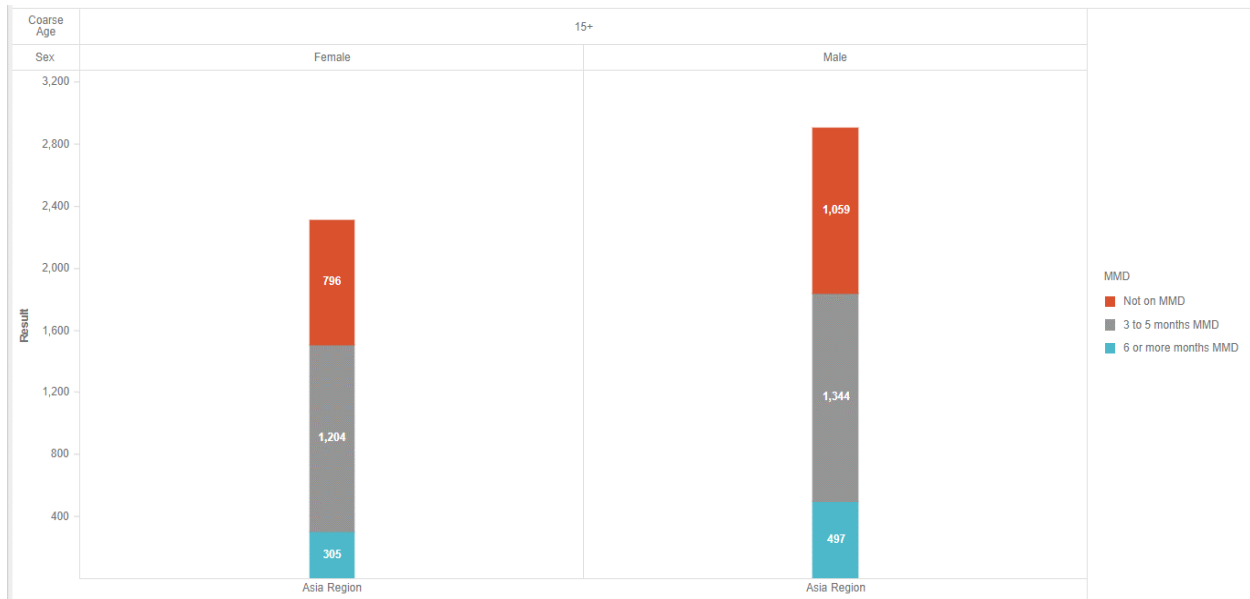
Papua New Guinea



Philippines



Tajikistan



Thailand

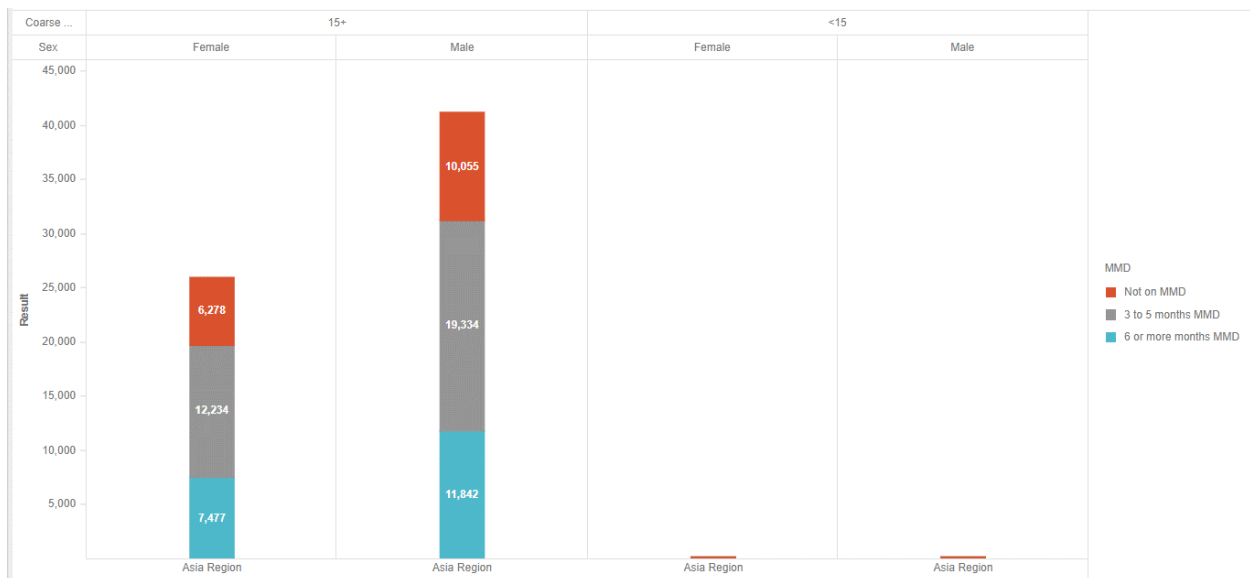
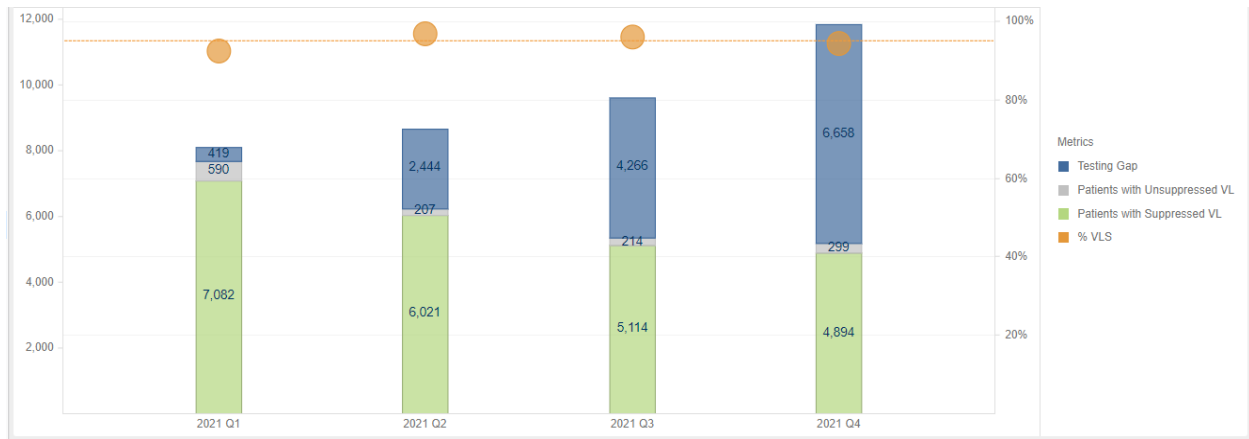
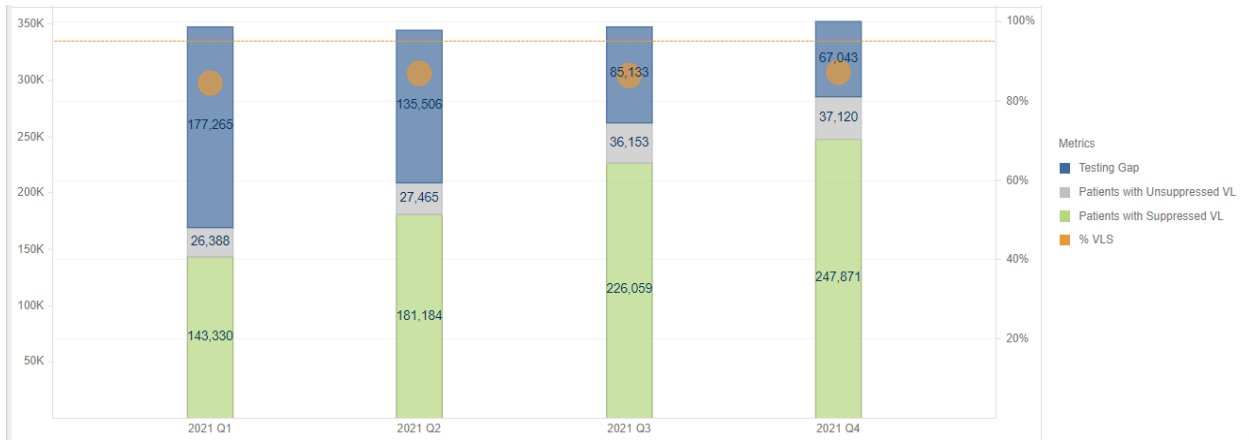


Figure 4.2.2 Viral Load Outcomes, FY21

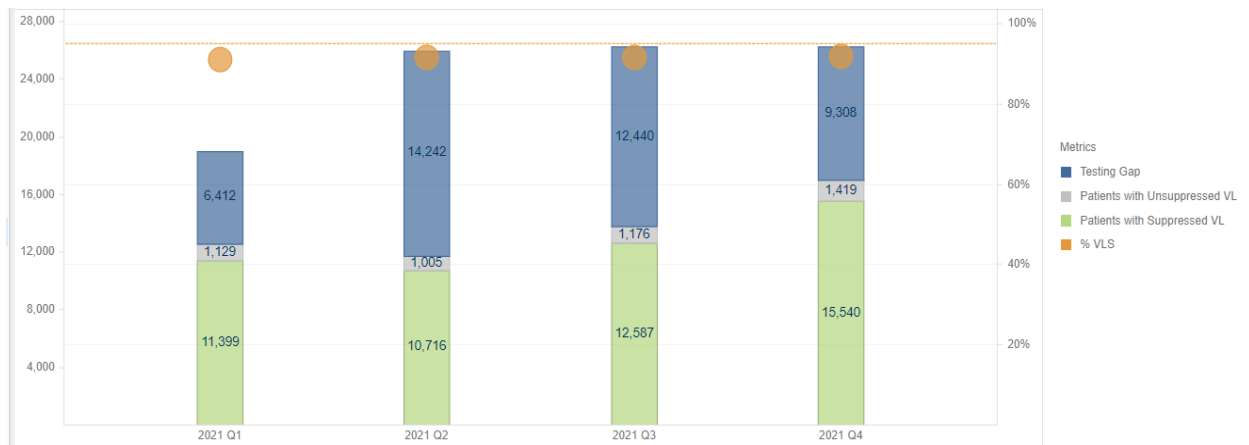
Burma



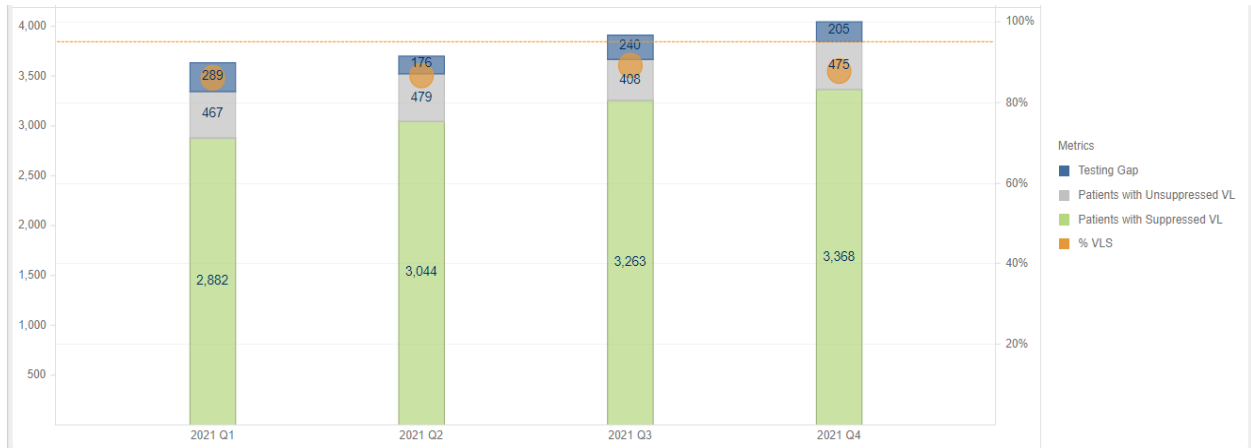
India



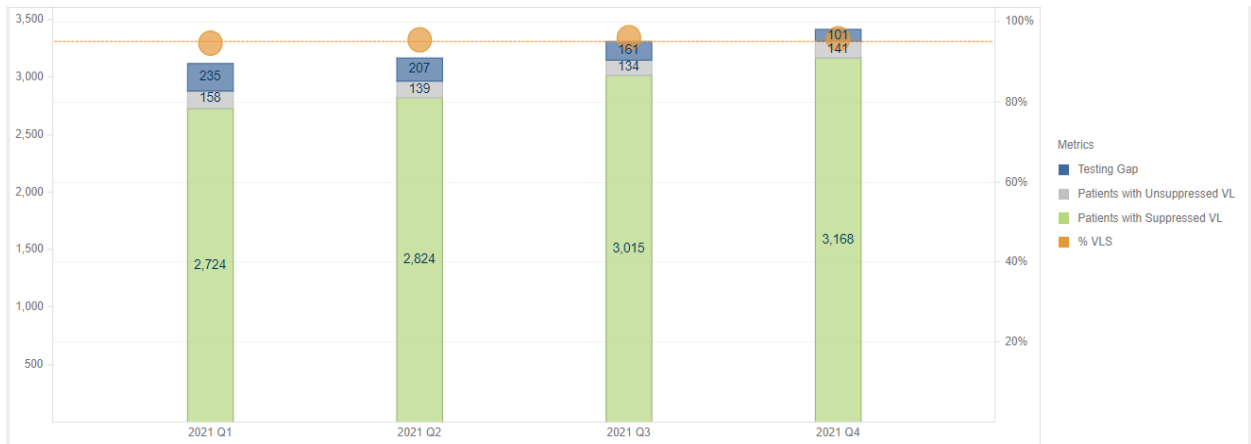
Indonesia



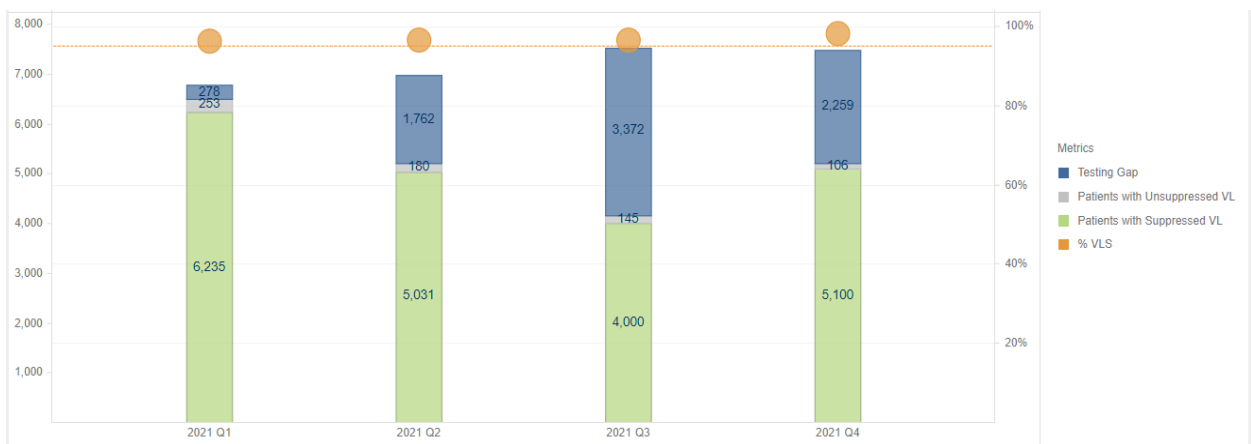
Kazakhstan



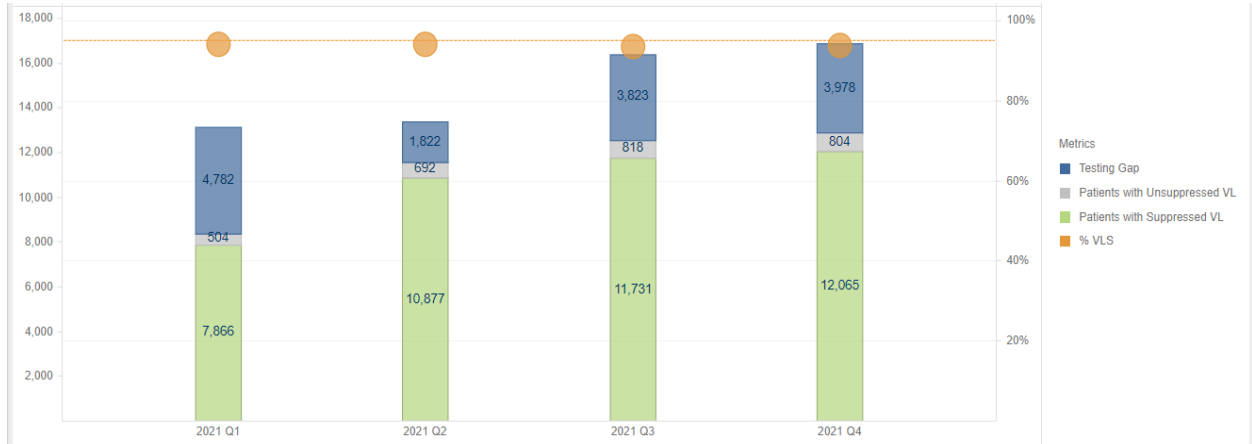
Kyrgyz Republic



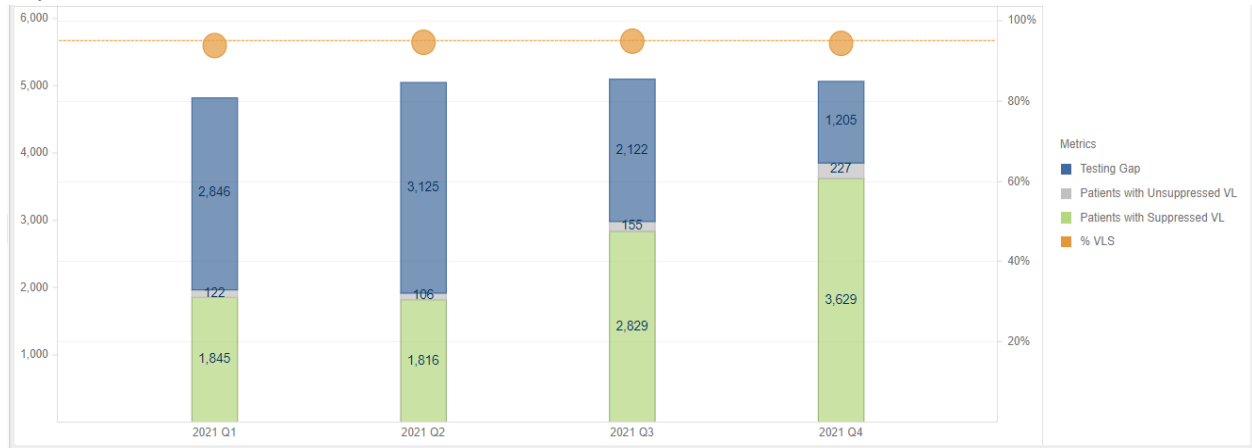
Laos



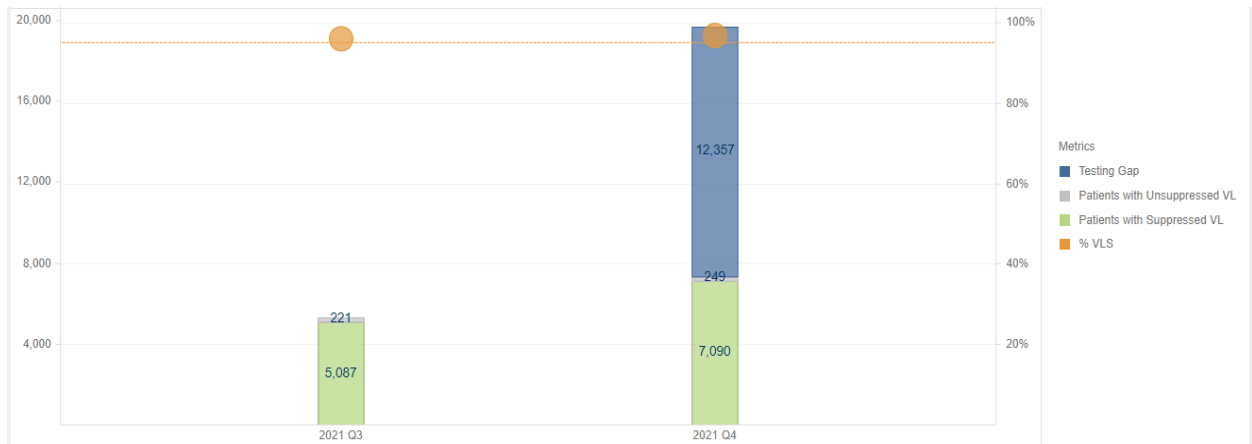
Nepal



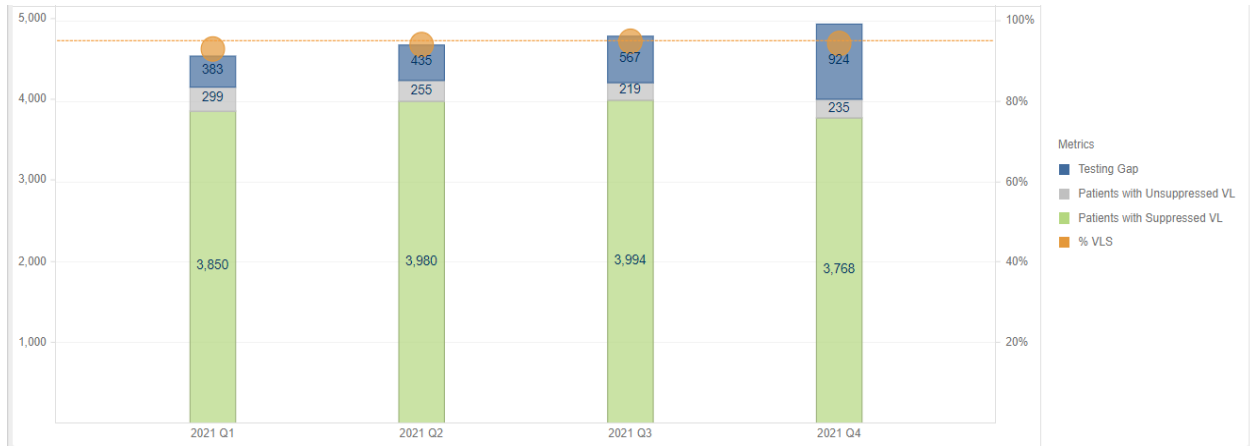
Papua New Guinea



Philippines



Tajikistan



Thailand

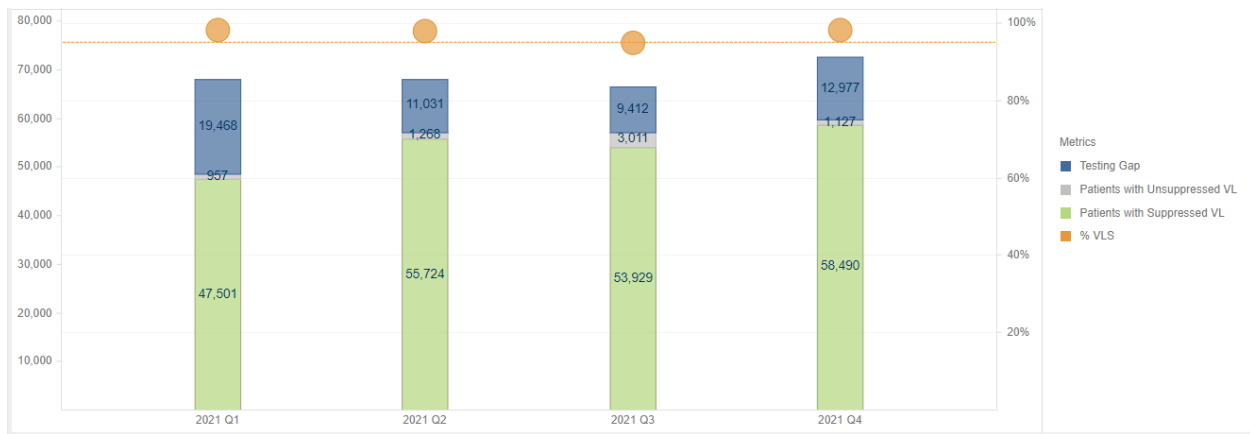
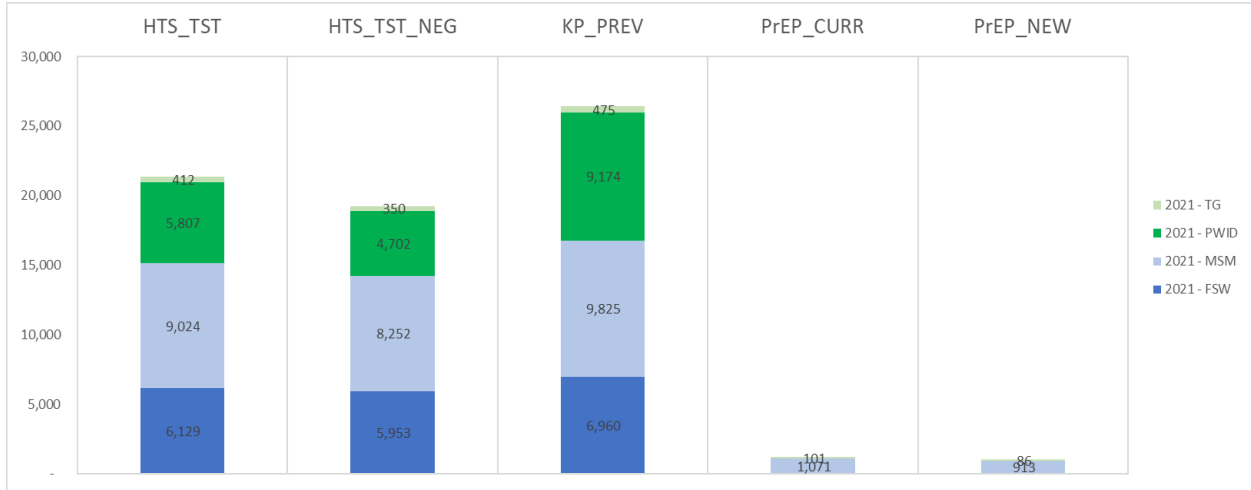
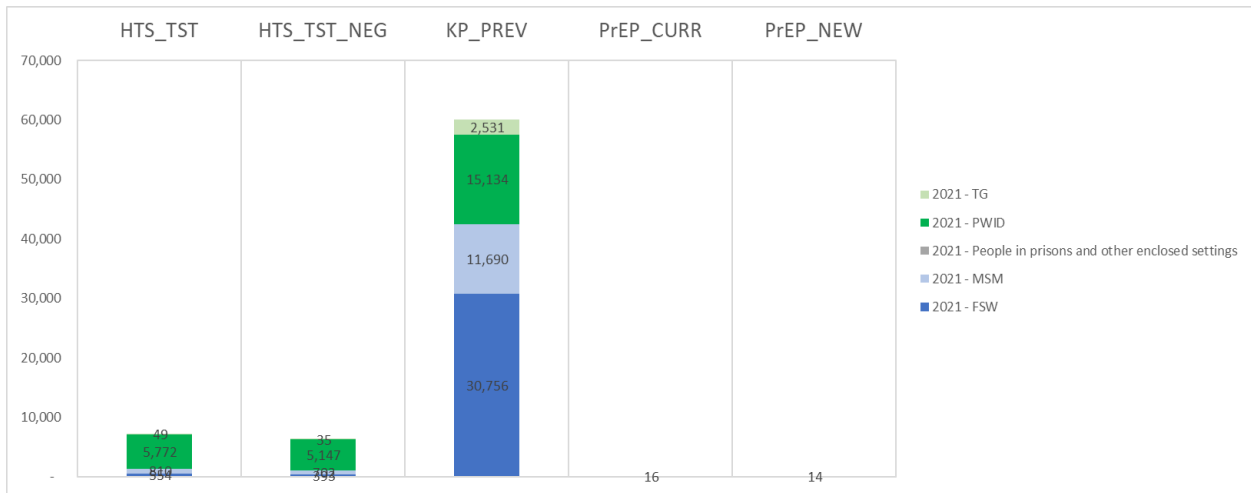


Figure 4.3.2 Prevention Continuum by Key Population Group

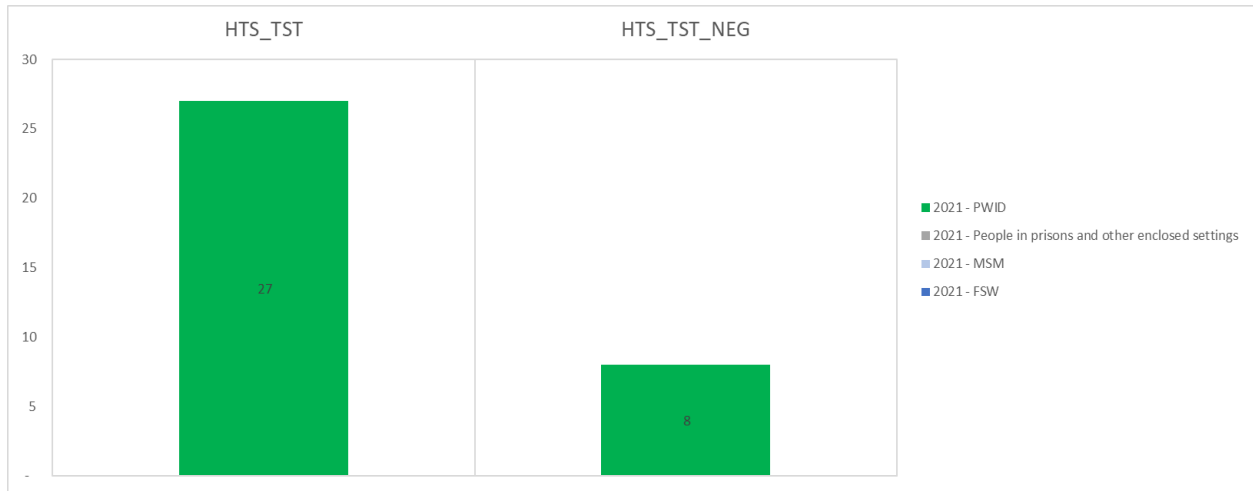
Burma



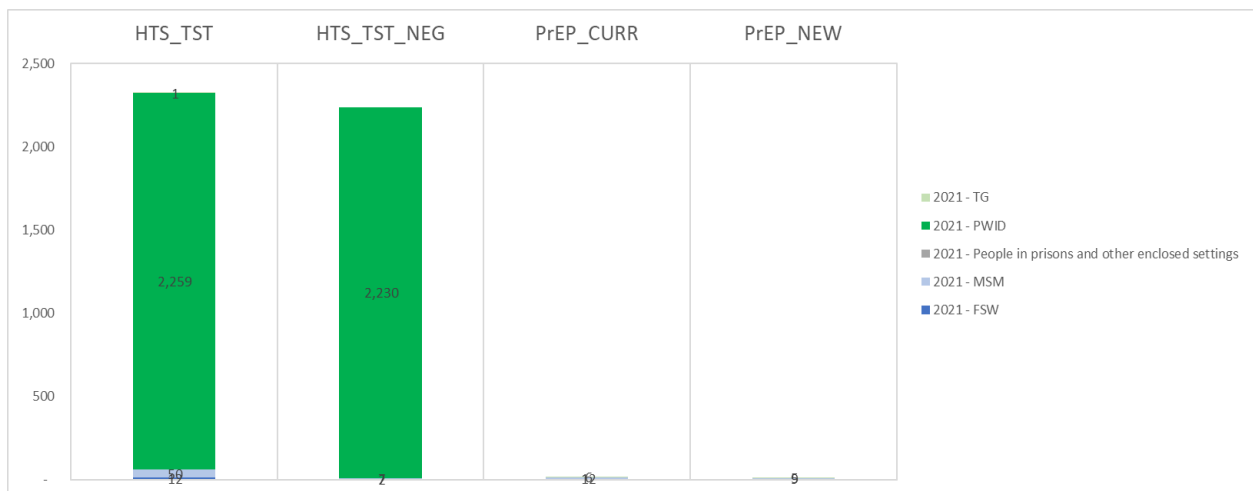
India



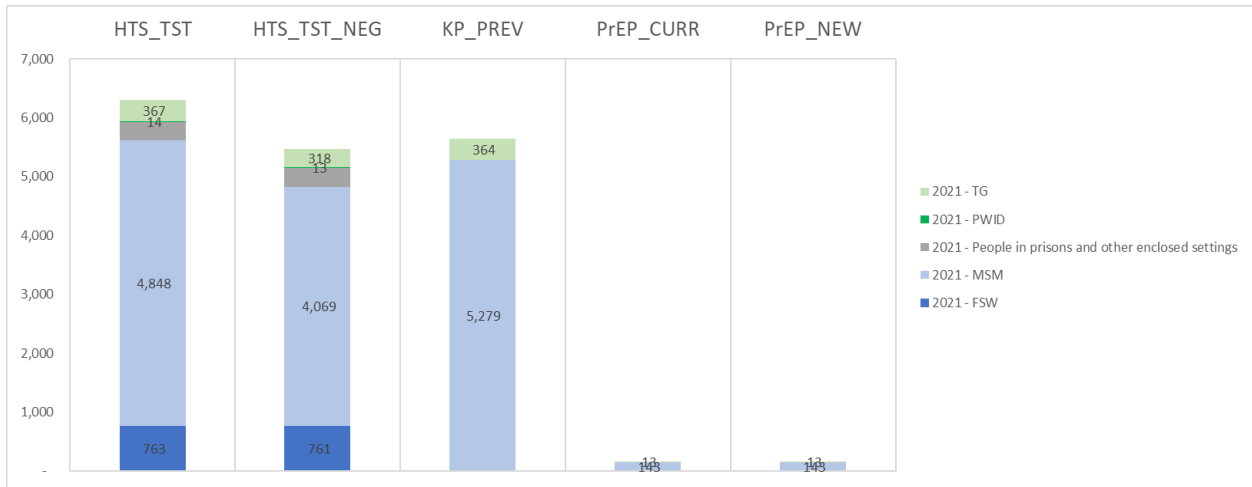
Kazakhstan



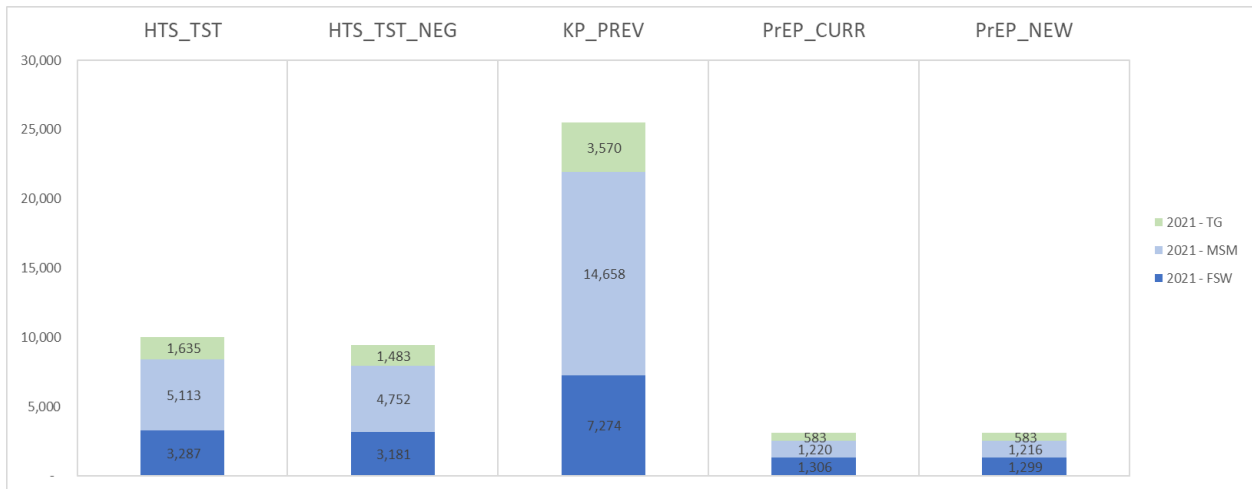
Kyrgyz Republic



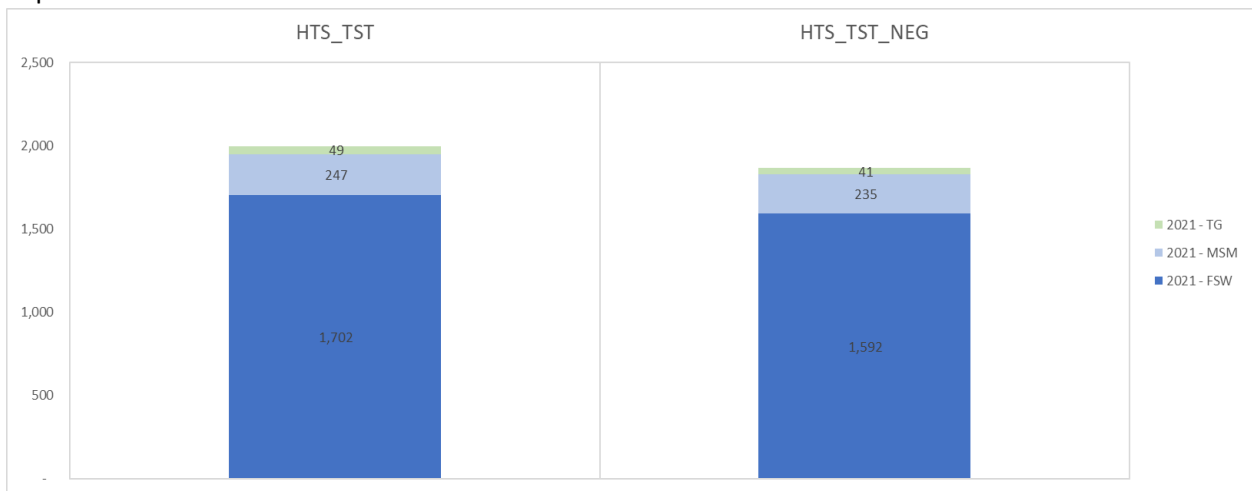
Laos



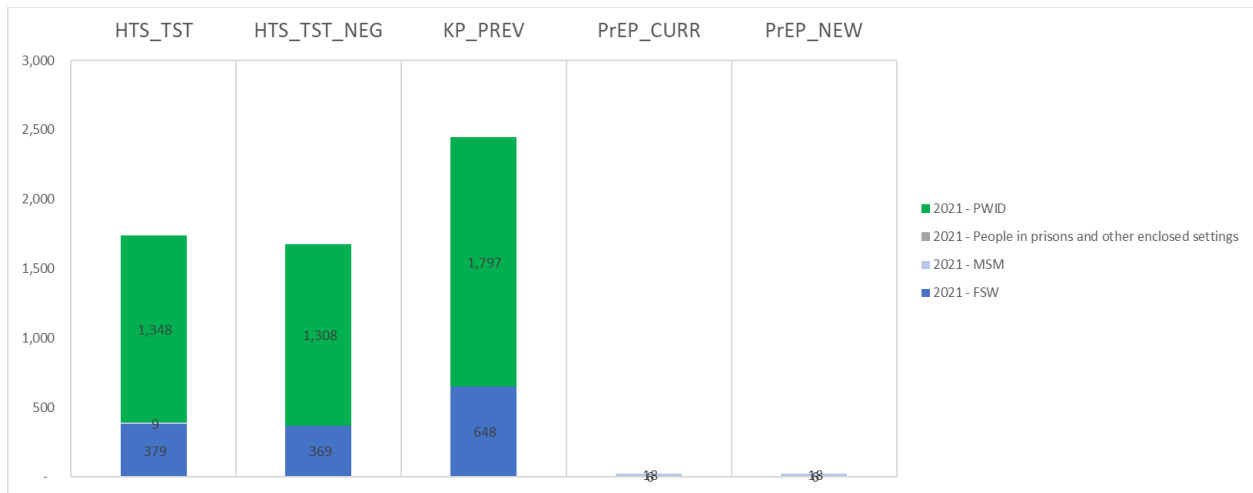
Nepal



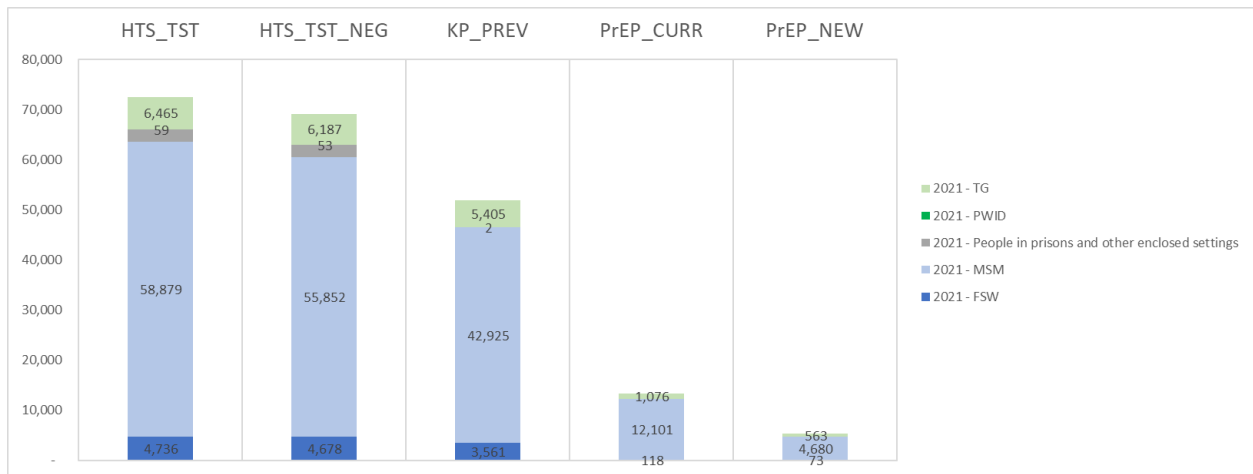
Papua New Guinea



Tajikistan



Thailand



APPENDIX A -- PRIORITIZATION **REQUIRED**

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1

CAMBODIA – N/A

SNU	COP	Prioritization	Results Reported	Attained: 90-90-90 by Each Age and Sex Band to Reach 95-95-95 Overall																											
				Treatment Coverage at APR by Age and Sex																										Overall TX Coverage	
				<1		1-4		5-10		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	F	M		
Hyderabad	COP 19	Scale-up: Aggressive	APR, 20	0%	0%	56%	62%	56%	62%	56%	61%	76%	80%	76%	80%	76%	80%	76%	80%	76%	80%	76%	80%	76%	80%	76%	80%	77%			
Rangareddy	COP 19	Scale-up: Aggressive	APR, 20	0%	0%	17%	17%	17%	17%	17%	17%	37%	22%	36%	22%	36%	22%	36%	22%	36%	22%	36%	22%	36%	22%	36%	22%	28%			
Mahabubnagar	COP 19	Scale-up: Aggressive	APR, 20	0%	0%	35%	0%	35%	55%	35%	55%	81%	66%	81%	66%	81%	66%	81%	66%	81%	66%	81%	66%	81%	66%	81%	66%	72%			
Nalgonda	COP 19	Scale-up: Aggressive	APR, 20	0%	0%	50%	0%	45%	71%	45%	72%	133%	89%	132%	89%	132%	88%	132%	88%	132%	88%	132%	88%	132%	88%	132%	88%	107%			
Karimnagar	COP 19	Scale-up: Aggressive	APR, 20	0%	0%	5%	7%	5%	7%	5%	7%	44%	49%	44%	49%	44%	49%	44%	49%	44%	49%	44%	49%	44%	49%	44%	49%	42%			
Hyderabad	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	33%	43%	33%	42%	33%	42%	76%	86%	76%	86%	76%	86%	76%	86%	76%	86%	76%	86%	76%	86%	76%	86%	78%			
Rangareddy	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	50%	50%	41%	43%	41%	42%	100%	60%	101%	61%	101%	59%	101%	59%	101%	59%	101%	59%	101%	59%	101%	59%	77%			
Mahabubnagar	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	0%	0%	0%	0%	1%	1%	100%	53%	100%	54%	100%	54%	99%	53%	99%	53%	99%	53%	99%	53%	99%	53%	69%			
Nalgonda	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	33%	50%	32%	39%	32%	39%	99%	58%	99%	58%	99%	58%	99%	58%	99%	58%	99%	58%	99%	58%	99%	58%	75%			
Karimnagar	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	0%	0%	0%	0%	7%	10%	87%	66%	87%	66%	86%	66%	86%	66%	86%	66%	86%	65%	86%	65%	86%	65%	73%			
Thane	COP 20	Scale-up: Saturation	APR, 21	0%	0%	24%	45%	23%	45%	23%	45%	54%	70%	54%	70%	54%	70%	54%	70%	54%	70%	54%	70%	54%	70%	54%	70%	60%			
Pune	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	18%	33%	18%	33%	18%	33%	79%	63%	79%	63%	79%	63%	79%	63%	79%	63%	79%	63%	79%	63%	79%	63%	69%			
Aizwal	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%		
Bishunpur	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	0%	0%	102%	102%	102%	85%	93%	91%	90%	90%	94%	95%	91%	93%	93%	90%	92%	84%	83%	87%	90%	91%	90%			
Champai	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	186%	83%	90%	213%	31%	56%	124%	62%	85%	72%	73%	72%	107%	90%	74%	62%	65%	69%	49%	50%	57%	49%	72%			
Chandel	COP 20	Scale-up: Aggressive	APR, 21	97%	106%	363%	116%	145%	67%	182%	39%	91%	107%	97%	109%	101%	86%	112%	93%	82%	79%	65%	62%	78%	41%	62%	89%	91%			
Chittoor	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	56%	67%	70%	55%	75%	58%	57%	63%	56%	53%	62%	64%	64%	60%	64%	63%	64%	62%	62%	62%	72%	79%	69%			

Dimapur	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	52%	73%	116%	69%	84%	68%	59%	69%	82%	66%	72%	73%	65%	61%	66%	59%	50%	65%	51%	58%	55%	44%	60%	
East Godavari	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	46%	60%	68%	72%	82%	66%	76%	66%	68%	60%	68%	59%	72%	61%	70%	68%	69%	71%	69%	68%	68%	68%	68%	
Guntur	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	129%	33%	58%	94%	85%	73%	65%	68%	70%	61%	67%	61%	74%	70%	73%	68%	71%	70%	71%	68%	70%	71%	70%	
Imphal East	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	123%	0%	62%	77%	74%	103%	95%	72%	327%	237%	304%	296%	187%	113%	133%	97%	97%	119%	88%	103%			86%	
Imphal West	COP 20	Scale-up: Saturation	APR, 21	0%	0%	0%	0%	46%	55%	183%	92%	202%	61%	73%	103%	71%	64%	90%	80%	76%	83%	82%	111%	63%	86%	75%	48%	74%	
Kiphiri	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	0%	0%	119%	34%	51%	119%	0%	0%	130%	53%	51%	81%	71%	64%	38%	65%	67%	31%	30%	75%	46%	100%	65%	
Kohima	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	34%	564%	78%	106%	113%	80%	69%	178%	54%	76%	90%	79%	83%	86%	71%	85%	59%	60%	50%	69%	63%	74%	73%	
Kolasib	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	182%	34%	78%	109%	164%	98%	100%	68%	129%	139%	77%	95%	75%	72%	82%	72%	79%	73%	51%	62%	110%	81%	84%	
Krishna	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	31%	50%	59%	71%	67%	63%	58%	61%	55%	49%	62%	54%	63%	59%	63%	63%	62%	60%	61%	61%	70%	74%	69%	
Lunglei	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	71%	52%	46%	164%	56%	19%	151%	105%	60%	45%	77%	59%	56%	55%	51%	58%	75%	55%	67%	72%	72%	69%	61%	
Mamit	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	0%	48%	0%	288%	0%	0%	12%	192%	19%	123%	104%	87%	90%	88%	100%	38%	125%	140%	82%	22%	100%	66%	48%	
Mokchung	COP 20	Scale-up: Saturation	APR, 21	0%	0%	0%	0%	61%	122%	147%	32%	139%	107%	112%	160%	67%	61%	72%	58%	72%	49%	83%	74%	37%	47%	65%	43%	66%	
Mumbai	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	57%	75%	67%	65%	66%	69%	68%	65%	60%	59%	62%	61%	66%	63%	67%	64%	68%	66%	68%	67%	69%	68%	67%	
Tamenglong	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	135%	0%	0%	270%	0%	0%	0%	0%	54%	0%	270%	180%	102%	92%	119%	84%	160%	157%	108%	40%	1%	1%	88%	
Thoubal	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	0%	0%	313%	104%	89%	60%	70%	37%	104%	170%	99%	43%	93%	63%	78%	66%	103%	144%	88%	96%	80%	61%	83%	
Tuensang	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	20%	27%	71%	76%	72%	114%	72%	32%	70%	85%	92%	73%	61%	78%	76%	49%	59%	74%	39%	36%	114%	48%	65%	
Anantpur	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	73%	67%	79%	73%	84%	83%	90%	92%	74%	72%	82%	73%	85%	80%	86%	84%	82%	85%	83%	80%	82%	81%	82%	
Churachandpur	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	0%	0%	0%	141%	106%	156%	60%	100%	69%	55%	92%	87%	85%	83%	80%	70%	83%	77%	86%	76%	79%	84%	80%	
Kurnool	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	50%	43%	71%	60%	65%	66%	55%	71%	61%	56%	65%	57%	67%	65%	65%	61%	66%	69%	64%	62%	76%	83%	57%	
Nellore	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	40%	71%	27%	73%	60%	55%	62%	67%	55%	55%	51%	49%	63%	60%	63%	58%	64%	62%	61%	63%	61%	63%	61%	
Prakasam	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	75%	133%	69%	86%	81%	82%	70%	65%	66%	62%	65%	58%	67%	65%	69%	66%	70%	67%	68%	70%	71%	69%	69%	
Srikakulam	COP 20	Scale-up: Aggressive	APR, 21	0%	0%		0%	94%	83%	73%	79%	64%	66%	64%	68%	68%	59%	73%	67%	70%	69%	74%	68%	71%	72%	67%	68%	70%	
Ukhrul	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	197%	0%	0%	786%	91%	0%	87%	0%	76%	0%	218%	370%	172%	188%	155%	109%	87%	163%	73%	24%	1%	1%	89%	
Visakhapatnam	COP 20	Scale-up: Aggressive	APR, 21	0%	0%	32%	100%	86%	69%	72%	81%	59%	73%	66%	70%	77%	66%	79%	66%	76%	74%	75%	74%	74%	74%	74%	72%	72%	74%

