Central Asia

PEPFAR Regional Operational Plan (ROP)

2016

Strategic Direction Summary

March 31, 2016

(Updated: May 6, 2016)

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Goal Statement

In Regional Operational Plan 2016 (ROP16), while collaborating with host country governments, multilateral partners, and civil society organizations, and other development partners, the Central Asia Region (CAR) PEPFAR Operating Unit (OU) will continue to scale up essential services toward achievement of the UNAIDS 90/90/90 targets in PEPFAR focus Sub-National Units (SNUs) in Tajikistan, the Kyrgyz Republic, and Kazakhstan. Achievement of 90/90/90 goals will make a significant contribution to national epidemic control in Tajikistan and Kyrgyz Republic since PEPFAR SNUs contain 72.5% and 80.6% of all adult People Living with HIV (PLHIV) in these countries, respectively. PEPFAR CAR's above site support of new service delivery and national guidelines development is expected to have additional benefits for national epidemic control, since the results of these efforts with host governments can be scaled nationally. Moreover, high level advocacy is expected to make services more accessible to Key Populations (KP). Across CAR, PEPFAR will focus prevention, case finding and treatment efforts on People Who Inject Drugs (PWID) and their partners, since injection drug use is estimated to account for the majority of new and prevalent HIV cases in the region.

Review of current epidemiologic and programmatic data revealed three key challenges to scale up of essential services: 1) the percent of PLHIV who know their status in the PEPFAR focus SNUs in Tajikistan and the Kyrgyz Republic is low, 2) current anti-retroviral treatment (ART) coverage rates in the PEPFAR focus SNUs are extremely low (ranging from 10.2% in Dushanbe to 25.8% in Eastern Kazakhstan oblast), and 3) the available host government and Global Fund (GF) supported budgets for ARVs are insufficient for scaling up to saturation in 2017. After consultations with the review team during the DC Management Meeting, all PEPFAR CAR focus SNUs were designated as "aggressive scale-up" with a goal of doubling ART coverage every year until saturation is achieved. This approach should result in achieving saturation in four SNUs by the end of FY18. The remaining SNUs, following the same aggressive scale up of doubling the number of PLHIV on ART annually, should achieve treatment saturation by the end of FY