Vizianagra	COP 20	Scale-up: Aggressive	APR, 21	0 %	0%		300 %	48 %	94 %	76 %	80 %	80 %	69 %	72 %	62 %	74 %	68 %	76 %	71 %	75 %	75 %	73 %	78 %	70 %	73 %	76 %	75 %	74%
West Godavari	COP 20	Scale-up: Aggressive	APR, 21	0 %	0%	33 %	67 %	75 %	83 %	80 %	86 %	65 %	72 %	68 %	60 %	67 %	57 %	74 %	67 %	72 %	68 %	71 %	71 %	69 %	68 %	63 %	66 %	68%
YSR	COP 20	Scale-up: Aggressive	APR, 21	0 %	0%	75 %	0%	44 %	83 %	72 %	59 %	67 %	79 %	62 %	57 %	72 %	63 %	70 %	69 %	73 %	70 %	69 %	72 %	70 %	68 %	81 %	88 %	80%
Wokha	COP 20	Scale-up: Aggressive	APR, 21	0 %	0%	19 %	9%	33 %	40 %	47 %	0%	0%	0%	57 %	242 %	42 %	126 %	78 %	36 %	63 %	52 %	58 %	74 %	14 %	54 %	25 %	51 %	52%

KAZAKHSTAN

					Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall																										
					Treatment Coverage at APR by Age and Sex																										
Country name	SNU	COP	Prioritization	Results Reported	<1		1-4		5-10		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
Kazakhstan	East Kazakhstan	COP15	Sustained	APR16										75%		22%	22%	34%	24%	35%	33%	36%	39%	36%	39%	51%	43%	45%	41%	36%	
Kazakhstan		COP 16	Sustained	APR 17										60%		54%	33%	55%	40%	56%	42%	49%	50%	49%	50%	63%	50%	55%	52%	49%	
Kazakhstan		COP 17	Sustained	APR 18										75%	100%	77%	57%	64%	53%	68%	50%	54%	53%	55%	56%	68%	55%	68%	54%	57%	
Kazakhstan		COP 18	Sustained	APR19										75%	100%	63%	65%	58%	54%	64%	52%	58%	57%	59%	58%	66%	56%	62%	56%	58%	
Kazakhstan		COP 19	Sustained	APR 20										60%	50%	65%	66%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%
Kazakhstan		COP 20	Sustained	APR 21										82%	100%	78%	79%	74%	75%	75%	68%	74%	72%	78%	68%	77%	68%	76%	66%	72%	
Kazakhstan	Pavlodar	COP15	Sustained	APR16										38%		10%	11%	17%	12%	27%	18%	31%	21%	28%	21%	38%	27%	39%	25%	24%	
Kazakhstan		COP 16	Sustained	APR 17										67%	100%	21%	29%	39%	19%	43%	26%	46%	34%	43%	34%	51%	34%	59%	36%	37%	
Kazakhstan		COP 17	Sustained	APR 18										67%		53%	100%	62%	45%	54%	41%	59%	46%	60%	47%	60%	50%	65%	48%	52%	
Kazakhstan		COP 18	Sustained	APR19										60%	67%	63%	50%	61%	47%	55%	47%	51%	44%	55%	47%	62%	53%	62%	53%	51%	
Kazakhstan		COP 19	Sustained	APR 20										67%	67%	63%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%	62%
Kazakhstan		COP 20	Sustained	APR 21										100%	100%	78%	82%	75%	64%	73%	66%	69%	66%	72%	67%	74%	68%	74%	70%	69%	
Kazakhstan	Akmola	COP15	Sustained	APR16										100%		0%	33%	42%	21%	44%	29%	35%	32%	33%	46%	58%	34%	52%	40%	37%	
Kazakhstan		COP 16	Sustained	APR 17												100%	83%	61%	61%	56%	50%	55%	24%	59%	32%	75%	43%	58%	22%	46%	
Kazakhstan		COP 17	Sustained	APR 18										100%		69%	57%	64%	55%	74%	51%	70%	69%	57%	59%	64%	64%	69%	59%	63%	
Kazakhstan		COP 18	Sustained	APR19										100%		93%	71%	68%	67%	81%	69%	72%	66%	75%	69%	77%	67%	81%	64%	71%	
Kazakhstan		COP 19	Sustained	APR 20										67%		79%	79%	75%	74%	75%	75%	75%	75%	74%	74%	73%	74%	74%	74%	74%	
Kazakhstan		COP 20	Sustained	APR 21										75%		82%	75%	74%	73%	77%	67%	76%	72%	76%	66%	75%	65%	77%	65%	71%	
Kazakhstan	Aktobe	COP15	Sustained	APR16										0%	0%	0%	40%	52%	9%	32%	32%	32%	26%	58%	25%	33%	28%	33%	23%	30%	
Kazakhstan		COP 16	Sustained	APR 17												100%	83%	61%	61%	56%	50%	55%	24%	59%	32%	75%	43%	58%	22%	46%	
Kazakhstan		COP 17	Sustained	APR 18												100%	50%	80%	82%	67%	71%	59%	58%	36%	81%	38%	71%	43%	62%	15%	54%
Kazakhstan		COP 18	Sustained	APR19												100%	40%	67%	68%	59%	58%	57%	60%	38%	61%	35%	54%	37%	63%	29%	50%
Kazakhstan		COP 19	Sustained	APR 20												100%	60%	56%	63%	59%	60%	61%	60%	60%	61%	60%	62%	60%	63%	59%	61%
Kazakhstan		COP 20	Sustained	APR 21												100%		67%	80%	76%	69%	65%	65%	69%	59%	68%	56%	76%	52%	68%	60%
Kazakhstan	Almaty Oblast	COP15	Sustained	APR16										50%	67%	19%	39%	28%	22%	32%	23%	33%	32%	43%	27%	30%	34%	26%	34%	30%	

KYRGYZ REPUBLIC

					Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall																								
					Treatment Coverage at APR by Age and Sex																								
Country name	SNU	COP	Prioritization	Results Reported	<1		1-4		5-10		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	
Kyrgyz Republic	Bishkek city	COP 15	Scale-Up Aggressive	16-Apr									33%	67%	23%	30%	27%	20%	24%	21%	25%	21%	27%	17%	30%	15%	34%	20%	22%
Kyrgyz Republic	Bishkek city	COP 16	Scale-Up Aggressive	17-Apr									33%	60%	41%	27%	33%	28%	26%	28%	31%	22%	31%	23%	34%	25%	42%	22%	27%
Kyrgyz Republic	Bishkek city	COP 17	Scale-Up Aggressive	18-Apr									0%	44%	35%	36%	33%	32%	32%	34%	34%	24%	32%	27%	41%	23%	37%	24%	30%
Kyrgyz Republic	Bishkek city	COP 18	Scale-Up Aggressive	19-Apr									33%	44%	35%	33%	37%	30%	37%	31%	40%	28%	36%	31%	40%	27%	34%	21%	31%
Kyrgyz Republic	Bishkek city	ROP 19	Scale-Up Aggressive	20-Apr									67%	77%	74%	75%	76%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
Kyrgyz Republic	Chui oblast	COP 15	Scale-Up Aggressive	16-Apr									14%	0%	31%	16%	39%	25%	32%	27%	34%	28%	34%	30%	32%	30%	36%	27%	30%
Kyrgyz Republic	Chui oblast	COP 16	Scale-Up Aggressive	17-Apr									33%	0%	33%	44%	45%	36%	39%	34%	44%	32%	42%	34%	35%	35%	44%	32%	36%
Kyrgyz Republic	Chui oblast	COP 17	Scale-Up Aggressive	18-Apr									57%		49%	45%	49%	42%	46%	41%	43%	38%	47%	40%	40%	40%	47%	38%	42%
Kyrgyz Republic	Chui oblast	COP 18	Scale-Up Aggressive	19-Apr									100%	0%	53%	44%	55%	33%	41%	38%	48%	35%	48%	35%	41%	39%	44%	36%	40%
Kyrgyz Republic	Chui oblast	ROP 19	Scale-Up Aggressive	20-Apr									67%		79%	79%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Kyrgyz Republic	Osh city	COP 15	Scale-Up Aggressive	16-Apr									0%	50%	50%	50%	42%	26%	47%	27%	39%	27%	42%	25%	37%	20%	42%	24%	32%
Kyrgyz Republic	Osh city	COP 16	Scale-Up Aggressive	17-Apr									33%	33%	55%	46%	51%	33%	47%	37%	49%	25%	49%	33%	43%	24%	42%	28%	37%
Kyrgyz Republic	Osh city	COP 17	Scale-Up Aggressive	18-Apr									44%	75%	54%	67%	62%	53%	52%	43%	57%	36%	56%	41%	48%	37%	55%	37%	47%
Kyrgyz Republic	Osh city	COP 18	Scale-Up Aggressive	19-Apr									61%	61%	50%	50%	55%	61%	59%	48%	57%	52%	61%	52%	61%	49%	55%	44%	54%
Kyrgyz Republic	Osh city	ROP 19	Scale-Up Aggressive	20-Apr									76%	76%	76%	75%	77%	78%	78%	78%	77%	78%	78%	78%	77%	78%	77%	78%	77%
Kyrgyz Republic	Osh oblast	COP 15	Scale-Up Aggressive	16-Apr									40%	57%	54%	43%	41%	50%	47%	27%	49%	22%	33%	26%	33%	31%	44%	26%	37%
Kyrgyz Republic	Osh oblast	COP 16	Scale-Up Aggressive	17-Apr									20%	55%	57%	55%	49%	46%	54%	32%	53%	39%	52%	40%	47%	31%	54%	33%	46%
Kyrgyz Republic	Osh oblast	COP 17	Scale-Up Aggressive	18-Apr									38%	63%	68%	57%	50%	42%	57%	40%	56%	31%	53%	41%	53%	33%	57%	33%	48%
Kyrgyz Republic	Osh oblast	COP 18	Scale-Up Aggressive	19-Apr									63%	64%	52%	56%	47%	40%	59%	42%	58%	33%	52%	37%	53%	35%	60%	31%	49%
Kyrgyz Republic	Osh oblast	ROP 19	Scale-Up Aggressive	20-Apr									79%	80%	82%	80%	81%	80%	80%	81%	81%	81%	80%	81%	81%	81%	81%	79%	80%
Kyrgyz Republic	Talas oblast	COP 15	Scale-Up Aggressive	16-Apr									0%		0%		20%	20%	10%	0%	27%	27%	0%	40%	0%	33%	50%		20%
Kyrgyz Republic	Talas oblast	COP 16	Scale-Up Aggressive	17-Apr											67%		25%	25%	8%	0%	0%	25%	36%	38%	33%	33%	50%	50%	25%
Kyrgyz Republic	Talas oblast	COP 17	Scale-Up Aggressive	18-Apr											33%		67%	67%	18%	25%	17%	22%	27%	17%	50%	38%	33%	67%	31%
Kyrgyz Republic	Talas oblast	COP 18	Scale-Up Aggressive	19-Apr											100%		75%	67%	50%	67%	43%	20%	46%	44%	33%	57%		75%	44%
Kyrgyz Republic	Talas oblast	ROP 19	Scale-Up Aggressive	20-Apr											100%		75%	67%	63%	56%	71%	60%	62%	56%	67%	71%		75%	61%

Kyrgyz Republic	Bishkek city	ROP20	Scale-Up Aggressive	21-Apr											100%	82%	78%	73%	65%	72%	70%	62%	58%	53%	64%	55%	67%	51%	65%	51%		60%
Kyrgyz Republic	Chui oblast	ROP20	Scale-Up Aggressive	21-Apr											100%	50%	72%	73%	80%	68%	76%	58%	69%	59%	72%	51%	72%	58%	69%	54%		62%
Kyrgyz Republic	Osh city	ROP20	Scale-Up Aggressive	21-Apr											87%	83%	80%	25%	68%	75%	67%	55%	86%	65%	70%	47%	69%	43%	73%	50%		62%
Kyrgyz Republic	Osh oblast	ROP20	Scale-Up Aggressive	21-Apr											91%	95%	100%	100%	82%	83%	78%	76%	88%	53%	88%	58%	81%	70%	76%	58%		80%
Kyrgyz Republic	Talas oblast	ROP20	Scale-Up Aggressive	21-Apr												100%	67%	100%	86%	67%	55%	82%	36%	50%	77%	50%	50%	57%	67%	83%		62%

LAOS

Attained: 90-90-90 (81%) by Each Age and sex Band to Reach 95-95-95 (90%) Overall

Treatment Coverage at APR by Age and Sex

Prioritization	Results Reported	<1		1-4		5-10		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	
		Scale-up: Aggressive	APR 22			75%	100%	70%	40%	133%	100%	50%	67%	34%	76%	69%	94%	43%	67%	64%	59%	61%	48%	62%	59%	
Scale-up: Aggressive	APR 22				100%	100%	100%	100%	0%	0%		71%	83%	54%	14%	50%	75%	58%	23%	86%	56%	75%	125%	200%	56%	79%
Scale-up: Aggressive	APR 22			50%	46%	100%	83%	67%	200%	38%	100%	46%	47%	69%	51%	55%	42%	67%	56%	63%	64%	50%	63%	58%	65%	74%
Scale-up: Aggressive	APR 22			50%	50%	86%	42%	60%	91%	100%	50%	43%	76%	57%	57%	54%	57%	62%	54%	64%	58%	65%	60%	66%	58%	76%
Scale-up: Aggressive	APR 22	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%
Scale-up: Aggressive	APR 23			63%	22%	78%	78%	138%	156%	44%	67%	55%	64%	45%	69%	67%	61%	71%	54%	81%	60%	87%	75%	85%	100%	68%
Scale-up: Aggressive	APR 23			0	50%	0	250%	50%	150%	100%	200%	44%	29%	124%	50%	73%	67%	91%	27%	65%	88%	45%	31%	36%	60%	63%
Scale-up: Aggressive	APR 23			83%	133%	50%	150%	50%	50%	100%	78%	88%	39%	136%	62%	72%	69%	67%	52%	38%	49%	50%	42%	29%	78%	64%
Scale-up: Aggressive	APR 23			14%	13%	67%	44%	57%	80%	50%	59%	19%	46%	30%	28%	52%	26%	53%	37%	69%	64%	107%	94%	110%	120%	55%
Scale-up: Aggressive	APR 23			38%	19%	62%	56%	76%	75%	43%	72%	48%	69%	63%	68%	65%	60%	53%	50%	50%	50%	44%	50%	69%	85%	59%

Papua New Guinea

Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall

Country name	SNU	COP	Prioritization	Results Reported	<15		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	
					Papua New Guinea	NCD	COP 19	Sustained	APR 20	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	
Papua New Guinea	NCD	COP 20	Sustained	APR 21	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Papua New Guinea	NCD	COP 21	Sustained	APR 22	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Note: PNG does not have disaggregated data for the respective age groups and performed a flat distribution with the top-line overall TX coverage.

TAJIKISTAN

Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall

Treatment Coverage at APR by Age and Sex

Country name	SNU	COP	Prioritization	Results Reported	Treatment Coverage at APR by Age and Sex																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	
Tajikistan	Dushanbe	COP15	Scale-up: Aggressive	APR16	26%	21%	36%	41%	15%	23%	25%	17%	32%	20%	40%	21%	50%	24%	61%	34%	26%
Tajikistan	Dushanbe	COP16	Scale-up: Aggressive	APR17	37%	63%	56%	48%	20%	30%	35%	25%	47%	26%	42%	26%	65%	30%	61%	40%	33%
Tajikistan	Dushanbe	COP17	Scale-up: Aggressive	APR18	52%	65%	80%	39%	27%	30%	42%	30%	51%	37%	55%	35%	66%	40%	68%	51%	42%
Tajikistan	Dushanbe	COP18	Scale-up: Aggressive	APR19	89%	70%	57%	47%	37%	40%	51%	41%	55%	48%	66%	42%	68%	49%	70%	59%	51%
Tajikistan	Dushanbe	COP19	Scale-up: Aggressive	APR20	74%	92%	79%	43%	47%	55%	59%	54%	64%	60%	70%	55%	68%	53%	65%	63%	60%
Tajikistan	Dushanbe	COP20	Scale-up: Aggressive	APR21	62%	67%	59%	64%	61%	60%	64%	56%	63%	57%	62%	54%	61%	49%	65%	49%	58%
Tajikistan	DRS	COP15	Scale-up: Aggressive	APR16	35%	39%	22%	31%	14%	27%	31%	32%	47%	27%	58%	39%	47%	55%	73%	63%	36%
Tajikistan	DRS	COP16	Scale-up: Aggressive	APR17	55%	46%	32%	40%	20%	37%	30%	38%	53%	31%	47%	40%	62%	55%	72%	72%	40%
Tajikistan	DRS	COP17	Scale-up: Aggressive	APR18	58%	58%	29%	51%	28%	35%	33%	38%	57%	36%	49%	44%	64%	52%	62%	70%	43%
Tajikistan	DRS	COP18	Scale-up: Aggressive	APR19	59%	64%	43%	47%	35%	38%	39%	44%	60%	44%	50%	44%	61%	47%	65%	68%	47%
Tajikistan	DRS	COP19	Scale-up: Aggressive	APR20	56%	70%	46%	42%	44%	43%	43%	50%	54%	46%	48%	46%	56%	51%	57%	57%	49%
Tajikistan	DRS	COP20	Scale-up: Aggressive	APR21	68%	68%	64%	66%	66%	62%	67%	58%	68%	59%	64%	58%	63%	59%	66%	63%	63%
Tajikistan	Sogd	COP15	Scale-up: Aggressive	APR16	24%	55%	18%	33%	27%	22%	29%	53%	39%	38%	55%	36%	92%	43%	92%	99%	43%
Tajikistan	Sogd	COP16	Scale-up: Aggressive	APR17	56%	75%	22%	50%	31%	28%	35%	52%	51%	41%	50%	44%	90%	48%	87%	78%	48%
Tajikistan	Sogd	COP17	Scale-up: Aggressive	APR18	72%	57%	23%	44%	33%	32%	40%	54%	51%	46%	57%	49%	75%	51%	80%	75%	51%
Tajikistan	Sogd	COP18	Scale-up: Aggressive	APR19	47%	62%	33%	37%	42%	45%	49%	50%	48%	54%	63%	49%	71%	53%	62%	69%	54%
Tajikistan	Sogd	COP19	Scale-up: Aggressive	APR20	64%	56%	53%	45%	47%	49%	52%	52%	55%	60%	60%	56%	69%	56%	61%	63%	57%
Tajikistan	Sogd	COP20	Scale-up: Aggressive	APR21	68%	68%	68%	68%	63%	64%	65%	66%	65%	64%	65%	62%	65%	61%	64%	65%	64%
Tajikistan	Khatlon	COP15	Scale-up: Aggressive	APR16	35%	39%	23%	33%	18%	28%	31%	25%	62%	33%	54%	38%	45%	38%	83%	63%	37%
Tajikistan	Khatlon	COP16	Scale-up: Aggressive	APR17	55%	40%	34%	40%	24%	36%	34%	31%	58%	43%	64%	53%	48%	47%	90%	67%	44%
Tajikistan	Khatlon	COP17	Scale-up: Aggressive	APR18	63%	44%	40%	57%	26%	42%	39%	35%	61%	49%	73%	59%	51%	46%	79%	76%	49%
Tajikistan	Khatlon	COP18	Scale-up: Aggressive	APR19	69%	51%	53%	45%	35%	49%	44%	44%	65%	54%	67%	63%	60%	49%	66%	70%	54%
Tajikistan	Khatlon	COP19	Scale-up: Aggressive	APR20	79%	91%	58%	49%	45%	55%	47%	46%	62%	57%	69%	64%	57%	58%	64%	65%	58%

Tajikistan	Khatlon	COP20	Scale-up: Aggressive	APR21	59%	64%	57%	47%	55%	49%	54%	51%	56%	49%	55%	48%	58%	48%	59%	51%	53%
Tajikistan	GBAO	COP15	Scale-up: Aggressive	APR16	32%	17%	33%	8%	24%	33%	21%	28%	28%	13%	29%	18%	83%	27%	44%	38%	27%
Tajikistan	GBAO	COP16	Scale-up: Aggressive	APR17	41%	14%	22%	22%	56%	20%	26%	37%	45%	22%	28%	24%	46%	37%	43%	44%	33%
Tajikistan	GBAO	COP17	Scale-up: Aggressive	APR18	67%	33%	19%	29%	41%	57%	38%	32%	41%	28%	41%	34%	96%	43%	50%	46%	41%
Tajikistan	GBAO	COP18	Scale-up: Aggressive	APR19	67%	75%	37%	12%	53%	56%	37%	53%	47%	36%	56%	41%	75%	52%	60%	60%	50%
Tajikistan	GBAO	COP19	Scale-up: Aggressive	APR20	89%	45%	45%	45%	64%	74%	47%	49%	53%	42%	61%	52%	67%	58%	64%	59%	56%
Tajikistan	GBAO	COP20	Scale-up: Aggressive	APR21	68%	68%	68%	68%	39%	49%	51%	59%	55%	54%	53%	48%	63%	50%	64%	46%	52%

Thailand	Nakhon Ratchasima	COP22	Centrally supported	APR 23			100%	71%	63%	86%	86%	68%	56%	58%	47%	59%	59%	70%	71%	85%	83%	96%	96%	102%	106%	108%	111%	93%
Thailand	Northaburi	COP22	Centrally supported	APR 23			100%	150%	114%	105%	100%	75%	64%	64%	53%	65%	65%	78%	79%	95%	92%	107%	106%	114%	118%	120%	123%	103%
Thailand	Pathum Thani	COP22	Scale-Up Saturation	APR 23			100%	10%	83%	81%	82%	58%	49%	50%	41%	51%	51%	61%	62%	74%	72%	84%	83%	89%	92%	94%	97%	81%
Thailand	Phuket	COP22	Centrally supported	APR 23			100%	10%	67%	88%	78%	64%	53%	54%	44%	54%	55%	66%	66%	80%	77%	90%	89%	96%	99%	101%	104%	87%
Thailand	Samut Prakan	COP22	Scale-Up Saturation	APR 23			100%	67%	88%	90%	90%	66%	55%	56%	46%	57%	57%	68%	68%	82%	80%	93%	92%	99%	102%	104%	107%	90%
Thailand	Songkhla	COP22	Scale-Up Saturation	APR 23			100%	10%	100%	87%	87%	64%	53%	55%	45%	55%	56%	66%	67%	80%	78%	91%	90%	97%	100%	102%	105%	88%
Thailand	Ubon Ratchathani	COP22	Scale-Up Saturation	APR 23			50%	10%	80%	86%	93%	64%	55%	55%	46%	57%	56%	67%	68%	81%	79%	92%	92%	98%	102%	103%	106%	89%
Thailand	Udon Thani	COP22	Sustained	APR 23			100%	10%	83%	93%	94%	67%	56%	57%	47%	59%	59%	70%	70%	85%	82%	95%	95%	102%	105%	107%	110%	93%

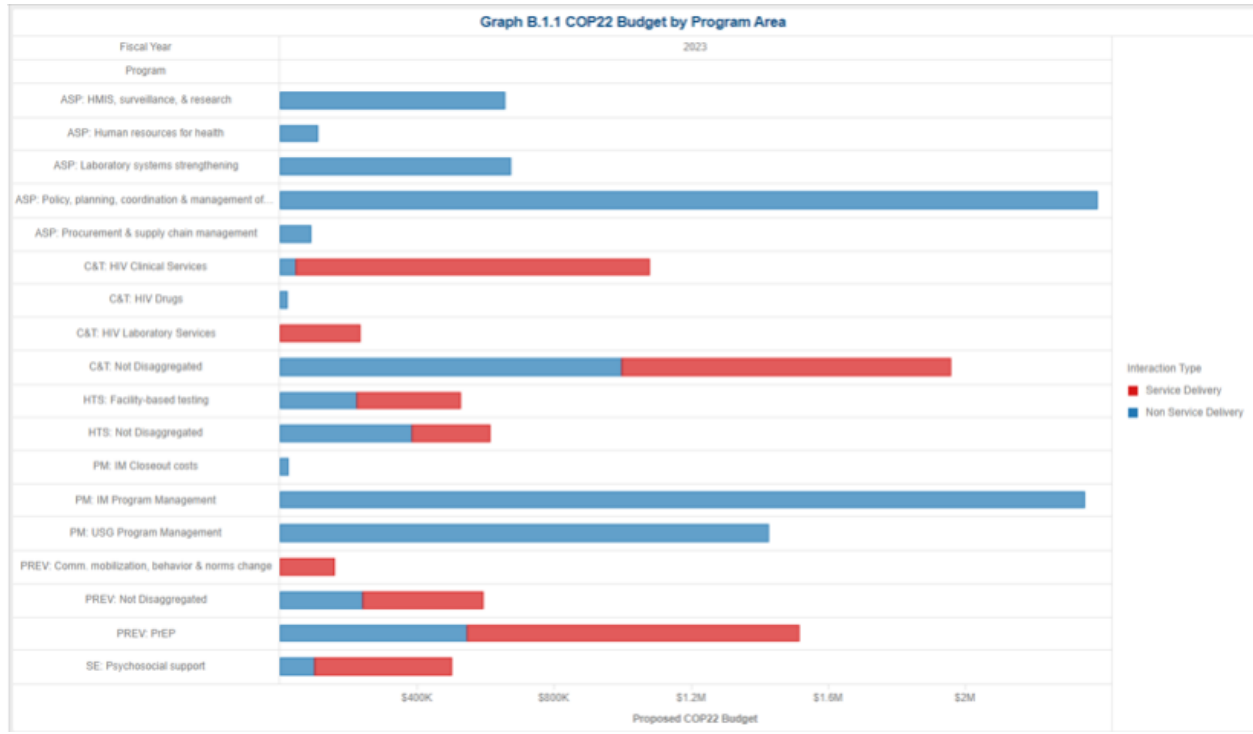
Thailand	Phitsanulok	CO P 22	Scale-Up Saturation	APR 23			100%	100%	50%	82%	75%	57%	50%	51%	41%	51%	51%	61%	61%	74%	72%	83%	83%	89%	92%	92%	95%	94%
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APPENDIX B – Budget Profile and Resource Projections REQUIRED

B1. COP22 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP22 Budget by Program Area

BURMA



Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget			
		Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total			\$10,276,669	\$4,633,331	\$14,910,000	69%	31%	100%
C&T	Total		\$1,062,998	\$2,228,105	\$3,291,103	32%	68%	100%
	HIV Clinical Services		\$45,000	\$1,033,590	\$1,078,590	4%	96%	100%
	HIV Drugs		\$20,811		\$20,811	100%		100%
	HIV Laboratory Services			\$233,742	\$233,742		100%	100%
	Not Disaggregated		\$997,187	\$960,773	\$1,957,960	51%	49%	100%
HTS	Total		\$611,083	\$524,970	\$1,136,053	54%	46%	100%
	Facility-based testing		\$224,987	\$299,983	\$524,970	43%	57%	100%
	Not Disaggregated		\$386,096	\$224,987	\$611,083	63%	37%	100%
PREV	Total		\$786,530	\$1,480,256	\$2,266,786	35%	65%	100%
	Comm. mobilization, behavior & norms change			\$158,828	\$158,828			100%
	Not Disaggregated		\$241,418	\$351,517	\$592,935	41%	59%	100%
PHEP			\$545,112	\$969,911	\$1,515,023	36%	64%	100%
	Total		\$100,000	\$400,000	\$500,000	20%	80%	100%
SE			\$100,000	\$400,000	\$500,000	20%	80%	100%
	Total		\$3,915,033		\$3,915,033	100%		100%
ASP	HMIS, surveillance, & research		\$654,533		\$654,533	100%		100%
	Human resources for health		\$110,000		\$110,000	100%		100%
	Laboratory systems strengthening		\$673,767		\$673,767	100%		100%
	Policy, planning, coordination & management of disease control programs		\$2,386,733		\$2,386,733	100%		100%
	Procurement & supply chain management		\$90,000		\$90,000	100%		100%
PM	Total		\$3,801,025		\$3,801,025	100%		100%
	IM Closeout costs		\$24,400		\$24,400	100%		100%
	IM Program Management		\$2,349,658		\$2,349,658	100%		100%
	USG Program Management		\$1,426,967		\$1,426,967	100%		100%

Metrics	Operating Unit	Proposed COP22 Budget		Total
		Applied Pipeline	New	
Total		\$1,160,848	\$13,749,152	\$14,910,000
Asia Region		\$1,160,848	\$13,749,152	\$14,910,000

Operating Unit	Metrics	Proposed COP22 Budget							Percent to Total							
		Beneficiary	C&T	HTS	PREV	SE	ASP	PM	Total	C&T	HTS	PREV	SE	ASP	PM	Total
Asia Region	Total		\$3,291,103	\$1,136,053	\$2,266,786	\$500,000	\$3,915,033	\$3,801,025	\$14,910,000	100%	100%	100%	100%	100%	100%	100%
	Key Pops		\$3,291,103	\$1,136,053	\$2,266,786	\$500,000	\$1,292,600	\$1,381,658	\$9,868,200	100%	100%	100%	100%	33%	36%	66%
	Non-Targeted Pop						\$2,622,433	\$2,419,367	\$5,041,800					67%	64%	34%

B.2 Resource Projections

PEPFAR has worked closely with country stakeholders to map key needs for the country and advocate for continued domestic support for ART and MMT after the political upheaval in the country. PEPFAR's contribution complements funding from the Global Fund and Access to Health toward the achievement of epidemic control, the National Strategic Plan and Interim HIV Action Plan. In ROP21, PEPFAR led a deduplication exercise with Global Fund to disentangle support for sites. Despite difficult circumstances, major donors, including PEPFAR, have come together to maximize programmatic impact of resources across donors.

CAMBODIA

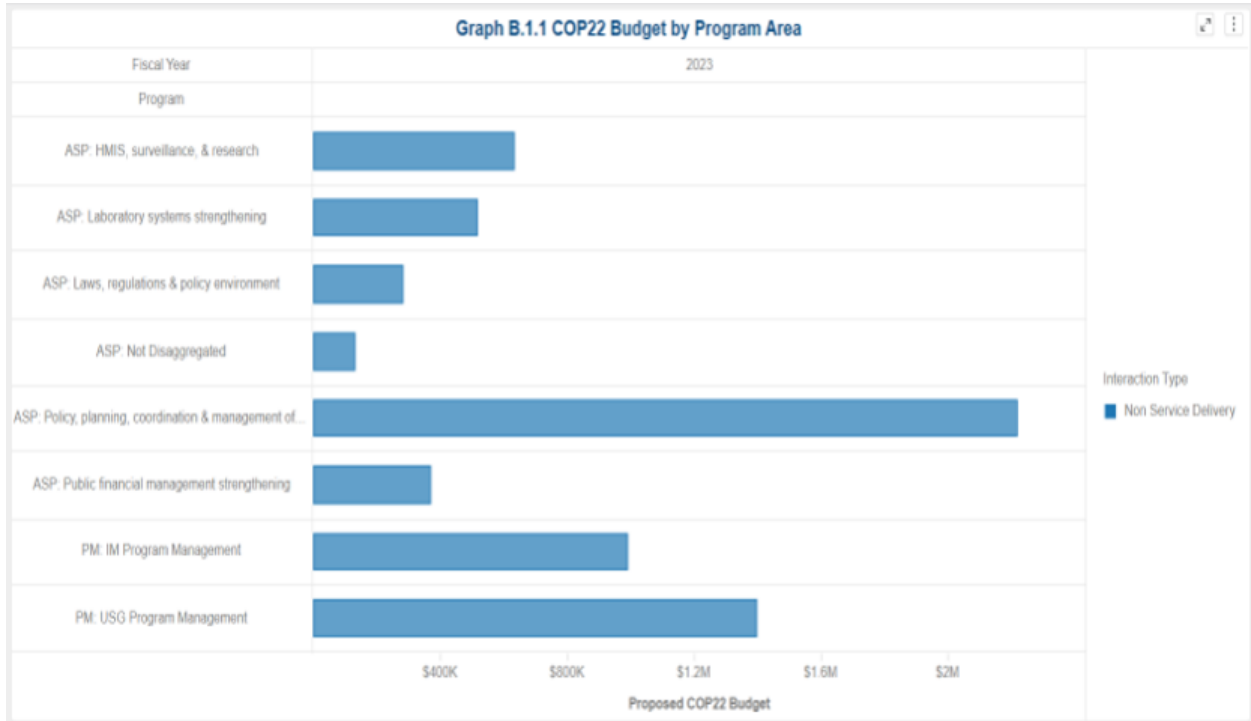


Table B.1.2 COP22 Budget by Program Area

Program	Metrics	Proposed COP22 Budget		Percent of Proposed COP 22 Budget	
	Sub-Program	Non Service Delivery	Total	Non Service Delivery	Total
Total		\$6,530,000	\$6,530,000	100%	100%
ASP	Total	\$4,144,218	\$4,144,218	100%	100%
	HMIS, surveillance, & research	\$629,973	\$629,973	100%	100%
	Laboratory systems strengthening	\$516,346	\$516,346	100%	100%
	Laws, regulations & policy environment	\$280,000	\$280,000	100%	100%
	Not Disaggregated	\$130,000	\$130,000	100%	100%
	Policy, planning, coordination & management of disease control programs	\$2,217,899	\$2,217,899	100%	100%
	Public financial management strengthening	\$370,000	\$370,000	100%	100%
PM	Total	\$2,385,782	\$2,385,782	100%	100%
	IM Program Management	\$990,000	\$990,000	100%	100%
	USG Program Management	\$1,395,782	\$1,395,782	100%	100%

Table B.1.3 COP22 Total Planning Level			
Metrics	Proposed COP22 Budget		
Operating Unit	Applied Pipeline	New	Total
Total	\$132,930	\$6,397,070	\$6,530,000
Asia Region	\$132,930	\$6,397,070	\$6,530,000

Table B.1.4: COP22 Resource Allocation by Program and Beneficiary							
Operating Unit	Metrics	Proposed COP22 Budget			Percent to Total		
	Beneficiary	ASP	PM	Total	ASP	PM	Total
Asia Region	Total	\$4,144,218	\$2,385,782	\$6,530,000	100%	100%	100%
	Key Pops	\$1,660,000	\$70,000	\$1,730,000	40%	3%	26%
	Non-Targeted Pop	\$2,484,218	\$2,315,782	\$4,800,000	60%	97%	74%

B.2 Resource Projections

Cambodia analyzed prior expenditures and agency needs for cost of doing business in order to allocate budget within the PLL funding level. Prioritized interventions were determined in consultation with the host government, development partners, civil society, and the private sector. The 2021 Resource Alignment Matrix provided additional information on partner focus areas. The current Global Fund grant's Funding Landscape provided the most up to date data on historical expenditures, future funding commitments, and anticipated resource gaps from the government and donors. The government of Cambodia has agreed to significantly increase its financial contribution, committing USD 19.7 million of its domestic resources for 3 years (2021-2023) as a co-financing commitment to the current global fund grant. More recent expenditure data was not available as NASA or NHA have not been conducted since 2019. The National HIV/AIDS joint program review was discussed and supported by the GF team who visited Cambodia the week of May 16. The review will guide PEPFAR Cambodia's resources, including any needed adjustments, to address key system barriers and focus on priority program areas.

INDIA

Graph B.1.1 COP 22 Budget by Program Area

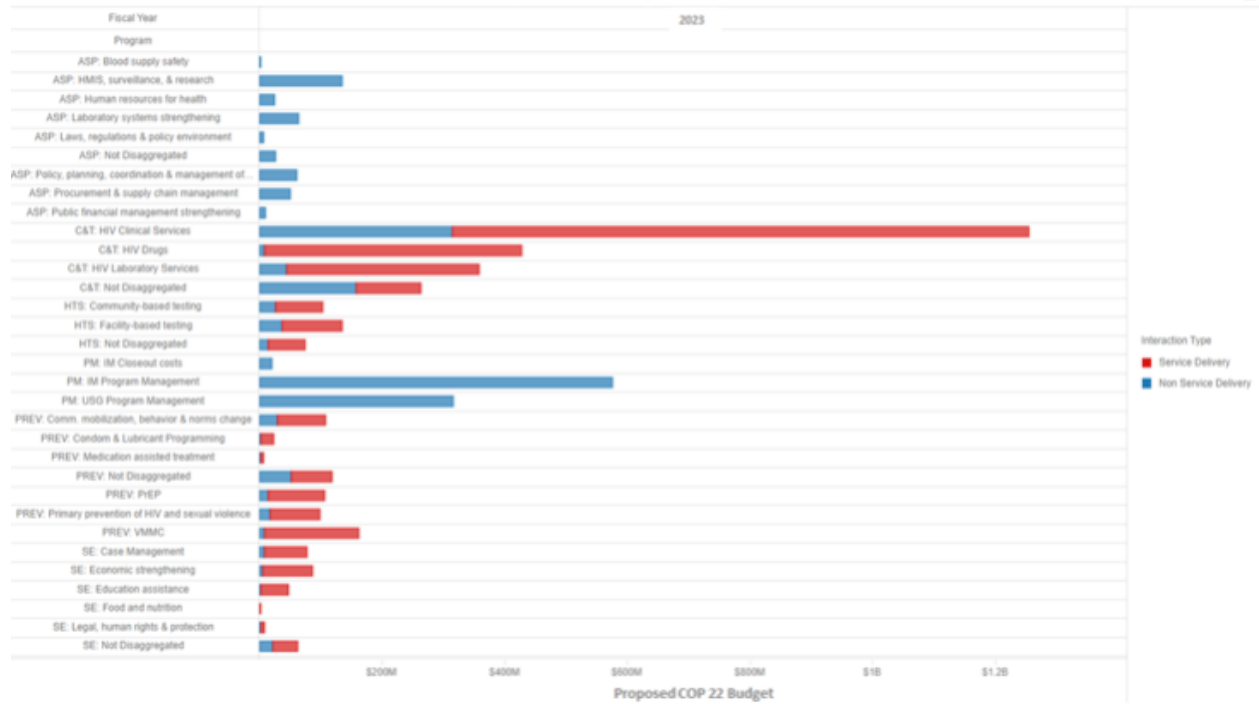


Table B.1.2 COP22 Budget by Program Area

Program	Memoranda Subprogram	Proposed COP 22 Budget			Percent of COP 22 Proposed Budget		
		Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		\$2,044,812,626	\$2,777,185,192	\$4,821,997,818	42%	58%	100%
C&T	Total	\$622,608,988	\$1,781,786,233	\$2,394,395,221	23%	77%	100%
	HIV Clinical Services	\$215,589,289	\$242,086,657	\$457,675,946	20%	75%	100%
	HIV Drugs	\$7,927,123	\$419,037,306	\$427,064,429	2%	66%	100%
	HIV Laboratory Services	\$43,661,247	\$214,356,530	\$258,017,777	12%	66%	100%
	Not Disaggregated	\$157,430,409	\$105,347,620	\$262,778,029	60%	40%	100%
HTS	Total	\$78,842,985	\$228,928,264	\$307,771,249	6%	76%	100%
	Community-based testing	\$25,336,175	\$77,074,482	\$102,410,657	33%	70%	100%
	Facility-based testing	\$36,773,836	\$96,213,297	\$133,087,133	27%	73%	100%
	Not Disaggregated	\$16,732,974	\$55,640,485	\$72,373,459	19%	82%	100%
PREV	Total	\$121,821,218	\$488,822,180	\$610,643,398	20%	60%	100%
	Comm. mobilization, behavior & norms change	\$25,145,179	\$77,856,627	\$103,001,806	27%	75%	100%
	Condom & Lubricant Programming	\$1,937,749	\$20,806,404	\$22,744,153	9%	91%	100%
	Medication assisted treatment	\$1,738,240	\$3,945,635	\$5,683,875	3%	69%	100%
	Not Disaggregated	\$94,000,051	\$87,139,709	\$181,139,760	43%	67%	100%
	PEP	\$13,712,040	\$92,324,278	\$106,036,318	13%	67%	100%
	Primary prevention of HIV and sexual violence	\$16,891,484	\$82,391,283	\$99,282,767	16%	84%	100%
	VMMC	\$8,208,438	\$102,958,543	\$111,166,981	8%	92%	100%
SE	Total	\$41,129,660	\$288,888,618	\$330,018,278	14%	86%	100%
	Case Management	\$8,127,304	\$25,100,080	\$33,227,384	11%	69%	100%
	Economic strengthening	\$4,594,036	\$21,743,488	\$26,337,524	8%	65%	100%
	Education assistance	\$1,339,980	\$44,898,289	\$46,238,269	3%	97%	100%
	Food and nutrition		\$185,260	\$185,260			100%
	Legal, human rights & protection	\$1,808,277	\$6,377,599	\$8,185,876	2%	77%	100%
	Not Disaggregated	\$20,586,723	\$45,927,138	\$66,513,861	34%	66%	100%
	Psychosocial support	\$4,590,708	\$17,430,636	\$22,021,344	2%	79%	100%

Budget by Program & Sub

Metrics	Amount			Percent to Total By Rows (Amount)		
Program and Sub	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total	\$1,975,138,514	\$2,834,744,354	\$4,809,882,868	41.06%	58.94%	100.00%
C&T: HIV Clinical Services	\$320,255,301	\$850,022,760	\$1,170,278,061	27.37%	72.63%	100.00%
PM: IM Program Management	\$571,014,001		\$571,014,001	100.00%		100.00%
C&T: HIV Drugs	\$7,973,952	\$464,102,163	\$472,076,115	1.69%	98.31%	100.00%
C&T: Not Disaggregated	\$167,049,032	\$185,552,061	\$352,601,093	47.38%	52.62%	100.00%
C&T: HIV Laboratory Services	\$37,135,737	\$305,376,923	\$342,512,660	10.84%	89.16%	100.00%
	\$188,386,289		\$188,386,289	100.00%		100.00%
PREV: VMMC	\$12,104,265	\$157,930,855	\$170,035,120	7.12%	92.88%	100.00%
ASP: HMIS, surveillance, & research	\$145,754,294		\$145,754,294	100.00%		100.00%
PREV: Not Disaggregated	\$35,668,957	\$104,414,121	\$140,083,078	25.46%	74.54%	100.00%
HTS: Facility	\$33,998,558	\$99,924,893	\$133,923,451	25.39%	74.61%	100.00%
PM: USG Program Management	\$120,574,504		\$120,574,504	100.00%		100.00%
PREV: Comm mobilization, behavior & norms change	\$16,455,050	\$101,063,890	\$117,518,940	14.00%	86.00%	100.00%
PREV: PrEP	\$10,624,347	\$89,175,929	\$99,800,276	10.65%	89.35%	100.00%
HTS: Community	\$15,262,387	\$74,030,345	\$89,292,732	17.09%	82.91%	100.00%
SE: Case Management	\$8,918,899	\$79,718,989	\$88,637,888	10.06%	89.94%	100.00%
SE: Economic strengthening	\$4,690,612	\$82,775,194	\$87,465,806	5.36%	94.64%	100.00%
HTS: Not Disaggregated	\$16,670,505	\$48,176,080	\$64,846,585	25.71%	74.29%	100.00%

Table B.1.3 COP22 Total Planning Level

Proposed COP22 Budget			Total
Applied Pipeline		New	
	\$35,474,602	\$384,625,398	\$420,100,000
	\$35,474,602	\$384,625,398	\$420,100,000

Table B.1.4: COP22 Resource Allocation by Program and Beneficiary

Program Beneficiary	C&T		HTS		PREV		SE		ASP		PM		Proposed COP22 Budget
	Proposed COP22 Budget	Percent to Total	Proposed COP22 Budget	Percent to Total	Proposed COP22 Budget	Percent to Total	Proposed COP22 Budget	Percent to Total	Proposed COP22 Budget	Percent to Total	Proposed COP22 Budget	Percent to Total	
Total	\$2,204,258,301	100%	\$211,482,244	100%	\$628,744,290	100%	\$201,808,175	100%	\$271,706,175	100%	\$911,090,610	100%	\$4,821,182,798
Females	\$70,856,535	3%	\$2,175,917	1%	\$178,308,507	28%	\$30,844,245	15%	\$6,000,761	2%	\$3,785,250	1%	\$260,084,218
Key Pop	\$78,045,957	3%	\$37,138,170	18%	\$81,306,415	13%	\$3,048,790	1%	\$20,775,881	8%	\$2,512,120	3%	\$254,016,491
Males	\$60,916,830	2%	\$9,552,463	4%	\$107,400,007	17%	\$1,800,060	0%	\$483,347	0%	\$14,000	0%	\$228,990,702
Non-Targeted Pop	\$1,990,696,393	90%	\$211,942,499	98%	\$122,442,721	20%	\$13,475,411	7%	\$333,127,958	90%	\$875,292,288	90%	\$3,646,047,848
CVC	\$8,054,251	0%	\$0,290,072	0%	\$16,432,741	3%	\$185,947,475	92%	\$2,896,470	1%	\$10,904,410	1%	\$228,928,619
Pregnant & Breastfeeding Women	\$62,771,363	3%	\$14,715,993	7%	\$12,098,423	2%			\$1,408,385	0%			\$92,055,164
Priority Pop	\$31,966,267	1%	\$11,560,130	5%	\$41,367,528	7%	\$4,891,254	2%	\$7,162,173	3%	\$12,582,467	1%	\$110,189,859

B.2 Resource Projections

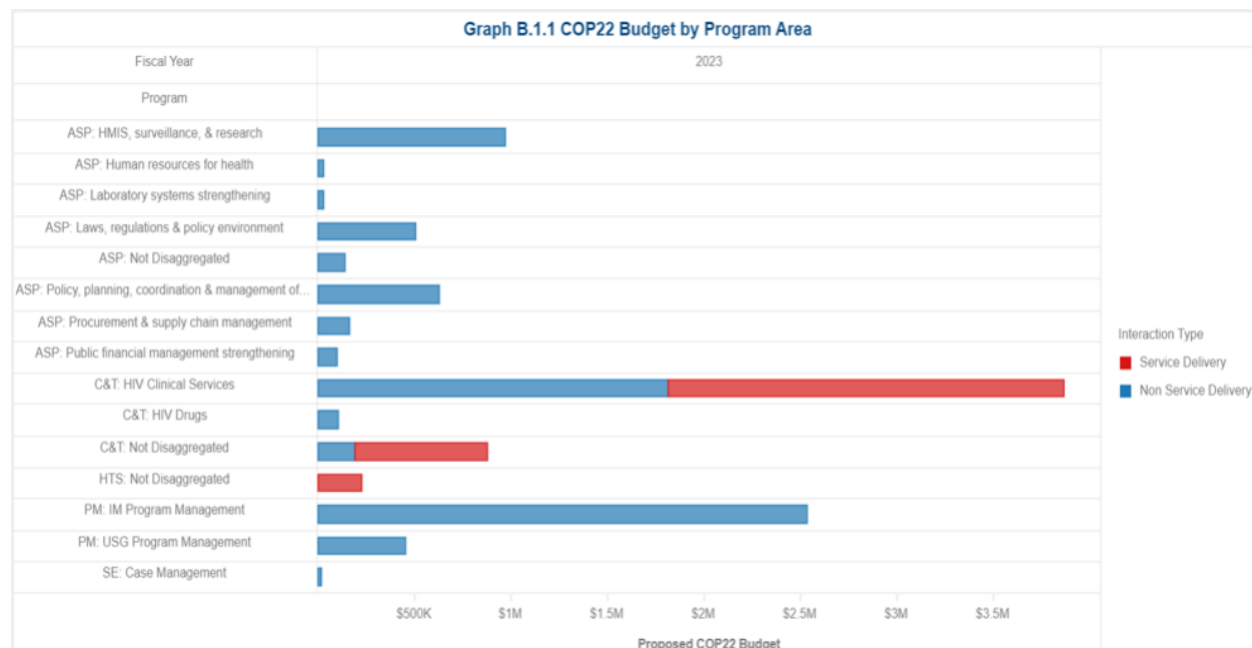
- PEPFAR India consulted with key stakeholders including the Government of India, communities and multilateral organizations including Global Fund partners to identify

key systems barriers (KSB) and prioritize activities and geographies. In addition, PEPFAR India reviewed data from the SID, MER indicators, and SIMS data along with other granular assessments to identify KSB and optimize resources.

- Table 6 investments leverage systems investments by the partner country government and other donor investments in three key ways: (1) closing the first 95 gap through a mix of comprehensive prevention and testing, with ongoing technical support for GOI one stop centers; (2) person-centered service delivery across the prevention to treatment cascade, including expanded viral load access, scaling proven, evidence-based strategies to decrease treatment interruption and (3) working with the GOI on the expanded focus on in strategic information, and cascade and epidemic monitoring towards 95-95-95 goals, including data quality and community led monitoring.
- The timelines and benchmarks were developed to support monitoring of progress on these investments. The GOI has prioritized digital health investments through ongoing investments in the SOCH platform. PEPFAR India will continue to partner with the GOI in this important priority to realize real time data for impact to strategically address program needs.
- PEPAR India used Resource Alignment Tool data to ensure coordination with Government of India and Global Fund investments and avoid duplication and overlap. The host government contribution to the HIV response is above 94% in India. With the approval of the National AIDS Control Program (NACP) Phase V, the next five years budget allocation is over \$2 billion USD. The Global Fund is the largest funding source in India, with the current budget of \$155 million, under the New Funding Model (2021-2024). The Global Fund supports ARVs procurement, and community system strengthening activities, and key population interventions in the virtual space. PEPFAR 's contribution to the total national investment is less than 5%.

INDONESIA

Graph B.1.1 COP22 Budget by Program Area



Program	Metrics Sub-Program	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
		Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		\$7,849,000	\$2,966,000	\$10,815,000	73%	27%	100%
C&T	Total	\$2,228,972	\$2,738,000	\$4,966,972	45%	55%	100%
	HIV Clinical Services	\$1,811,096	\$2,054,000	\$3,865,096	47%	53%	100%
	HIV Drugs	\$107,287	\$0	\$107,287	100%	0%	100%
	Not Disaggregated	\$310,589	\$684,000	\$994,589	31%	69%	100%
HTS	Total	\$0	\$228,000	\$228,000	0%	100%	100%
	Not Disaggregated	\$0	\$228,000	\$228,000	0%	100%	100%
SE	Total	\$38,266	\$0	\$38,266	100%	0%	100%
	Case Management	\$38,266	\$0	\$38,266	100%	0%	100%
ASP	Total	\$2,620,625	\$0	\$2,620,625	100%	0%	100%
	HMIS, surveillance, & research	\$888,445	\$0	\$888,445	100%	0%	100%
	Human resources for health	\$16,826	\$0	\$16,826	100%	0%	100%
	Laboratory systems strengthening	\$26,822	\$0	\$26,822	100%	0%	100%
	Laws, regulations & policy environment	\$563,422	\$0	\$563,422	100%	0%	100%
	Not Disaggregated	\$236,700	\$0	\$236,700	100%	0%	100%
	Policy, planning, coordination & management of disease control programs	\$625,420	\$0	\$625,420	100%	0%	100%
	Procurement & supply chain management	\$162,990	\$0	\$162,990	100%	0%	100%
	Public financial management strengthening	\$100,000	\$0	\$100,000	100%	0%	100%
PM	Total	\$2,961,137	\$0	\$2,961,137	100%	0%	100%
	IM Program Management	\$2,486,848	\$0	\$2,486,848	100%	0%	100%
	USG Program Management	\$474,289	\$0	\$474,289	100%	0%	100%

Table B.1.3 COP22 Total Planning Level

Metrics Operating Unit	Proposed COP22 Budget		
	Applied Pipeline	New	Total
Total	\$12,790	\$10,802,210	\$10,815,000
Asia Region	\$12,790	\$10,802,210	\$10,815,000

Table B.1.4: COP22 Resource Allocation by Program and Beneficiary

Operating Unit	Metrics	Proposed COP22 Budget						Percent to Total					
	Beneficiary	C&T	HTS	SE	ASP	PM	Total	C&T	HTS	SE	ASP	PM	Total
Asia Region	Total	\$4,966,972	\$228,000	\$38,266	\$2,620,625	\$2,961,137	\$10,815,000	100%	100%	100%	100%	100%	100%
	Key Pops	\$4,859,685	\$228,000		\$1,049,976	\$7,350	\$6,145,011	98%	100%		40%	0%	57%
	Non-Targeted Pop	\$107,287		\$38,266	\$1,570,649	\$2,953,787	\$4,669,989	2%		100%	60%	100%	43%

B.2 Resource Projections

Indonesia analyzed the results of the Responsibility Matrix, 2021 Sustainability Index Dashboard and the strategic direction provided in the PLL. In addition, PEPFAR Indonesia also synchronized the proposed priorities for ROP 22 with the approved 2022-2023 Funding Request of the GFATM. Furthermore, the MOH collects data on the spending for HIV program activities regularly from key actors such as national and sub-national government budgets, the GFATM, PEPFAR and other funders. This information was utilized to ensure synergistic and complementary investment to the MOH.

The Government of Indonesia (GOI) finances 95 per cent of HIV commodities (ARVs) and GFATM funds approximately five per cent for the procurement of pediatrics ARVs and ARV second-line drugs. The GFATM procures essential commodities, such as condoms and lubricants through the Ministry of Health and distributes them by its Community Principal Recipient. In the approved funding request for 2021-2023, GFATM prioritizes differentiated testing services, treatment, care and support, prevention, integration of TB and HIV, and addressing human barriers in priority 100 districts in Indonesia. PEPFAR resources in ROP 22 will be dedicated to further enhancing the service delivery for quality of care and treatment to achieve epidemic control in PEPFAR priority districts.

KAZAKHSTAN

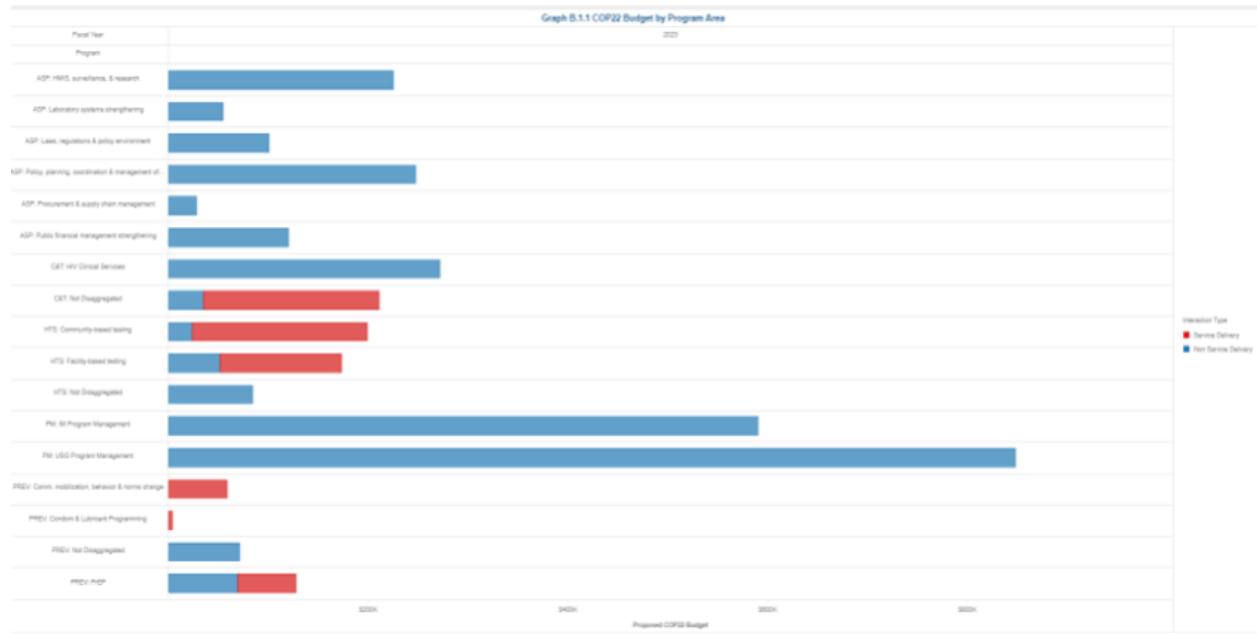


Table B.1.2 COP22 Budget by Program Area

Program	Metrics	Sub-Program	Proposed COP22 Budget			Percent of Proposed COP22 Budget		
			Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total			\$2,816,750	\$933,250	\$3,410,000	83%	17%	100%
C&T	Total		\$306,658	\$175,500	\$482,158	64%	36%	100%
	HIV Clinical Services		\$271,558		\$271,558	100%		100%
	Not Disaggregated		\$35,100	\$175,500	\$210,600	17%	83%	100%
HTS	Total		\$158,382	\$291,300	\$449,682	35%	65%	100%
	Community-based testing		\$23,400	\$175,500	\$198,900	12%	88%	100%
	Facility-based testing		\$91,207	\$121,800	\$213,007	30%	70%	100%
	Not Disaggregated		\$83,775		\$83,775	100%		100%
PREV	Total		\$139,884	\$120,450	\$260,334	54%	46%	100%
	Comm. mobilization, behavior & norms change			\$58,500	\$58,500	100%		100%
	Condom & Lubricant Programming			\$3,450	\$3,450	100%		100%
	Not Disaggregated		\$70,775		\$70,775	100%		100%
ASP	Total		\$773,747		\$773,747	100%		100%
	HMS, surveillance, & research		\$224,811		\$224,811	100%		100%
	Laboratory systems strengthening		\$54,207		\$54,207	100%		100%
	Laws, regulations & policy environment		\$100,000		\$100,000	100%		100%
	Policy planning, coordination & management of disease control programs		\$247,000		\$247,000	100%		100%
	Procurement & supply chain management		\$27,729		\$27,729	100%		100%
	Public financial management strengthening		\$120,000		\$120,000	100%		100%
	PEEP		\$89,109	\$58,500	\$147,609	54%	46%	100%
PM	Total		\$1,438,079		\$1,438,079	100%		100%
	IM Program Management		\$596,230		\$596,230	100%		100%
	USG Program Management		\$841,849		\$841,849	100%		100%

Table B.1.3 COP22 Total Planning Level

Metrics	Operating Unit	Applied Pipeline	Proposed COP22 Budget		Total
			Existing	New	
Total			\$264,358		\$3,145,641
Asia Region			\$264,358		\$3,145,641

Table B.1.4: COP22 Resource Allocation by Program and Beneficiary

Operating Unit	Metrics	Beneficiary	Proposed COP22 Budget					Total	Percent to Total				
			C&T	HTS	PREV	ASP	PM		C&T	HTS	PREV	ASP	PM
Asia Region	Total		\$482,158	\$465,682	\$293,334	\$773,747	\$1,438,079	\$3,410,000	100%	100%	100%	100%	100%
	Key Pops		\$210,880	\$345,400	\$291,259	\$32,759	\$111,700	\$801,718	44%	79%	77%	4%	1%
	Non-Targeted Pop		\$271,558	\$110,282	\$59,075	\$740,988	\$1,426,379	\$2,608,282	56%	24%	23%	96%	99%

B.2 Resource Projections

The national matrix of funding was used to analyze the expenditures within COP 21 and calculate the required resources to sustain program activities in COP22. The Kazakh Scientific

Center of Dermatology and Infectious Diseases (KSCDID) collects expenditures for HIV program activities annually for all major actors (i.e. Government of Kazakhstan, Global Fund, PEPFAR and UN agencies) as part of the Global AIDS Monitoring (GAM). National expenditure analysis ensures a proper resource alignment, avoiding duplication at all levels.

KYRGYZ REPUBLIC

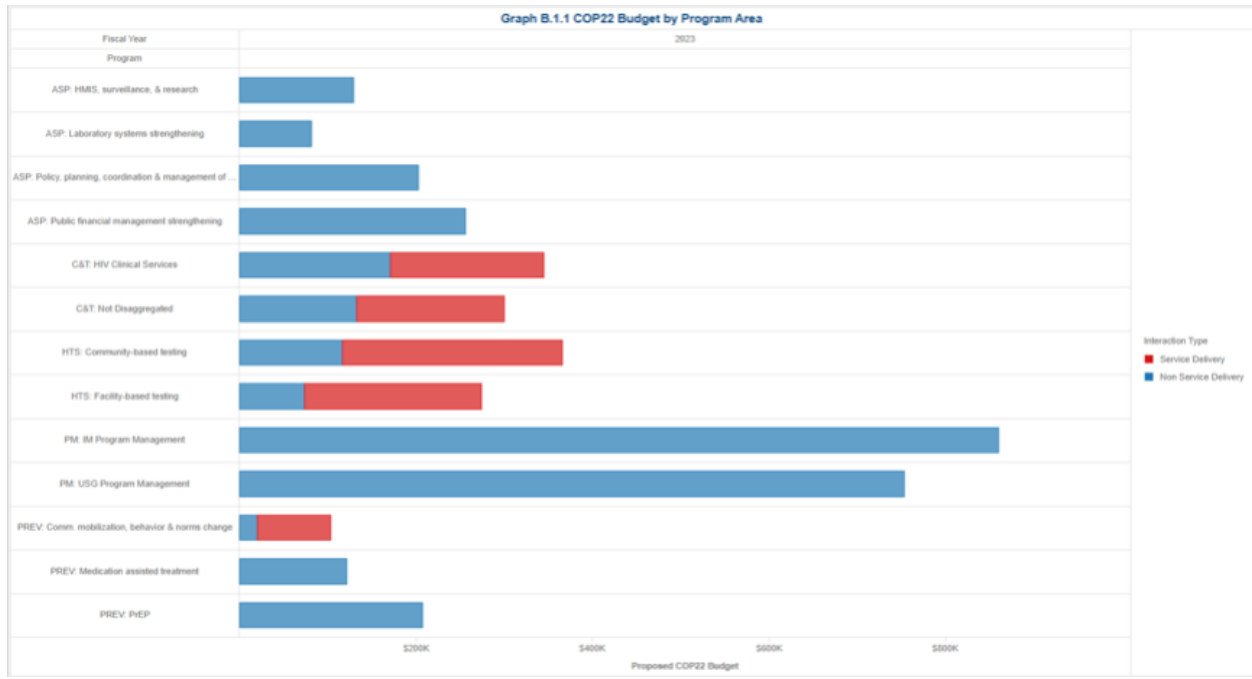


Table B.1.2 COP22 Budget by Program Area

Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget			
		Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total			\$1,122,192	\$872,808	\$3,995,000	78%	22%	100%
C&T	Total		\$304,000	\$339,425	\$643,425	47%	53%	100%
	HIV Clinical Services		\$171,000	\$173,175	\$344,175	50%	50%	100%
	Not Disaggregated		\$133,000	\$166,250	\$299,250	44%	56%	100%
HTS	Total		\$189,375	\$450,258	\$639,633	30%	70%	100%
	Community-based testing		\$116,375	\$249,375	\$365,750	32%	68%	100%
	Facility-based testing		\$73,000	\$200,883	\$273,883	27%	73%	100%
PREV	Total		\$348,458	\$83,125	\$431,583	81%	19%	100%
	Comm. mobilization, behavior & norms change		\$20,000	\$83,125	\$103,125	19%	81%	100%
	Medication assisted treatment		\$121,000		\$121,000	100%		100%
	PEP		\$207,458		\$207,458	100%		100%
ASP	Total		\$667,729		\$667,729	100%		100%
	HMS, surveillance, & research		\$128,854		\$128,854	100%		100%
	Laboratory systems strengthening		\$81,000		\$81,000	100%		100%
	Policy, planning, coordination & management of disease control programs		\$202,375		\$202,375	100%		100%
	Public financial management strengthening		\$255,500		\$255,500	100%		100%
PM	Total		\$1,612,630		\$1,612,630	100%		100%
	IM Program Management		\$859,830		\$859,830	100%		100%
	USG Program Management		\$752,800		\$752,800	100%		100%

Table B.1.3 COP22 Total Planning Level

Metrics	Proposed COP22 Budget			Total
	Operating Unit	Applied Pipeline	New	
Total			\$352,186	\$3,642,814
Asia Region			\$352,186	\$3,642,814

Table B.1.4: COP22 Resource Allocation by Program and Beneficiary

Operating Unit	Metrics	Proposed COP22 Budget						Percent to Total						
		Beneficiary	C&T	HTS	PREV	ASP	PM	Total	C&T	HTS	PREV	ASP	PM	Total
Asia Region	Total		\$643,425	\$639,633	\$431,583	\$667,729	\$1,612,630	\$3,995,000	100%	100%	100%	100%	100%	100%
	Key Pops		\$370,250	\$599,633	\$381,583	\$238,000	\$381,000	\$1,970,466	58%	94%	88%	36%	24%	49%
	Non-Targeted Pop		\$273,175	\$40,000	\$50,000	\$429,729	\$1,231,630	\$2,024,534	42%	6%	12%	64%	76%	51%

B.2 Resource Projections

The national matrix of funding was used to analyze the expenditures within COP 21 and calculate the required resources to sustain program activities in COP22. The Kyrgyz MOH is collecting the expenditures for HIV program activities annually for all actors as government budget, Global Fund, PEPFAR and other funders. National expenditure analysis ensures a proper resource alignment, avoiding duplication

LAOS

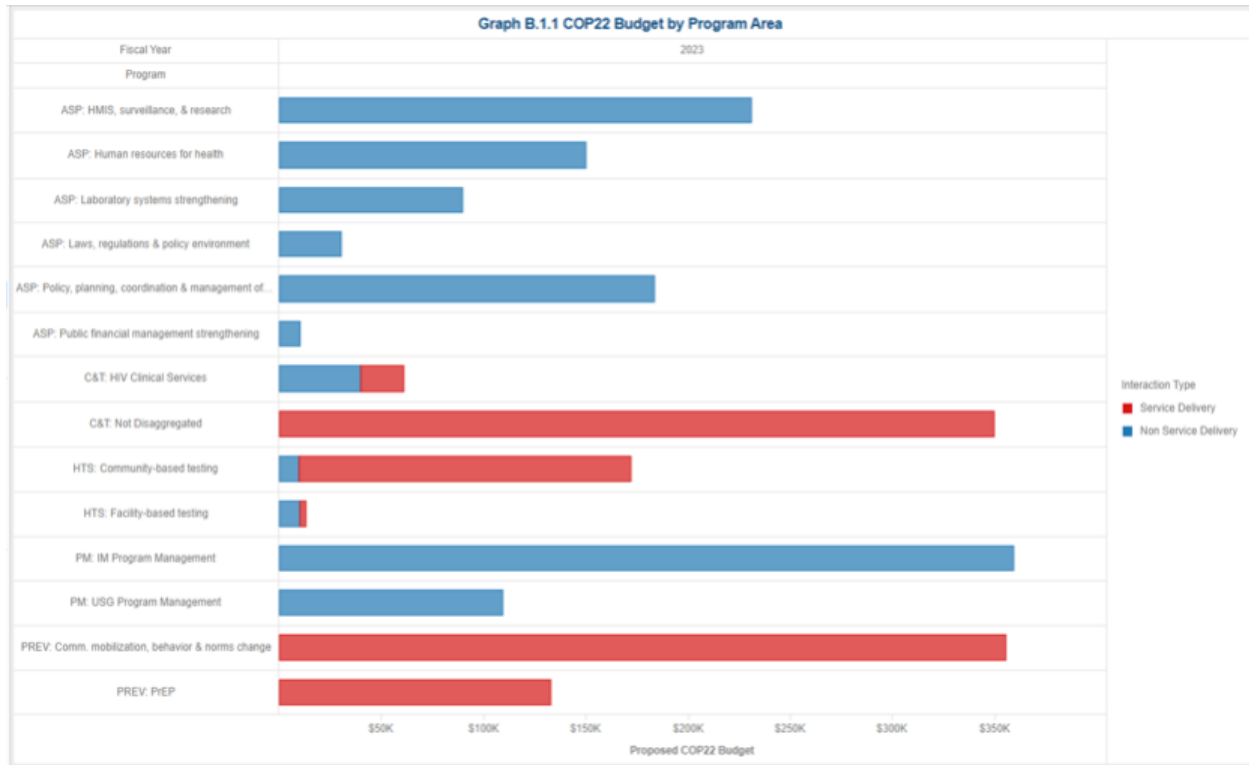


Table B.1.2 COP22 Budget by Program Area

Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
	Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		\$1,221,250	\$1,023,750	\$2,245,000	54%	46%	100%
C&T	Total	\$39,987	\$370,500	\$410,487	10%	90%	100%
	HIV Clinical Services	\$39,987	\$21,000	\$60,987	66%	34%	100%
	Not Disaggregated		\$349,500	\$349,500		100%	100%
HTS	Total	\$19,492	\$165,500	\$184,992	11%	89%	100%
	Community-based testing	\$9,492	\$162,500	\$171,992	6%	94%	100%
	Facility-based testing	\$10,000	\$3,000	\$13,000	77%	23%	100%
PREV	Total		\$487,750	\$487,750		100%	100%
	Comm. mobilization, behavior & norms change		\$355,250	\$355,250		100%	100%
	PrEP		\$132,500	\$132,500		100%	100%
ASP	Total	\$693,617		\$693,617	100%		100%
	HMIS, surveillance, & research	\$230,717		\$230,717	100%		100%
	Human resources for health	\$150,000		\$150,000	100%		100%
	Laboratory systems strengthening	\$89,494		\$89,494	100%		100%
	Laws, regulations & policy environment	\$30,000		\$30,000	100%		100%
	Policy, planning, coordination & management of disease control programs	\$183,406		\$183,406	100%		100%
	Public financial management strengthening	\$10,000		\$10,000	100%		100%
PM	Total	\$468,154		\$468,154	100%		100%
	IM Program Management	\$359,100		\$359,100	100%		100%
	USG Program Management	\$109,054		\$109,054	100%		100%

Metrics		Proposed COP22 Budget		
Operating Unit	Applied Pipeline	New		Total
Total	\$534,004	\$1,710,996		\$2,245,000
Asia Region	\$534,004	\$1,710,996		\$2,245,000

Operating Unit	Metrics	Proposed COP22 Budget						Percent to Total					
		Beneficiary	C&T	HTS	PREV	ASP	PM	Total	C&T	HTS	PREV	ASP	PM
Asia Region	Total	\$410,487	\$184,992	\$487,750	\$693,617	\$468,154	\$2,245,000	100%	100%	100%	100%	100%	100%
	Key Pops	\$349,500	\$162,500	\$487,750			\$998,750	85%	88%	100%			45%
	Non-Targeted Pop	\$60,987	\$22,492		\$693,617	\$468,154	\$1,245,250	15%	12%		100%	100%	55%

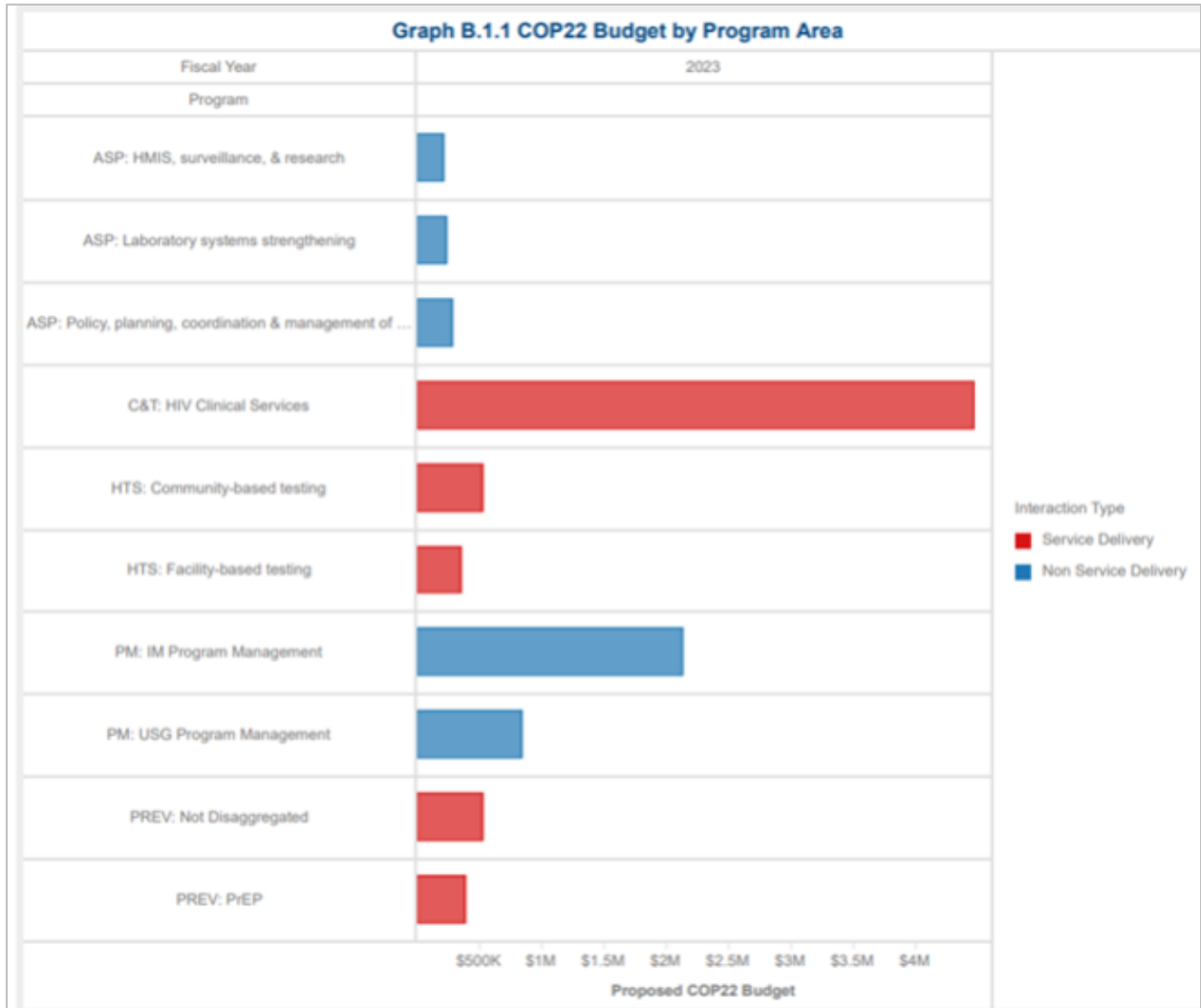
B.2 Resource Projections

Lao PDR's HIV/AIDS National Action Plan (2021-2025) was costed based on historical expenditures and current and anticipated funding levels. This NSAP's estimated total cost for the 5-year period 2021-2025 is US\$67.8M. During PEPFAR Laos National Stakeholder Consultation Workshop, CHAS informed the large budget gap with fund received at only USD 2.98 million compared to planned budget at USD 11.39 million in the first year-2021.

ROP22 resources are calculated based on the holistic analysis of actual expenditure and the level of target achieved during FY21 by each program area. The projected increase in PrEP allocation reflects the higher level of target as well as the investment in the demand generation activities such as training and supervision of PrEP services for KP in Savannakhet and Champasack provinces. Slight overall budget increase of \$245,000 will be used to support both site and above-site level investment; introducing the Community Based Monitoring in three KP program provinces, institutionalizing the recency testing to inform the new infection trend and better align our program focus to prevent further infection, and supporting index testing and index testing PLUS model where HIV self-test is integrated and partners connected to PrEP and ARVs. Due to the unclear impact of COVID-19 infection during ROP22, the cost covering PPEs to ensure the continued safe delivery of the community-based supporters and health care workers are also included despite there was no additional ARPA made available this year. The home delivery of ARVs as a decentralized service delivery model will also continue be supported during ROP22.

The program investment across PEPFAR, GF, host government and other funders are aligned to avoid duplication of effort and maximize programmatic impact of the resources.

NEPAL



Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
	Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		\$3,685,147	\$6,239,853	\$9,925,000	37%	63%	100%
C&T	Total		\$4,462,642	\$4,462,642		100%	100%
	HIV Clinical Services		\$4,462,642	\$4,462,642		100%	100%
HTS	Total		\$874,102	\$874,102		100%	100%
	Community-based testing		\$521,628	\$521,628		100%	100%
	Facility-based testing		\$352,474	\$352,474		100%	100%
PREV	Total		\$903,109	\$903,109		100%	100%
	Not Disaggregated		\$521,628	\$521,628		100%	100%
	PrEP		\$381,481	\$381,481		100%	100%
ASP	Total	\$718,986		\$718,986	100%		100%
	HMIS, surveillance, & research	\$208,200		\$208,200	100%		100%
	Laboratory systems strengthening	\$229,645		\$229,645	100%		100%
	Policy, planning, coordination & management of disease control programs	\$281,141		\$281,141	100%		100%
PM	Total	\$2,966,161		\$2,966,161	100%		100%
	IM Program Management	\$2,126,780		\$2,126,780	100%		100%
	USG Program Management	\$839,381		\$839,381	100%		100%

Table B.1.3 COP22 Total Planning Level

Metrics	Proposed COP22 Budget	Proposed COP22 Budget	Proposed COP22 Budget
Operating Unit	Applied Pipeline	New	Total
Total	\$4,493,352	\$5,431,648	\$9,925,000
Asia Region	\$4,493,352	\$5,431,648	\$9,925,000

Table B.1.4: COP22 Resource Allocation by Program and Beneficiary

Operating Unit	Metrics Beneficiary	Proposed COP22 Budget					Total	Percent to Total					Total
		C&T	HTS	PREV	ASP	PM		C&T	HTS	PREV	ASP	PM	
Asia Region	Total	\$4,462,642	\$874,102	\$903,109	\$718,986	\$2,966,161	\$9,925,000	100%	100%	100%	100%	100%	100%
	KeyPops	\$2,287,812	\$523,989	\$729,233	\$92,600	\$2,966,161	\$3,633,634	51%	60%	81%	13%		37%
	Non-Targeted Pop				\$626,386	\$2,966,161	\$3,592,547				87%	100%	36%
	PriorityPops	\$2,174,830	\$350,113	\$173,876			\$2,698,819	49%	40%	19%			27%

B.2 Resource Projections

Program priorities were identified through consultative process with the national level stakeholders and program implementation evidence. Based on identified priorities and agreed upon responsibility matrix, rationalization and resource alignment were done with the national government and global fund team to avoid duplications. Prior year expenditure and current experience of cost of doing business were used to allocate budget within the PLL envelope for the prioritized interventions.

PHILIPPINES

COP22 FAST Dossier

SDS Appendix B - Graph B.1.1 COP22 Budget by P... - Graph B.1.1 COP22 Budget by Progr...

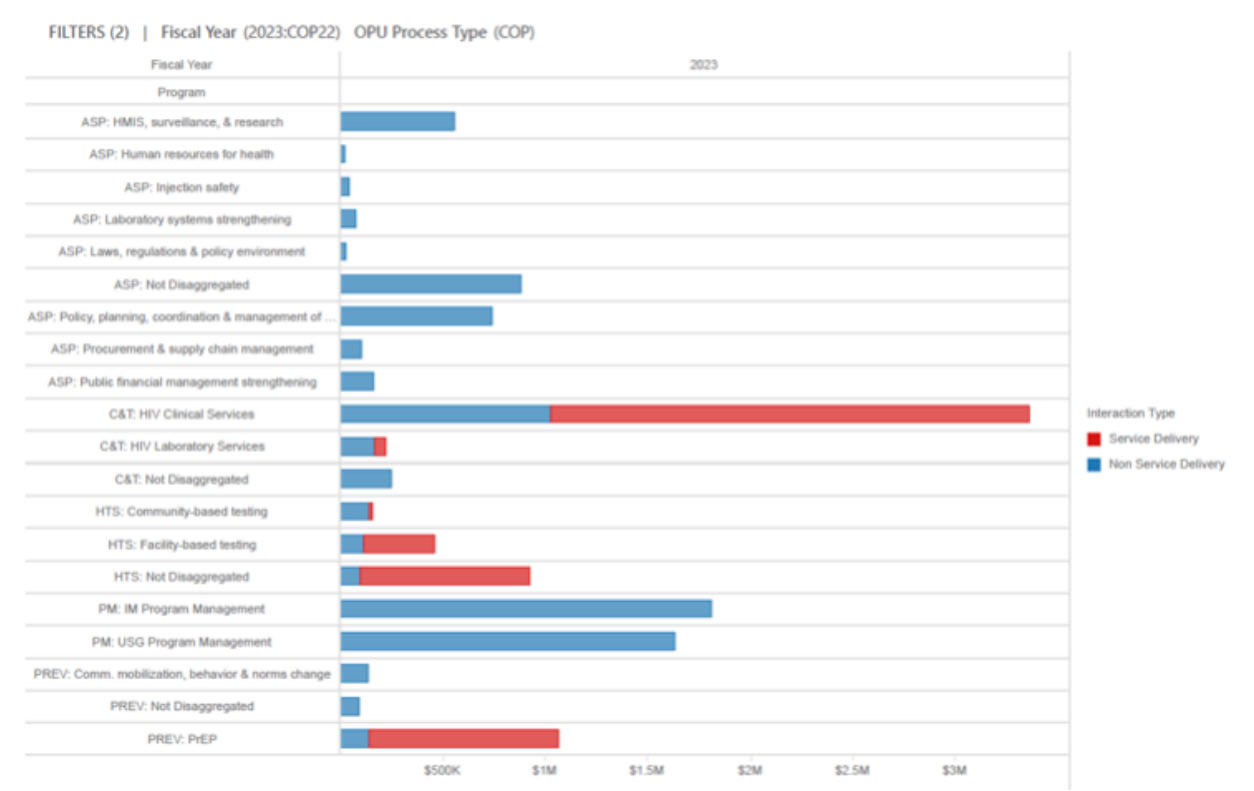


Table B.1.2 COP22 Budget by Program Area

Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget			
		Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total			\$8,168,398	\$4,511,602	\$12,670,000	64%	36%	100%
C&T	Total		\$1,436,247	\$2,390,084	\$3,826,331	38%	62%	100%
	HIV Clinical Services		\$1,025,455	\$2,337,070	\$3,362,525	30%	70%	100%
	HIV Laboratory Services		\$165,792	\$53,014	\$218,806	76%	24%	100%
	Not Disaggregated		\$245,000	\$0	\$245,000	100%	0%	100%
HTS	Total		\$346,531	\$1,196,018	\$1,542,549	22%	78%	100%
	Community-based testing		\$134,016	\$20,601	\$154,617	87%	13%	100%
	Facility-based testing		\$114,015	\$347,417	\$461,432	25%	75%	100%
	Not Disaggregated		\$98,500	\$828,000	\$926,500	11%	89%	100%
PREV	Total		\$353,055	\$925,500	\$1,278,555	28%	72%	100%
	Comm. mobilization, behavior & norms change		\$127,777	\$0	\$127,777	100%	0%	100%
	Not Disaggregated		\$90,000	\$0	\$90,000	100%	0%	100%
	PrEP		\$135,278	\$925,500	\$1,060,778	13%	87%	100%
ASP	Total		\$2,581,975	\$0	\$2,581,975	100%	0%	100%
	HMIS, surveillance, & research		\$553,419	\$0	\$553,419	100%	0%	100%
	Human resources for health		\$17,778	\$0	\$17,778	100%	0%	100%
	Injection safety		\$40,000	\$0	\$40,000	100%	0%	100%
	Laboratory systems strengthening		\$75,000	\$0	\$75,000	100%	0%	100%
	Laws, regulations & policy environment		\$22,778	\$0	\$22,778	100%	0%	100%
	Not Disaggregated		\$878,000	\$0	\$878,000	100%	0%	100%
	Policy, planning, coordination & management of disease control programs		\$735,000	\$0	\$735,000	100%	0%	100%
	Procurement & supply chain management		\$100,000	\$0	\$100,000	100%	0%	100%
	Public financial management strengthening		\$160,000	\$0	\$160,000	100%	0%	100%
	Total		\$3,440,590	\$0	\$3,440,590	100%	0%	100%
	PM	IM Program Management		\$1,807,090	\$0	\$1,807,090	100%	0%
USG Program Management			\$1,633,500	\$0	\$1,633,500	100%	0%	100%

Budget by Program & Sub

Metrics	Amount			Percent to Total By Rows (Amount)		
Program and Sub	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total	\$1,975,138,514	\$2,834,744,354	\$4,809,882,868	41.06%	58.94%	100.00%
C&T: HIV Clinical Services	\$320,255,301	\$850,022,760	\$1,170,278,061	27.37%	72.63%	100.00%
PM: IM Program Management	\$571,014,001		\$571,014,001	100.00%		100.00%
C&T: HIV Drugs	\$7,973,952	\$464,102,163	\$472,076,115	1.69%	98.31%	100.00%
C&T: Not Disaggregated	\$167,049,032	\$185,552,061	\$352,601,093	47.38%	52.62%	100.00%
C&T: HIV Laboratory Services	\$37,135,737	\$305,376,923	\$342,512,660	10.84%	89.16%	100.00%
	\$188,386,289		\$188,386,289	100.00%		100.00%
PREV: VMMC	\$12,104,265	\$157,930,855	\$170,035,120	7.12%	92.88%	100.00%
ASP: HMIS, surveillance, & research	\$145,754,294		\$145,754,294	100.00%		100.00%
PREV: Not Disaggregated	\$35,668,957	\$104,414,121	\$140,083,078	25.46%	74.54%	100.00%
HTS: Facility	\$33,998,558	\$99,924,893	\$133,923,451	25.39%	74.61%	100.00%
PM: USG Program Management	\$120,574,504		\$120,574,504	100.00%		100.00%
PREV: Comm mobilization, behavior & norms change	\$16,455,050	\$101,063,890	\$117,518,940	14.00%	86.00%	100.00%
PREV: PrEP	\$10,624,347	\$89,175,929	\$99,800,276	10.65%	89.35%	100.00%
HTS: Community	\$15,262,387	\$74,030,345	\$89,292,732	17.09%	82.91%	100.00%
SE: Case Management	\$8,918,899	\$79,718,989	\$88,637,888	10.06%	89.94%	100.00%
SE: Economic strengthening	\$4,690,612	\$82,775,194	\$87,465,806	5.36%	94.64%	100.00%
HTS: Not Disaggregated	\$16,670,505	\$48,176,080	\$64,846,585	25.71%	74.29%	100.00%

FILTERS (2) | Fiscal Year (2023:COP22) OPU Process Type (COP)

Metrics	Proposed COP22 Budget			Total
Operating Unit	Applied Pipeline		New	Total
Total		\$5,210,683	\$7,459,317	\$12,670,000
Asia Region		\$5,210,683	\$7,459,317	\$12,670,000

FILTERS (2) | Fiscal Year (2023:COP22) OPU Process Type (COP)

Operating Unit	Metrics Beneficiary	Proposed COP22 Budget						Percent to Total					
		C&T	HTS	PREV	ASP	PM	Total	C&T	HTS	PREV	ASP	PM	Total
Asia Region	Total	\$3,826,331	\$1,542,549	\$1,278,555	\$2,581,975	\$3,440,590	\$12,670,000	100%	100%	100%	100%	100%	100%
	Key Pops	\$84,352	\$81,839	\$1,088,000	\$266,731		\$1,520,922	2%	5%	85%	10%		12%
	Non-Targeted Pop	\$3,496,423	\$1,335,155	\$90,000	\$2,221,000	\$3,440,590	\$10,583,168	91%	87%	7%	86%	100%	84%
	Priority Pops	\$245,556	\$125,555	\$100,555	\$94,244		\$565,910	6%	8%	8%	4%		4%

B.2 Resource Projections

The PEPFAR program utilized expenditure data from ROP20 and ROP21 to calculate program budgetary needs for ROP22 in line with PLL directives. Given the reduction in the overall approved funding level in ROP22 from ROP21 as ASAP funds draw down, the program analyzed programmatic and epidemiological data to inform ROP22 priority interventions and

approaches. The PEPFAR country team is meeting regularly with the DOH and Global Fund to ensure funds and activities are closely aligned and not duplicative. PEPFAR and Global Fund are carrying out joint budget advocacy for increased commodity procurement by the DOH for FY2023.

Papua New Guinea:

Graph B.1.1 COP22 Budget by Program Area

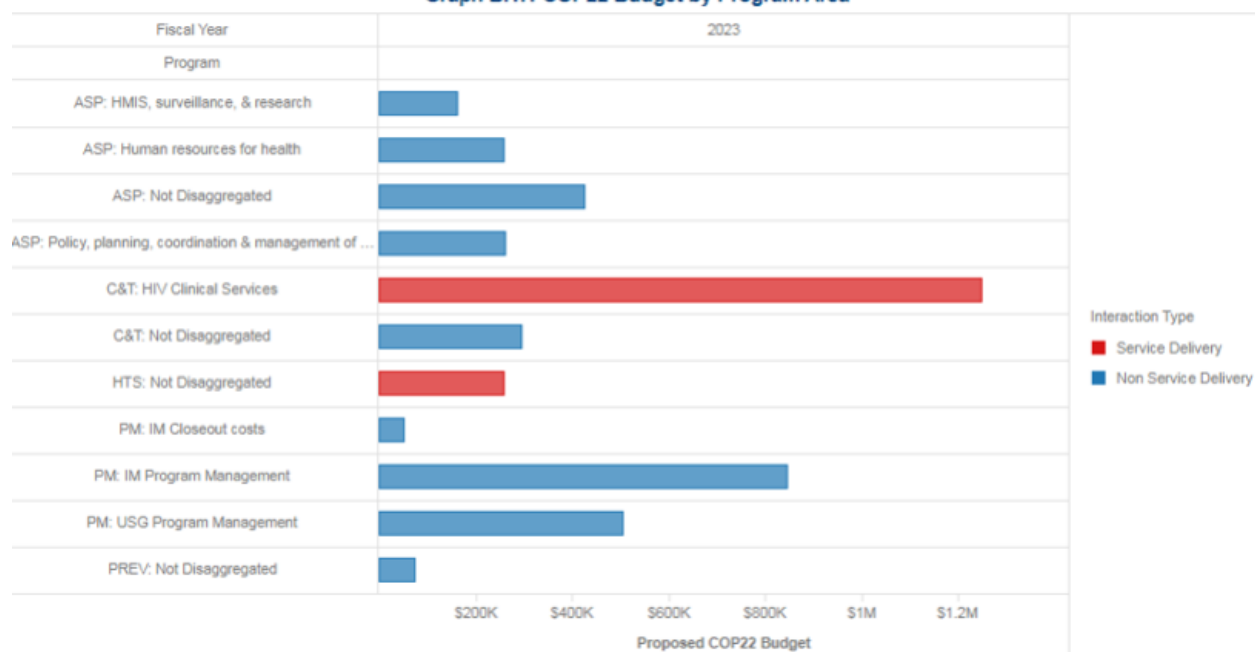


Table B.1.2 COP22 Budget by Program Area

Program	Metrics Sub-Program	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
		Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		\$2,875,387	\$1,504,612	\$4,379,999	66%	34%	100%
C&T	Total	\$294,489	\$1,246,716	\$1,541,205	19%	81%	100%
	HIV Clinical Services		\$1,246,716	\$1,246,716		100%	100%
	Not Disaggregated	\$294,489		\$294,489	100%		100%
HTS	Total		\$257,896	\$257,896		100%	100%
	Not Disaggregated		\$257,896	\$257,896		100%	100%
PREV	Total	\$75,000		\$75,000	100%		100%
	Not Disaggregated	\$75,000		\$75,000	100%		100%
ASP	Total	\$1,104,764		\$1,104,764	100%		100%
	HMIS, surveillance, & research	\$161,184		\$161,184	100%		100%
	Human resources for health	\$257,895		\$257,895	100%		100%
	Not Disaggregated	\$426,235		\$426,235	100%		100%
	Policy, planning, coordination & management of disease control programs	\$259,450		\$259,450	100%		100%
PM	Total	\$1,401,134		\$1,401,134	100%		100%
	IM Closeout costs	\$50,000		\$50,000	100%		100%
	IM Program Management	\$845,925		\$845,925	100%		100%
	USG Program Management	\$505,209		\$505,209	100%		100%

Table B.1.2 COP22 Budget by Program Area

Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total	\$2,875,387	\$1,504,612	\$4,379,999	66%	34%	100%
HIV Clinical Services		\$1,246,716	\$1,246,716		100%	100%
HMIS, surveillance, & research	\$161,184		\$161,184	100%		100%
Human resources for health	\$257,895		\$257,895	100%		100%
IM Closeout costs	\$50,000		\$50,000	100%		100%
IM Program Management	\$845,925		\$845,925	100%		100%
Not Disaggregated	\$795,724	\$257,896	\$1,053,620	76%	24%	100%
Policy, planning, coordination & management of disease control programs	\$259,450		\$259,450	100%		100%
USG Program Management	\$505,209		\$505,209	100%		100%

Table B.1.3 COP22 Total Planning Level

Metrics	Proposed COP22 Budget		
Operating Unit	Applied Pipeline	New	Total
Total	\$1,962,226	\$2,417,773	\$4,379,999
Asia Region	\$1,962,226	\$2,417,773	\$4,379,999

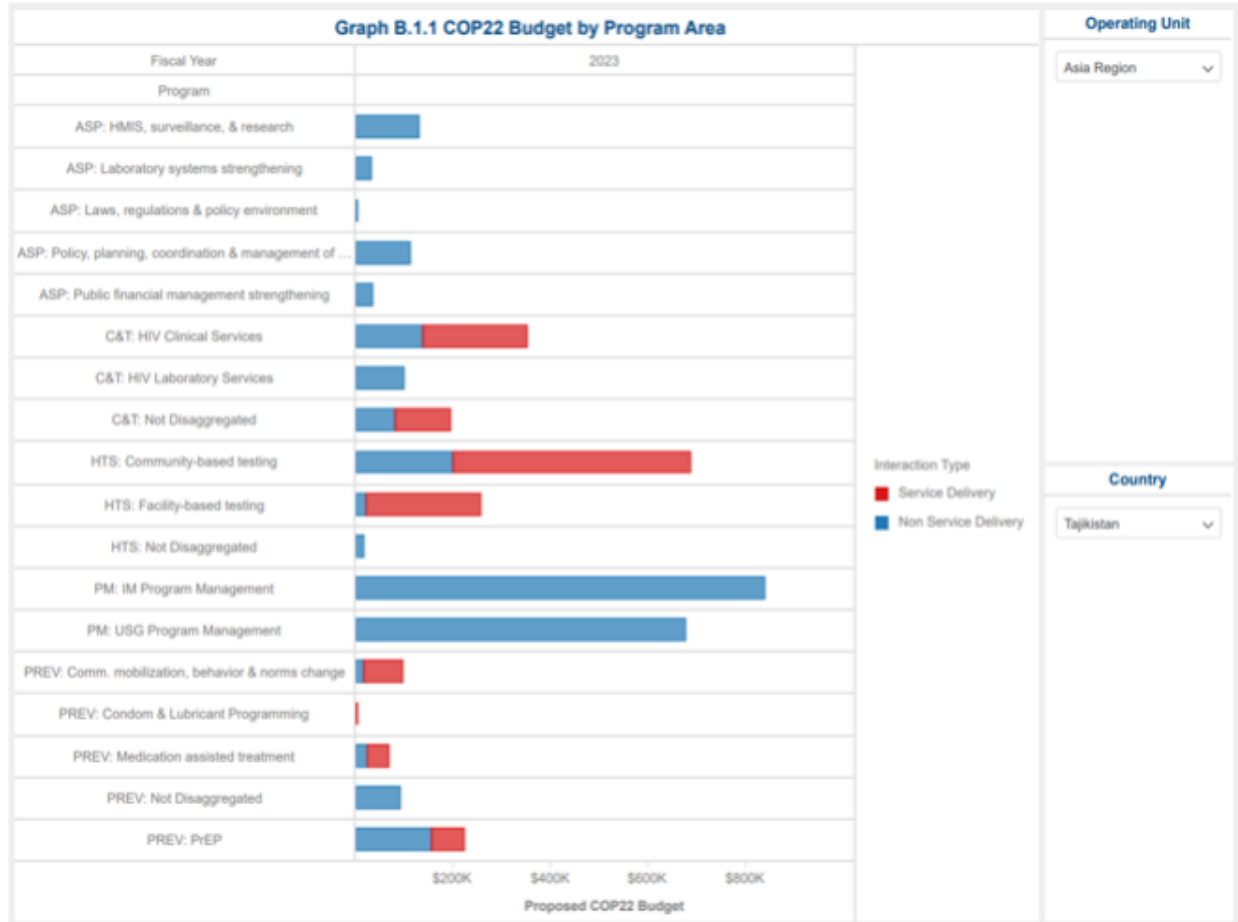
Table B.1.4: COP22 Resource Allocation by Program and Beneficiary

Operating Unit	Metrics	Proposed COP22 Budget						Percent to Total					
	Beneficiary	C&T	HTS	PREV	ASP	PM	Total	C&T	HTS	PREV	ASP	PM	Total
Asia Region	Total	\$1,541,205	\$257,896	\$75,000	\$1,104,764	\$1,401,134	\$4,379,999	100%	100%	100%	100%	100%	100%
	Key Pops			\$75,000			\$75,000			100%			2%
	Non-Targeted Pop	\$1,541,205	\$257,896		\$1,104,764	\$1,401,134	\$4,304,999	100%	100%		100%	100%	98%

B.2 Resource Projections

PNG analyzed expenditures from previous ROP years and the strategic direction set by the PLL, in addition to maintaining support to CSOs through sub-awards currently being funded under PEPFAR. The decrease in budget resulted in PNG identifying programmatic efficiencies, building on the work that has already been started by PEPFAR, partners, and the NDoH. ROP22 also includes specific budget allocations for KPs at approximately 27%. In ROP22, PNG additionally is continuing investments in the KP Consortium to lead and implement CLM. PNG is strengthening its partnerships with UNAIDS, DFAT, GF, and the NDoH to identify areas of support that can be covered through their respective streams of funding to maximize available resources and avoid duplication of effort while ensuring coverage of high-quality person-centered HIV services.

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Program	Metrics		Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
	Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total	
Total		\$2,655,465	\$1,244,535	\$3,900,000	68%	32%	100%	
C&T	Total	\$316,424	\$327,750	\$644,174	49%	51%	100%	
	HIV Clinical Services	\$137,816	\$214,000	\$351,816	39%	61%	100%	
	HIV Laboratory Services	\$97,358		\$97,358	100%		100%	
	Not Disaggregated	\$81,250	\$113,750	\$195,000	42%	58%	100%	
HTS	Total	\$233,750	\$722,125	\$955,875	24%	76%	100%	
	Community-based testing	\$198,750	\$487,500	\$686,250	29%	71%	100%	
	Facility-based testing	\$20,000	\$234,625	\$254,625	8%	92%	100%	
	Not Disaggregated	\$15,000		\$15,000	100%		100%	
PREV	Total	\$283,269	\$194,660	\$477,929	59%	41%	100%	
	Comm. mobilization, behavior & norms change	\$15,000	\$81,250	\$96,250	16%	84%	100%	
	Condom & Lubricant Programming		\$2,160	\$2,160		100%	100%	
	Medication assisted treatment	\$22,500	\$45,000	\$67,500	33%	67%	100%	
	Not Disaggregated	\$90,644		\$90,644	100%		100%	
	PrEP	\$155,125	\$66,250	\$221,375	70%	30%	100%	
ASP	Total	\$306,000		\$306,000	100%		100%	
	HMIS, surveillance, & research	\$130,000		\$130,000	100%		100%	
	Laboratory systems strengthening	\$30,000		\$30,000	100%		100%	
	Laws, regulations & policy environment	\$2,500		\$2,500	100%		100%	
	Policy planning	\$111,000		\$111,000	100%		100%	

Metrics		Proposed COP22 Budget		
Operating Unit	Applied Pipeline	New	Total	
Total		\$389,557	\$3,510,443	\$3,900,000
Asia Region		\$389,557	\$3,510,443	\$3,900,000

COP22 FAST Dossier

SDS Appendix B - Table B.1.4 COP22 Resource ... - Table B.1.4: COP22 Resource Allo...

Operating Unit	Metrics		Proposed COP22 Budget					Percent to Total					
	Beneficiary	C&T	HTS	PREV	ASP	PM	Total	C&T	HTS	PREV	ASP	PM	Total
Asia Region	Total	\$644,174	\$955,875	\$477,929	\$306,000	\$1,516,022	\$3,900,000	100%	100%	100%	100%	100%	100%
	Key Pops	\$195,000	\$915,875	\$387,285	\$5,000		\$1,503,160	30%	96%	81%	2%		39%
	Non-Targeted Pop	\$449,174	\$40,000	\$90,644	\$301,000	\$1,516,022	\$2,396,840	70%	4%	19%	98%	100%	61%

B.2 Resource Projections

The national matrix of funding was used to analyze the expenditures within COP 21 and calculate the required resources to sustain program activities in COP22. Moreover, program priorities were identified through consultative process with the national level stakeholders. Based on identified priorities and agreed upon responsibility matrix, rationalization and resource

alignment were done with the national government and partners to avoid duplications. The MoH is regularly collecting the expenditures for HIV program activities for all supporting partners to conduct a national expenditure analysis to ensure a proper resource alignment and avoiding any duplication between partner organizations.

THAILAND

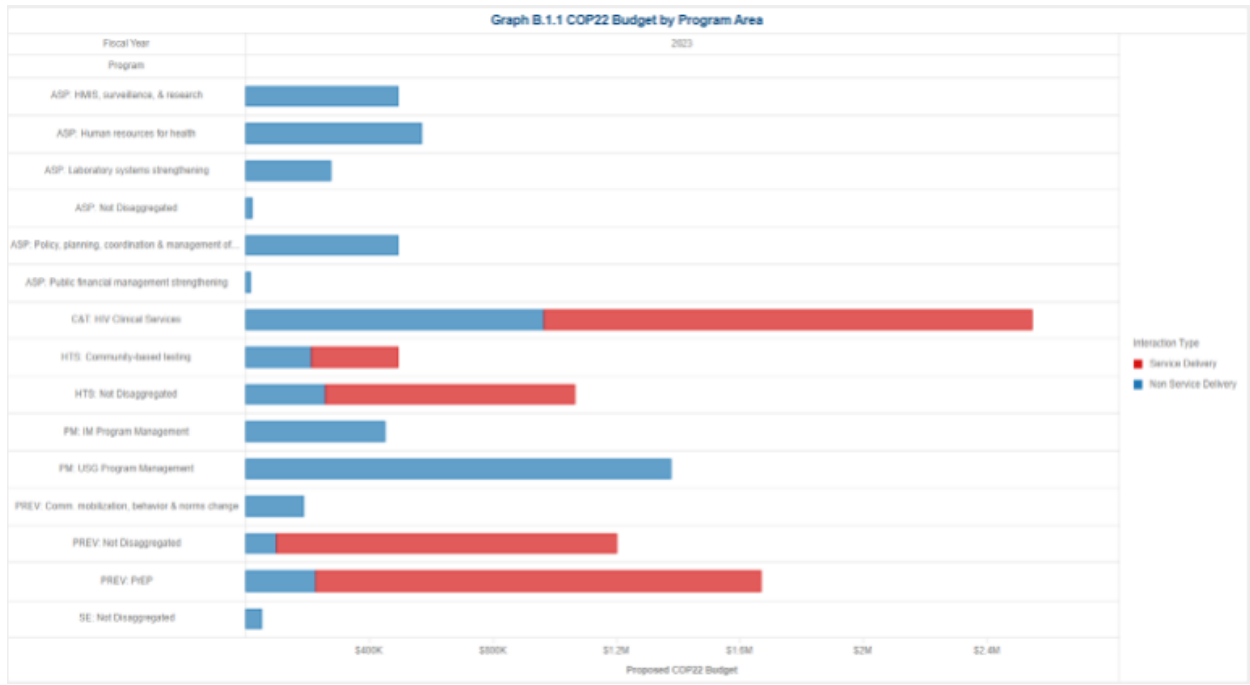


Table B.1.2 COP22 Budget by Program Area

Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget			
		Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total			\$5,690,474	\$5,204,730	\$10,895,204	52%	48%	100%
C&T	Total		\$965,983	\$1,578,730	\$2,544,713	38%	62%	100%
	HIV Clinical Services		\$965,983	\$1,578,730	\$2,544,713	38%	62%	100%
HTS	Total		\$470,028	\$1,086,000	\$1,556,028	30%	70%	100%
	Community-based testing		\$211,828	\$280,000	\$491,828	43%	57%	100%
	Not Disaggregated		\$258,200	\$806,000	\$1,064,200	24%	76%	100%
PREV	Total		\$614,433	\$2,540,000	\$3,054,433	17%	83%	100%
	Comm. mobilization, behavior & norms change		\$187,395	\$0	\$187,395	100%	0%	100%
	Not Disaggregated		\$100,000	\$1,100,000	\$1,200,000	8%	92%	100%
SE	Total		\$50,000	\$0	\$50,000	100%	0%	100%
	Not Disaggregated		\$50,000	\$0	\$50,000	100%	0%	100%
ASP	Total		\$1,863,253	\$0	\$1,863,253	100%	0%	100%
	HIMS, surveillance, & research		\$492,180	\$0	\$492,180	100%	0%	100%
	Human resources for health		\$569,693	\$0	\$569,693	100%	0%	100%
	Laboratory systems strengthening		\$274,200	\$0	\$274,200	100%	0%	100%
	Not Disaggregated		\$20,000	\$0	\$20,000	100%	0%	100%
	Policy, planning, coordination & management of disease control programs		\$492,180	\$0	\$492,180	100%	0%	100%
	Public financial management strengthening		\$15,000	\$0	\$15,000	100%	0%	100%
PM	Total		\$1,826,777	\$0	\$1,826,777	100%	0%	100%
	IM Program Management		\$450,000	\$0	\$450,000	100%	0%	100%
	USG Program Management		\$1,376,777	\$0	\$1,376,777	100%	0%	100%

Metrics	Proposed COP22 Budget			Total
	Operating Unit	Applied Pipeline	New	
Total		\$679,337	\$10,215,867	\$10,895,204
Asia Region		\$679,337	\$10,215,867	\$10,895,204

Table B.1.4: COP22 Resource Allocation by Program and Beneficiary

Operating Unit	Metrics	Proposed COP22 Budget						Percent to Total								
		Beneficiary	C&T	HTS	PREV	SE	ASP	PM	Total	C&T	HTS	PREV	SE	ASP	PM	Total
Asia Region	Total	\$2,544,713	\$1,556,028	\$3,054,433	\$50,000	\$1,863,253	\$1,826,777	\$10,895,204	100%	100%	100%	100%	100%	100%	100%	100%
	Key Pops	\$2,028,313	\$1,297,828	\$3,054,433	\$50,000	\$104,293	\$9,905	\$6,544,772	80%	83%	100%	100%	6%	1%	60%	
	Non-Targeted Pop	\$516,400	\$258,200			\$1,266,780	\$1,816,872	\$3,858,252	20%	17%			68%	99%	38%	
	Priority Pops					\$492,180		\$492,180					26%		5%	

B.2 Resource Projections

PEPFAR **Thailand** used actual expenditure and target levels achieved in FY21 by program area to calculate resources required to sustain programmatic activities in ROP22. However, due to budget cuts, PEPFAR Thailand made further adjustments (i.e., dropped or deferred activities) to allocate resources within the total funding envelope. ROP22 budget cuts will affect the overall progress of both above site and site level activities, impacting national uptake of PEPFAR-supported interventions (i.e., index testing, PrEP, SDART, retention, etc.).

The national HIV response is primarily supported with domestic funds. Program investments across PEPFAR, GF, RTG, and other funders are aligned to maximize programmatic impact and avoid duplication of efforts.

APPENDIX C – Tables and Systems Investments for Section 6.0 REQUIRED

-  Burma_Table 6_SRE_Appendix C.pdf
-  Cambodia Table 6_SRE_Appendix C.pdf
-  India_Table 6_SRE_Appendix C.pdf
-  Indonesia_Table 6_SRE_Appendix C_v2.pdf
-  Kazakhstan_Table 6_SRE_FINAL_Appendix C.pdf
-  Kyrgyzstan_Table 6_SRE_Appendix C.pdf
-  Laos_Table 6 SRE_Tool_Appendix C.pdf
-  Nepal_Table 6_SRE_Appendix C.pdf
-  Philippines_Table 6_SRE_Appendix C.pdf
-  PNG_Table 6_SRE_Final_Appendix C.pdf
-  Tajikistan_Table 6_SRE_Appendix C.pdf
-  Thailand_Table 6_SRE_Appendix C.pdf

APPENDIX D– Minimum Program Requirements

BURMA:

Care and Treatment	
<p>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 uninterrupted treatment across age, sex, and risk groups.</p>	<p>Partial: In Q4, ROP20, Public ART facilities could gradually resume ARV initiation services for their PLHIV cohorts with immediate test and start. However, availability of information on test and start and linkage to care services managed by public facilities is limited until now. In contrast, PLHIV cohorts receiving care at private NGO sector & PEPFAR sites could make immediate linkage to care and timely ARV initiation services.</p>
<p>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.</p>	<p>Partial: TLD provision along with MMD has been maintained at PEPFAR sites in 5PSNU.</p> <p>Site level: TLD has been provided to 30% of the ART cohort at PEPFAR sites and 57% of TX_NEW in Q1 FY22.</p>
<p>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.</p>	<p>National: In response to the impact of the coup and COVID-19, differentiated service delivery with MMD has been sustained with the support of peers and community members.</p> <p>Site level: Burma has achieved 72% >3+ month MMD at PEPFAR sites in Q1 FY22 - with some sites experiencing tighter government controls on ART distribution in Kachin and Mandalay.</p>
<p>4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.</p>	<p>Partial: Along with MMD ARV, TPT dispensing at NGO sites has continued. Site level: PEPFAR continues to provide TPT at site level with commodities support from GF and enrolled 1,525 clients on TPT in FY21.</p>
<p>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</p>	<p>Partial: Follow-up DNO exercise was suspended since the majority of VL laboratories at public sectors stopped functioning in ROP20 . Therefore, targeted VL testing for PLHIV/ARV clients from public sectors was conducted by outsourcing VL testing services to private laboratories in ROP20. However, access to routine VL</p>

<p>testing and results delivered to caregiver within 4 weeks.</p>	<p>testing services were maintained with rapid laboratory turnaround time for PLHIV/ARV clients who are receiving care at private NGO sites.</p>
<p>Case Finding</p>	
<p>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 should be offered testing for HIV.</p>	<p>Partial: Index testing strategy has been implemented in PEPFAR sites. Self-testing activities have been demonstrated at a few selected sites by the national program. PEPFAR site-level plans to implement HIVST in ROP21 and further expansion in ROP22. Planning efforts on further expansion of index-testing and self-testing to non-PEPFAR sites with standardized SOPs and M&E guidelines are ongoing. Site level: PEPFAR has scaled safe, ethical index testing to 17 sites with high yield at 34% in Q1 FY21.</p>
<p>Prevention and OVC</p>	
<p>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)</p>	<p>Partial: PrEP implementation has been rolled out in selected sites (including PEPFAR sites) for MSM and TG in ROP20.</p> <p>Burma will offer services to eligible KP and at risk groups within the identified sites in the 5 SNU during ROP22.</p>
<p>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 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.</p>	<p><i>Not applicable to the Burma country context</i></p>
<p>Policy & Public Health Systems Support</p>	
<p>9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the</p>	<p>Adopted: Policy, strategies, and goal to address advancement of equity, reduction of stigma and</p>

<p>2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.</p>	<p>discrimination and promotion of human rights are included in the HIV National Strategic Plan (2021-2025) but national rollout is currently not feasible.</p>
<p>10) 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.</p>	<p>National: No user fees for service provision at public and NGO sectors.</p>
<p>11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.</p>	<p>Partial: National policy and scale-up plan for QA/QI system were included in the HIV National Strategic Plan 2021-2025. Limited implementation of Service Quality Monitoring System (SQMS) for ARV and MAT services occurred after the 2021 February event due to limited human resources at public facilities and prioritizing treatment continuity over quality initiatives. However, QA/QI measures for laboratory (HIV serology and VL) could be maintained for national and subnational reference and POC labs. CQI assessment and practices are regularly implemented by PEPFAR's partners.</p>
<p>12) Evidence of treatment literacy 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.</p>	<p>Partial (+): U=U messaging, and efforts on reduction of stigma and discrimination & demand creation activities for PrEP and HTS are being amplified through social media platforms, virtual trainings, and advocacy meetings. Site level: PEPFAR Burma will launch a new visual tool U=U called B-OK beads for counselors to explain VL suppression and community VL.</p>
<p>13) Clear evidence of agency progress toward local partner direct funding, including increased funding to</p>	<p>Partial (+) : PEPFAR continues working with KP community networks, CSOs and local partners as PEPFAR's subrecipients to implement KP friendly and</p>

<p>key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses</p>	<p>KP-led services. PEPFAR TA continues to improve the institutional and technical capacity of all KP networks, CSO/local partners to expand their KP-led services. In ROP21, PEPFAR launched the HIV/TB Agency, Information, and Services Activity (HIV/TB AIS) program which will shift to local leadership within the grant. PEPFAR is also directly funding a local organization to implement CLM, with subgrants to additional CSOs.</p>
<p>14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended</p>	<p>Partial: The regime MOH has maintained the same amount of government budget for the HIV response, including support for all methadone and a major proportion of antiretrovirals (approximately 80% with some fluctuation due to the exchange rate).</p>
<p>15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.</p>	<p>Partial: . Only a few NGOs could monitor treatment outcomes.</p>
<p>16) Scale-up of case surveillance and unique identifiers for patients across all sites.</p>	<p>Preparing : Burma was preparing to develop national case surveillance system and utilize unique identifiers for all patients. Above site TA to support case surveillance and UIC has been paused due to lack of commitment by the regime, and concerns around data security and confidentiality,</p>

CAMBODIA:

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 uninterrupted treatment across age, sex, and risk groups.	88% of newly diagnosed PLHIV initiated on ART within 7 days (77% is less than 24 hours)
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.	(A) 43% of PLHIV on TLD (B) 95% of newly diagnosed PLHIV on TLD (C) 23% of <14-year-olds received DTG-based regimen
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.	(A) 78% of PLHIV on ART received 3+MMD (B) 8% of PLHIV on ART received 6MMD
4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	Among PLHIV who started TPT treatment, 77% completed it.
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.	(A) 97% of new PLHIV enrolled in ART (B) 89% ART retention at 12 months (C) 98% of patients on ART virally suppressed (D). PLHIV mortality rate is <1% (D) 91% VL coverage (B) 80% VL tests had Turnaround Time (TAT) <10 days
Case Finding	
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	4,082 new cases diagnosed in FY20 HIV testing yield in 2021: Index Testing:43% <ul style="list-style-type: none"> • HIV ST:9.5%

<p>age 19 with an HIV positive biological parent should be offered testing for HIV.</p>	<ul style="list-style-type: none"> • VCCT:8% • KPs: 1.7% • Recent infection per algorithm: 5% <p>Index testing: (A) Used assessment findings to incorporate into the national training program and field visit tools (B) 67% of newly identified PLHIV with at least 1 partner tested (C) 71% of partners of index cases with recent infection tested for HIV</p> <p>Recency testing: (A) 87% of newly identified PLHIV received rapid test for recent infection (B) 88% of PLHIV with recent infection received viral load test</p>
<p>Prevention and OVC</p>	
<p>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)</p>	<p>PrEP expanded to 10 sites in 4 high burden provinces and two-fold increase in PrEP_new in Q1-FY22. We will expand PrEP to 32 sites in all HIV high burden provinces by the end of FY2023.</p>
<p>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 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.</p>	<p>N/A</p>
<p>Policy & Public Health Systems Support</p>	

<p>9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.</p>	<p>S&D concerns have been integrated into our community approaches, patient feedback system and quality improvement processes and expanded to almost all ART sites. However, stigma and discrimination continue to exist against KPs, especially transgender women and entertainment workers.</p>
<p>10) 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.</p>	<p>All direct HIV services and medications are provided for free at all public facilities. In addition, public facilities are able to get reimbursement from the Health Equity Fund (HEF) for enrolled patients. All PLHIV are eligible for HEF enrollment.</p>
<p>11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.</p>	<p>(A) CQI program is being implemented in 25 provinces (B). ARPA-funded IPC: baseline assessment completed. Training curriculum and materials updated to address the identified gaps. Healthcare workers are being trained. (C). 91% (51/56) of labs enrolled in HIV EQAS program, including HIV recency test, with correct core >85%. 11 sites did not submit results</p>
<p>12) Evidence of treatment literacy 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.</p>	<p>(A) All provinces in Cambodia adopt and implement U=U messages (B) 70% of health care providers understood U=U</p>
<p>13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses</p>	<p>National government has committed to funding 50% of the response by 2023. PEPFAR is supporting provincial governments to increase domestic contributions.</p>

<p>14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended</p>	<p>HIV and NCD integrated model piloted in three hospitals</p> <p>An evaluation of the HIV-NCD integration model is planned in 2022 to inform feasibility of scale up to more sites</p>
<p>15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.</p>	<p>Key variables of morbidity and mortality outcomes are identified and included into patient registration form (Form B), quarterly report template, and ART database.</p>
<p>16) Scale-up of case surveillance and unique identifiers for patients across all sites.</p>	<p>(A) Data from legacy databases (ART, VCCT, B-IACM and Lab) migrated into one database using the DHIS2 platform</p> <p>(B) Project roadmap developed (complementing key activities from the 2021-2023 Global Fund grant)</p> <p>(C) Finalized core national indicators and calculation formula in DHIS-2</p> <p>(D) Ongoing assessment of hardware, software and internet connection for all ART sites</p> <p>(E) Direct data entry platform being finalized and will be piloted at 7 sites and rolled out nationally</p> <p>(F) 19/25 provinces can analyze and use data for monitoring and strategic planning purposes</p>

INDIA:

<p>Care and Treatment</p>	
<p>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 uninterrupted treatment across age, sex, and risk groups.</p>	<p>Adopted 4/2017: National implementation being scaled with fidelity to all regions/sites by expansion of ART facilities including decentralized sites. Rapid ART (including SD-ART) has been adopted by the National AIDS Control Programme. SOP for the site level implementation is part of the National Guidelines, 2021 and trainings have been conducted.</p>

	<p>In process: Linkage improving quarterly (all age, sex and risk groups) (introduction of peer navigators, SDART, and integrated service delivery strategies)</p>
<p>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.</p>	<p>Adopted 10/2018: The National transition to DTG is reaching completion, and DTG is the preferred first and second-line regimens for adults, including women of childbearing age (with informed choice), and children (weight-appropriate). As on March 2021, 85% of PLHIV are on DTG based regimen nationally. DTG based regimen for children who are ≥ 4 weeks of age and weigh ≥ 3 kg, has also been adopted as national policy with procurement in process.</p>
<p>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.</p>	<p>Adopted (3-month MMD and 6-month MMS) 08/2018: National 3-month MMD and 6-month MMS 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. 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</p>
<p>4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.</p>	<p>TPT and CPT for all eligible PLHIV, including children and adolescents is part of the national policy since 2017 and is integrated into the HIV clinical care package at no cost to the patient. TPT is implemented by the National HIV and TB program with $>85\%$ 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 inclusion in advanced disease management for increased TPT coverage.</p>
<p>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</p>	<p>Under the National HIV program, Routine viral load (RVL) is available free of cost to all the PLHIV receiving care and treatment at the 500 plus ARTCs. All the 64 viral load labs are functional and are receiving PEPFAR inputs on network optimization to achieve the 95%</p>

<p>testing and results delivered to caregiver within 4 weeks.</p>	<p>coverage targets. To address the systemic issues affecting VL scale-up and to ensure access to VL testing, differentiated models were successfully demonstrated during COVID-19 pandemic like dual sample type, hub and spoke and community led camp approaches targeting key and vulnerable population and are currently being adopted at national level for scale up. Proficiency Testing program is successfully expanded to all the 64 viral load labs.</p>
<p>Case Finding</p>	
<p>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 should be offered testing for HIV.</p>	<p>Adopted 7/2019: Index Testing and/or partner notification services is implemented and scaled with fidelity across all PEPFAR geographies and has been adapted by the national program under the revised TI strategy as an effective and key case finding strategy to bridge the first 95 gap. PEPFAR has supported the national program in drafting the Technical and operational guidelines for Index testing services in addition, trained the facility staff on index testing, including added sessions on assessment of IPV. 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 22, 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</p>
<p>Prevention and OVC</p>	
<p>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)</p>	<p>Adopted: NACO has approved the National PrEP Technical Guidelines and released on World AIDS Day 2021. PEPFAR is implementing PrEP service delivery in the private sector. In ROP22, PEPFAR India will provide TA to NACO for rolling out PrEP service delivery in selected sites in public sector including the flagship Sampoorna Suraksha Centers for comprehensive prevention. PrEP demand generation activities and community consultations have been carried out across all PEPFAR geographies.</p>

<p>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 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.</p>	<p>Adopted: 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</p>
<p>Policy & Public Health Systems Support</p>	
<p>9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.</p>	<p>In ROP22 PEPFAR India will continue to prioritize health equity, the reduction of stigma and discrimination, the promotion of human rights to improve HIV prevention and treatment outcomes for key populations and other vulnerable groups.</p>
<p>10) 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.</p>	<p>GOI provides HIV services including testing and treatment free of cost to all residents</p>
<p>11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.</p>	<p>In Progress: Quality Improvement, Quality assurance and Continuous Quality Improvement will be a priority for ROP 22 , along with consolidation of the programmatic gains in the areas of HIV prevention, testing, care and treatment. PEPFAR is supporting national program in strengthening implementation of 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. Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices, including infection prevention & control interventions and site safety standards, are integrated into the national guidelines.</p>
<p>12) Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health,</p>	<p>In Progress: Updated HIV messaging regarding treatment literacy and U=U, to</p>

<p>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.</p>	<p>reduce stigma and encourage HIV treatment and prevention, has been incorporated into the national guidelines. PEPFAR India has undertaken workshops on treatment literacy engaging health care providers and community members.</p> <p>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</p>
<p>13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses</p>	<p>PEPFAR India supports indigenous partners. There has been an upward trend in the provision of funding to local partners</p>
<p>14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended</p>	<p>GOI funds 95% of its program response. There has been increased host country ownership and many interventions have been taken on and scaled by the national government.</p>
<p>15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.</p>	<p>Adopted. Clinic monthly progress reports track OIs and deaths at site level. Verbal autopsy exercise conducted in selected ART centers. 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.</p>
<p>16) Scale-up of case surveillance and unique identifiers for patients across all sites.</p>	<p>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.</p>

INDONESIA:

Care and Treatment	*Up to December 2021
<p>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 uninterrupted treatment across age, sex, and risk groups.</p>	<p>Partial</p> <p>(a) In <u>Jakarta</u>, 74% of newly diagnosed PLHIV initiated on ART within 7 days (55% in less than 24 hours). At sub-district facilities and direct service delivery sites, 86% of newly diagnosed PLHIV initiated on ART within 7 days (69% in less than 24 hours).</p> <p>(b) In <u>West Java and Banten</u>, 35% (West Java) and 44% (Banten) of newly diagnosed PLHIV initiated on ART within 7 days, following 1-2 quarters of PEPFAR TA</p> <p>(c) At the <u>national level</u>, PEPFAR assisted the Ministry of Health to incorporate rapid and same day ART reporting functions in the national ART cohort system (ARK 6.0); recording and reporting of these parameters, however, is inconsistent across sites</p>
<p>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.</p>	<p>Partial</p> <p>(a) In <u>Jakarta</u>, 82% of new-on-ART PLHIV received TLD. At sub-district facilities and direct service delivery sites, 96% of new-on-ART PLHIV received TLD</p> <p>(b) In <u>West Java and Banten</u>, 37% (West Java) and 65% (Banten) of new-on-ART PLHIV received TLD, following 1-2 quarters of PEPFAR TA</p> <p>(c) At the <u>national level</u>, 10% of new-on-ART PLHIV received TLD</p>
<p>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.</p>	<p>Partial</p> <p>(a) In <u>Jakarta and Greater Jakarta</u>, 26% of total PLHIV on ART received home-based ART services, while 3.2% of total PLHIV on ART received 3-5 MMD</p> <p>(b) At the <u>national level</u>, the MOH is in the process of developing an MMD acceleration roadmap, with TA from PEPFAR</p>
<p>4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.</p>	<p>Partial Plus</p> <p>(a) In <u>Jakarta and Greater Jakarta</u>, less than 10% of eligible PLHIV received TPT; a TPT acceleration strategy has been initiated in 2022.</p> <p>(b) At the <u>national level</u>, The Ministry of Health has expanded TPT into other priority provinces</p>
<p>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.</p>	<p>Partial</p> <p>In <u>Jakarta</u></p> <p>(a) 90% of new PLHIV enrolled in ART</p> <p>(b) 77% ART retention at 12 months</p> <p>(c) 94% of patients on ART virally suppressed</p> <p>(d) PLHIV mortality rate is <5%</p> <p>Regarding DNO, PEPFAR partner has presented the preliminary results of the Diagnostic Network Optimization analysis in 8 Districts in Jakarta and</p>

	Greater Jakarta to NAP, the result of the meeting was NAP accepted and agreed to expand the use of the GeneXpert machine for VL testing.
Case Finding	
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 should be offered testing for HIV.	<p>Partial Plus</p> <p>In <u>Jakarta</u>, 2,971 new cases diagnosed in FY21, with HIV testing yields as follows:</p> <ul style="list-style-type: none"> ● Index Testing: 17.4% ● Targeted PITC: 3.0% ● VCCT (not including KP): 0.1% ● KP Testing: 11.1% <p>In <u>Greater Jakarta</u>, 265 new cases diagnosed in FY21, with HIV testing yields as follows:</p> <ul style="list-style-type: none"> ● Index Testing: 17.1% ● Targeted PITC: 10.5% ● VCCT (not including KP): 2.9% ● KP Testing: 8.7% <p>At the <u>national level</u>, PEPFAR assisted the MOH to develop and disseminate the <i>National Partner Notification Technical Guidelines</i> to guide index testing implementation</p>
Prevention and OVC	
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)	<p>Partial</p> <p>PrEP was introduced at 12 facilities in <u>Jakarta</u>, with expansion to additional sites in <u>Jakarta and Greater Jakarta</u> taking place in FY22. The GFATM has initiated the activities in other priority districts.</p>
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 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	N/A
Policy & Public Health Systems Support	

<p>9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.</p>	<p>Partial Plus</p> <p>All facilities in <u>Jakarta and Greater Jakarta</u> have participated in stigma and discrimination reduction training and have signed anti-stigma pledges which will be reviewed through community-led monitoring processes</p> <p>Patient feedback is routinely collected at every PEPFAR-supported outreach and case management contact. Community-led monitoring systems are now in the process of implementation across the <u>national program</u> with support from PEPFAR and the GFATM.</p>
<p>10) 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.</p>	<p>Direct HIV services and medications are provided for free at all public facilities.</p>
<p>11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.</p>	<p>Partial Plus</p> <p>A CQI program is being implemented at 137 facilities supported by PEPFAR in <u>Jakarta, Banten and West Java provinces</u></p>
<p>12) Evidence of treatment literacy 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.</p>	<p>Partial</p> <p>All facilities supported by PEPFAR have adopted and utilized U=U messaging.</p> <p>Indonesia's <u>national program</u> is supporting viral load literacy activities as it expands coverage of viral load testing</p>
<p>13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses</p>	<p>Partial</p> <p>PEPFAR Indonesia awarded the first award to local partners in October 2021, and the implementer of the award is Jaringan Indonesia Positif (The Positive Indonesia Network). PEPFAR Indonesia will further prioritize on improving CSO organizational capacity throughout the ROP22 period, with customized technical assistance provided to both PEPFAR- and the Global Fund-supported CSOs to implement effective programming and to access Government of Indonesia financing for long-term sustainability.</p>

<p>14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended</p>	<p>National</p> <p>Domestic financing for HIV and AIDS has increased steadily over the past several years in absolute terms and as a proportion of total resources available, the latter reaching an estimated 70% of total resources on HIV and AIDS in 2018/19. The domestic budget was dominantly allocated for medicines and consumables, while funding for health promotion and any prevention programs, including prevention commodities (i.e condoms, lubricants, clean needles, and syringes) was covered by the international fund.</p>
<p>15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.</p>	<p>Partial Plus</p> <p>Key variables of morbidity and mortality outcomes are identified and included in patient registration forms and the national ART cohort database (ARK 6.0). For the community-facility partnerships program, PEPFAR continues to provide intensive support on the expansion “Lost and Link” to 11 new targeted health facilities in Greater Jakarta.</p>
<p>16) Scale-up of case surveillance and unique identifiers for patients across all sites.</p>	<p>Partial</p> <p>SIHA 2.0 Upgrade (new MOH patient records system) is currently in the process of prototype testing and rollout. Data from legacy systems (SIHA 1.7, ARK 6.0) will be migrated into the SIHA 2.0 Upgrade.</p> <p>Case identification, new treatment initiation, treatment retention, and viral load coverage and suppression (at individual levels) will be reported routinely into the new national system to guide programmatic action.</p>

KAZAKHSTAN:

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 uninterrupted treatment across age, sex, and risk groups.	Policy adopted nationwide; 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 who are ≥ 4 weeks of age and weigh ≥ 3 kg, and removal of all NVP- and EFV-based ART regimens.	TLD will be available in 2023; transition underway
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.	Adopted; transition underway
4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	Nationally scaled with fidelity (note that this is not a program area that receives significant PEPFAR support).
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.	Implemented with fidelity (PEPFAR). PLHIV have 100% access to VL testing and results delivered to caregivers within 3 -5 days in average.
Case Finding	
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 should be offered testing for HIV.	<p>Kazakhstan meets this requirement. Index testing scaled-up and offered confidential, voluntary, index partner testing in full compliance with WHO's Self-Testing and Partner Notification and PEPFAR Guidelines. All children under age 19 with an HIV positive biological parent are tested for HIV.</p> <p>In COP22, Kazakhstan will continue expanding self-testing through various offline channels and will continue utilizing online platforms for tailored messaging to increase demand for HIVST among different populations, using the HIVST demand generation strategy. We will provide online self-test give-away service at East Kazakhstan AIDS Center targeting KPs.</p>
Prevention and OVC	
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,	<p>Kazakhstan meets this requirement.</p> <p>Policy status: PrEP is adopted in the National HIV Clinical Protocol.</p> <p>PrEP expanded among all high-risk groups.</p> <p>Communication strategy for demand creation is being planned.</p>

key populations and adult men engaged in high-risk sex practices)	Plans for ROP22: continuing to scale PrEP, moving forward with differentiated service delivery at community level (CBART, CB-PrEP); continue operationalizing HIV-negative cascade. PrEP will continue to be linked to HIV testing services and all HIV-negative contacts of index clients will immediately linked to the full package of comprehensive prevention interventions including PrEP..
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 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	NA
Policy & Public Health Systems Support	
9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.	Adopted; challenges but improving
10) 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.	Nationally scaled with fidelity
11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.	Implemented with fidelity (PEPFAR)
12) Evidence of treatment literacy 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.	Adopted; challenges but improving
13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses	Transition underway
14) Evidence of partner government assuming greater responsibility of the HIV response including	Adopted; challenges but improving

demonstrable evidence of year after year increased resources expended	
15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Adopted; rollout underway
16) Scale-up of case surveillance and unique identifiers for patients across all sites.	Adopted; rollout underway

KYRGYZ REPUBLIC:

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 uninterrupted treatment across age, sex, and risk groups.	Adopted nationwide; 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 who are ≥ 4 weeks of age and weigh ≥ 3 kg, and removal of all NVP- and EFV-based ART regimens.	Adopted; transition underway
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.	Adopted; transition underway
4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	Nationally scaled with fidelity (note that this is not a program area that receives significant PEPFAR support).
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.	Implemented with fidelity (PEPFAR). PLHIV have 100% access to VL, EID testing and results delivered to caregivers within 3 -5 days in average.
Case Finding	
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 should be offered testing for HIV.	<p>Kyrgyz Republic meets this requirement. Index testing scaled-up and offered confidential, voluntary, index partner testing in full compliance with WHO's Self-Testing and Partner Notification and PEPFAR Guidelines. All children under age 19 with an HIV positive biological parent are tested for HIV</p> <p>In COP22, Kyrgyz Republic will continue expanding self-testing through various offline channels and will continue utilizing online platforms for tailored messaging to increase demand for HIVST among different populations, using the HIVST demand generation strategy. We have plans to add distribution of self-test through vending machines and provide online self-test give-away service at Bishkek AIDS Center targeting KPs.</p>
Prevention and OVC	

<p>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)</p>	<p>Kyrgyz Republic meets this requirement. Policy status: PrEP is adopted in the National HIV-infection Policy Guidelines. Current Update: Clinical Protocol on PrEP revised according to last (2021-2022) WHO recommendations and approved by MOH. PrEP expanded among PWID at significant risk. Communication strategy for demand creation is being implemented. Plans for COP22: continuing to scale PrEP, including ED-PrEP, moving forward with differentiated service delivery at community level (CBART, CB-PrEP); continue operationalizing HIV-negative cascade; support roll-out of e-PrEP register, software improvement. PrEP will continue to be linked to HIV testing services and all HIV-negative contacts of index clients will immediately linked to the full package of comprehensive prevention interventions including PrEP.</p>
<p>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 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.</p>	<p>NA</p>
<p>Policy & Public Health Systems Support</p>	
<p>9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.</p>	<p>Adopted; challenges but improving</p>
<p>10) 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.</p>	<p>Nationally scaled with fidelity</p>
<p>11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.</p>	<p>Implemented with fidelity (PEPFAR)</p>
<p>12) Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health,</p>	<p>Adopted; challenges but improving</p>

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.	
13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses	Transition underway
14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	Adopted; challenges but improving
15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Adopted; rollout underway
16) Scale-up of case surveillance and unique identifiers for patients across all sites.	Adopted; rollout underway

LAOS:

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 uninterrupted treatment across age, sex, and risk groups.	National treatment and care guidelines recommended test and start to all PLHIV across all age, sex and risk groups. ARV medications supported by GFATM & Lao government providing to 11 ART sites in 8 provinces. Newly diagnosed PLHIV have to be referred from VCT sites to ART sites in which may not immediately link for ART.
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.	National: TLD transition to 92% of PLHIV in Laos. Pediatric DTG dispersible is under approval in the national program
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.	>80% of PLHIV receiving MMD 3-4 months. Uptake of MMD 6 was <5%. During COVID-19 situation, ART was distributed by peer, home delivery and by post.
4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	High TPT uptake among newly diagnosed PLHIV in Laos with no cost (>70% in 2021). TPT completion rate not available currently. TPT initiation rate varies from 44% to 88% across different SNU. ART sites still encountered stock issue in some period.
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.	Decentralized viral load testing laboratories has been implemented and web-based application has been established to increase the coverage of testing and ensure quality of result delivered. The data from application has been exchanged with DHIS2.
Case Finding	
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 should be offered testing for HIV.	In Laos, Index Testing currently being implemented nationally (at all 11 ART facilities and Communities sites. self-testing is integrated with index testing to encourage uptake of index. self testing is focusing in HIV high burden provinces, Vientiane Capital, Savannakhet and Champasack targeting MSM/TG. Client Consent and IPV screening are included and closely monitored.
Prevention and OVC	

<p>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)</p>	<p>Currently (FY2022), PrEP services are provided in HIV high burden provinces, Vientiane Capital, Savannakhet and Champasack targeting MSM/TG. PrEP also will be introduced to discordant couple at the PEPFAR site during ROP22.</p>
<p>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 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.</p>	<p>N/A</p>
<p>Policy & Public Health Systems Support</p>	
<p>9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.</p>	<p>Department of Health Care, Ministry of Health is implementing POLICY ON HEALTH CARE SERVICE QUALITY ASSURANCE called “FIVE GOOD, ONE SATISFACTION” at all levels of health facilities in the country; National HIV/AIDS program conducted S&D assessment, results has been applied for actions training health care providers and PHLIV Peers; the regular mini S&D online surveys among health care workers and PLHIV are still ongoing to monitor the S&D and guiding for remedial actions.</p>
<p>10) 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.</p>	<p>HIV services are provided free of charge in public sector across the HTC and ART facilities in Laos</p>
<p>11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.</p>	<p>CQI has been implemented in all 11 ART sites as part of national QI program. Infection prevention and control interventions were trained to all ART sites during COVID-19. National guidelines is available. The EQA program for HIV testing, viral load testing and RTRI testing have been implemented to ensure the testing quality.</p>
<p>12) Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country</p>	<p>Enhance adherence counseling training was organized in Laos including messaging on U=U for 11 ART sites. However, no data on real implementation of U=U and treatment literacy in the field.</p>

<p>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.</p>	
<p>13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses</p>	<p>Civil Society Organizations receive funding from external donor countries/organizations. There is an on going advocacy for the government of Laos considering social contracting/giving funding to CSOs for the social service provision. CLM channels funding to local KP CSOs and build their capacity to manage direct funding in the future.</p>
<p>14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended</p>	<p>The Lao government has demonstrated strong leadership in development of national HIV/AIDS strategy, enabling policy and coordinating the HIV epidemic response. The Lao Government commitment for co-financing was \$462,033 for 2018, \$473,575 for 2019 and \$547,334 for 2020, in total \$1,482,942. However, the country remains highly dependent on external resources to fund its HIV response especially among those of key population</p>
<p>15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.</p>	<p>AIDS related morbidity and mortality are currently reported through DHIS2. However, current morbidity and mortality list on DHIS2 is not detailed and does not conform to any international standards and is not coded</p>
<p>16) Scale-up of case surveillance and unique identifiers for patients across all sites.</p>	<p>National UIC is used to track HIV/AIDS services through DHIS2 but no other health services. Administrative data sources are not integrated in a data warehouse</p>

NEPAL:

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 uninterrupted treatment across age, sex, and risk groups.	Test & start is being implemented nationally including PEPFAR supported sites. The national HIV Testing and Treatment Guidelines recommends immediate linkage and treatment initiation for all eligible PLHIV. FY22 Q1 treatment linkage rate for newly diagnosed PLHIV was 93%, and 94% of them were initiated on treatment same day or within two weeks of HIV diagnosis.
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 and NVP phase-out completed in FY21.
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 model including MMD for 3 to 6 months is part of the National HIV Testing and Treatment Guidelines 2020. Despite the existence of national guidelines, implementation of MMD is lagging mainly due to the national HIV program delay to roll out the implementation for fear of ARV stockout. PEPFAR has recently procured TLD to alleviate risk of stock breach following rollout of MMD. Networks of people living with HIV (PLHIV) and key populations (KPs) will be mobilized extensively to advocate for strengthening MMD In ROP21 period. In ROP22 MMD will be implemented at ART service providing sites. Since ROP20, with approval from the national HIV program, 25 PEPFAR supported clinics in the community are dispensing ARV drugs to key populations and this has helped to improve accessibility and treatment continuity among KP.
4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	Provision of TPT and cotrimoxazole is in place and is being provided as per national guidelines to all PLHIV. There was a stockout of TPT drugs during ROP 20 and the first quarter for ROP 21. That is now addressed and TPT service is being provided at all ART sites.
5) Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring	Diagnostic network optimization for VL/EID and other coinfection is done. VL testing site and sample transport is mapped out. There is at least one VL

<p>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.</p>	<p>machine in each province with a back-up site. Feasibility assessment of COVID-19 PCR machines at provincial labs for its utilization for HIV VL testing completed. One of the COVID-19 machines is currently being used for HIV VL testing. In PEPFAR supported sites VL testing coverage has increased to 84%. In ROP22, PEPFAR will work with the government of Nepal, Global fund and VL testing laboratories services to strengthen laboratory systems for VL sample collection/transportation, VL test reagent quantification and procurement, preventive maintenance of VL machines, training and mentoring of laboratory personnel to ensure quality of VL laboratory services include timely return of test results to ART sites for clinical decision making.</p>
<p>Case Finding</p>	
<p>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 should be offered testing for HIV.</p>	<p>Index testing and HIV self-testing optimized and scaled up nationally.</p>
<p>Prevention and OVC</p>	
<p>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)</p>	<p>Not Applicable</p>
<p>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 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.</p>	<p>Not Applicable</p>
<p>Policy & Public Health Systems Support</p>	
<p>9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration,</p>	<p>Nepal constitution recognizes rights to health for all population, human rights and recognizes gender minority KP groups in its constitution and policy</p>

<p>OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.</p>	<p>document. HIV services are accessible to all age, sex and population groups including KP.</p>
<p>10) 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.</p>	<p>There is no use fee to access HIV services. All HIV medicines and laboratory reagents are procured by GON, PEPFAR, and GF to ensure their accessibility at all service delivery points throughout the country.</p>
<p>11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.</p>	<p>Continuous quality improvement is being implemented in PEPFAR supported sites. GON is also committed to improving the quality of HIV services and already has periodic QA monitoring site visits to all HIV service providing sites. The PEPFAR program is currently implementing CQI to address issues of treatment continuity and VL service uptakes. In ROP22, CQI will continue to be implemented across all HIV service areas. Site improvement through monitoring systems (SIMS) and community led monitoring interventions will be used to inform the CQI processes and priorities.</p>
<p>12) Evidence of treatment literacy 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.</p>	<p>National treatment literacy manual is revised with emphasis on U=U, TLD regimen and VL testing and suppression messages. Training of trainers (TOT) conducted and VL literacy is rolled out in all PEPFAR districts in ROP20. The national stigma and discrimination reduction toolkit/training curriculum revised by working jointly with the Global Fund and national program. PEPFAR will support in implementing of recommendations from Stigma Index 2.0 and the SID exercise to support in reduction of stigma and discrimination</p>
<p>13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses</p>	<p>PEPFAR/Nepal has conducted local partner capacity assessment 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 to ensure their readiness to subsume prime partner roles.</p>
<p>14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence</p>	<p>GON has assumed 100% of the funding for ARVs (including TLD) and most of HIV test kits. Public health facilities and their human resources are providing ART services to PLHIV. However, the</p>

<p>of year after year increased resources expended</p>	<p>major portion of resources needed for the national program and community level HIV services are implemented through the Global Fund and PEPFAR.</p>
<p>15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.</p>	<p>Morbidity and mortality are being reported through a regular reporting system as an aggregate data. Roll out training of one national HIV information system will allow for recording and reporting of morbidity and mortality outcomes for each client. The HIV information system will track reasons for mortality. PEPFAR is supporting the development and rollout of this information system.</p>
<p>16) Scale-up of case surveillance and unique identifiers for patients across all sites.</p>	<p>Host government has already started UIC at all HIV service delivery points by using biometric data (fingerprint) to identify unique ART service recipients. With the rollout of One National HIV information system, remaining sites will start to implement UIC. The HIV information system is currently deployed to all sites and all relevant staff are trained for its implementation.</p>

PHILIPPINES:

Care and Treatment	
<p>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 uninterrupted treatment across age, sex, and risk groups.</p>	<p>Partial adoption. 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. To date, of the 168 treatment facilities across the country, only 29 are licensed and capable of conducting the new algorithm.</p> <p>Fifty-six percent (5,371/12,341) of newly diagnosed cases for CY2021 were confirmed using the rapid HIV diagnostic algorithm or rHIVda in PEPFAR supported regions. Confirmatory testing through rHIVda is lowest in the National Capital Region and CALABARZON due to inadequate referral networks and accredited rHIVda sites, respectively.</p>
<p>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.</p>	<p>Partial + TLD transition. TLD added to the Philippine National Formulary in ROP21. National procurement is scheduled for FY23 Q1. Advocacy is ongoing for the DOH to adopt a more aggressive transition plan as TLD initiation is limited to ART naive clients and 20% of clients on efavirenz-based regimens.</p>
<p>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.</p>	<p>Partial? Differentiated service delivery models have been developed and identified by the DOH in response to challenges posed by the pandemic. These have not been implemented with fidelity across sites. 3+MMD is high at 75% with an increase in 6MMD seen in FY22 Q1. Telemedicine and courier/Grab delivery services are all being expanded currently.</p>
<p>4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.</p>	<p>Preparing. TB_HIV Policy is in place that stipulates the provision of TPT services. Complementary capacity building is being provided by PEPFAR-USAID for FY22.</p>
<p>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.</p>	<p>Preparing. A DNO activity is slated for FY22 and will inform FY23 activities to enhance access to EID VL testing.</p>
Case Finding	
<p>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</p>	<p>Preparing. The country is awaiting for the Omnibus Guidelines to be released by the DOH that will officially allow for the conduct of index testing and other targeted case finding strategies</p>

<p>positive biological parent should be offered testing for HIV.</p>	<p>among KPs. Sites in NCR, Central Luzon, and CALABARZON received capacity building to better equip them to conduct IPV assessments for index testing clients.</p>
<p>Prevention and OVC</p>	
<p>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)</p>	<p>Partial+. Six of the seventeen sub-national regions dispensed PrEP to mostly MSM and transgender women clients in 2021. These regions include all of the PEPFAR supported regions in the country. PrEP implementation has so far been led by community-based organizations.</p>
<p>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 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.</p>	<p>Not applicable to the Philippines context.</p>
<p>Policy & Public Health Systems Support</p>	
<p>9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.</p>	<p>Preparing. The broad PEPFAR-USAID campaign that the Philippine DOH adopted incorporates a component on stigma and discrimination reduction. In ROP21/FY22, further evidence building will also be conducted through a qualitative assessment of quality of care in HIV service provision as part of the PEPFAR CLM activities.</p>
<p>10) 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.</p>	<p>Partial. The national health insurance (PhilHealth) currently has an outpatient HIV/AIDS treatment package. Implementation of the package varies across sites. Related services (e.g., baseline lab testing required for ART initiation) are not always covered. Free treatment for opportunistic infections depends on the availability of government-procured drugs. Other packages partially cover inpatient care.</p> <p>There is currently no prevention, testing, and PrEP package under PhilHealth. Condoms and HIV testing are free in the public sector. PrEP drugs are also free through community and public sector sites but similar to HIV treatment initiation, related services such as baseline tests are not always covered.</p>
<p>11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program</p>	<p>Partial? PEPFAR-USAID has started its monthly CQI and data deep dive exercises with sub-awardees. The National Mentoring Tool that the WHO adopted from the SIMS will be used to</p>

management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.	
12) Evidence of treatment literacy 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.	Partial. Free to Be U, the PEPFAR-USAID U=U campaign, has been adopted by the Department of Health and will be launched in April 2022 and rolled out to the rest of the country.
13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses	None. Current PEPFAR sub-awards are focused on community-led and community-based organizations. IPs are providing input to prepare them for direct funding.
14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	National. The Philippines DOH currently funds all ART procurement and is expected to remain the primary funding source for drug procurement. In ROP22, the DOH will also procure PrEP, following its adoption into the national formulary.
15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Partial. Morbidity and mortality reporting is covered in the HIV, AIDS, and ART Registry of the Philippines (HARP). However, mortality reporting remains a challenge because of the reluctance of next of kin to declare HIV status of expired patients due to stigma and discrimination.
16) Scale-up of case surveillance and unique identifiers for patients across all sites.	National. The HIV, AIDS, and ART Registry of the Philippines (HARP), the country's case-based surveillance that covered diagnosis, treatment initiation and retention, viral suppression, and mortality has been in place since 2015. Advocacy through PEPFAR paved the way for the expansion of the system to include HIV testing and PrEP surveillance. The DOH is in the process of ensuring reporting compliance across the different service providers with PEPFAR support.

Papua New Guinea:

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 uninterrupted treatment across age, sex, and risk groups.	USAID is currently increasing the number of individuals tested and treated the same day in the NCD. PNG will continue TA to expand SDART nationally and in non-PEPFAR sites.
2) Rapid optimization of ART by offering TLD to all PLHIV weighing ≥ 30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥ 4 weeks of age and weigh ≥ 3 kg, and removal of all NVP- and EFV-based ART regimens.	PEPFAR PNG completed the national transition to TLD in ROP21. A DTG-based regimen for >20kg is in the guidelines and implemented nationally. For >4 weeks of age or >3kg to <20kg, DTG 10mg scored dispersible tablets have been procured and guidelines updated. Phased roll-out of pDTG began in PEPFAR SNU in 2021 and the national transition took place in Q3 ROP2021.
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; PEPFAR is supporting national projections to increase MMD. PEPFAR SNU supports DSDM and has over 90% PLHIV on 3+ MMD.
4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	Policy adapted into national guidelines and scaled up nationally. National uptake is 12 percent; uptake in the PEPFAR SNU is 40 percent.
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.	Pursuing DNO exercise with GF/WV; increasing support through C19RM \$1 million in wraparound support.
Case Finding	
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 should be offered testing for HIV.	Phased roll-out of index testing in NCD; SOP developed and will be adopted by sites. PNG is providing TA for national scale-up.
Prevention and OVC	
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,	Beginning PrEP phased introduction in ROP22 with preparation in ROP21.

key populations and adult men engaged in high-risk sex practices)	
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 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	N/A
Policy & Public Health Systems Support	
9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.	HAMP Act protects HIV patients. Additional resources to operationalize strategies to reduce stigma and discrimination however more needs more TA support. CLM activity will support progress for PLHIV and KP.
10) 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 as part of the national policy and PEPFAR PNG ensures this in the NCD.
11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/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 the HIV Quality Improvement Framework. The policy is implemented in the PEPFAR PSNU. PNG will utilize CLM activity to provide TA for its national scale-up.
12) Evidence of treatment literacy 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 campaigns and demand generation activities
13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses	USAID is pursuing organizational assessments and other institutional strengthening activities. Currently, PNG has six local CSOs awarded subgrants, thus increasing coverage of HIV service provision in NCD. Established sub-grantee relationship with the Key Population Advocacy Consortium under the CLM Activity which now comprises five PLHIV, FSW, KP, transgender, and young KP community groups.
14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	Funding for HIV increased but has flatlined since FY 2019. Current budget and forecast for FY 2023 is forecasted to decrease slightly.

15) 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.
16) Scale-up of case surveillance and unique identifiers for patients across all sites.	Surveillance tools were updated with NUIC included to facilitate tracking of patients. Updated surveillance tools and patient management tools are currently in use.

TAJIKISTAN:

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 uninterrupted treatment across age, sex, and risk groups.	Test and Start has been adopted and implemented across the country with fidelity. In PEPFAR SNUs, the linkage rates increased to 94% in Q1FY22. 98% of linked to ART, started treatment with 7 days after diagnosis. There was low linkage for PWID in the beginning of FY21 but increased to 93% since that.
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.	Adopted for adult patients. Implementation on national level in process. Nationally almost 98% of adult ART patients receive TLD.
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.	Adopted and evenly implemented across the country. As of Q1FY22 we had 55% and 15% of TX_CURR on 3 to 5 and 6 MMD accordingly. TWG is working on recommendations to lift any restrictions to MMD implementation.
4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	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 viral load testing and results delivered to caregiver within 4 weeks.	Implemented with fidelity across the whole country
Case Finding	
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 should be offered testing for HIV.	Implemented with fidelity only in PEPFAR SNUs. HIV self testing started to be used in PEPFAR SNUs Tajikistan in FY21 with 690 tests handed over and 79% of those tests reported to be used with reactivity rate 1.3%. In FY23, a total of 3,000 HIV self tests are planned to be handed over through facilities and community outreach workers.
Prevention and OVC	
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,	PrEP has been partially implemented in PEPFAR SNUs. Rollout underway among MSM, sero-discordant couples, PWID, and FSW. Non-PEPFAR SNUs remains in the

key populations and adult men engaged in high-risk sex practices)	advocacy phase as of the conclusion of ROP20.
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 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	Not applicable
Policy & Public Health Systems Support	
9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.	Adopted; implemented with challenges but improving
10) 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.	Nationally scaled with fidelity
11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.	Implemented in PEPFAR SNUs.
12) Evidence of treatment literacy 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.	Adopted; rollout underway.
13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses	Transition underway
14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	Adopted; Because of a number of other competing priorities and shortage of budget it is implemented slowly and with challenges.
15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Nationally scaled with fidelity
16) Scale-up of case surveillance and unique identifiers for patients across all sites.	Adopted; rollout underway

THAILAND:

Care and Treatment	
<p>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 uninterrupted treatment across age, sex, and risk groups.</p>	<p>Test and start has been implemented nationwide. The national HIV treatment and care guidelines 2020/2021 recommend ART initiation regardless of CD4 level, age, sex and risk group. The guidelines recommend initiating same-day ART if PLHIV is ready and no later than 7 days if PLHIV have no contraindications. Free ART and lab packages are supported by the national AIDS program (NAP). All populations can access HIV testing free of charge at least 2 times a year and ART package in public hospitals registered in the NAP system. In FY2022, MOPH will disseminate the national SDART manual to all public hospitals in Thailand and provide MOPH SDART training to more than 300 health care workers in 4 regions. Thailand anticipates seeing improved national results by the end of FY2022.</p> <p>In community-based HIV service provision, CHWs will continue to provide ART counseling and offer index testing for all KP-PLHIV and facilitate KP-PLHIV to initiate SDART at referral hospitals smoothly.</p>
<p>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</p>	<p>Thai national HIV treatment and care guidelines 2020/2021 recommend TLD as the preferred first line regimen for all PLHIV. TLD was registered in the Thai national essential drug list in July 2021 and</p>

<p>kg, and removal of all NVP- and EFV-based ART regimens.</p>	<p>NAP system in January 2022. NAP system is planning to make TLD available for all PLHIV including new patients and active treatment patients in June 2022. MOPH expects to transition 80% of all PLHIV by end of 2022.</p> <p>Pediatric DTG dispersible 10 mg is being reviewed by Thai FDA and it is currently not available in the NAP system.</p> <p>In ROP21, all CHWs were trained in TLD drug use and in ROP22 they will provide TLD literacy to KP-PLHIV clients. CHWs will also provide ART including TLD care and support to ensure adherence of ARVs.</p>
<p>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.</p>	<p>MMD 3-6 months is recommended in the Thailand National Guidelines on HIV/AIDS Treatment and Prevention, 2021. NAP system allows a maximum of 6 months for ART dispensing while social security scheme system allows a maximum of 3 months. This is due to their concern about employees not being entitled to receive ART benefits after quitting their jobs.</p> <p>Differentiated service delivery models have been implemented in Thailand for many years. During the COVID-19 outbreak, common DSD models included telemedicine and ARV delivery via post, MMD4-6, fast-track ART refill, and ARV delivery by community or peers.</p> <p>All KPLHS sites will continue to monitor their KP-PLHIV clients whether or not their clients are receiving 6MMD and work</p>

	<p>closely with pair-referral hospitals to specialize 6MMD for KP-PLHIV.</p>
<p>4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.</p>	<p>TPT is recommended in the Thailand National Guidelines on HIV/AIDS Treatment and Prevention, 2021 for newly diagnosed PLHIV receiving ART <12 months with CD4 count < 200 cells/cu.mm. For newly diagnosed PLHIV with CD4 >200 cells/cu.mm or treatment_curr patients, provision of TPT is based on clinician’s recommendation or if using IGRA or TST guided for TPT. Uptake of TPT among Thai PLHIV is currently low, <2% of eligible target. The new TB/HIV guidelines will be published in May-June 2022 to provide a clear algorithm and clear indications for TPT among PLHIV.</p>
<p>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.</p>	<p>The Thailand National Guidelines on HIV/AIDS Treatment and Prevention, 2021 recommend VL testing annually and EID for babies from HIV infected mothers. VL/EID testing is under the HIV benefits package for all Thai people. VL laboratory network is well defined and fully implemented nationwide to allow 100% access to free annual VL testing under the universal health coverage and all health insurance schemes.</p>
<p>Case Finding</p>	
<p>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</p>	<p>Index testing is implemented in all 14 PEPFAR supported provinces (all PLHIV for facility-based and KP-PLHIV in KPLHS sites) plus 2 GF support provinces. PEPFAR Thailand provided trainings including IPV</p>

<p>under age 19 with an HIV positive biological parent should be offered testing for HIV.</p>	<p>assessment and supportive supervision. A national web-based reporting platform to monitor service data has been established and it is being used to provide programmatic feedback to sites for QI purposes.</p>
<p>Prevention and OVC</p>	
<p>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)</p>	<p>In Thailand the National PrEP Guidelines, 2021 recommend PrEP for all people who have high HIV risk including KPs and HIV-negative partners of HIV-positive index cases. PrEP is being scaled up through the NHSO. MOPH aims to train at least one hospital in each province to provide PrEP and build a foundation for PrEP service. MOPH also supports collaboration between government and CBO as partners in providing PrEP services.</p>
<p>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 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.</p>	<p>Not applicable</p>
<p>Policy & Public Health Systems Support</p>	
<p>9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs</p>	<p>Collaboration with UNAIDS Thailand and the National S&D task force led by the Human Rights Committee will move</p>

<p>demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.</p>	<p>forward the implementation of national S&D action plans by various stakeholders, including government and non-government sectors. CDC HQ S&D central funding through UNAIDS Thailand will be allocated to HIV CSOs to develop U=U communication messages, empower PLHIV and KP, and reduce self-stigma. This fund will also be allocated to a human rights CSO to implement non-discriminatory employment policies by advocating against mandatory HIV testing before employment through 4 major employee councils and labor unions covering more than 400,000 members.</p>
<p>10) 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.</p>	<p>All HIV services are fully covered under the health insurance schemes and by the government under the universal health coverage for all Thais in the public health facilities and some participating private health facilities. GF will continue to support and cover migrant health.</p>
<p>11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.</p>	<p>All hospitals in Thailand have an infection control unit to guide implementation of infection prevention and control measures. PEPFAR Thailand support DQA and DQI data efforts for CQI. Coaching is provided to hospitals based on their performance. CQI activities are developed based on data.</p>
<p>12) Evidence of treatment literacy 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</p>	<p>PEPFAR Thailand worked with the Thai MOPH to develop a treatment literacy and viral load literacy manual and job aids for health care providers and patients. The job aids for patients have been distributed to</p>

<p>U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.</p>	<p>all public hospitals in FY2022 and job aids and manuals for health care workers will be disseminated to all public hospitals by the end of FY22. PEPFAR supported sites will be trained in ROP22.</p>
<p>13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses</p>	
<p>14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended</p>	<p>For PrEP, NHSO fund accounted for 15% of PrEP users in 2020 and 44% in 2021.</p>
<p>15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.</p>	<p>The national health data center at MOPH can provide morbidity and mortality data.</p>
<p>16) Scale-up of case surveillance and unique identifiers for patients across all sites.</p>	<p>All Thai people have their own Thai identity card with a unique identifier.</p>

NEW APPENDIX E – Assessing Progress towards Sustainable Control of the HIV/AIDS Epidemic **REQUIRED**

BURMA

1. Misalignments between Investments and Outcomes

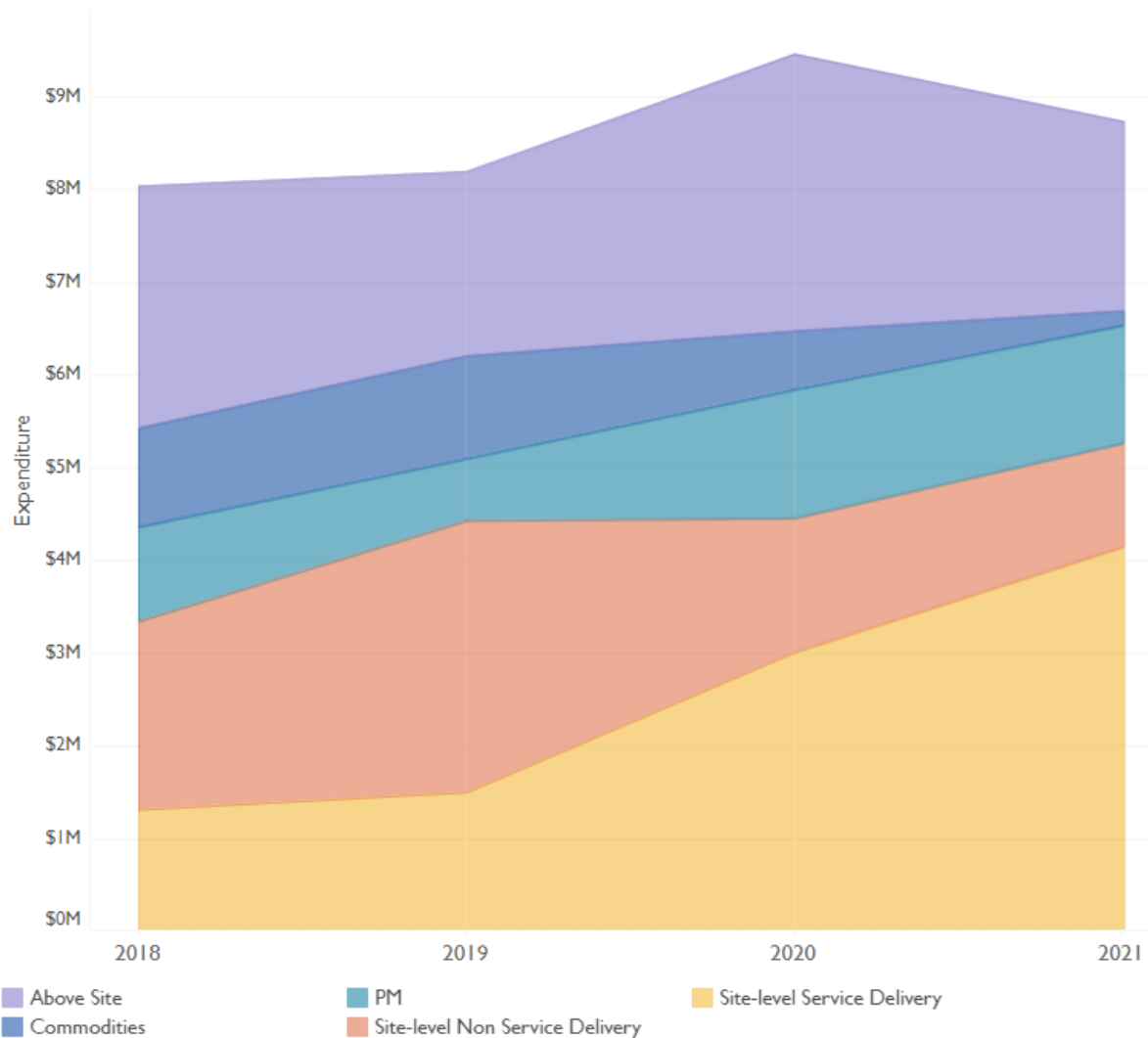
Due to the disruption and instability over the past year, PEPFAR Burma is not including figures for Trends in Investments (Figure E.1.1) and SID Scores for System-Related Elements (Figure E.1.2). Figure E.1.3., which shows the expenditure trends vis-à-vis interaction type and epidemic control status, reveals that efforts for greater domestic responsibility will require a strategic, multi-year, staged approach in partnership with local governments and institutions. The timeline for domestic responsibility of different elements of the response will vary, with some requiring continued donor investment over an extended period. Others, however, may present opportunities for exploring potential transfer of responsibility mechanisms within a shorter time frame.

The current political upheaval in **Burma** makes it difficult to make assumptions for sustainability planning. Following the U.S. Government non-engagement policy, PEPFAR has not been able to have the discussions to meaningfully plan for sustainability with the regime. Due to increased conflict and violence facing health workers and implementing partners, it is difficult to assess the extent to which the de facto leaders of Burma can serve as sustainability partners for HIV programming. In addition, there has been documented increased violence against the LGBTQI community and increasing conflict and internal displacement, and continued criminalization of key populations. In this environment, PEPFAR Burma has pivoted to support an increasing ART patient cohort, strengthen capacity of KP/community networks, CSOs, and private sector to fill gaps in HIV service delivery and actively participate in the Interim Coordinating Mechanism comprised of key stakeholders, UN agencies, technical partners and community / CSO groups. In the interim, PEPFAR Burma launched the HIV/TB Agency, Information, and Services Activity (HIV/TB AIS) in ROP21, paving the way for transition to a local partner. PEPFAR continues to invest directly in CSOs to lead design and delivery of HIV services (Community PrEP Distribution Points) and also quality monitoring through local CSO Pyi Gyi Khin. National domestic contribution has been maintained in ROP21 during the political instability. PEPFAR Burma is working closely with the Global Fund and other donors to maintain investment to ensure continued services.

Figure E.1.3.

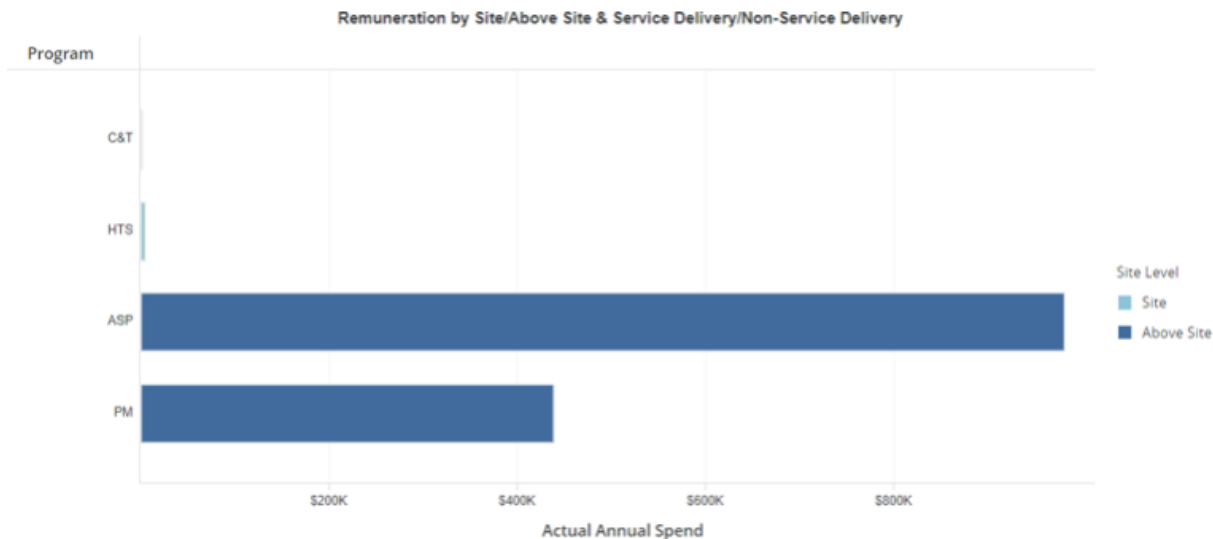
Interaction Type EXPENDITURE TREND

Agency:All | OU: Asia Region | Country: Burma



Trends in program spending for service delivery, above-site investment and program management reflect the changing situations in Burma and resources needed to maintain the progress towards epidemic control. Increased spending on site-level service delivery is required to fill the service gaps and the overall above-site level investment is maintained to strengthen the capacity of community networks, CSOs and private sector to deliver essential HIV services and ensure continuity of treatment in Burma.

Figure E.1.4.



PEPFAR Burma got exemption to report HRH inventory due to current crisis situation but three out of eight implementing mechanisms submitted their HRH reports. As two of those implementing mechanisms are above-site programs, major proportion of HRH remuneration in the figure 1.4 goes to above-site programming and program management. HRH data for Burma in this figure 1.4 do not reflect the actual HRH remuneration for the whole PEPFAR Burma program as the data from five other implementing mechanisms include site level and service delivery staffing expenditures were not reported.

2. Areas for Transition

Burma launched the HIV/TB Agency, Information, and Services Activity (HIV/TB AIS) in ROP21, paving the way for transition to a local partner. PEPFAR continues to invest directly in CSOs to lead design and delivery of HIV services (Community PrEP Distribution Points) and also quality monitoring through local CSO Pyi Gyi Khin. National domestic contribution has been maintained in ROP21 during the political instability. PEPFAR Burma is working closely with the Global Fund and other donors to maintain investment to ensure continued services.

3. Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response

PEPFAR Burma plays a major role in coordinating the HIV response with key stakeholders and supported a rapid assessment with the Global Fund to assess the status of HIV, TB and methadone services at township level after the coup. In ROP22, PEPFAR will continue to work alongside HIV stakeholders, including community groups, CSOs, UN agencies, technical partners and non-government actors to maintain essential HIV services and sustain progress toward epidemic control.

4. Agreements and plans on Data Use and Sharing and Quality control (including Central Support reporting).

The current political upheaval in **Burma** makes it difficult to make assumptions for sustainability planning.

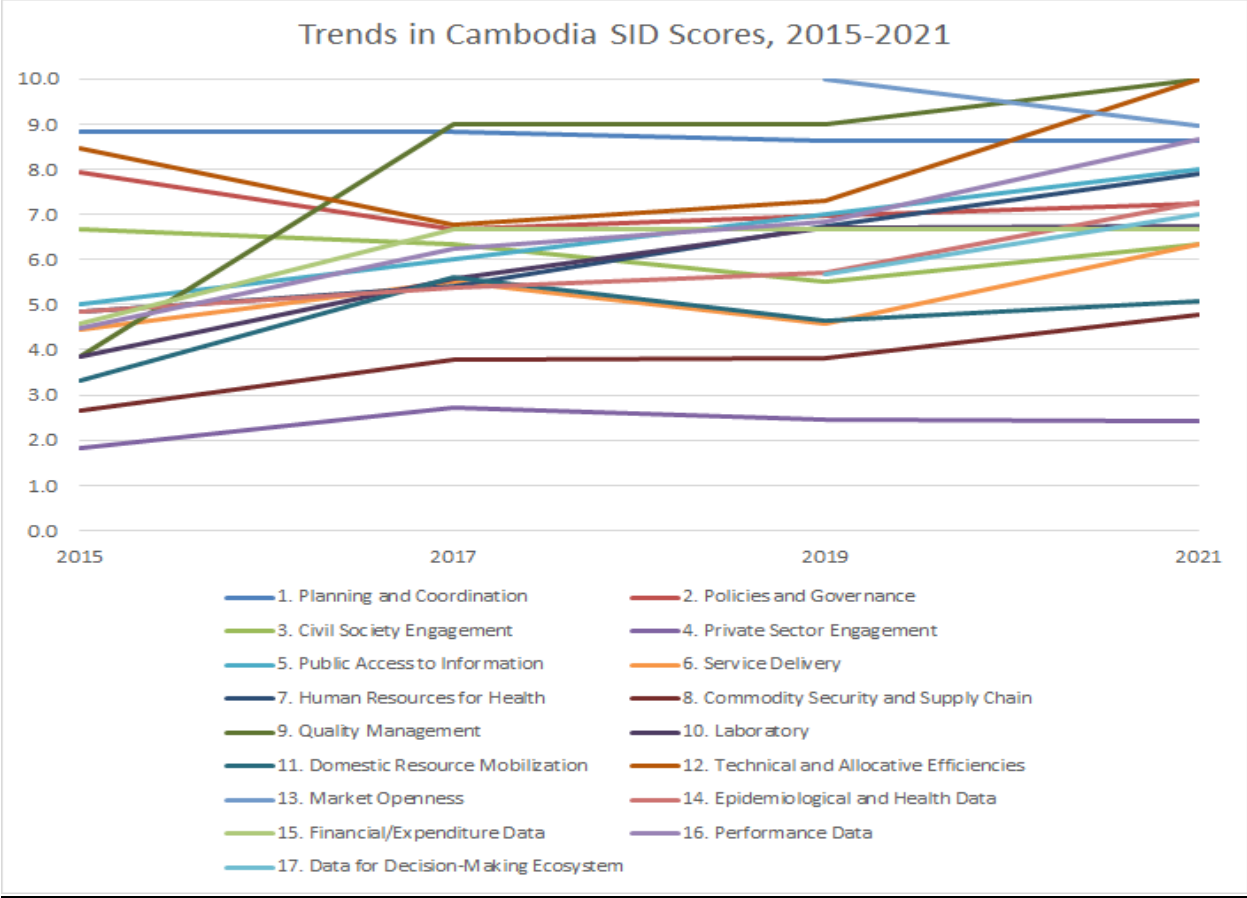
CAMBODIA

1. Misalignments between Investments and Outcomes

- ***Program Expenditures vs. SID Score Trends and Responsibility Ratings:***

Program Expenditures vs. SID Score Trends and Responsibility Ratings (in Figure E.1.1.a) shows most Cambodia SID elements have trended upwards over the four rounds of the Cambodia SID. Market Openness and Policies and Governance scores have declined slightly but remain strong. However, Private Sector Engagement scores have remained consistently low. Other areas of concern include domestic resource mobilization and civil society engagement. Figure E.1.1b demonstrates a trend in expenditure by sub-program area over time. Procurement and Supply Chain Management phased out in 2020 and HMIS and Surveillance work has declined over time. Public financial management and Laboratory Strengthening have remained relatively constant, while Policy, Planning and Coordination expenditures have increased. This reflects the program's shift towards technical assistance and strengthening country-led systems. As a result, PEPFAR Cambodia will focus on providing technical assistance during ROP22 to address these vulnerabilities. This will include PEPFAR support to provincial governments to mobilize funding for HIV to meet the government's commitment of funding 50% of the response by 2023; CSOs to generate revenue as social enterprises; and engagement with private sector for greater testing and referral of HIV services.

Figure E.1.1.a Trends in SID Scores for System-Related Elements

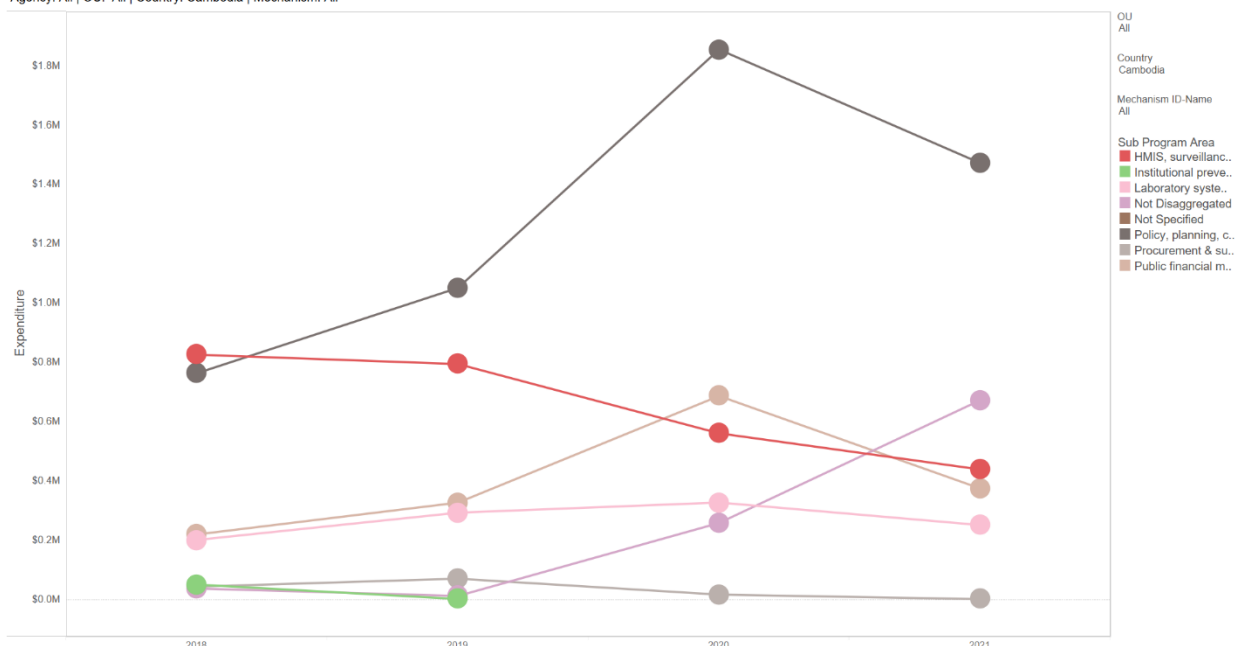


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Figure E.1.1.b Trends in Investments for System-Related Elements

ABOVE SITE EXPENDITURE BY SUB PROGRAM AREA

Agency: All | OU: All | Country: Cambodia | Mechanism: All



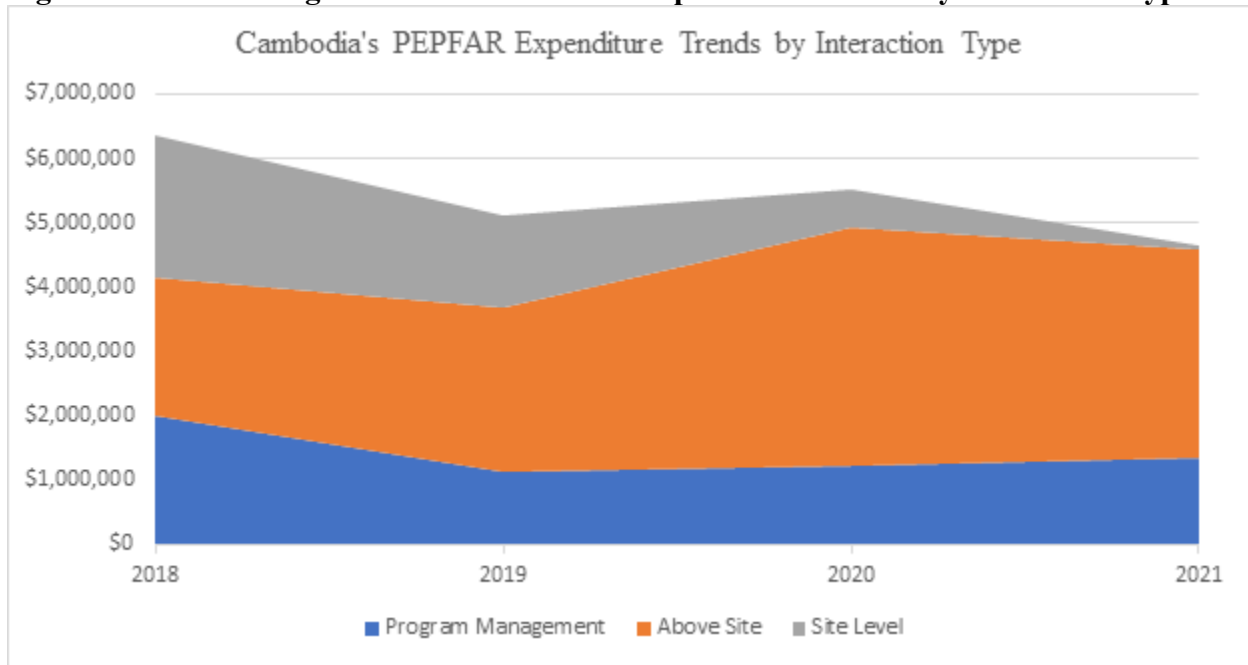
Responsibility Matrix data show that the host government has primary responsibility for nearly all investment areas, except for health workforce, where it has primary responsibility for 81%, with Global Fund (GF) responsible for the remainder. GF maintains primary responsibility for commodity procurement and KP programming, two areas (not shown in Table E.1.2) with opportunity for greater domestic involvement. As a technical assistance provider, PEPFAR has secondary or nominal responsibility in all areas. In ROP22, PEPFAR will engage in dialogue with the government, UNAIDS, DFAT and partners to look for opportunities to expand social contracting for KP-focused CSOs.

Cambodia			
% Primary Responsibility Ratings from Responsibility Matrix			
Health Systems Area	Host Country	PEPFAR	Global Fund
HMIS	100%	0%	0%
Laboratory Systems	100%	0%	0%
Supply Chain	100%	0%	0%
HRH Systems	100%	0%	0%
Policy	100%	0%	0%
Health Financing	100%	0%	0%
Other Systems Support	100%	0%	0%
Health Workforce	81%	0%	19%

- ***Trajectory of Service Delivery, Commodities, Non-Service Delivery, Above Site Program, and Program Management Expenditures and Country’s Status of Achieving HIV/AIDS Epidemic Control:***

PEPFAR Cambodia discontinued site level programming in 2018 and fully expended all site-level funds in 2021 as part of a strategic shift to a technical assistance-only program. Program management expenditures have also decreased over time as the overall PEPFAR funding envelope has decreased. PEPFAR Cambodia achieved 90-90-90 status in 2017 and is now focused on improving case finding and prevention to achieve the 95-95-95 goals by 2025. Current programming focuses on technical assistance aimed at institutionalizing health policies, practices and systems that are equitable and sustainable and transitioning to a country-owned public health and HIV response.

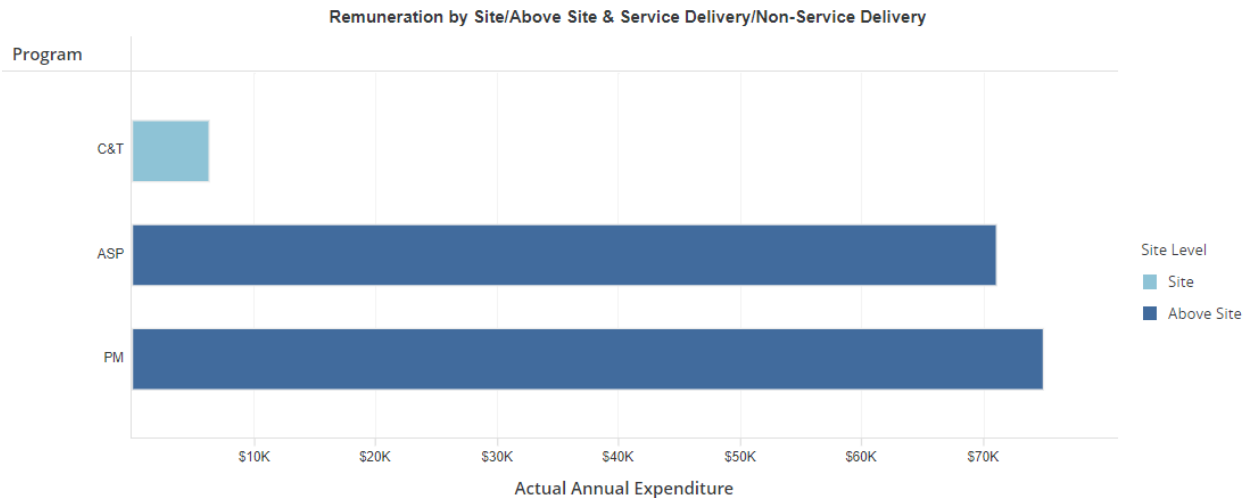
Figure E.1.3. Assessing Cambodia’s PEPFAR Expenditure Trends by Interaction Type



HRH Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery:

HRH data for Cambodia show that in FY21 PEPFAR invested in staffing mostly for above-site programming and program management. Care and treatment staffing expenditures were for close-out costs of procurement and supply-chain activities. For ROP22, all staffing expenditures will be in above-site programs and program management.

Figure E.1.4. Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery



2. Areas for Transition

UNAIDS and the National AIDS Authority (NAA), in collaboration with PEPFAR Cambodia and key stakeholders, developed a Transition Readiness Assessment (TRA) and Sustainability Roadmap in December 2018. These documents lay out key vulnerabilities to sustainability, recommended mitigating actions, and a timeline for increasing domestic responsibility of the HIV response. The TRA and Sustainability Roadmap identified key sustainability risks in the categories of service delivery and health systems, civil society organizations and costs and financing. A central focus was the need to transition donor-funded and contract staff to government systems; find sustainable funding for KP-focused CSOs; and cover the funding gap with domestic funds as PEPFAR and GF funding decline. During ROP21, UNAIDS with PEPFAR-USAID regional funding is supporting a review of the Sustainability Roadmap to assess progress and update recommendations. These findings will be used to inform future sustainability interventions from PEPFAR and partners moving forward.

3. Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response

PEPFAR Cambodia regularly engages with the Government of Cambodia on sustainability concerns. The Government-Donor Joint Technical Working Group (GDJ TWG), chaired by the NAA, with membership from NCHADS, PEPFAR, UNAIDS, GF, and other partners, meets regularly to coordinate and inform key strategies of the HIV response. During COP22, key areas of engagement will include reviewing progress against the Sustainability Roadmap and key government policies including decentralization and de-concentration, social contracting, and private sector engagement. During 2023, the GDJ will also discuss how to advance sustainability through the next round of the GF grant. PEPFAR is an active member of the GF's Country Coordinating Mechanism (CCM), chaired by the Ministry of Economy and Finance, which discusses country strategy and plans, and coordinates activities and government and donor resources. During ROP22, PEPFAR will continue as an active CCM member.

4. Agreements and plans on Data Use and Sharing and Quality control (including Central Support reporting).

Since 2019, NCHADS, with support from PEPFAR, UNAIDS, WHO, GF, and other partners, has developed the Cambodia Master Patient Index (MPI) using the DHIS2 platform. The MPI allows for data import, indicator calculation, dashboards and visualizations, and report generation. During ROP21, PEPFAR Cambodia finalized core national indicators for the MPI; regular reviews of the imported data ensure data quality and ART site hardware, software, and internet connection are regularly assessed. Piloting of the finalized data entry platform will be launched at seven sites by the end of ROP21; currently PEPFAR is working on user acceptance testing.

The program has been providing capacity building to NCHADS to calculate and analyze national monitoring indicators and to build management capacity for the MPI project. In May 2022, PEPFAR Cambodia will conduct a data use workshop to develop a visualization dashboard for recency data in the DHIS2 MPI, which will be used for recency reporting, quality control monitoring, and hotspot detection and response.

INDIA

1. Misalignments between Investments and Outcomes

Figure E.1.1

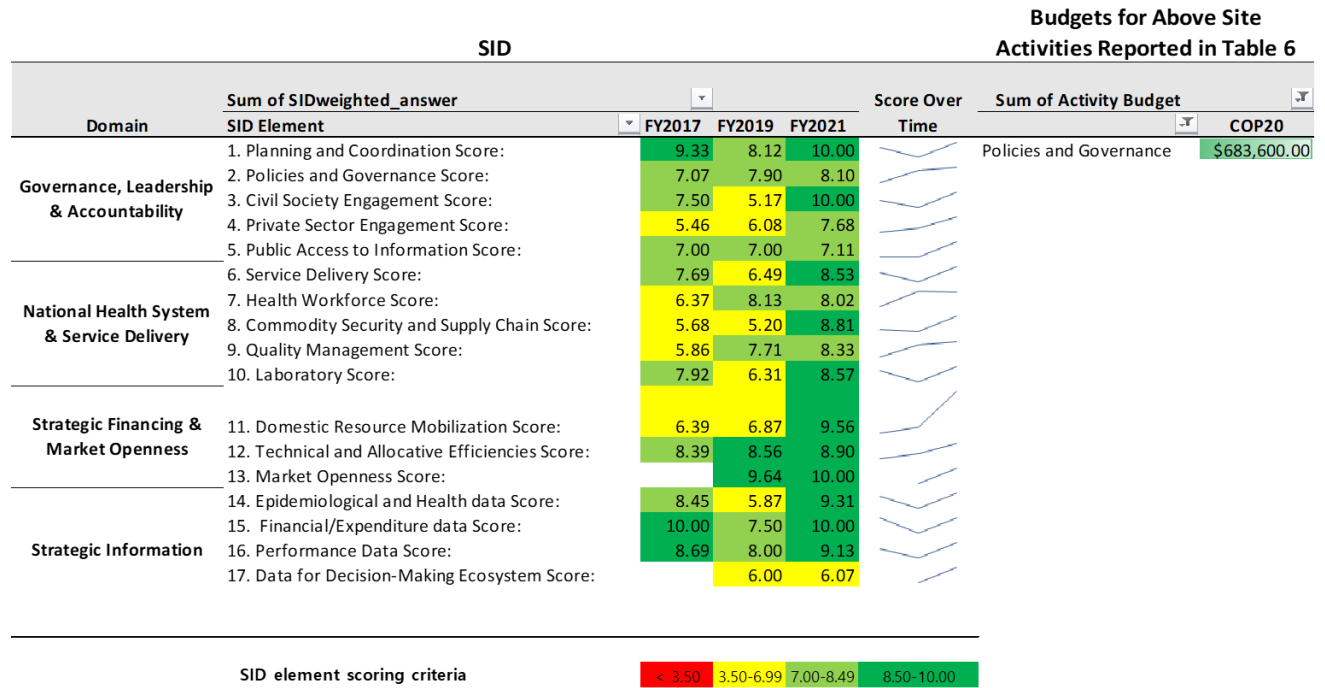


Figure E.1.2 - Data not available

Figure E.1.3.

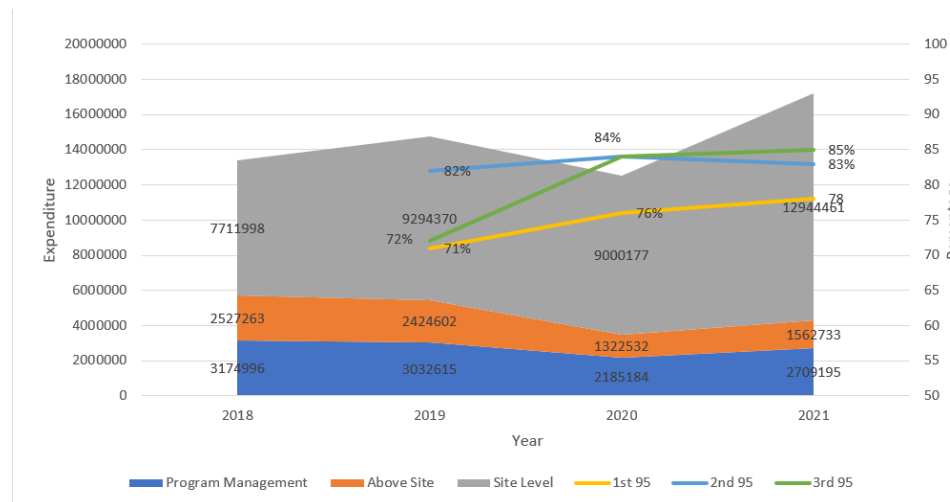
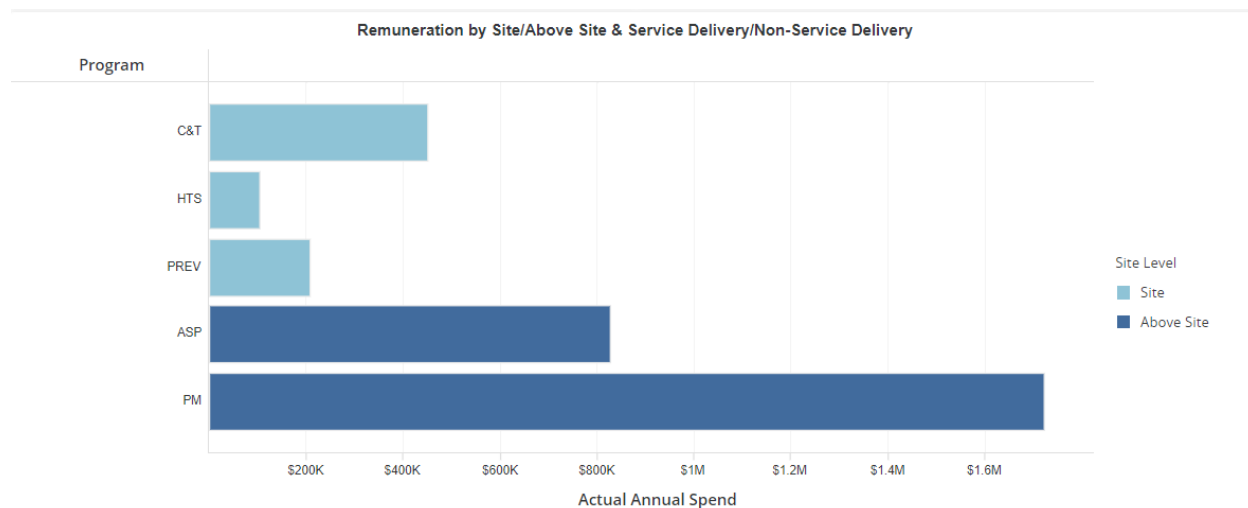


Figure E.1.4.



PEPFAR India conducted a staffing analysis to ensure staffing aligns with new and continued PEPFAR priorities and requirements. PEPFAR India is not proposing any new positions. To maximize effectiveness and efficiency within the ARP, Several PEPFAR India staff provide regional support as “regional assets”.

USAID’s PEPFAR funding for cost-of-doing-business (CODB) includes resources to provide targeted support to partners to meet rigorous PEPFAR results and expenditure reporting requirements, as well as USAID award compliance guidelines. USAID’s CODB ensures adequate staffing to design, award, and effectively manage implementing mechanisms as well as anticipated surge support requirements when necessary.

The total ROP 22 PEPFAR India Budget is \$ 24, 360,000. For the program area, Care & Treatment budget is the highest at 25.6%, followed by Prevention budget at 12.4%, Above site budget at 10.7%, HTS budget at 9.2% and OVC budget is 7.3%.

Assessing Progress towards Sustainable Control of HIV/AIDS

The National AIDS Control Program (NACP) 5 is a five-year National Plan that launched at the start of April 21 and will serve as the implementation roadmap through ROP22. This plan has a five-year budget of over \$2 billion allocated for the national HIV/AIDS response, which domestically funds more than 95% of the national program.

The Government of India is prioritizing HIV service integration with the general health services along with human resource optimization in an effort to move towards long-term sustainability. The sustainability effort is shown through the GOI flagship prevention program Sampoorna Suraksha Strategies and cross engagement across line ministries for greater collaboration toward person-centered services.

The GOI is the major donor at the country level for the health systems, including HMIS, laboratory services, supply chain, HRH systems, policy and other support services. Areas that could be further strengthened include Policies and Governance, Private Sector Engagement, and Public Access to information.

New infections in India have declined by 48% since 2010 against the global average of 31% and annual AIDS-related deaths have declined by 82% between 2010 and 2020 against the global average of 42%. PEPFAR India works in close collaboration with NACO, playing a catalytic role in supporting NACO for developing a clear pathway to full country ownership of a sustainable HIV response. PEPFAR India will continue to collaborate with the GOI to demonstrate and scale sustainable strategies for person-centered services with a focus on health equity and expanded access for all, including key populations.

Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response

The host government's contribution to the HIV response is above 94% in India. With the approval of the National AIDS Control Program (NACP) Phase V, the next five years' budget allocation is over \$2 billion USD. The Global Fund is the largest funding source in India, with the current budget of \$155 million, under the New Funding Model (2021-2024). A key focus of the national government is to 'break the silos and to build synergies'. There is significant engagement from the national government around sustainability of the HIV response as a domestically funded program. PEPFAR India continues to provide technical assistance to strengthen evidence-based programming to accelerate towards epidemic control.

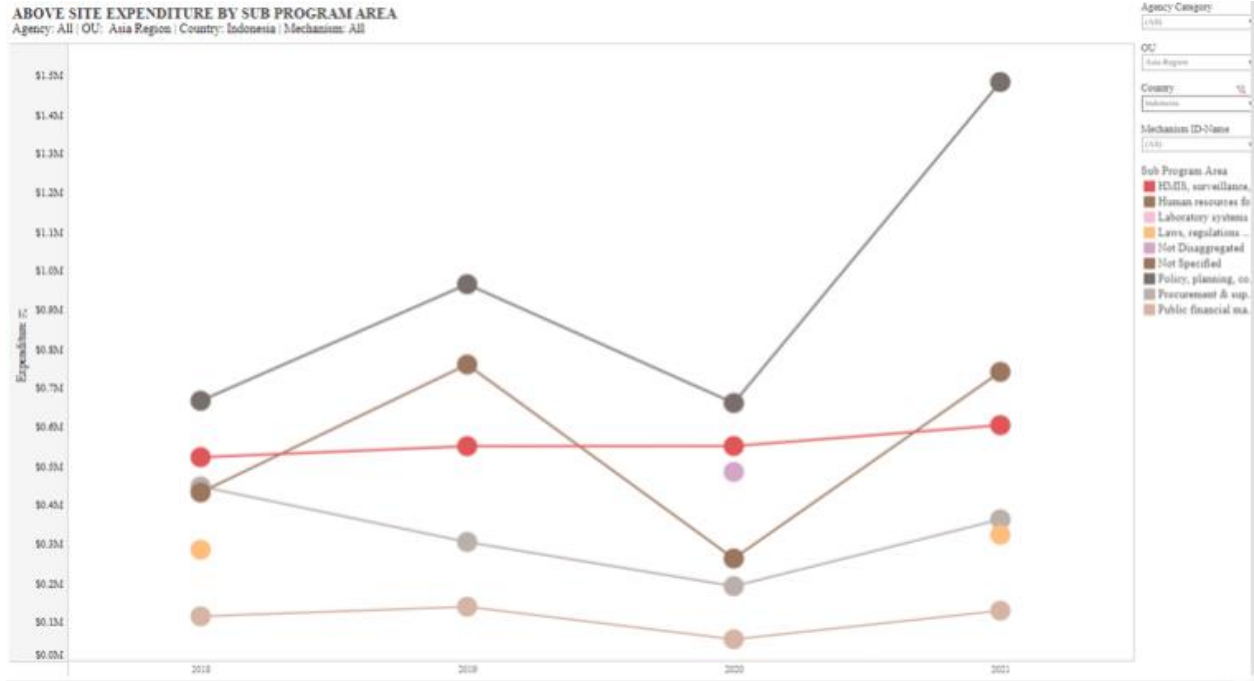
Agreements and plans on Data Use and Sharing and Quality control (including Central Support reporting).

The GOI and the National AIDS Control Program maintains standard operating procedures for data use, sharing and quality control. All partners are required to have MOU with the GOI and adopt data protection procedures including confidentiality protection per the MOU. These are updated on a regular basis.

INDONESIA

1. Misalignments between Investments and Outcomes

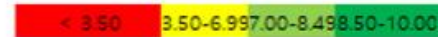
Figure E.1.1



SID

Domain	Sum of SIDweighted_answer SID Element	FY			Score Over Time
		FY2017	FY2019	FY2021	
Governance, Leadership & Accountability	1. Planning and Coordination Score:	8.57	6.45	6.81	
	2. Policies and Governance Score:	7.06	6.48	4.75	
	3. Civil Society Engagement Score:	4.67	5.83	5.67	
	4. Private Sector Engagement Score:	4.78	4.67	4.49	
	5. Public Access to Information Score:	5.00	9.78	4.89	
National Health System & Service Delivery	6. Service Delivery Score:	7.69	7.32	5.42	
	7. Health Workforce Score:	6.74	5.44	5.32	
	8. Commodity Security and Supply Chain Score:	7.11	6.17	4.05	
	9. Quality Management Score:	7.38	8.00	6.24	
	10. Laboratory Score:	5.33	5.76	6.46	
Strategic Financing & Market Openness	11. Domestic Resource Mobilization Score:	7.93	7.90	7.08	
	12. Technical and Allocative Efficiencies Score:	8.00	6.86	4.00	
	13. Market Openness Score:		6.29	8.45	
Strategic Information	14. Epidemiological and Health data Score:	5.54	6.06	5.47	
	15. Financial/Expenditure data Score:	8.33	7.50	8.33	
	16. Performance Data Score:	7.11	9.72	8.17	
	17. Data for Decision-Making Ecosystem Score:		7.67	5.00	

SID element scoring criteria



SID: Financing by Domestic Sources				Change Over Time
	2017 Response	2019 Response	2021 Response	
National HIV Response				
% financed with domestic public and private sector funding	Most (50 – 89%)	Most (50 – 89%)	Most (50 – 89%)	
Service Delivery				
% financing for service delivery from host country	Most (50 – 89%)	Most (50 – 89%)	Some (10–49%)	
% financing for service delivery to key populations from host country	Most (50 – 89%)	Some (10–49%)	Most (50 – 89%)	
Health Workforce				
% health worker salaries provided by host country institutions	All or almost all (90%+)	All or almost all (90%+)	All or almost all (90%+)	
Commodities				
% financing for ARVs from host country	All or almost all (90%+)	All or almost all (90%+)	All or almost all (90%+)	
% financing for rapid test kits from host country	All or almost all (90%+)	All or almost all (90%+)	All or almost all (90%+)	
% financing for condoms from host country	Minimal (1–9%)	None	None	
Supply Chain Plan				
% financing for supply chain plan from host country	Most (50 – 89%)	Some (10–49%)	All or almost all (90%+)	
Laboratories				
% financing for laboratories from domestic public or private sources	Some (10–49%)	Some (10–49%)	Most (50 – 89%)	
Surveys and Surveillance				
% financing for general population surveys and surveillance from host country	None	Not conducted within the past 5 years	Not conducted within the past 5 years	
% financing for key population surveys and surveillance from host country	Minimal (1–9%)	Minimal (1–9%)	Most (50 – 89%)	
Service Delivery Data				
% financing for service delivery data collection from host country	Some (10–49%)	All or almost all (90%+)	Most (50 – 89%)	

Tabulation of Responsibility Matrix Responses 2021

Functional Element	Host Govt.			PEPFAR		
	Primary	Secondary	Nominal or None	Primary	Secondary	Nominal or None
Total across elements	161	12	24	26	71	102
Above Site (Systems) Programs	31	2	22	0	27	19
Commodities	41	1	1	1	3	48
Health Workforce	15	9	0	0	15	18
Program Management	2	0	0	0	0	0
Site-Level Programs (excl. Commodities and Health Workforce)	72	0	1	25	26	17

Host Government Responsibility

■ Primary ■ Secondary ■ Nominal or NA



PEPFAR Responsibility

■ Primary ■ Secondary ■ Nominal or NA



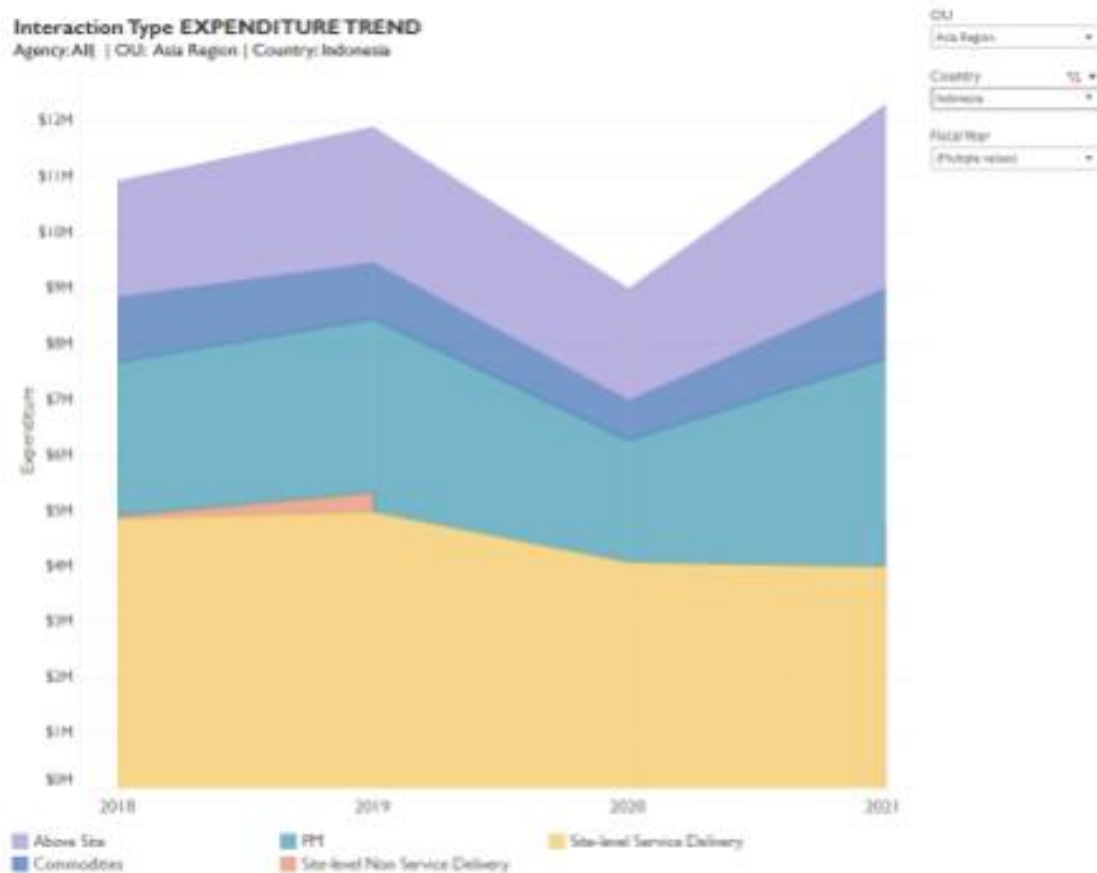
Indonesia has experienced an overall decrease in SID Score in 2021. Notably, Public Access to Information (element 5), Commodity Security and Supply Chain (element 8), Policies and Governance (element 2), and Service Delivery (element 6) have dropped by almost 50, 34, 27, and 26 per cent respectively. Additionally, while some of the elements (Planning and Coordination, Laboratory, Market Openness, and Financial/Expenditure) increased slightly, none of the elements had a red score which is unsustainable and requires significant investment. Due to the ending of ASAP funding in ROP21, PEPFAR Indonesia will prioritize the investment in the following areas: policy and governance, service delivery and public access to information.

WHO guidelines, internationally recognized standards, will serve as primary references to support MOH in developing national health sector guidelines translating best evidence into best practices, including recommendations intended to optimize patient care, promoting health care quality by improving diagnostic accuracy and effective therapy. Hence, with continued support from PEPFAR Indonesia, the NAP, through its Technical Expert Panel, will update the national

HIV treatment guidelines to include a dolutegravir (DTG)-based regimen such as TLD as the preferred first-line and second-line treatment for PLHIV. Additionally, the national guidelines will also accommodate the same-day initiation of ART policy and built-in the scale-up of 3-6 month multi-month dispensing (MMD).

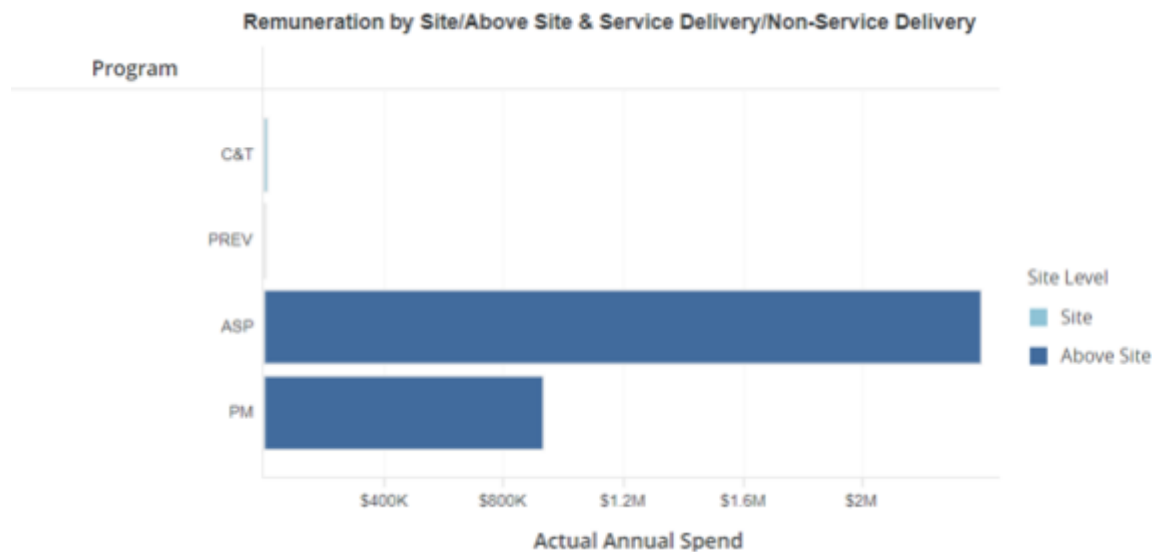
The 2021 SID score for Laboratory has slightly increased, in ROP22, PEPFAR Indonesia is prioritizing diagnostics network optimization (DNO) to ramp up the viral load and early infant diagnostics testing to achieve the third 95 goal. Innovative tools such as geographic information system (GIS)-based solutions can identify optimal locations for instrument installation and/or network expansion through a specimen transport system (STS). In addition, the Indonesian government must pursue its commitment to strengthening national laboratory networks, maximizing lab capacity, and increasing the number of Indonesians with viral load suppressed.

Figure E.1.3.



PEPFAR Indonesia expanded its technical assistance to eight districts (28 sites) in Greater Jakarta with ASAP Year-1 funding. Several above site activities such as coordination meetings, capacity building, and monitoring & evaluation activities were conducted with PHOs and DHOs in West Java and Banten to strengthen program management further. Particular attention to improving site-level data availability, collection, analysis, and timely reporting in Greater Jakarta to increase data quality. In addition, in close collaboration with the Global Fund, PEPFAR Indonesia, through our partners, provided small grants to several new CSOs in Greater Jakarta, which resulted in higher program management expenditure. Furthermore, COVID-19 has greatly affected in-person activities; most of the site-level activities were conducted virtually with high intensity to ensure the quality of technical assistance provided to the GOI.

Figure E.1.4.



In FY21, PEPFAR Indonesia spent HRH investment mostly to continue build the capacity of Provincial Health Offices, District Health Offices and selected health facilities in Jakarta and Greater Jakarta through various in-person, online training, on-the-job training, Training-of-Trainers (ToT) and mentoring. HRH has also prioritized on Data Collection, Monitoring and Evaluation, and Recording and Reporting to the National HIV Information system (SIHA), highlighting PEPFAR Indonesia’s priority for strengthening information systems and using data to improve HIV/AIDS program quality of service. In ROP22, PEPFAR resources in Indonesia will be mostly in above-site program and program management.

2. Areas for Transition

Building on the concerted efforts of PEPFAR’s partners, PEPFAR Indonesia will continue in ROP22 to advocate for policy changes following WHO recommendations to use TLD/DTG regimens as the preferred first-line and second-line treatment for all PLHIV, including pregnant women and those of childbearing age. PEPFAR will also actively advocate for rapid phasing out of nevirapine formulations through recommendations of optimal ARV regimens in the national treatment guidelines, removing nevirapine formulations from the national quantification and discouraging the procurement of nevirapine through market analysis for price and supply bottlenecks.

PEPFAR Indonesia will continue improving Strategic Information at the national and sub-national levels to analyze site-level data to monitor, identify, and trace those who have missed appointments and experienced interruptions in treatment. PEPFAR Indonesia and the GFATM will work closely to ensure the systematic deployment of the SIHA 2.0 upgrade. PEPFAR Indonesia will work closely with the GFATM PRs to utilize quarterly data analysis of SIHA 2.0 for programmatic improvement in the 13 priority districts.

The organization of health administrations in Indonesia is conducted through decentralization to 34 provincial governments, which protracted into districts and municipalities with health-related obligations. As a result, local governments and municipalities became the key administrative units responsible for providing and budgeting public services. PEPFAR Indonesia will strengthen collaboration with the GFATM to ensure intensive technical assistance at the district level: Strengthening the clinical mentoring system (doctor, nurse, pharmacy staff, lab staff) in Jakarta and adopting the system to be implemented in 13 priority districts.

3. Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response

The Ministry of Health finalized the National Action Plan in 2020 with the following main targets (outcomes) to pave the way to end the HIV epidemic in 2030, namely: in 2024, at least 90% of PLHIV know their HIV status, at least 75% of PLHIV will receive ARV treatment, and 90% of PLHIV who are on ARV treatment succeeded in suppressing the number of HIV viruses. In addition, MOH will prioritize increasing domestic funding to ensure there will be 100 per cent from national and sub-national governments.

In alignment with the National AIDS Strategy 2020-2024 and strengthened collaboration with the GFATM, PEPFAR Indonesia will continue to work in 13 districts in Jakarta and Greater Jakarta. These 13 districts cover 12% of the estimated KP, 19% of the estimated PLHIV, and 48,632 of the PLHIV not yet on treatment. In 2022, GFATM partners will take over community-based case finding efforts in these 13 districts, with PEPFAR implementing partners conducting case finding among MSM and PLHIV partners only. In addition, PEPFAR technical assistance will be directed to strengthening the provision of partner notification (index testing), improving the use of client segmentation data to increase testing efficiencies, and expanding online testing services and HIVST among hard-to-reach key populations.

PEPFAR Indonesia plans to initiate one-stop MMD and VL testing services to build a person-centered approach at health facilities in Jakarta. PEPFAR Indonesia will also further support MOH to optimize VL networks to maximize laboratory capacity to achieve the third 95, using innovative tools such as transport specimen application-based solution that can be used to identify optimal locations for instrument installation and/or network expansion through a specimen transport system (STS).

4. Agreements and plans on Data Use and Sharing and Quality control (including Central Support reporting).

PEPFAR Indonesia will prioritize the systematic deployment and data analysis of the SIHA 2.0 upgrade in the 13 priority districts. PEPFAR Indonesia will also continue to provide targeted technical assistance that improves data collection, analysis, and utilization at the site, district, provincial and national levels. The program will also support the Jakarta and Greater Jakarta PHOs and the MOH to coordinate, implement and monitor programming for 95-95-95 goals. In

addition, PEPFAR will continue technical assistance efforts to build an evidence-based practice, and strengthen the HRH system, including operationalization of district clinical mentorship teams.

At the moment, PEPFAR Indonesia will not pursue any agreement related to Data Use and Data Sharing with the Government of Indonesia.

KAZAKHSTAN

1. Misalignments between Investments and Outcomes

The SID 2021 revealed that, in the Governance, Leadership and Accountability domain, four out of five areas showed a slight decrease in scoring. Vulnerabilities remain with civil society’s participation in decision making such as national health financing decisions (0.83 score). The civil society participants of the SID discussion commented that policies for domestic funding of civil society are in place (1.67 score) but implementation of the policies faces multiple structural and system barriers. PEPFAR Kazakhstan addresses this issue in ROP22 by including a grant to a local HIV-related organizations to continue to address lack of PLHIV participation in decision making at the local PSNU level but also at the national level. PEPFAR Kazakhstan will also continue to address barriers to implementation of social contracting by developing and algorithm of social contracting process and promotion of the social contracting plan that was developed under ROP20 and ROP21.

The role of community-based workers is not specified in national policies (zero score for 7.2 in SID 2021) will be addressed by developing legal framework that will help the official approval of job descriptions and tariffs (salary schedule) for community health care workers and include them in the list of official jobs under the Ministry of Health. In the Strategic Information domain, the areas of performance data and data for decision making showed decrease in scoring and for the area of data for decision making the score decreased and remained in a “yellow” range. The vulnerabilities identified in this SID compared to the previous SID are due to absence of the national, approved data quality strategy for HIV/AIDS data quality assurance and data review for quality issues. In ROP22, PEPFAR Kazakhstan will address this by focusing on quality of web-EHCMS data at the facility level and DHIS data at the community level.

Figure E.1.2

Kazakhstan			
% Primary Responsibility Ratings from Responsibility Matrix			
Health Systems Area	Host Country	PEPFAR	Global Fund
HMIS	67%	22%	11%
Laboratory Systems	74%	4%	22%
Supply Chain	63%	4%	33%
HRH Systems	89%	11%	0%
Policy	93%	3%	4%
PFM	74%	7%	19%
Other Systems Support	74%	22%	4%
Health Workforce	100%	0%	0%

As it was mentioned in Investment Profile section and above matrix shows the Government of Kazakhstan predominantly funds National HIV Response, however PEPFAR, Global Fund and UNAIDS investments are covering additional needs for site-level community-based services and policy-level contributions.

- **Trajectory of Service Delivery, Commodities, Non-Service Delivery, Above Site Program, and Program Management Expenditures and Country’s Status of Achieving HIV/AIDS Epidemic Control:**

Figure E.1.3.

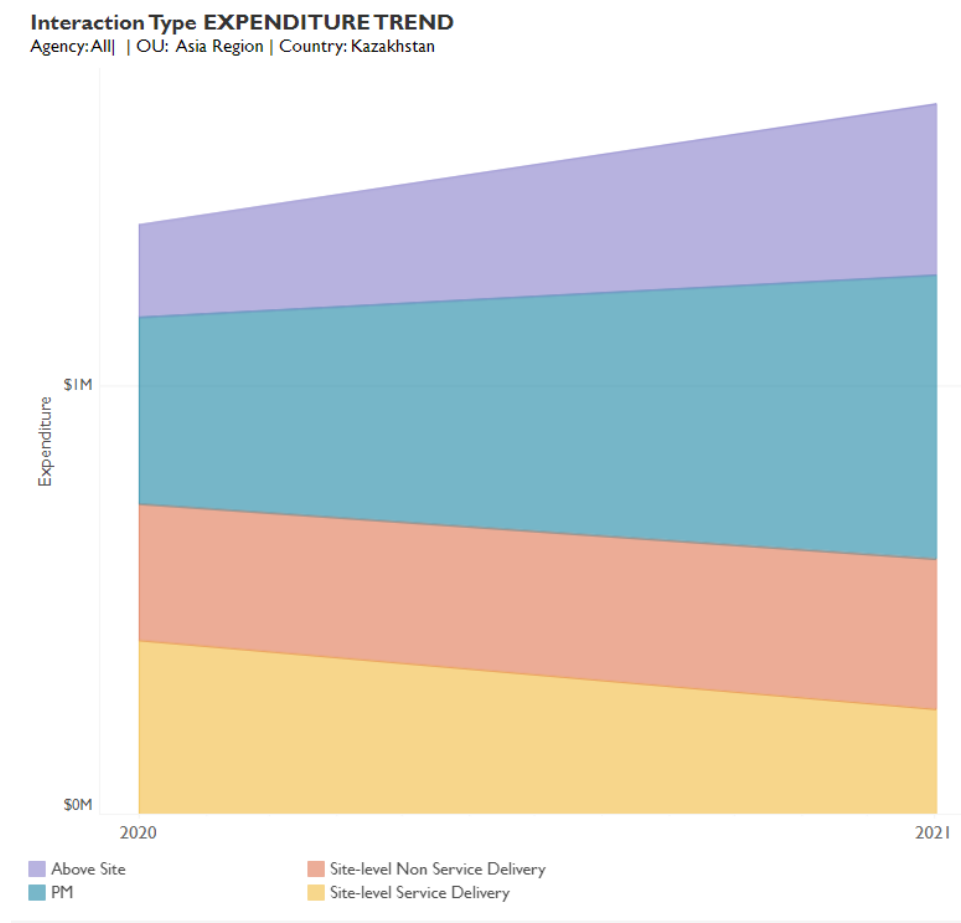
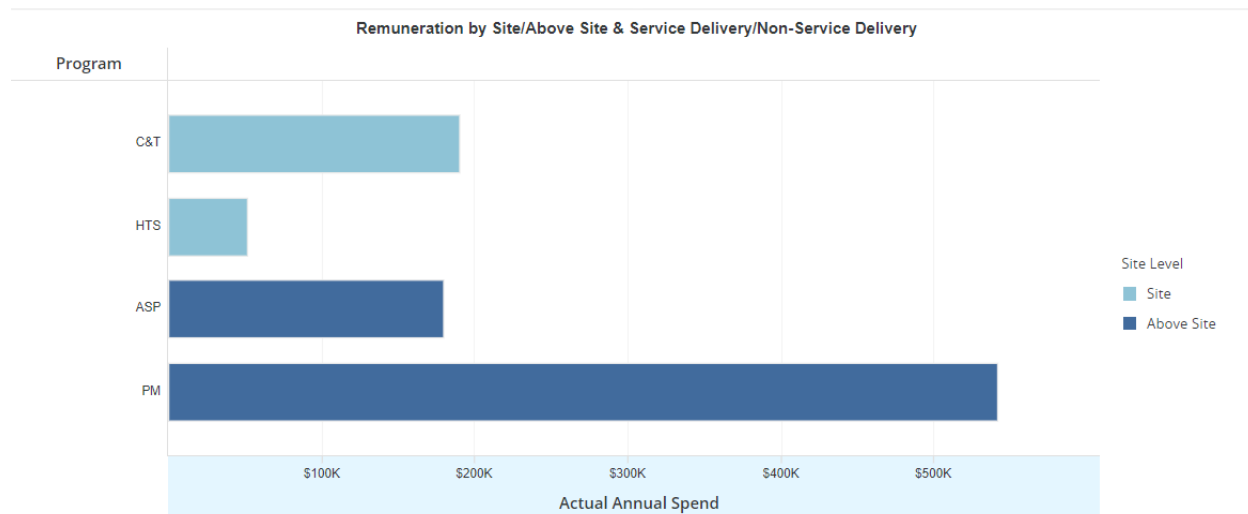


Figure E.1.4.



PEPFAR Kazakhstan is focused on technical assistance (above-site) level and continues site level programming in pilot sites for the last 3 years. Program management expenditures, primarily due to human resources for health (HRH) have slightly increased over time to support these programmatic priorities and shifts. NSD’s portion has increased whereas SD has the trend of decreasing. PEPFAR Kazakhstan is now focused on improving case finding, prevention (PrEP expansion) and treatment to achieve the 95-95-95 goals by 2025. Current programming focuses on technical assistance aimed at institutionalizing and adopting international health policies, practices and systems that are equitable and sustainable.

PEPFAR Kazakhstan reduced the number of sites from 14 to eight in two PSNUs and for community partners, from four NGOs to two NGOs in ROP19. In ROP21, PEPFAR Kazakhstan added one community partner to focus on HIV services among men who have sex with men. The above site level activities and funding increased starting ROP19-20 and the funding for above site activities will remain the same in ROP22 to focus on sustainability of community-based HIV services, on financial sustainability of the national HIV response, on data quality and on transition to more modern treatment and testing protocols.

2. Areas for Transition

Based on the analysis of the SID, RM, and other tools, PEPFAR Kazakhstan considers the following areas for the partner country government to take responsibility in the short-term:

- Service delivery (TLD transition, MMD and SDART)
- Continuous quality improvement (GSM, EQA) under “Service Delivery”,
- Improving quality data under “Strategic Information”.
- Governance and coordination under “Governance, Leadership and accountability” to improve financing of CBO through different mechanisms such as social contracting under “Strategic Financing”.

Transition of HIV service delivery to local and government partners continues to be a priority in COP22. According to SID 21, the government supports 90+% of the National HIV program needs. However, the country needs PEPFAR TA in introducing life-saving TLD that will finally be purchased by the Government of Kazakhstan in CY2023. Continuous quality improvement plays an important role and KSCDID is gradually starting to lead this process (regular GSM meetings and joint routine monitoring combined with SIMS visits). The newly developed web-Electronic HIV Case – based Management System was developed by the GOK with PEPFAR support and needs to be fully functional to provide reliable data for program monitoring. Timeline is one-three years.

KSCDID has been demonstrating increased leadership, governance, and coordination role in the recent years.

Given the current accomplishments, and planned support in ROP22, transition to the host country government is foreseen in the next two-three years. Risks – inadequate level of funding of health sector especially CBOs working on HIV and political and economic stability.

3. Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response

In ROP22 the PEPFAR Kazakhstan team will focus its engagement with the host country government (KSCDID, Social Health Insurance Fund- SHIF), CCM, and local partners (CSOs) to ensure sustainability of the following core elements:

1. Strategic financing: domestic resource mobilization, including social contracting and other financing solutions for CSO sustainability.
2. Differentiated service delivery (MMD), PrEP scale up, and HIV self-testing, targeted and ethical/safe case finding.
3. Care and treatment (TLD transition, linkage to care, SDART initiation)
4. Laboratory (EQA, QMS, laboratory accreditation, sustainability of tests procurement/registration issues)
5. Surveillance (improvement reliability of web EHCMS; BBS; improving capacities on surveillance and monitoring)
6. Eliminating of stigma and discrimination

PEPFAR Kazakhstan will continue to engage with the Government of Kazakhstan and other stakeholders at the PSNU and national level through individual and group meetings. The team will continue to regularly meet for granular site management to improve epidemic control indicators. PEPFAR will also continue to engage with the Government of Kazakhstan during joint CDC/USAID and implementing partners visits and during SIMS. PEPFAR is negotiating a position of an embedded advisor at KSCDID who will be helping in addressing program and financial sustainability of community HIV services.

4. Agreements and plans on Data Use and Sharing and Quality control (including Central Support reporting).

PEPFAR Kazakhstan supports development and implementation of the web-based Electronic HIV Case Management System (web-EHCMS). Web-EHCMS is a unified and single data source system for the country on HIV program. PEPFAR/KSCDID works day-to-day on the quality of the web-EHCMS to provide reliable data for decision making. During the next 2 years, KSCDID will develop e-PrEP within the database for community level services that is being developed by the Global Fund. KSCDID will develop and implement a tool for assessing the quality of HIV services in health facilities and a guide to M&E of the National HIV Program with the analytical algorithm. Quality control of the data is ensured through regular DQA, GMS, SIMS and site visits.

KYRGYZ REPUBLIC

1. Misalignments between Investments and Outcomes

PEPFAR Kyrgyz Republic used data from the SID-light conducted in 2021 to inform ROP22 priorities. In recent years we have seen a decrease in spending on HIV in the Kyrgyz Republic due to COVID-19 pandemic. In ROP22, PEPFAR Kyrgyz Republic will continue building the management and technical capacity of the RAC/MOH and civil society organizations to ensure the sustainability of program achievements.

PEPFAR Kyrgyz Republic will continue to build upon existing partnerships and close collaborations with the MOH institutions such as Republican AIDS Center (RAC) and Republican Psychiatric and Narcology Center (RPNC), CSOs, NGOs, KP-led organizations, and development partners (i.e., UNAIDS and Global Fund) in ROP22. The development of ROP22 was a participatory process which included consultation with all the key stakeholders of the HIV national response. Between January and April 2022, PEPFAR Kyrgyz Republic held events attended by a range of key stakeholders, including MOH, CSOs, GF, UNAIDS, WHO, Soros Fund and AFEW. PEPFAR Kyrgyz Republic team introduced the priorities for the next year and provided the opportunity for all participants to inform ROP22 development. Collaboration with community groups, CSOs, and clients helped us diagnose and pinpoint persistent problems, challenges, and barriers with service uptake and client outcomes at the site level. PEPFAR Kyrgyz Republic team reviewed progress, activities, and complementarity across all development partners; as well as discussed in detail the development of ROP22 plans, to ensure alignment and inclusive planning, and to obtain preliminary commitments of others to ambitious PEPFAR targets and goals.

Figure E.1.1

PEPFAR Kyrgyz Republic conducted its first SID-light in 2021 so is not able to provide trends in SID scores.

Figure E.1.2

Kyrgyz Republic			
% Primary Responsibility Ratings from Responsibility Matrix			
Health Systems Area	Host Country	PEPFAR	Global Fund
	%	%	%
HMIS	32.2%	67.8%	0.0%
Laboratory Systems	23.9%	29.3%	46.7%

Supply Chain	100.0%	0.0%	0.0%
HRH Systems	0.0%	100.0%	0.0%
Policy	16.0%	36.9%	47.1%
PFM	0.7%	6.5%	92.8%
Other Systems Support	31.6%	68.4%	0.0%
Health Workforce	7.2%	92.8%	0.0%

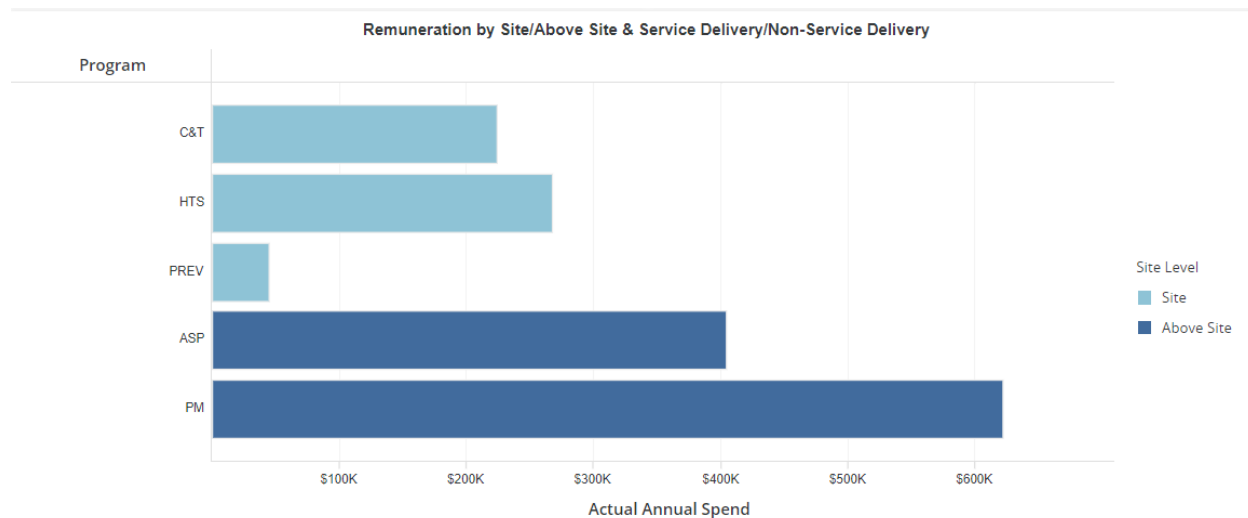
The above matrix shows that each investment agency has predominant responsibility ratings in some specific areas. Similarly, there are investment areas where all three investment agencies share their responsibilities. In particular, this concerns areas such as Laboratory Systems, Policy, and PFM. Functional responsibilities for HMIS, Health Workforce, and Other System Support are mainly divided between Government and PEPFAR.

Trends in program spending is almost the same as the previous years. The government budget is increased and fully cover all ART procurement. The overall NSD spending is potentially decreased, and CDC is more focused on granular site management to ensure the person-centered approach.

Figure E.1.3.



Figure E.1.4.



Major proportion of human resources for health remuneration goes to the above site activities with program management prevailing followed by the policy support activities. Site level and service delivery remuneration contributes mainly to testing (HTS), care and treatment and to some extent to prevention. This is aligned with the current distribution of roles/mandates of stakeholders in the country with the host government taking over more of the treatment and ARV procurement, GF providing prevention services, and PEPFAR working on innovative case finding, C&T and prevention (PrEP, MAT) solutions.

2. Areas for Transition

Based on the analysis of the SID, RM and other tools, PEPFAR Kyrgyz Republic team considers the following areas as three “low hanging” fruits for the Kyrgyz partner country government to take responsibility in the short-term: governance and coordination under “Governance, Leadership and accountability”, domestic resource mobilization (social contracting) under “Strategic Financing”, service delivery to non-KP (MMD, SDART, TLD transition) and quality management (GSM, DQA) under “Service Delivery”, as well as performance data under “Strategic Information”.

Kyrgyz Republic’s RAC has been demonstrating increased leadership, governance and coordination role in the recent years. Provided there are no management staff changes in the next years, transition of those areas would be possible in one-three years. There are risks for this transition if staff changes, which is possible, given political instability and frequent changes in the partner country government.

Transition of HIV service delivery to local and government partners continues to be a priority in COP22. Service delivery to KPs will still require further support from development partners due to limitations with local funding and capacity of local providers, however provision of HIV service delivery for non-KP population have been adequately implemented by the partner country government (RAC, PHC). Quality management of HIV services has also been improving through GSM and DQA and monitoring systems, and expected to be transitioned safely short-term. Timeline – one-three years. Risks – emerging pandemics as COVID-19 or political instability may lead to disruptions in service delivery and resource reallocation/decrease.

PEPFAR has been supporting introduction and implementation of social contracting in HIV for several years, and Kyrgyz Republic’s progress is considered as one of the best practices. Given the current accomplishments, and planned support in ROP21 and ROP22, transition to partner country government is

foreseen in the next two-three years. Risks – inadequate level of funding of health sector leading to overall declines in allocations within the sector.

RAC's Performance data is at an adequate level and is gradually transitioned within the next couple of years.

3. Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response

In ROP22, the PEPFAR Kyrgyz Republic team will focus its engagement with the partner country government (MOH, RAC, Republican Narcology Center, MHIF), CCM, and local partners (CSOs) to ensure sustainability of the following core elements:

1. Strategic financing: a) domestic resource mobilization, including social contracting and other financing solutions for CSO sustainability; b) integration of HIV services (including MAT program) into Mandatory Health Insurance Fund; and, c) assessment of and identifying next steps for increasing private sector engagement;
2. Differentiated service delivery (CBART, community-based PrEP), scale up of PrEP and HIV self-testing, targeted and ethical/safe case finding;
3. HRH exercise (GF initiative) relevant to Social Contracting;
4. Care and treatment (linkage to care, SD-ART initiation, MMD and TLD transition);
5. Laboratory (EQA, QMS, laboratory accreditation, sustainability of tests procurement/registration issues);
6. Surveillance (improvement of local capacities on surveillance and monitoring); and,
7. Elimination of stigma and discrimination.

4. Agreements and plans on Data Use and Sharing and Quality control (including Central Support reporting).

PEPFAR Kyrgyz Republic supported the development and implementation of Electronic HIV Case Management System (EHCMS), Electronic MAT Register (EMR), and e-PrEP that have been institutionalized and owned as a national information management system of the MOH. These are unified and single data source systems for the country on HIV program. All partners have the right to request and get the needed data from EHCMS, EMR, and e-PrEP from the MOH. In addition, PEPFAR has introduced DHIS2 for data management at community level, and there are discussions with RAC on the potential of using this open-source platform as a unified platform for the country-wide data at community level. Quality control of the data is ensured through regular SIMS, DQA and site visits.

LAOS

The results of a series of consultation with key stakeholders to complete 2021 SID & RM revealed that Lao government (GOL) has demonstrated strong leadership in development of national HIV/AIDS strategy, enabling policy and coordinating the HIV epidemic response with further improved national strategic information and quality management systems. GOL has been able to steadily improve many of

the sustainability elements in SID. However, the country remains highly dependent on external resources to secure ARV drugs and HIV test kits and to fund its HIV response especially among key populations. GOL has limited engagement of private sector in HIV/AIDS program response and has yet to provide funding for civil society organizations. 2021 SID assessment found key health systemic challenges including inadequate service delivery system, laboratory quality and data use for decision making. The challenges were related to the country's health infrastructure and lack of both human and financial resources.

- **Misalignments between Investments and Outcomes**

ROP22 intends to support GOL to address the identified key systemic barriers mentioned above especially in the areas of Service Delivery, Epidemiological and Health Data and Civil Society Organization Engagement with relative low SID Scoring to accelerate program gain and achieve sustained HIV epidemic control in long term.

- ***Program Expenditures vs. SID Score Trends and Responsibility Ratings:***

Looking at the three-year trend of SID scores, planning and coordination, policies and governance, health workforce, epidemiological and health data, and performance data continued to improve reflecting on the years of investment in those areas. However, the scores for the civil society engagement, private sector engagement, laboratory and data for decision making declined or remains at low level. Therefore, the COP22 above-site expenditure will focus on the areas where SID scored consistently low.

Figure E.1.1

SID Scores Reported in Table 6

Above Site Activities and Budget Reported in Table 6

Domain	SID Score			COP19		COP20			
	Element	2017	2019	2021	SID Budget Element	Activities	Budget	Activities	Budget
Governance, Leadership & Accountability	1. Planning and Coordination Score:	8.12	8.29	8.29	Policies and Governance	1	\$50,000	1	\$10,000
	2. Policies and Governance Score:	6.66	7.61	7.98	Public Access to Information			3	\$140,000
	3. Civil Society Engagement Score:	4.67	5	4.17	Service Delivery	4	\$180,000		
	4. Private Sector Engagement Score:	2.39	5.86	5.22	Human Resources for Health	2	\$55,000	3	\$180,000
	5. Public Access to Information Score:	10	8.33	8.33	Laboratory			1	\$30,000
National Health System & Service Delivery	6. Service Delivery Score:	6.67	6.11	6.59	Epidemiological and Health Data			2	\$70,000
	7. Health Workforce Score:	6.2	6.92	7.94					
	8. Commodity Security and Supply Chain Score:	7.08	7.78	7.36					
	9. Quality Management Score:	6.81	8.33	8.33					
	10. Laboratory Score:	5.58	6.01	5.14					
Strategic Financing & Market Openness	11. Domestic Resource Mobilization Score:	8.19	7.74	7.12					
	12. Technical and Allocative Efficiencies Score:	5.71	7.58	8.1					
	13. Market Openness Score:		9.28	9.38					
Strategic Information	14. Epidemiological and Health data Score:	6.25	6.76	7.03					
	15. Financial/Expenditure data Score:	10	10	10					
	16. Performance Data Score:	5.67	9.03	9.2					
	17. Data for Decision-Making Ecosystem Score:		6	6					

The Responsibility Matrix below shows that the host government already assumes responsibility in the HRH systems, Policy, and Public Financial Management to a greater extent.

Opportunities for transition in medium- to long- term may be in the area of HMIS when DHIS2 becomes more operational and robust in terms of data visualization and use. The Health Workforce is another area of potential transition. GOL covers salary for all health care workers including clinicians and ancillary staff at HTC and ART facilities while key stakeholders including PEPFAR and GF provide technical assistance for in-service capacity building. As the technical capacity built among the Health Workforce and the GOL were to be able to retain them effectively, it is possible for the GOL to take greater responsibility in this area.

Figure E.1.2

Laos			
% Primary Responsibility Ratings from Responsibility Matrix			
Health Systems Area	Host Country	PEPFAR	Global Fund
HMIS	57%	0%	43%
Laboratory Systems	50%	0%	50%
Supply Chain	50%	0%	50%
HRH Systems	100%	0%	0%
Policy	100%	7%	4%
PFM	67%	0%	33%
Other Systems Support	0%	0%	0%
Health Workforce	55%	27%	18%

FUNCTIONAL ELEMENTS	FUNCTIONAL DIMENSIONS											
	SERVICE DELIVERY ¹				NON-SERVICE DELIVERY ASSISTANCE ²				STRATEGY FORMULATION AND PLANNING ³			
	Host Govt.	Private Sector	PEPFAR & Implementers	Global Fund & Implementers	Host Govt.	Private Sector	PEPFAR & Implementers	Global Fund & Implementers	Host Govt.	Private Sector	PEPFAR	Global Fund
Site-Level Programs (excl. Commodities and Health Workforce)												
<i>Care and Treatment (excl. ARV drugs)</i>												
Clinical	Dark Blue	White	Light Blue	Medium Blue	Dark Blue	White	Medium Blue	Dark Blue	Dark Blue	White	Light Blue	Light Blue
Laboratory (e.g., Lab monitoring; OI, EID, TB, CD4, VL testing)	Dark Blue	White	White	Dark Blue	Dark Blue	White	Medium Blue	Light Blue	Dark Blue	White	White	White
Community (e.g., Linkage, Retention, Adherence)	Medium Blue	White	Dark Blue	Dark Blue	Dark Blue	White	Medium Blue	Light Blue	Dark Blue	White	Light Blue	Light Blue
TB-HIV	Dark Blue	White	White	Dark Blue	Dark Blue	White	Light Blue	Medium Blue	Dark Blue	White	Light Blue	Dark Blue
<i>HIV Testing Services</i>												
Facility-based Testing	Dark Blue	White	Light Blue	Dark Blue	Dark Blue	White	Medium Blue	Light Blue	Dark Blue	White	Medium Blue	Light Blue
Community-based Testing	Dark Blue	White	Medium Blue	Dark Blue	Dark Blue	White	Medium Blue	Dark Blue	Dark Blue	White	Medium Blue	Dark Blue
Self-testing	Dark Blue	White	Dark Blue	Dark Blue	Dark Blue	White	Dark Blue	Dark Blue	Dark Blue	White	Dark Blue	Dark Blue
Testing at Pregnancy-related Visits	Dark Blue	White	White	Medium Blue	Dark Blue	White	White	White	Dark Blue	White	White	White
<i>Prevention</i>												
Community Mobilization, Behavior and Norms Change	Dark Blue	White	Medium Blue	Medium Blue	Dark Blue	White	Medium Blue	Medium Blue	Dark Blue	White	Light Blue	Light Blue
Condom and Lubricant Programming	Dark Blue	Light Blue	Light Blue	White	Dark Blue	Light Blue	Light Blue	White	Dark Blue	White	White	White
Prevention of Mother-To-Child Transmission (PMTCT)	Dark Blue	White	White	White	Dark Blue	White	White	White	Dark Blue	White	White	White

Voluntary Medical Male Circumcision (VMMC)												
Pre-Exposure Prophylaxis (PrEP)												
Other Biomedical Prevention												
Adolescent Girls and Young Women (AGYW) HIV Prevention												
Key and Priority Populations												
Female Sex Workers (FSW)												
People Who Inject Drugs (PWID)												
Men Who have Sex with Men (MSM)												
Transgender Population (TG)												
Prison Population												
Priority Population												
Gender-Based Violence (GBV) Programming												
Orphans and Vulnerable Children (OVC)												
Commodities												
Antiretroviral Drugs												
ARVs for Treatment												
ARVs for PrEP												
Consumables												
Condoms and Lubricants												

Rapid Test Kits	Dark Blue		Light Blue	Dark Blue	Dark Blue		Light Blue		Dark Blue	Light Blue	Dark Blue
Self-testing Kits	Dark Blue		Dark Blue	Dark Blue	Dark Blue		Dark Blue	Dark Blue	Dark Blue	Dark Blue	Dark Blue
Male Circumcision Kits and Supplies	Light Gray	Light Gray	Light Gray	Light Gray	Light Gray	Light Gray	Light Gray	Light Gray	Light Gray	Light Gray	Light Gray
Medicines											
Medication-Assisted Treatment (e.g., Naloxone)	Dark Blue				Dark Blue				Dark Blue		
Tuberculosis Medicines	Dark Blue				Dark Blue			Dark Blue	Dark Blue	Light Blue	Dark Blue
Other Essential Medicines	Dark Blue				Dark Blue			Dark Blue	Dark Blue	Light Blue	Dark Blue
Laboratory											
CD4									Dark Blue		Dark Blue
Viral Load					Dark Blue		Dark Blue		Dark Blue		Dark Blue
Reagents and Supplies (exclusive of VL & CD4)	Dark Blue				Dark Blue		Light Blue	Dark Blue	Dark Blue	Light Blue	Dark Blue
Health Equipment	Dark Blue				Dark Blue				Dark Blue		
PSM Costs	Dark Blue		Light Blue	Dark Blue	Dark Blue			Dark Blue	Dark Blue		Dark Blue
Health Workforce											
Health Care Worker: Clinical					Gray				Gray		
Salary and Benefits	Dark Blue			Dark Blue							
Salary Top-Ups	Light Gray	Light Gray	Light Gray	Light Gray							
Training and Supervision	Dark Blue		Dark Blue	Dark Blue							
Health Care Worker: Ancillary					White				Gray		
Salary and Benefits	Dark Blue		Dark Blue	Dark Blue							
Salary Top-Ups	Light Gray	Light Gray	Light Gray	Light Gray							
Training and Supervision	Dark Blue		Dark Blue	Light Blue							

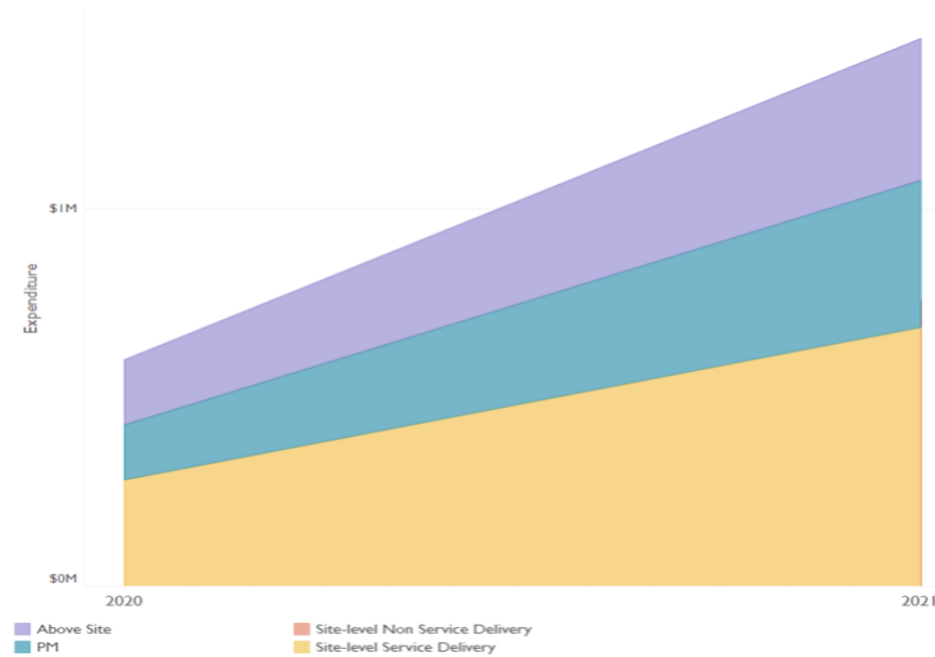
Sourcing and Procurement							
Quality Assurance and Control							
Risk Management							
Logistics Management							
Warehousing and Inventory Management							
Transport and Distribution							
Waste Management and Return							
Health Management Information Systems (HMIS), Surveillance, and Research							
Data Systems							
Monitoring and Evaluation							
Surveys and Surveillance							
HIV Population-based survey (e.g., PHIA)							
KP Demographic Surveys (e.g., IBBS)							
Laboratory Systems							
Conventional and Point of Care Instruments							
Laboratory Infrastructure and Equipment							
Laboratory Information System							
Procurement							

Quality Management Systems and Accreditation	[Grey Box]	[Dark Blue]	[Dark Blue]	[Dark Blue]	[Dark Blue]	[Dark Blue]
Logistics Management		[Dark Blue]	[Dark Blue]	[Dark Blue]	[Dark Blue]	[Dark Blue]
Sample Transport System		[Dark Blue]	[Dark Blue]	[Dark Blue]	[Dark Blue]	[Dark Blue]
<i>Health Financing</i>		[Dark Blue]	[Light Blue]	[Dark Blue]	[Dark Blue]	[Light Blue]
<i>Governance and Policy</i>		[Dark Blue]	[Medium Blue]	[Light Blue]	[Dark Blue]	[Light Blue]
<i>Institutional and Organizational Development</i>		[Dark Blue]	[Medium Blue]	[Light Blue]	[Dark Blue]	[Medium Blue]
<i>Site Level Quality Management</i>		[Dark Blue]	[Dark Blue]	[Light Blue]	[Dark Blue]	[Light Blue]
<i>Other Systems Support</i>		[Light Grey]	[Light Grey]	[Light Grey]	[Light Grey]	[Light Grey]
Program Management	[Light Grey Bar]					
<i>At the Implementation Level (Implementing Partners)</i>	[Grey Box]	[Dark Blue]	[Medium Blue]	[Medium Blue]	[Grey Box]	[Grey Box]
<i>At the Donor Level</i>	[Grey Box]	[Dark Blue]	[Medium Blue]	[Medium Blue]	[Grey Box]	[Grey Box]

- **Trajectory of Service Delivery, Commodities, Non-Service Delivery, Above Site Program, and Program Management Expenditures and Country’s Status of Achieving HIV/AIDS Epidemic Control:**

The below trends in service delivery, above site program and program management spending reflects the Laos current status of HIV/AIDS epidemic control of 76:73:72 where response requires the combination of increased site level service delivery and above-site investment to build capacity of the healthcare workers to deliver the services and the health systems to properly monitor and respond to the program performance. The increased level of program management also reflects the need to fill the capacity gap in country with stronger in-country management of program and oversight.

Figure E.1.3.

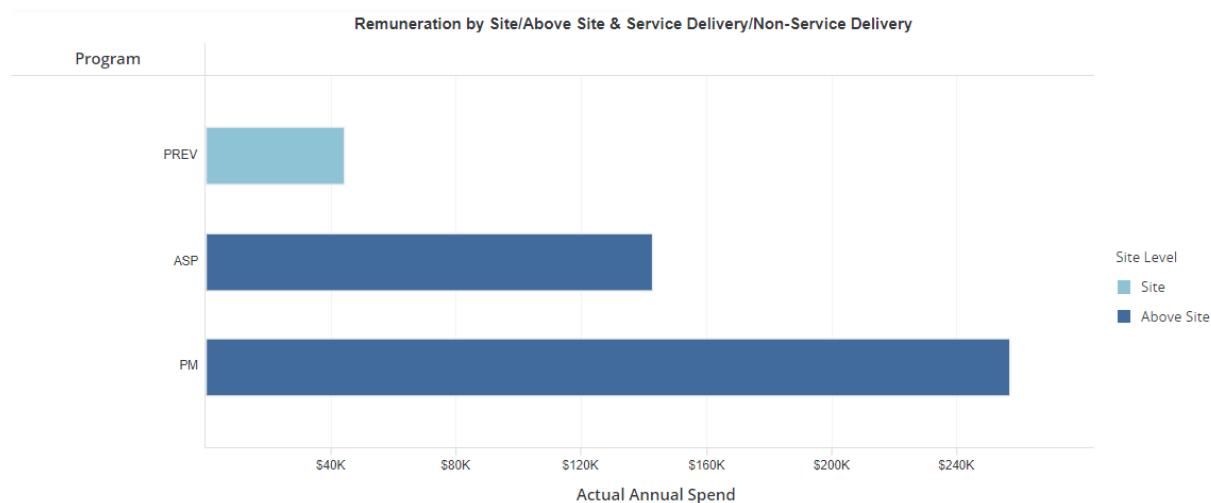


	Laos	
	2019	2020
Known Status	67	73
PLHIV on ART	75	74
VLS	78	75

- **HRH Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery:**

The primary site-level HRH remuneration supports the community-based supporters who provide the critical comprehensive prevention program outreach and HTS to the key population in Laos. The above-site program management fills the capacity gap in country due to the lack of local CSOs who can manage the KP program with the technical, managerial and financial capacity equivalent to the international NGO. The HRH for the above-site program supports the gap in human resource capacity at the health facilities to provide the linkage between communities and facilities as well as to provide incentives for the healthcare workers to support additional services that are required as part of comprehensive service provision for key population.

Figure E.1.4.



2. Areas for Transition

In reference to the three-year trend of SID scores, planning and coordination, policies and governance, Public Financial Management, health workforce continue to improve over the period and GOL has assumed primary responsibility in the area of Policy and HRH systems according to Responsibility Matrix.

However, greater domestic resource allocation to HIV program and services, service delivery especially for key populations, laboratory, data use for decision making, supply chain and civil society engagement will require continued donor investment and medium to long term strategic planning among key stakeholders and partners to ensure that investments can be effectively sustained. PEPFAR will work with national stakeholders including GF to discuss and develop the transition road map in preparation for the next SID and RM consultation.

3. Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response

ROP 22 development 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 March 2022, PEPFAR Laos PDR team held meetings attended by a range of key stakeholders, including MOH, CSOs, GF, UNAIDS, WHO, CHAI, WB, and AHF. The teams reviewed progress and challenges (including those indicated in SID dashboard), activities, and complementarity across all development partners. PEPFAR teams discussed in detail the development of ROP22 plans, to ensure alignment and inclusive planning, and to obtain preliminary commitments of PEPFAR implementing partners and development partners to ambitious PEPFAR targets and goals. PEPFAR will work with national stakeholders including GF to discuss and develop the transition road map in preparation for the next SID and RM consultation.

4. Agreements and plans on Data Use and Sharing and Quality control (including Central Support reporting).

Lao PDR Ministry of Health and the development partners including PEPFAR have established an open and transparent mechanism to increase technical collaboration to continuously improve data use, sharing and quality control of the health information. Data is periodically shared for the purposes of strengthening HIV/AIDS and health information systems and used for service quality improvement, program planning, monitoring and reporting. As mentioned in other sections and Table 6, ROP22 plans to address system capacity gaps in data quality, visualization and use.

NEPAL

1. Misalignments between Investments and Outcomes

Nepal has developed its National HIV Strategic Plan 2021-2026 setting a clear direction and priorities for sustained HIV epidemic control in the country. PEPFAR together with UNAIDS, national HIV program and other stakeholders has completed SID 4.0 in November 2021 and assessed 17 elements of sustainability under four domains: namely 1) governance, leadership, and accountability, 2) national health system and service delivery, 3) strategic financing and market openness, and 4) strategic information. Of those assessed 17 sustainability elements were scored as emerging sustainability elements having significant gaps needing investment; five as approaching sustainability requiring minimal investment; and one (market openness) as sustainable requiring no investment. Lack of adequately trained human resources for HIV service delivery and VL laboratory services in the public sector, and lack of plan to absorb into GON payroll or state financing mechanism to donor supported PLHIV and KP networks who are providing community level KP services are among sustainability challenges identified. The SID exercise findings were one of the inputs used to inform alignment of resources and PEPFAR/Nepal system level investment prioritization. See Nepal's SID 4.0 under Figure E.1.1.

Figure E.1.1. Trends in Investments and SID Scores for System-Related Elements

	2015 (SID 2.0)	2017 (SID 3.0)	2019 (SID 4.0)	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	N/A	N/A	N/A	8.33
2. Policies and Governance	N/A	N/A	N/A	6.44
3. Civil Society Engagement	N/A	N/A	N/A	5.71
4. Private Sector Engagement	N/A	N/A	N/A	3.98
5. Public Access to Information	N/A	N/A	N/A	6.67
National Health System and Service Delivery				
6. Service Delivery	N/A	N/A	N/A	4.27
7. Human Resources for Health	N/A	N/A	N/A	3.75
8. Commodity Security and Supply Chain	N/A	N/A	N/A	4.70
9. Quality Management	N/A	N/A	N/A	6.14
10. Laboratory	N/A	N/A	N/A	3.64
Strategic Financing and Market Openness				
11. Domestic Resource Mobilization	N/A	N/A	N/A	5.48
12. Technical and Allocative Efficiencies	N/A	N/A	N/A	7.30
13. Market Openness	N/A	N/A	N/A	10.00
Strategic Information				
14. Epidemiological and Health Data	N/A	N/A	N/A	7.12
15. Financial/Expenditure Data	N/A	N/A	N/A	7.50
16. Performance Data	N/A	N/A	N/A	7.12
17. Data for Decision-Making Ecosystem	N/A	N/A	N/A	6.83

Figure E.1.2

HIV/AIDS Responsibility Matrix

Country: Nepal
 Epidemic Type: Concentrated
 Income Level (source WBG): Lower middle income

Legend

Primary-Primary responsibility for/contribution to element
 Secondary-Secondary responsibility for element (i.e., doesn't lead, but offers substantial level of support)
 Nominal-Contributes to this effort, but offers a nominal/marginal level of support
 None-No responsibility/level of support
 N/A-Not Applicable to this OI/Region

FUNCTIONAL ELEMENTS	FUNCTIONAL DIMENSIONS														
	SERVICE DELIVERY ¹					NON-SERVICE DELIVERY ASSISTANCE ²					STRATEGY FORMULATION AND PLANNING ³				
	Host Govt.	PEPFAR & Implementers	Global Fund & Implementers	Others (AIF & Others)	Private Sector	Host Govt.	PEPFAR & Implementers	Global Fund & Implementers	Others (AIF & Others)	Private Sector	Host Govt.	PEPFAR	GFATM	Other Partners	Private
Site-Level Programs (incl. Community and Health Workforce)															
Care and Treatment (incl. ART drop)															
Clinical	Primary	Secondary	Secondary	Secondary	Nominal	Primary	Secondary	Secondary	Secondary	None	Primary	Secondary	Secondary	Secondary	None
Laboratory (e.g., Lab monitoring, CD4, TB, CDA, VL testing)	Primary	Nominal	Nominal	Nominal	Nominal	Primary	Secondary	Secondary	Secondary	None	Primary	Secondary	Secondary	Secondary	None
Community (e.g., Linkage, Retention, Adherence)	Secondary	Primary	Primary	Primary	None	Secondary	Primary	Primary	Secondary	None	Primary	Secondary	Secondary	Secondary	None
Library	Primary	Secondary	Secondary	Secondary	Nominal	Primary	Secondary	Secondary	Secondary	None	Primary	Secondary	Secondary	Secondary	None
HTV Testing Services															
Facility-based Testing	Primary	Primary	Secondary	Secondary	Nominal	Primary	Secondary	Secondary	Secondary	None	Primary	Secondary	Secondary	Secondary	None
Community-based Testing	Secondary	Primary	Primary	Primary	Nominal	Primary	Primary	Secondary	Secondary	None	Primary	Secondary	Secondary	Secondary	None
Self-testing	Secondary	Primary	Primary	Secondary	Nominal	Primary	Primary	Secondary	Secondary	None	Primary	Secondary	Secondary	Secondary	None
Testing at Pregnancy-related Visits	Primary	None	None	None	Nominal	Primary	Secondary	Secondary	Secondary	None	Primary	Secondary	Secondary	Secondary	None
Prevention															
Community Mobilization, Behavior and Norms Change	Secondary	Primary	Primary	Primary	None	Primary	Secondary	Secondary	Secondary	None	Primary	Secondary	Secondary	Secondary	None
Condom and Lubricant Programming	Primary	Primary	Primary	Primary	Nominal	Primary	Primary	Primary	Primary	Nominal	Primary	Primary	Primary	Primary	Nominal
Prevention of Mother-to-Child Transmission (PMCT)	Primary	Nominal	Nominal	Nominal	Nominal	Primary	Secondary	Secondary	Secondary	None	Primary	Secondary	Secondary	Secondary	None
Voluntary Medical Male Circumcision (VMMC)	None	None	None	None	None	None	None	None	None	None	None	None	None	None	None
Pre-exposure Prophylaxis (PrEP)	Primary	Primary	None	None	None	Primary	Primary	Secondary	Secondary	None	Primary	Secondary	Secondary	Secondary	None
Other Biomark of Prevention	Primary	Primary	None	None	None	Primary	Primary	Secondary	Secondary	None	Primary	Secondary	Secondary	Secondary	None
Adolescent Girls and Young Women (AGYW) HIV Prevention	Primary	Nominal	Nominal	Nominal	None	Primary	Nominal	Nominal	Nominal	None	Primary	Nominal	Nominal	Nominal	None
Key and Priority Populations															
Female Sex Workers (FSW)	Secondary	Primary	Nominal	Nominal	None	Secondary	Nominal	Nominal	Nominal	None	Primary	Primary	Nominal	Nominal	None
People Who Inject Drugs (PWID)	Secondary	Secondary	Primary	Nominal	None	Secondary	Secondary	Primary	Nominal	None	Primary	Secondary	Primary	Nominal	None
Men Who have Sex with Men (MSM)	Secondary	Primary	Nominal	Nominal	None	Secondary	Primary	Nominal	Nominal	None	Primary	Primary	Nominal	Nominal	None
Transgender Population (TG)	Secondary	Primary	Nominal	Nominal	None	Secondary	Primary	Nominal	Nominal	None	Primary	Primary	Nominal	Nominal	None
Prison Population	Primary	None	Primary	Nominal	None	Primary	None	Primary	Nominal	None	Primary	None	Primary	Nominal	None
Homeless Population	Primary	Primary	Primary	Secondary	Nominal	Primary	Primary	Primary	Secondary	Nominal	Primary	Primary	Primary	Secondary	Nominal
Gender-Based Violence (GBV) Programming	Nominal	Nominal	Nominal	Nominal	None	Nominal	Nominal	Nominal	Nominal	None	Nominal	Nominal	Nominal	Nominal	None
Orphans and Vulnerable Children (OVC)															
Commodities															
Antiretroviral Drugs															
ARV for Treatment	Primary	Nominal	Secondary	None	None	Primary	Secondary	Secondary	Secondary	None	Primary	Secondary	Secondary	Secondary	None
ARV for PrEP	None	Primary	None	None	None	Primary	Primary	Secondary	Secondary	None	Primary	Secondary	Secondary	Secondary	None
Condoms and Lubricants															
Rapid Test Kits	Primary	None	Primary	Nominal	Secondary	Primary	Secondary	Secondary	Secondary	None	Primary	Secondary	Secondary	Secondary	None
Self-testing Kits	None	Primary	Primary	None	None	Primary	Primary	Secondary	Secondary	None	Primary	Secondary	Secondary	Secondary	None
Male Circumcision Kits and Supplies	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medicines															
Medication Assisted Treatment (e.g., Naloxone)	None	None	Primary	None	None	None	None	Primary	None	None	Primary	None	Secondary	None	None
Tuberculosis Medicines	Primary	None	Secondary	None	None	Primary	Secondary	Secondary	None	None	Primary	Secondary	Secondary	None	None
Other Essential Medicines	Primary	Nominal	Nominal	Nominal	None	Primary	Secondary	Secondary	Nominal	None	Primary	Secondary	Secondary	Nominal	None
Laboratory															
CD4	Primary	None	Secondary	Nominal	None	Primary	None	Secondary	Nominal	None	Primary	Secondary	Secondary	Secondary	None
Viral Load	Primary	Nominal	Nominal	None	None	Primary	Primary	Secondary	Nominal	None	Primary	Primary	Secondary	Secondary	None
Reagents and Supplies (inclusive of VL & CD4)	Primary	Primary	Secondary	None	None	Primary	Secondary	Secondary	Secondary	None	Primary	Secondary	Secondary	Secondary	None
Health Equipment															
PHM Coats	Primary	Nominal	Primary	Nominal	None	Primary	Secondary	Secondary	Secondary	None	Primary	Secondary	Secondary	Secondary	None
Health Workforce															
Health Care Workers Clinical															
Safety and Benefits	Primary	Secondary	Secondary	Secondary	None										
Safety Top-Up	None	None	None	None	None										
Training and Supervision	Primary	Nominal	Nominal	Nominal	None										
Health Care Workers Ancillary															
Safety and Benefits	Nominal	Primary	Primary	Primary	None	Primary	None	None	None	None					
Safety Top-Up	None	None	None	None	None	None	None	None	None	None					
Training and Supervision	Nominal	Primary	Primary	Primary	None	Primary	Secondary	Nominal	Nominal	None					
Ancillary Staff (Site-Level)															
Safety and Benefits	Nominal	Primary	Primary	Primary	None	Primary	None	None	None	None					
Safety Top-Up	None	None	None	None	None	None	None	None	None	None					
Training and Supervision	Nominal	Primary	Primary	Primary	None	Primary	Secondary	Nominal	Nominal	None					
Other Staff															
Safety and Benefits	Primary	Secondary	Secondary	Secondary	None	Primary	None	None	None	None	Primary	Secondary	Secondary	Secondary	None
Safety Top-Up	None	None	None	None	None	None	None	None	None	None	Primary	Secondary	Secondary	Secondary	None
Training and Supervision	Primary	Nominal	Nominal	Nominal	None	Primary	Secondary	Nominal	Nominal	None	Primary	Secondary	Secondary	Secondary	None
<i>(Please enter actual number where data is available)</i>															
Health Care Workers - Clinical															
Health Care Workers - Ancillary															
Ancillary Staff (Site-level)															
Other Staff															
Above Site (System) Programs															
Human Resources for Health (HRH) Systems															
HR Service Training	Primary	None	None	None	Secondary	Primary	None	None	None	None	Primary	None	None	None	None
In-Service Training/Continuing Medical Education Systems	Primary	None	None	None	None	Primary	None	None	None	None	Primary	None	None	None	None
Procurement and Supply Chain Management (PCM) Systems															
Forecasting and Planning	Primary	Secondary	Secondary	Nominal	Nominal	Primary	Secondary	Secondary	Nominal	None	Primary	Secondary	Secondary	Nominal	None
Sourcing and Procurement	Primary	Secondary	Secondary	Nominal	Nominal	Primary	Secondary	Secondary	Nominal	None	Primary	Secondary	Secondary	Nominal	None
Quality Assurance and Control	Primary	Secondary	Nominal	Nominal	None	Primary	Secondary	Secondary	Nominal	None	Primary	Secondary	Secondary	Nominal	None
Risk Management	Primary	Secondary	Secondary	Nominal	None	Primary	Secondary	Secondary	Nominal	None	Primary	Secondary	Secondary	Nominal	None
Logistics Management	Primary	Secondary	Secondary	Nominal	Nominal	Primary	Secondary	Secondary	Nominal	Nominal	Primary	Secondary	Secondary	Nominal	Nominal
Warehousing and Inventory Management	Primary	Secondary	Secondary	Nominal	Nominal	Primary	Secondary	Secondary	Nominal	Nominal	Primary	Secondary	Secondary	Nominal	Nominal
Transport and Distribution	Primary	Secondary	Secondary	Nominal	Nominal	Primary	Secondary	Secondary	Nominal	Nominal	Primary	Secondary	Secondary	Nominal	Nominal
Waste Management and Systems	Primary	Secondary	Secondary	Nominal	Nominal	Primary	Secondary	Secondary	Nominal	Nominal	Primary	Secondary	Secondary	Nominal	Nominal
Health Management Information Systems (HMIS), Surveillance, and Research															
Data Systems	Primary	Primary	Primary	Secondary	None	Primary	Secondary	Secondary	None	None	Primary	Secondary	Secondary	Nominal	None
Monitoring and Evaluation	Primary	Primary	Primary	Secondary	None	Primary	Primary	Secondary	None	None	Primary	Secondary	Secondary	Nominal	None
Surveys and Surveillance	Primary	Secondary	Secondary	Nominal	None	Primary	Secondary	Secondary	Nominal	None	Primary	Secondary	Secondary	Nominal	None
HIV Prevalence-based surveys (e.g., PHAS)	Primary	Secondary	Secondary	Nominal	None	Primary	Secondary	Secondary	Nominal	None	Primary	Secondary	Secondary	Nominal	None
IP Demographic Surveys (e.g., IHSS)	Primary	Secondary	Secondary	Nominal	None	Primary	Secondary	Secondary	Nominal	None	Primary	Secondary	Secondary	Nominal	None
Laboratory Systems															
Conventional and Point of Care Instruments	Primary	Secondary	Nominal	Nominal	None	Primary	Secondary	Nominal	Nominal	None	Primary	Secondary	Nominal	Nominal	None
Laboratory Infrastructure and Equipment	Primary	Secondary	Nominal	Nominal	None	Primary	Secondary	Nominal	Nominal	None	Primary	Secondary	Nominal	Nominal	None
Laboratory Information Systems	Primary	None	None	None	None	Primary	None	None	None	None	Primary	Secondary	Nominal	Nominal	None
Procurement	Primary	Secondary	Secondary	Nominal	None	Primary	Secondary	Secondary	Nominal	None	Primary	Secondary	Secondary	Nominal	None
Quality Management Systems and Accreditation	Primary	Secondary	Nominal	Nominal	None	Primary	Secondary	Secondary	Nominal	None	Primary	Secondary	Secondary	Nominal	None
Logistics Management	Primary	Secondary	Secondary	Nominal	None	Primary	Secondary	Secondary	Nominal	None	Primary	Secondary	Secondary	Nominal	None
Sample Transport Systems	Primary	Secondary	Secondary	Secondary	None	Primary	Secondary	Secondary	None	None	Primary	Secondary	Secondary	Secondary	None
Health Financing															
Government Policy	Primary	Secondary	Secondary	Nominal	Nominal	Primary	Secondary	Secondary	Nominal	Nominal	Primary	Secondary	Secondary	Secondary	None
Institutional and Organizational Development	Primary	Secondary	Secondary	Nominal	Nominal	Primary	Secondary	Secondary	Nominal	Nominal	Primary	Secondary	Secondary	Secondary	None
Site-Level Quality Management	Primary	Secondary	Secondary	Nominal	Nominal	Primary	Secondary	Secondary	Nominal	Nominal	Primary	Secondary	Secondary	Secondary	None
Other Systems Support	Primary	Secondary	Secondary	Nominal	Nominal	Primary	Secondary	Secondary	Nominal	Nominal	Primary	Secondary	Secondary	Secondary	None
Program Management															
At the Implementation Level (Implementing Partners)															
At the Donor Level						Primary	Primary	Primary	Secondary	None					
						N/A	Primary	Secondary	Nominal	None					

Figure E.1.3.

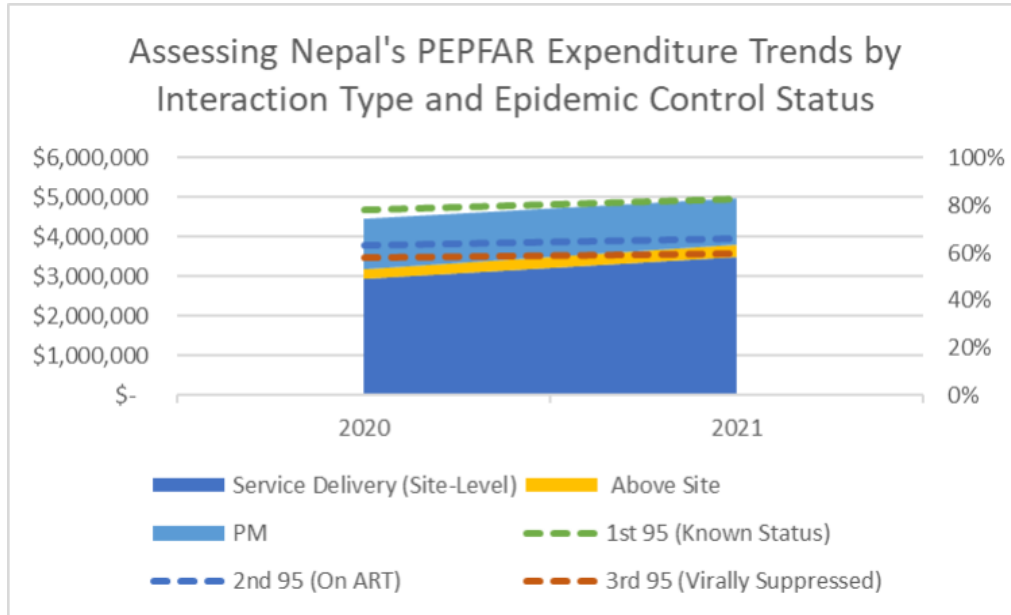
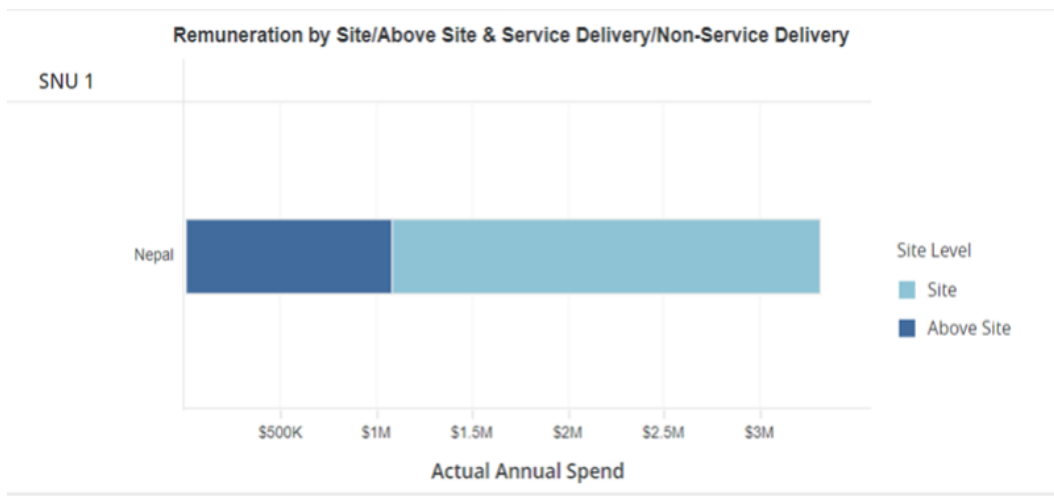


Figure E.1.4.



2. Areas for Transition

Sustainability index and responsibility matrix exercise conducted in November 2021 shows that sustainability elements including planning and coordination (SID score 8.33), and performance data (SID score 7.12) have shown good progress towards sustainability. Though some critical support still remains, these sustainability elements are the low hanging fruits to achieve sustainable capability and have the potential to be transitioned to the government of Nepal by ROP23 or ROP24 at the latest.

The remaining gaps to move the planning and coordination element to a fully sustained capability are due to weak coordination among the three tiers of government of Nepal governance structures and the

frequent turnover of trained human resources, including National Center for AIDS and STI Control (NCASC)'s leadership position. The impact of these challenges has negatively impacted the timely adoption of policies, coordination of stakeholders, swift decision making and programmatic changes, and inconsistent adoption of and adherence to national guidelines.. In ROP22, PEPFAR Nepal will closely support NCASC to build their coordination and planning, stakeholder engagement and coordination at all levels as demonstrated by challenges in the implementation of MMD and viral load testing strategies.

Regarding the performance data element, Nepal is continuing to roll-out one national HIV information system (ONHIS) in all HIV service delivery points. Currently the system is deployed to all HIV service-providing sites and first rounds of training on the system is completed. Its implementation is expected to start in subsequent quarters of ROP21, although retention of trained staff is an ongoing issue. In the remaining quarters of ROP21 and ROP22, PEPFAR Nepal will continue to support and ensure the full implementation of ONHIS at PEPFAR supported site by providing mentoring, gap filling training and system maintenance as well as support in data analytics and interpretation capacity using data generated from the system.

In ROP22, PEPFAR/Nepal will continue to closely work with NCASC, and jointly monitor and assess progress to ensure ONHIS's readiness and concurrence to transition to the government of Nepal.

3. Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response

Moreover, Nepal through the Global Fund and support from all stakeholders including PEPFAR has started developing a consolidated sustainability plan for HIV, TB, and Malaria program. The draft document is submitted to GON for their review and input. Once this document is finalized and approved costing and operationalizing the plan will be the next step. In ROP 22, PEPFAR will continue supporting these crucial exercises so that Nepal identifies its sustainability needs and starts operationalizing it to ensure sustainability of HIV epi-control gains.

4. Agreements and plans

Nepal's government has formulated "The Electronic Transaction Act, 2063 (Nepal calendar)" to secure the electronic data and streamline data sharing processes. For health data systems, including One National HIV Information System (ONHIS), data sharing process involves secure access to program information to the concerned stakeholder while maintaining overall control over data system by GON. All the partners and implementers get complete access and control to their individual program as well as access aggregated national health data.

PAPUA NEW GUINEA

1. Misalignments between Investments and Outcomes

PEPFAR PNG used data from the SID-light conducted in 2021 to inform ROP22 priorities. Faced with a decreasing budget despite reaching historical high targets and milestones, in ROP22, PEPFAR PNG will identify current programmatic efficiencies and identify key responsibilities that can be shifted to government and development partners. In ROP22, PEPFAR PNG will remain laser-focused on building the management and technical capacity of the NDoH and HIV-focused CSOs to ensure sustainability of program achievements.

Inherent in PEPFAR PNG's ROP22 strategy is a focus on sustaining achievements gleaned through program implementation to date. In ROP22, PEPFAR PNG will focus efforts on increasing capacity across the NDoH, NCD PHA, and local partners to improve supply chain management to mitigate the risk of stock-outs, implement recommendations identified under the CLM activity, and improve laboratory systems.

In commodities and supply chain, the Government of PNG holds the primary responsibility to ensure there are no commodity gaps and/or stock-outs at the health facility level; in ROP22, PNG will continue to provide TA at the national level to provide assistance with quantification, management, and projections of future demand to maintain adequate stock levels of HIV commodities including in ARVs to reach increased provision of 3/6+MMD. Additional support will be provided to the NDoH and NCD PHA staff to be capacitated to manage commodity procurement and distribution through the open data source mSupply system.

In an effort to sustain laboratory strengthening activities, PEPFAR PNG will work closely with the NDoH, NCD PHA and Global Fund to implement recommendations from the DNO exercise conducted in ROP21 to ensure adequate capacity for VL testing coverage. PEPFAR PNG will build upon successes achieved through ROP21 to strengthen facility, provincial, and national SI systems to better track PLHIV data and decrease risks of treatment interruption. In ROP22, PEPFAR PNG will increase utilization and functionality of PNG's diagnostic laboratory network, address demand creation, and sample referral linkages through the development of a formal plan to monitor the sample referral network through the laboratory system.

PEPFAR PNG will continue to build upon existing partnerships and close collaborations with the NDoH and NCD PHA in addition to HIV clinics, CSOs, KP-led organizations and development partners (i.e., UNAIDS, Global Fund, and DFAT) in ROP22. Beyond support directed at the NDoH to address key findings from the SID-light conducted in 2021 across HRH, supply chain management, and laboratory systems strengthening, PEPFAR PNG will continue our work to capacitate NDoH, NCD PHA, and CSO/KP-led organizations to sustain HIV program achievements and optimize the impacts of PEPFAR investments.

In areas of HIV testing including the roll out and expansion of the three-test algorithm, index testing, and increased ANC testing for PMTCT, PEPFAR PNG will work closely with partners to identify remaining gaps and support required to ensure its operationalization by non-PEPFAR sites. To address the high rates of treatment interruption, of which were exacerbated by COVID-19's impact on health systems and health-seeking behavior, PEPFAR PNG will additionally continue to support partners and the government by information sharing in ACM, strengthening monitoring, and reporting systems, and increasing the quality of back-to-care strategies to ensure treatment continuity and treatment growth.

PEPFAR PNG will work with the NDoH and development partners to develop and implement recommendations from Organizational Capacity Assessments (OCA) planned for ROP21. Results from the planned PrEP Feasibility Assessment in ROP22 – the first formal PrEP introduction in PNG’s history – will be adapted to ensure adoption at the national level and ensure sustainability of the activity. PEPFAR PNG will work with the NDoH and NCD PHA to ensure sufficient resource allocation to continue HRH gains achieved through prior ROP investments. Through the provision of above-site support to other PHAs in high-burden HIV provinces and in collaboration with other development partners including the Global Fund and DFAT, best practices and lessons learned through PEPFAR investments in the NCD will translate into improved and sustained national-level HIV metrics across PNG. As highlighted in Figure E.1.1 below, PNG made notable progress in several areas in the past two SID assessments including in civil society engagement, service delivery, domestic resource mobilization, and technical and allocative efficiencies. Additional updates are expected for the 2021 SID scores as it was completed as part of the SID-light process and did not encompass a full consultation with all stakeholders and scores are not fully reflective of the improvements and changes within the subcomponents.

Figure E.1.1. Trends in Investments and SID Scores for System-Related Elements

	2015 (SID 2.0)	2017 (SID 3.0)	2019 (SID 4.0)	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	8.53	9.79	9.29	10.00
2. Policies and Governance	4.95	7.30	7.37	7.02
3. Civil Society Engagement	4.83	7.58	6.54	7.58
4. Private Sector Engagement	5.63	8.13	6.76	6.77
5. Public Access to Information	5.00	7.00	7.56	7.56
National Health System and Service Delivery				
6. Service Delivery	4.40	6.67	6.75	7.06
7. Human Resources for Health	4.83	5.46	6.94	5.36
8. Commodity Security and Supply Chain	4.25	7.36	6.20	6.60
9. Quality Management	8.05	6.52	7.00	6.52
10. Laboratory	7.36	6.42	6.86	5.52
Strategic Financing and Market Openness				
11. Domestic Resource Mobilization	6.11	7.17	7.10	7.61
12. Technical and Allocative Efficiencies	5.53	6.71	8.33	7.20
13. Market Openness	N/A	N/A	9.52	9.11
Strategic Information				
14. Epidemiological and Health Data	5.10	6.37	7.06	6.39
15. Financial/Expenditure Data	2.08	5.00	6.67	5.00
16. Performance Data	6.63	6.84	8.00	6.84
17. Data for Decision-Making Ecosystem	N/A	N/A	6.00	5.00

The Responsibility Matrix completed as part of PEPFAR PNG’s SID-light exercise in 2021 demonstrated that primary responsibility for all HIV activities lies with the NDoH; PEPFAR plays a secondary role and Global Fund a nominal one (**Figure E.1.2**). However, when comparing the intended responsibilities of the NDoH with the realities on the ground, significant gaps begin to emerge. For example, in PNG, Global Fund procures more than 50 percent of the country’s ARV supplies with supply chain monitoring

overseen by PEPFAR’s implementing partner. Although the NDoH is primarily responsible for implementation of the national HIV program, PNG remains reliant on funding from development partners for all interventions and associated drugs and commodities.

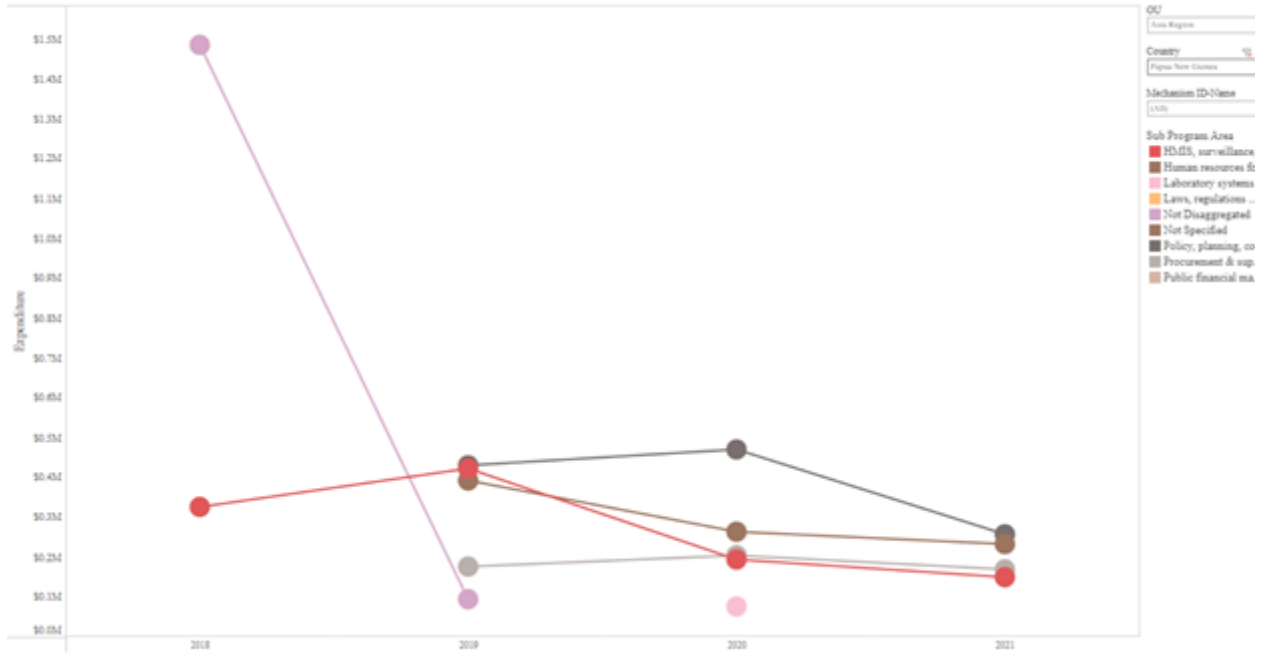
Figure E.1.2. Percent Primary Responsibility Ratings from Responsibility Matrix

FUNCTIONAL ELEMENTS	FUNCTIONAL DIMENSIONS											
	SERVICE DELIVERY*				NON-SERVICE DELIVERY ASSISTANCE*				STRATEGY FORMULATION AND PLANNING*			
	Host Govt.	Private Sector	PEPFAR & Implementers	Global Fund & Implementers	Host Govt.	Private Sector	PEPFAR & Implementers	Global Fund & Implementers	Host Govt.	Private Sector	PEPFAR	Global Fund
Above Site (Systems) Programs												
<i>Human Resources for Health (HRH) Systems</i>												
Pre-Service Training												
In-Service Training/Continuing Medical Education Systems												
<i>(PSCM) Systems</i>												
Forecasting and Planning												
Sourcing and Procurement												
Quality Assurance and Control												
Risk Management												
Logistics Management												
Warehousing and Inventory Management												
Transport and Distribution												
Waste Management and Return												
<i>(HMIS), Surveillance, and Research</i>												
Data Systems												
Monitoring and Evaluation												
Surveys and Surveillance												
HIV Population-based survey (e.g., PHA)												
KP Demographic Survey (e.g., BBS)												
<i>Laboratory Systems</i>												
Conventional and Point of Care Instruments												
Laboratory Infrastructure and Equipment												
Laboratory Information Systems												
Procurement												
Quality Management Systems and Accreditation												
Logistics Management												
Sample Transport System												
<i>Health Financing</i>												
<i>Governance and Policy</i>												
<i>Institutional and Organizational Development</i>												
<i>Site Level Quality Management</i>												
<i>Other Systems Support</i>												
Program Management												
<i>Partners</i>												
<i>At the Donor Level</i>												

Since 2019, non-service delivery spending has stabilized and slightly decreased in PNG (Figure E.1.3 and E.1.4). Through the lens of sustainability, PEPFAR PNG-focused efforts on training, supportive supervision, and mentorship across the NDoH and NCD PHA have resulted in significant gains. PNG will build upon the achievements realized to date through PEPFAR’s investments in ROP22, expanding above-site TA to other high-burden provinces to improve the country’s national efforts to reach epidemic control.

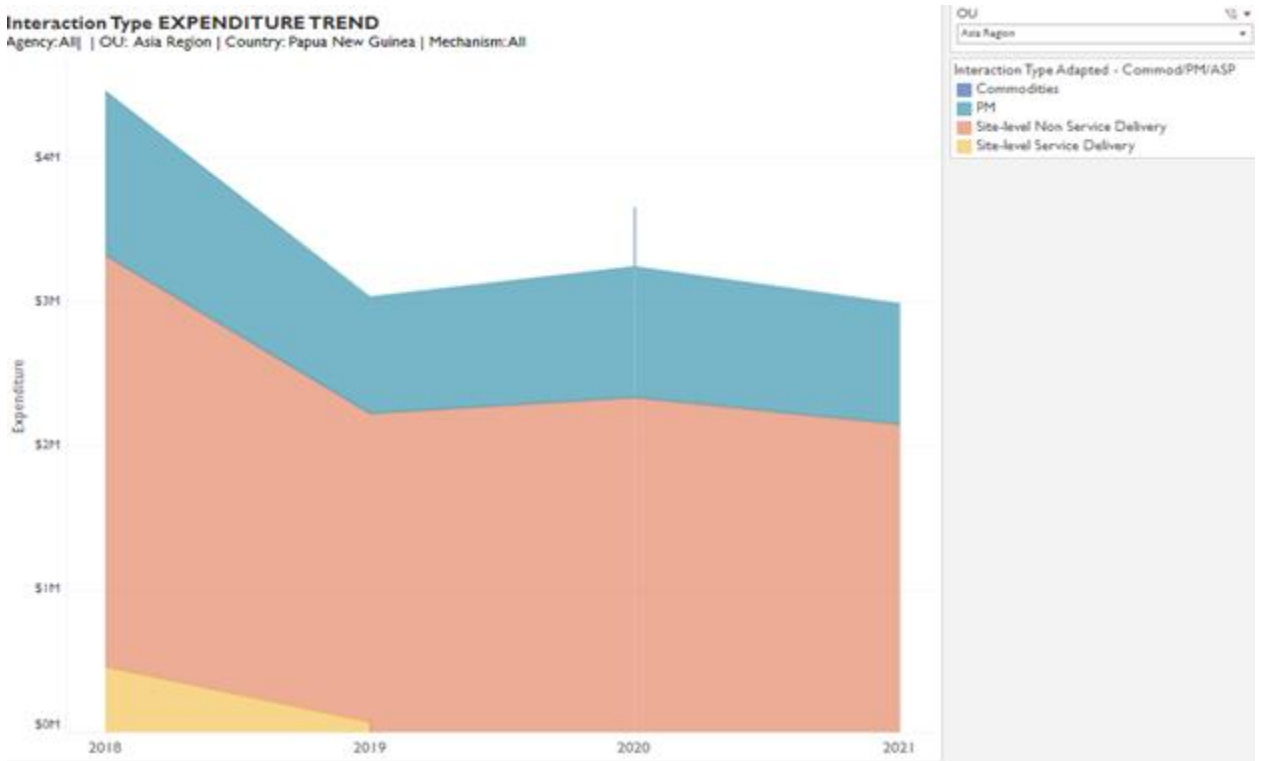
Figure E.1.3. Assessing Papua New Guinea’s Expenditure Trends by Interaction Type and Epidemic Control Status

ABOVE SITE EXPENDITURE BY SUB PROGRAM AREA
 Agency: All | OU: Asia Region | Country: Papua New Guinea | Mechanism: All

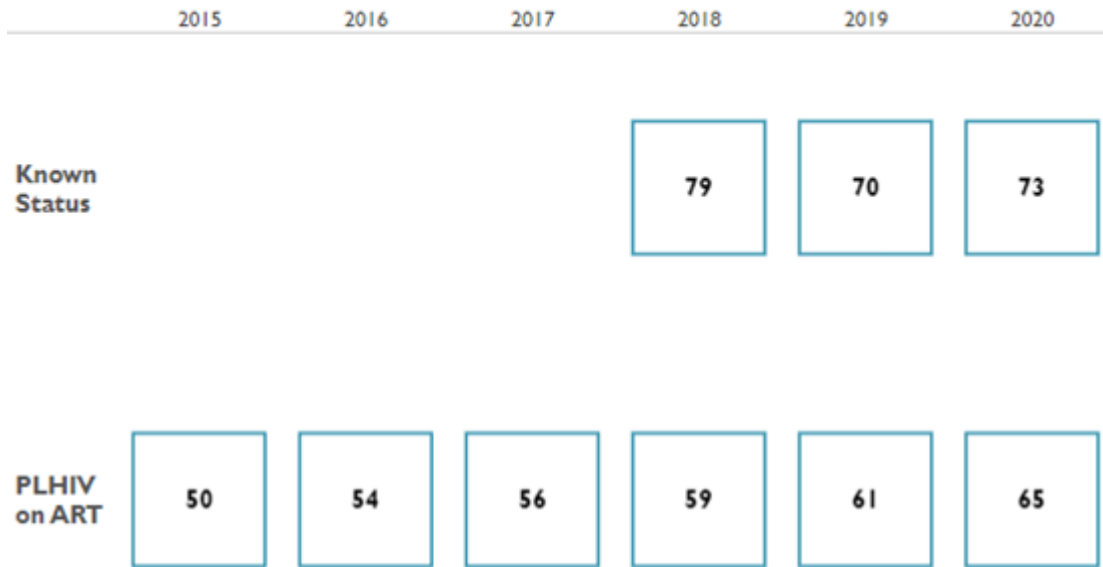


Interaction Type EXPENDITURE TREND

Agency: All | OU: Asia Region | Country: Papua New Guinea | Mechanism: All



Papua New Guinea

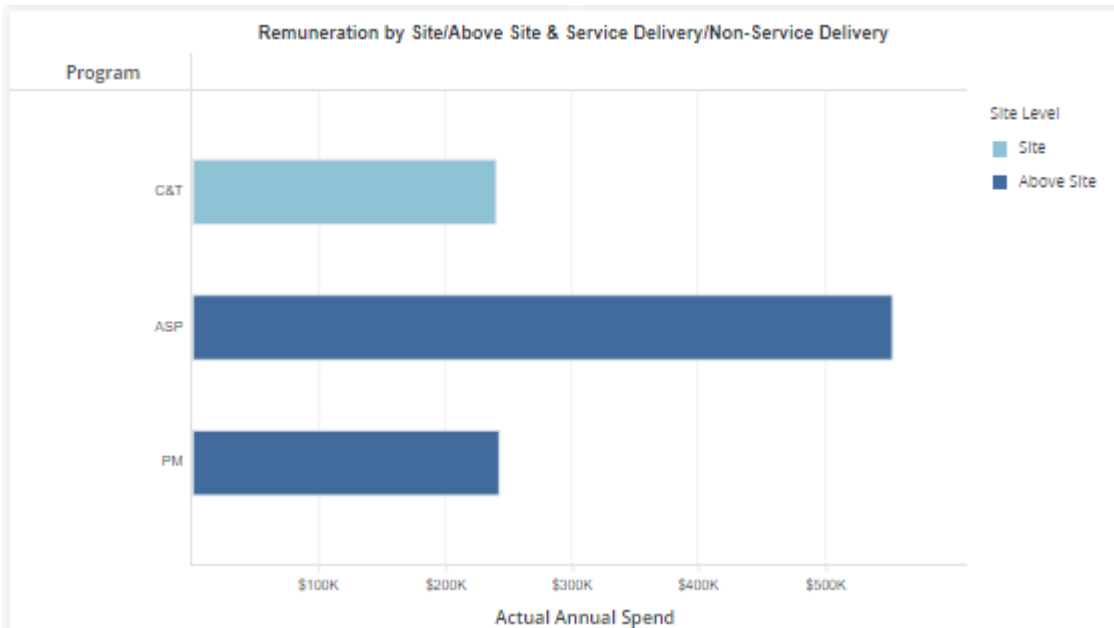


VLS

Data Source: UNAIDS AIDSInfo

In ROP22, PEPFAR PNG will continue to support above-site support to national and local partners and facilities. PEPFAR PNG is increasing its focus on sustainability and transition of ownership to the government and other donors, but challenges remain in capacity and the funding landscape to ensure a successful transition of the high-quality services that is currently being provided; additional conversations and strategic planning will be conducted in ROP21 and ROP22.

Figure E.1.4. Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery



PEPFAR PNG staffing expenditures and support for human resources for health (HRH) are focused at the above site level with direct non-service delivery TA at the site level in the National Capital District (NCD). In ROP22, PEPFAR PNG will continue to provide a similar level of support while also addressing critical challenges to improved national and provincial level management, local ownership of critical components in HIV programming, and sustainability. The additional ROP22 support will include providing technical assistance to build government partners' technical and management capacity, assisting in resource planning to ensure sufficient coverage of critical HIV positions, and developing transition strategies for key PEPFAR-supported positions to the government and local partners.

2. Areas for Transition

Programmatic transition and increase in domestic responsibility will require additional conversations with the NDoH and partners including UNAIDS, GF, DFAT, and WHO. PEPFAR PNG has shared previous years and the SID-light results and will continue conversations to identify gaps and opportunities for increased improvements in the national and provincial HIV program management and strategy in ROP22.

3. Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response

PEPFAR PNG, as part of the ROP22 planning process and increased collaboration with development partners, is continuously identifying strategies to ensure comprehensive coverage of HIV services and sustainability of PEPFAR-supported services.

4. Agreements and plans

PEPFAR PNG has a bilateral agreement and has standard USAID data use and sharing contracts.

PHILIPPINES

1. Misalignments between Investments and Outcomes

Domestic spending in the Philippines on HIV program above site activities and systems is lacking, particularly at the local government level. In its second year of implementation, the PEPFAR Philippines program is investing in select systems strengthening activities that underlie high quality HIV service provision. In ROP22 PEPFAR will continue to target key systems activities to address gaps revealed in the recently completed SID. Interventions will include institutionalizing continuous quality improvement, strengthening laboratory systems, and increasing capacity for HIV budget planning and advocacy at the local government unit level. Please see section 5.0 Program Support Necessary to Achieve Sustained Epidemic Control for more details.

Figure E1.1 SID Element Scores

		Sustainability Analysis for Epidemic Control: Countries			
		2015 (SID 2.0)	2017 (SID 3.0)	2019 (SID 4.0)	2021
		Epidemic Type: Concentrated			
		Income Level: #N/A			
		PEPFAR COP 19 Planning Level: N/A			
		2015 (SID 2.0)	2017 (SID 3.0)	2019 (SID 4.0)	2021
SUSTAINABILITY DOMAINS AND ELEMENTS	Governance, Leadership, and Accountability				
	1. Planning and Coordination	#N/A	#N/A	#N/A	9.07
	2. Policies and Governance	#N/A	#N/A	#N/A	7.19
	3. Civil Society Engagement	#N/A	#N/A	#N/A	5.63
	4. Private Sector Engagement	#N/A	#N/A	#N/A	5.61
	5. Public Access to Information	#N/A	#N/A	#N/A	8.33
	National Health System and Service Delivery				
	6. Service Delivery	#N/A	#N/A	#N/A	6.47
	7. Human Resources for Health	#N/A	#N/A	#N/A	4.88
	8. Commodity Security and Supply Chain	#N/A	#N/A	#N/A	7.18
	9. Quality Management	#N/A	#N/A	#N/A	2.00
	10. Laboratory	#N/A	#N/A	#N/A	3.14
	Strategic Financing and Market Openness				
	11. Domestic Resource Mobilization	#N/A	#N/A	#N/A	6.35
	12. Technical and Allocative Efficiencies	#N/A	#N/A	#N/A	5.10
	13. Market Openness	N/A	N/A	#N/A	9.91
	Strategic Information				
14. Epidemiological and Health Data	#N/A	#N/A	#N/A	7.58	
15. Financial/Expenditure Data	#N/A	#N/A	#N/A	0.00	
16. Performance Data	#N/A	#N/A	#N/A	7.26	
17. Data for Decision-Making Ecosystem	N/A	N/A	#N/A	7.33	

Program Expenditures vs. SID Score Trends and Responsibility Ratings:

The Responsibility Matrix below shows that the Philippines government has primary responsibility for the strategy formulation, planning and non-service delivery assistance for

above-site programs. Institutional and organizational development is an area requiring further investment, particularly important for sustaining programmatic progress as management of the HIV response increasingly transitions to local government units and community-based organizations. Notably, the private sector's responsibility for and investment in HIV-related above-site programs is limited due to the lack of data available to accurately track these inputs. The private sector's role in scaling and sustaining the HIV program will be essential to achieving epidemic control, thus requiring further engagement and collaboration in the coming ROP year(s).

Figure E1.2 Responsibility for Above-Site x Stakeholder

HIV/AIDS Responsibility Matrix												
Country:		Legend										
Epidemic Type:		Primary=Primary responsibility for/contribution to element										
Income Level (source WBG):		Secondary=Secondary responsibility for element (i.e., doesn't lead, but offers substantial level of support)										
		Nominal=Contributes to this effort, but offers a nominal/marginal level of support										
		None=No responsibility/level of support										
		N/A=Not Applicable to this OU/Region										
FUNCTIONAL DIMENSIONS												
FUNCTIONAL ELEMENTS												
SERVICE DELIVERY ¹				NON-SERVICE DELIVERY ASSISTANCE ²				STRATEGY FORMULATION AND PLANNING ³				
Host Govt.	Private Sector	PEPFAR & Implementers	Global Fund & Implementers	Host Govt.	Private Sector	PEPFAR & Implementers	Global Fund & Implementers	Host Govt.	Private Sector	PEPFAR	Global Fund	
Above Site (Systems) Programs												
Human Resources for Health (HRH) Systems												
Pre-Service Training				None	None	None	None	None	None	None	None	None
In-Service Training/Continuing Medical Education Systems				Primary	Nominal	Nominal	Nominal	Primary	Nominal	Nominal	Nominal	
Procurement and Supply Chain Management (PSCM) Systems												
Forecasting and Planning				Primary	None	Secondary	Nominal	Primary	Nominal	Secondary	Nominal	
Sourcing and Procurement				Primary	Nominal	Secondary	Secondary	Primary	Secondary	Secondary	Secondary	
Quality Assurance and Control				Primary	None	Secondary	Secondary	Primary	Secondary	Secondary	Secondary	
Risk Management				Primary	None	Nominal	Nominal	Primary	Nominal	Nominal	Nominal	
Logistics Management				Primary	Nominal	Secondary	Secondary	Primary	Secondary	Secondary	Secondary	
Warehousing and Inventory Management				Primary	None	Secondary	Secondary	Primary	None	Secondary	Secondary	
Transport and Distribution				Primary	N/A	Secondary	Secondary	Primary	N/A	Secondary	Secondary	
Waste Management and Return				Primary	N/A	None	None	Primary	Nominal	None	None	
and Research												
Data Systems				Primary	Nominal	Secondary	Secondary	Primary	Secondary	Secondary	Secondary	
Monitoring and Evaluation				Primary	Nominal	Secondary	Secondary	Primary	Secondary	Secondary	Secondary	
Surveys and Surveillance				Primary	Nominal	Nominal	Nominal	Primary	Secondary	Secondary	Secondary	
HIV Population-based survey (e.g., PHIA)				Primary	Secondary	Secondary	Secondary	Primary	Secondary	Secondary	Nominal	
KP Demographic Surveys (e.g., IBBS)				Primary	Nominal	Nominal	Secondary	Primary	Secondary	Secondary	Secondary	
Laboratory Systems												
Conventional and Point of Care Instruments				Primary	Secondary	Secondary	Secondary	Primary	Secondary	Nominal	Nominal	
Laboratory Infrastructure and Equipment				Primary	Primary	Nominal	Secondary	Primary	Nominal	Nominal	Nominal	
Laboratory Information System				Primary	Secondary	Secondary	Secondary	Primary	Nominal	Secondary	Secondary	
Procurement				Primary	Nominal	Secondary	Secondary	Primary	Nominal	Secondary	Secondary	
Quality Management Systems and Accreditation				Primary	Nominal	Secondary	Secondary	Primary	Secondary	Secondary	Secondary	
Logistics Management				Primary	Nominal	Secondary	Secondary	Primary	Nominal	Secondary	Secondary	
Sample Transport System				Primary	Secondary	Secondary	Secondary	Primary	Secondary	Secondary	Secondary	
Health Financing				Primary	Nominal	Secondary	Secondary	Primary	Nominal	Secondary	Nominal	
Governance and Policy				Primary	Nominal	Secondary	Secondary	Primary	Secondary	Secondary	Secondary	
Institutional and Organizational Development				Nominal	Nominal	Nominal	Nominal	Nominal	None	Nominal	Nominal	
Site Level Quality Management				Primary	Secondary	Secondary	Secondary	Primary	Secondary	Secondary	Secondary	
Other Systems Support				Primary	None	Secondary	Secondary	Primary	Nominal	Secondary	Secondary	
Program Management												
At the Implementation Level (Implementing Partners)				Primary	Secondary	Primary	Primary					
At the Donor Level				Secondary	None	Primary	Primary					

- **Trajectory of Service Delivery, Commodities, Non-Service Delivery, Above Site Program, and Program Management Expenditures and Country's Status of Achieving HIV/AIDS Epidemic Control**

In ROP21, the Philippine PEPFAR program is contributing almost a third of the country's resources for care and treatment and more than a fifth for those of prevention and HIV testing. This translates to 20 additional sites in Mega Manila with additional sites in Western and Central Visayas. This is a direct response to a still expanding epidemic (i.e., 22,000 estimated new

infections for 2022) in a country two years into PEPFAR implementation. PEPFAR is assisting the country to regain the lost momentum following the impact of the pandemic on the HIV response.

PEPFAR’s substantial above-site work comprises 81 percent of donor funds that address challenges in continuous quality improvement (CQI), supply chain, sustainable financing, and surveillance impacting the country’s achievement of the three 95s.

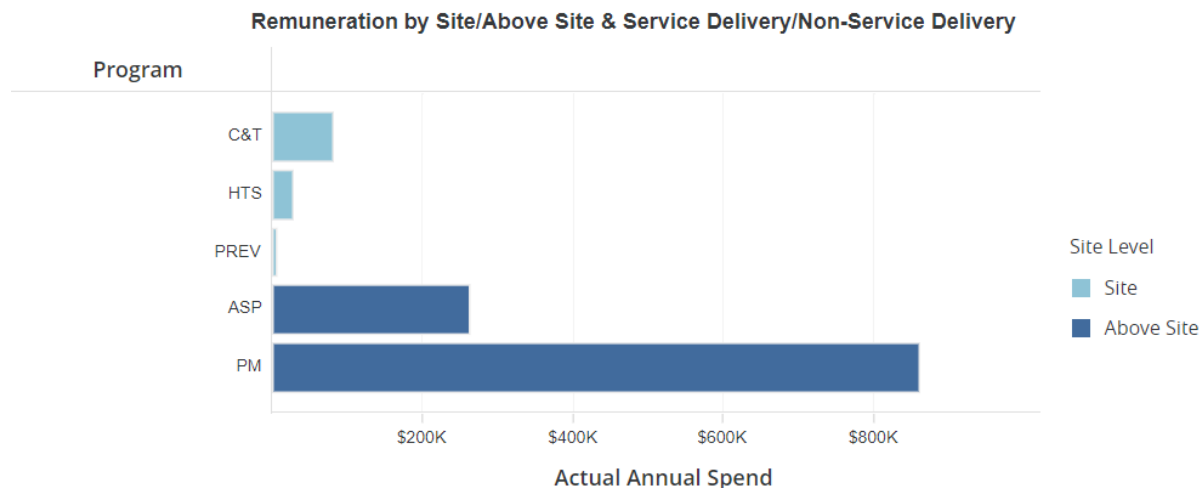
For ROP22, while efforts will be sustained in Western and Central Visayas, the PEPFAR response in Mega Manila will be scaled back with corresponding reductions in the treatment cohort and testing targets to be supported. Similarly, the above-site work, specifically those relating to supply chain and sustainable financing, will have to be reduced given available PEPFAR resources.

E1.3 Epi Progress



Data Source: UNAIDS AIDSInfo

Figure E.1.4. Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery



FY21 remuneration reflects the Philippine program's first year of implementation and its focus on critical above site work towards meeting the PEPFAR minimum requirements. Key health systems issues required substantial technical assistance investments. Remuneration for service delivery comprises of a smaller proportion of total investments but show the program's emphasis on care and treatment as well as testing.

The level of investments for technical assistance is expected to remain constant in the next two to three years as CQI, procurement and supply chain management, sustainable health financing, and surveillance are further strengthened.

2. Areas for Transition

Three areas of transition will be prioritized for ROP22: commodities and supply chain management, sustainable financing of community-based activities and social contracting, and demand generation through social and behavior change communication.

- Commodities/supply chain management.** Focusing on TLD will address client hesitancy to start treatment immediately and prevent further treatment interruption. It will also assuage concerns relating to stock security among providers—one of the barriers identified to TLD initiation in the past year. Government procurement of PrEP will allow for further scale-up of the nascent national program, allow for expansion to other high burden regions, and have greater impact to curb onward HIV transmission currently estimated to be at 22,000 for 2022. VL commodities in the public sector, contingent on the resolution of market-related barriers, will drastically improve viral testing coverage currently at 35%. ARV and HIV commodity procurement is currently a central DOH mandate. Meanwhile, the DOH has set earmarks for VL commodities but procurement has been hampered by supply chain issues, making it possible to facilitate increased public sector investments with technical assistance on PSCM. Transitioning the procurement of newly-introduced TLD and PrEP as well as VL cartridges will thus be consistent with current DOH direction. It will also be an initial step towards the incremental transition of procurement to local governments given the country's shift towards primary health care / universal health care.
- Sustainable financing of community-based activities and social contracting.** The emphasis on social contracting models allows for increased government spending for prevention and testing services which are both not covered by any PhilHealth package and currently relies on external donor support. Moreover, it will establish sustainable financing for critical community-led interventions (i.e., peer outreach, community-based screening, and PrEP delivery) and

consequently result in strengthened complementary community systems. PEPFAR support will be geared towards identifying different models for social contracting given the varying contexts across subnational regions and local government units, where resources will be shifted given the slated increased devolution of services.

- **Demand generation through social and behavior change communication.** In ROP21, the Department of Health adopted PEPFAR-developed SBCC campaigns and collaterals that generate demand for services and increase treatment and U=U literacy. PEPFAR is well positioned to provide technical input and develop targeted KP-focused materials responsive to the different segments of groups that need to be reached. This provides the impetus for increased government responsibility in scaling up the coverage of SBCC campaigns and allowing for greater impact of PEPFAR investments.

3. Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response

Following the Philippine National Presidential Elections in May 2022, the PEPFAR program will recommence strong engagement with the Philippine government at the central level to promote close collaboration and advance country ownership of the program. PEPFAR will also work closely with the DOH in the operationalization of the Philippines Universal Health Care (UHC) mandate and ongoing transition of the national health system from siloed, vertical technical programs to an integrated primary healthcare-based program. The impact of this transition is still unclear in terms of how PEPFAR will operate given the DOH's directive for all donors and partners to program within the new integrated systems-based structure. PEPFAR will continue to consult regularly with the DOH throughout this process and ensure that PEPFAR investments are protected, while supporting the Philippine government's UHC vision and HIV program objectives.

In ROP22, PEPFAR will increase engagement with regional, municipal and local DOH offices. PEPFAR will advocate at these levels for increased funding for HIV service provision, ARVs and associated commodities, including medications for opportunistic infections. PEPFAR will also build the capacity of these decentralized DOH offices in preparation for the transition of increased management and financial responsibility of the HIV program. This will require targeted technical assistance and strong advocacy efforts. PEPFAR will also build the capacity of community-based and civil society organization partners to advocate for high quality, person-centered, accessible service delivery. CLM efforts in ROP22 will seek to institutionalize a sustained accountability mechanism for HIV service provision, led and implemented by community organizations.

PEPFAR Philippines will work closely with the Global Fund, UNAIDS, WHO and other donors to leverage resources and collectively advocate to the DOH for policy change, adoption of new and innovative approaches, and increased transition of programmatic elements. Additionally, PEPFAR, DOH and other donors and partners will conduct quarterly program data reviews and participate in Joint Programmatic Reviews led by Global Fund in order to ensure programs and funding are well-aligned.

4. Agreements and plans on Data Use and Sharing and Quality control (including Central Support reporting).

Implementation to date has so far relied on a data sharing agreement with the Philippine Department of Health's Epidemiology Bureau (DOH-EB) for MER reporting. Data extracts for the different MER indicators are provided by the DOH-EB on a quarterly basis for MER reporting and monthly for the HFR.

The country team will expand the existing agreement in FY23 to cover the reporting needs across the interagency.

Data quality assurance activities are slated for FY22 and will be done in concert with the DOH and other development partners.

TAJIKISTAN

1. Misalignments between Investments and Outcomes

PEPFAR Tajikistan used data from the SID-light conducted in 2021 to inform ROP22 priorities. In ROP22, PEPFAR will continue provide technical support to the MoH and civil society organizations to ensure the sustainability of program achievements.

To sustain laboratory strengthening activities, PEPFAR Tajikistan will work closely with the MoH and RAC to support efforts to maintain quality for laboratory systems and activities, including diagnostics, viral load measurement and participate in EQA/PT to be certified. In addition, we will support two laboratories for accreditation as per the international standards.

PEPFAR Tajikistan will build upon successes achieved through ROP21 to strengthen SI systems to better track PLHIV data and decrease risks of treatment interruption by providing onsite and offsite data quality assessments (for Electronic HIV Case Management System [HCMS] and e-PrEP); technical support to EHCMS, e-Nurse and e-PrEP implementation (trainings, trouble-shooting, hosting and maintenance, changes and improvements, etc.); Routine service delivery data analysis to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including linkage to care and prevention services such as PrEP and MAT, adherence and retention, and viral load testing coverage and suppression.

Domestic spending in the Tajikistan on HIV programs is still not adequate. In ROP22 PEPFAR will continue to target key activities to advocate more public spending and support local CBOs for applying on social contracting grants. PEPFAR Tajikistan will continue to address barriers to implementation of social contracting by supporting revision of legislation, developing list of services which can be supported through social contracting mechanism and promotion of the social contracting plan that was developed under ROP21.

Quality management is one of concern areas and PEPFAR Tajikistan will focus on providing technical assistance during ROP22 to address this through supporting implementation of granular site management in all sites in PEPFAR supported regions.

Figure E.1.2

Tajikistan			
% Primary Responsibility Ratings from Responsibility Matrix			
Health Systems Area	Host Country	PEPFAR	Global Fund
HMIS	67%	48%	11%
Laboratory Systems	74%	44%	22%
Supply Chain	63%	37%	33%
HRH Systems	89%	15%	0%
Policy	93%	7%	4%
PFM	74%	30%	19%
Other Systems Support	74%	11%	4%
Health Workforce	26%	0%	0%

Responsibility Matrix data show that host government has primary responsibility for almost all investment areas, but sharing these responsibilities with the main donors, PEPFAR and GFATM. PEPFAR maintains for almost fifty percent for HMIS and laboratory systems, while the GFATM maintains primary responsibility for ARV and other commodity procurement. As a technical assistance provider, PEPFAR has secondary or nominal responsibility in all other areas. In ROP22, PEPFAR will continue working to look for more opportunities to expand social contracting for KP focused CSOs.

Figure E.1.3.

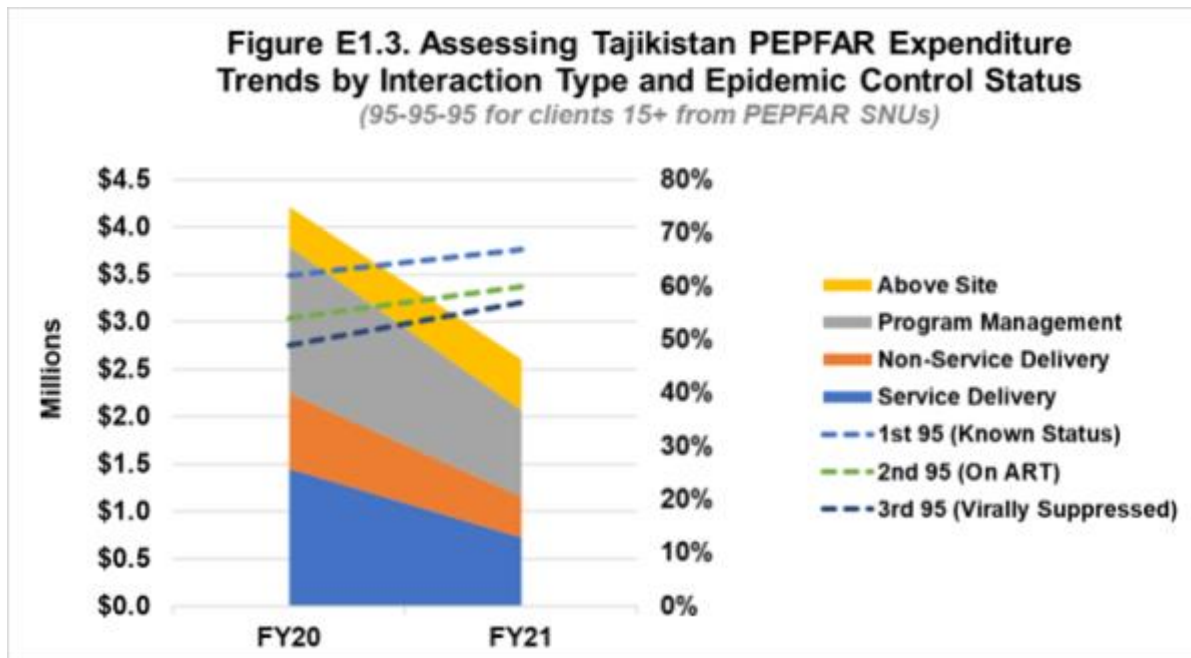
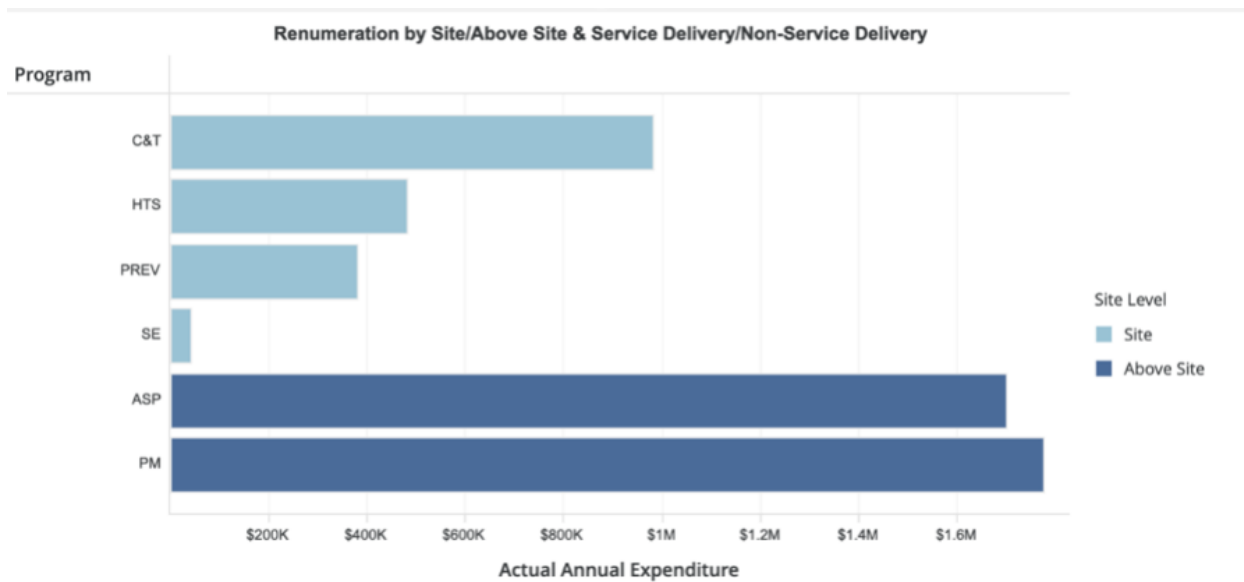


Figure E.1.4.



2. Areas for Transition

In 2021, the Government of Republic of Tajikistan approved a new National AIDS Program for 2021-2025. This document was developed by the MoH in collaboration with key country partners such as GFATM, PEPFAR, UNAIDS, civil society organizations and other partners. This document outlines key vulnerabilities to resilience, recommends mitigation measures and a phased plan to increase the share of public funding for HIV/AIDS programs to 50% by 2025. Given the great dependence of the Tajik economy on Russia and remittances from labor migrants, economic indicators are expected to decline, and the Government will not fulfill its obligations. Therefore, to encourage the government to increase responsibilities will require additional conversations with the MoH and partners, mainly GFATM as a main country HIV program donor. Service delivery to KPs will still require further support from development partners due to limitations with local funding and capacity of local providers, and therefore, PEPFAR Tajikistan will continue directly support CSOs to delivery of HIV services and quality monitoring through implementation of CLM. We will continue improving Strategic Information and support for decentralization of HIV services.

PEPFAR team will continue work with partners to identify gaps and opportunities for increased improvements in the HIV program management and strategy in ROP22

3. Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response

PEPFAR Tajikistan has regular engagement with the Government of Tajikistan on sustainability concerns. The Country Coordination Mechanism (CCM), chaired by the Deputy Prime Minister, with membership of PEPFAR, GFATM, WHO and CBOs, regularly meets to discuss country strategy and plans, and coordinates activities and resources among the government and key donors. During ROP 22, PEPFAR will continue our role as a member of the CCM and

participate at the other country dialogues to work for encouraging the MoH to increase domestic resources for HIV program.

4. Agreements and plans on Data Use and Sharing and Quality control (including Central Support reporting).

Since 2011, RAC, with support from PEPFAR has developed the Electronic HIV case management system (EHCMS). This system allows for collection of epidemiological, clinical and laboratory data and report generation. PEPFAR has been providing capacity building to the AIDS Centers staff on using the system and for the RAC data management specialists to calculate and analyze national monitoring indicators and manage and take over the EHCMS.

THAILAND

1. Misalignments between Investments and Outcomes

- **Program Expenditures vs. SID Score Trends and Responsibility Ratings:**

Figure E.1.1. Trends in Investments and SID Scores for System-Related Elements

SID Scores Reported in Table 6			Above Site Activities and Budget Reported in Table 6						
Domain	SID Score Element	2017	2019	2021 SID Budget Element	COP19 Activities	COP19 Budget	COP20 Activities	COP20 Budget	
Governance, Leadership & Accountability	1. Planning and Coordination Score:	9.5	9	9.5	Policies and Governance	2	\$229,461	4	\$309,500
	2. Policies and Governance Score:	8.18	8.85	8.39	Public Access to Information	6	\$765,231	5	\$100,500
	3. Civil Society Engagement Score:	8.33	7.92	8.33	Service Delivery	30	\$2,786,905		
	4. Private Sector Engagement Score:	4	5.44	7.9	Human Resources for Health			8	\$346,333
	5. Public Access to Information Score:	8	9	9	Laboratory			2	\$40,000
National Health System & Service Delivery	6. Service Delivery Score:	7.69	7.58	7.42	Epidemiological and Health Data			7	\$380,000
	7. Health Workforce Score:	8.26	8.17	7.58	Performance Data			3	\$253,000
	8. Commodity Security and Supply Chain Score:	9.38	7.7	7.22					
	9. Quality Management Score:	7.67	6.81	7.38					
Strategic Financing & Market Openness	10. Laboratory Score:	10	9.67	10					
	11. Domestic Resource Mobilization Score:	8.77	8.85	9.88					
	12. Technical and Allocative Efficiencies Score:	7.78	8.06	7.6					
	13. Market Openness Score:		9.04	8.73					
Strategic Information	14. Epidemiological and Health data Score:	8.92	8.47	8.74					
	15. Financial/Expenditure data Score:	9.17	9.17	9.17					
	16. Performance Data Score:	7.23	7.42	8.66					
	17. Data for Decision-Making Ecosystem Score:		8.5	8.64					

There is no single SID element that stands out as weak in terms of the analysis of the SID tool. There are two elements that have been rated as a sustainability risk since 2019, namely, Private Sector Engagement and Quality Management (QM); however, both scores have slightly increased compared to the 2019 scores. Thailand has a strong nationwide HIV/AIDS program response that is sustainable. However, the sustainability does not necessarily extend into the unique requirements for HIV/AIDS service delivery for hard-to-reach key populations. Considerable work still needs to take place to ensure that the response to the challenges faced by MSM, transgender people (in particular TGW), and sex workers (in particular MSM and TGW) is as robust as the overall national HIV/AIDS response in Thailand. There are six elements that have decreased in scores (Policies and Governance, Service Delivery, Human Resource for Health, Commodities Securities and Supply Chain, Technical Allocative Efficiencies, and Market Openness). In ROP22, Table 6 activities will focus on SID areas that have scored consistently low or decreased since 2017.

Figure E.1.2. Percent Primary Responsibility Ratings from Responsibility Matrix

Thailand			
% Primary Responsibility Ratings from Responsibility Matrix			
Health Systems Area	Host Country	PEPFAR	Global Fund
HMIS	100%	0%	0%
Laboratory Systems	100%	0%	0%
Supply Chain	100%	0%	0%
HRH Systems	66%	17%	17%
Policy	67%	0%	33%
PFM	100%	0%	0%

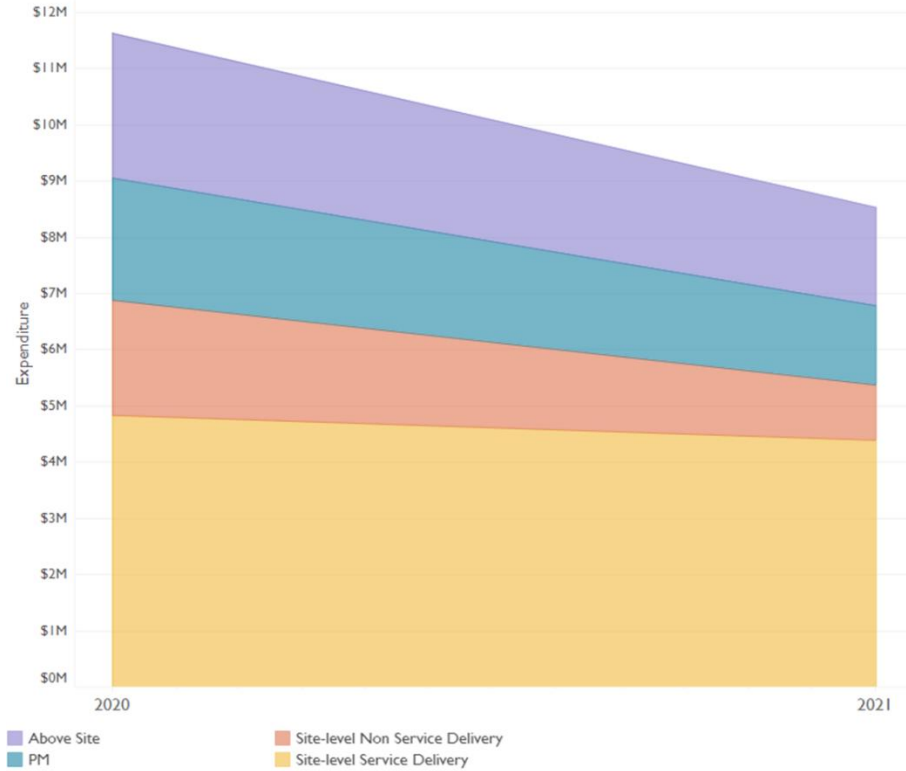
Other Systems Support	20%	40%	40%
Health Workforce	65%	15%	20%

The RTG has been the primary contributor in nearly all dimensions and program areas of HIV, particularly for service delivery, support for clinical and ancillary health care workers in government systems, and strategic planning. The RTG has funded 98% of annual HIV expenditures covering all Thai populations under UHC through three main health insurance schemes: 1. Universal Coverage Scheme [UC]; 2. Social Security Scheme [SSS]; and 3. the Civil Servant Medical Benefit Scheme [CSMBS]. The RTG has been the primary contributor for ARVs, PrEP, methadone maintenance treatment, condom lubricant supplies, and has gradually increased prevention funding for community-led health services.

PEPFAR and the Global Fund have been primary or secondary contributors for key population-led prevention programs, some point-of-care laboratory supplies, HIV self-tests, needle and syringe supplies, and other medical assisted treatment for people who inject drugs (PWID). The community health workers outside the government system still rely on funding from PEPFAR or the Global Fund. External donors also provide substantial contributions to activities outside of direct service delivery, such as training and capacity building to healthcare professionals and community health workers for key population services; policy work; quality management and quality improvement; and maintaining the health information management system for program monitoring and evaluation and data utilization activities. In ROP22, PEPFAR Thailand plans to support HIV self-test kits for case finding strategies under PEPFAR funded sites.

- ***Trajectory of Service Delivery, Commodities, Non-Service Delivery, Above Site Program, and Program Management Expenditures and Country's Status of Achieving HIV/AIDS Epidemic Control:***

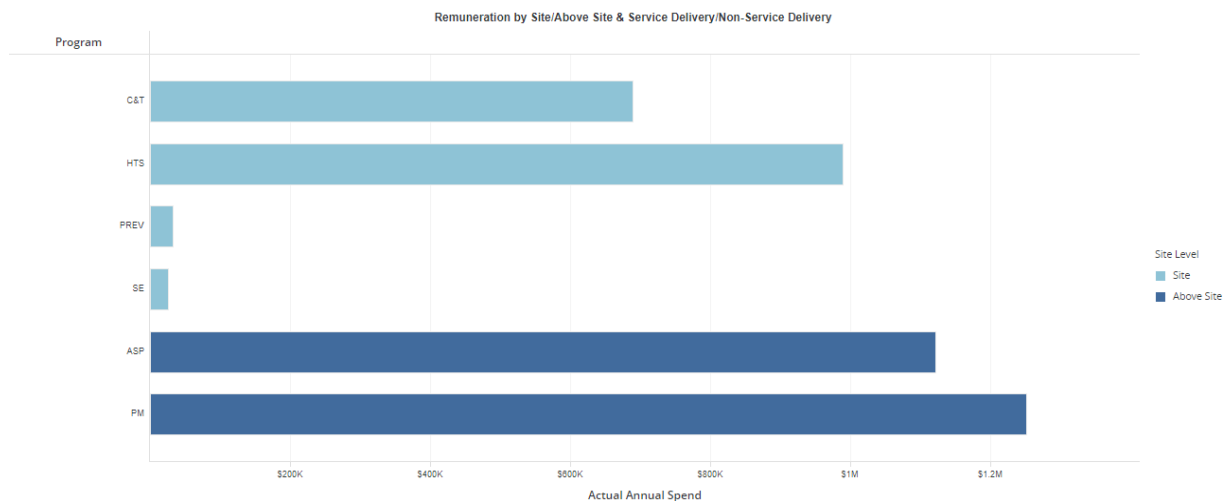
Figure E.1.3. Assessing Thailand’s PEPFAR Expenditure and Program Trends by Interaction Type



Thailand is currently at 94-86-84 (2022 estimates), which requires a combination of site-level and above-site investments to increase uptake of global interventions and strengthen health systems to properly monitor and improve program performance. Decreased trends in program management, site-level, and above-site activities reflect reductions in total budget envelope over the years, with a focus on maintaining the budget for service delivery to key populations.

- **HRH Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery:**

Figure E.1.4. Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery



HRH investments to provide critical site-level service were approximately \$1M in HTS (HIV testing services) and \$700K in C&T (care & support and treatment). HRH remuneration for above-site programs supported gaps in human resource capacity to strengthen technical areas, as described in Table 6.

2. Areas for Transition

PEPFAR Thailand resources have declined significantly since ROP19. For KPLHS financial sustainability, KPLHS are increasingly accessing NHSO’s prevention funds targeted on reach, recruit, and test. However, the domestic funds from NHSO have not reached the level of sustainability for these KPLHS sites. Therefore, in ROP22, PEPFAR Thailand will prioritize financial sustainability with RTG, NHSO, UN agencies and key CSOs to increase domestic financing as a goal of transitioning CSOs to domestic funds. Multiple stakeholder discussions will be held to outline a path forward with NHSO to increase domestic financing for KPLHS sites by expanding HIV service free-flow targets (no quota or fixed minimum number of NHSO testing targets) and propose realistic unit costs from NHSO. The CSO capacity building for social contracting and blended financing among donors will be emphasized as key priorities among PEPFAR, the Royal Thai Government, NHSO, UN agencies, and CSOs in ROP22.

Transitioning CSOs to the host country government has been rigorously discussed during ROP22 planning. We expect to gradually and safely transition PEPFAR support to CSOs in the next two to five years depending on the capacity of each CSO. Transition risks include emergence of negative effects of COVID-19 pandemic, insufficient or unstable domestic financing, inadequate levels of funding of CBOs, reduction of HIV targets as the country reaches epidemic control, and potential political and economic instability. To address insufficient funds, PEPFAR, in collaboration with UNAIDS, will propose adequate HIV unit costs to NHSO to reflect the reality of services performed by CSOs. The new HIV unit costs will be calculated from a whole spectrum of HIV services to support the full HIV cascade. PEPFAR will work closely with the GF and its principal recipients (PRs) to support the C19RM (COVID-19 Response Mechanism) application and help mitigate the negative impact of COVID-19 on HIV services.

Another ROP22 priority is to continue to roll up PEPFAR's level of engagement at government-supported health care facilities from site-level to above site (i.e., provincial and national level). In ROP20, PEPFAR Thailand proposed benchmarks for site readiness to fully transfer to the national program. In ROP21, this site transition plan was revised, and five key indicator targets were selected to indicate readiness to roll up PEPFAR's level of engagement from site level to above site level. In ROP22 planning, PEPFAR Thailand further revised the ROP21 site transition criteria due to budget cuts. Population VLS was selected as the key indicator to measure site/SNU readiness to transition from site-level to above-site. In ROP22, PEPFAR will transition five sites to above-site level and continue to monitor performance very closely at the provincial level and suggest appropriate quality improvement activities as needed to ensure a responsible hand-off. PEPFAR will continue to focus on KP-centric clinical services and promote KP-led health services, HIV service quality improvement, and data systems support to national programs through provincial health offices and public health facilities. PEPFAR Thailand will have a series of consultations with RTG, NHSO, GF, UN agencies, and key CSOs to plan for transitioning KPLHS to Thailand national healthcare system under RTG. Transition criteria are still being negotiated.

3. Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response

The development of the ROP22 plan included a series of consultation meetings and collaborations with key stakeholders contributing to the national HIV response (i.e., MOPH, BMA, NHSO, CSOs, GF, UNAIDS, and WHO). One of the main priorities of ROP22, as discussed with the PEPFAR Co-Chairs and relevant stakeholders, is to support the transition of PEPFAR-supported CSOs to domestic systems and financing through the established NHSO system and ongoing efforts to improve and streamline the system.

CSO participation in the HIV response has significantly contributed to the Ending AIDS strategy in Thailand. However, capacity strengthening for all CSOs is needed in order to meet the criteria to qualify to become an NHSO node to provide HIV services within the national healthcare system and thereby qualify to access domestic funding from NHSO. The NHSO criteria include a) CSO is accredited by public organization; b) 70% of community health workers (CHW) who provide HIV services are certified by MOPH; and c) drop-in-center held by that CSO is assessed on HIV services and accredited by the Department of Disease Control (DDC, MOPH). PEPFAR Thailand will continue working collaboratively with DAS on capacity strengthening to support CSOs to meet the above criteria and eventually transition all CSOs to receive 100% domestic financing.

MOPH and NHSO have recognized the critical contribution in HIV service provision made by KPLHS to meet national targets. In ROP22, NHSO will change the social contracting mechanism from contract-based (annual project-based) to having all CSOs register as NHSO nodes for HIV services. This will enhance free-flow targets and help CSOs get reimbursed for additional costs related to HIV services based on monthly performance (known as the free schedule reimbursement mechanism). The challenges of free schedule reimbursement could disrupt CSO programming because many CSOs do not have their own buffer funds during the first 2-3 months of the fiscal year to provide services before they receive reimbursement from NHSO. Therefore, PEPFAR Thailand plans to support KPLHS services during the piloting of the free schedule reimbursement mechanism and strengthen the reimbursement mechanism in the next ROP.

Additionally, PEPFAR Thailand will continue to support the provincial Ending AIDS network to demonstrate strong local political commitment and collaboration between health facilities, CSOs, and private sectors to improve the quality of

HIV services at PEPFAR-supported sites and provinces. MOPH will collaborate with the Healthcare Accreditation Institute to certify provinces as Ending AIDS provinces to ensure integration into the government system to sustain the Ending AIDS goal.

4. Agreements and plans on Data Use and Sharing and Quality control (including Central Support reporting).

PEPFAR Thailand has implemented DQI tools to analyze site-level data to monitor, identify, and trace those who have missed appointments and experienced interruptions in treatment at all PEPFAR-supported health facilities. In ROP22, PEPFAR Thailand, in collaboration with MOPH, will expand SI activities to the national and sub-national levels. As indicated in Table 6, PEPFAR Thailand will strengthen SI capacity of MOPH, community, and other partners to use data to strengthen the national HIV response and health information systems, improve quality and implementation of site-level services, and maintain a robust data monitoring and reporting system.

Critical challenges identified included quality control of health information and data sharing with local, provincial, and national partners. In ROP22, PEPFAR Thailand will 1) continue to support and build a self-sustained M&E program by developing standard operating procedures (SOPs) for regular data review, training new staff and CHWs, and strengthening digital platform (HIV Info Hub) to regularly update program indicators for self-monitoring; 2) enhance CQI for optimizing PEPFAR-supported interventions (i.e., voluntary counseling and testing (VCT)/provider-initiated testing and counseling (PITC), linkage to SDART, DSD, VL coverage, coaching, HIV Disease Specific Certification (DSC) and provincial network strategy) to help local governments promote community-health facility collaboration and networks for sustainable implementation; 3) support a routinized process of sharing and using data through provincial AIDS networks and national M&E platforms for local ownership of HIV programs, and 4) develop and follow up corrective & collaborative action plans to improve service outcomes.

ⁱ www.aidsdatahub.org based on UNAIDS 2019 HIV Estimates and UNAIDS Data 2020.

ⁱⁱ Spectrum estimates 2021 (updated using program data up to 2020), Ministry of Health

ⁱⁱⁱ UNAIDS 2021 estimates (1990-2017), Ministry of Health of Kazakhstan (2018-2021)

^{iv} UNAIDS 2020 estimates

^v National HIV Estimates 2020

^{vi} Spectrum files, RAC, Tajikistan (data retrieved on March 29, 2022)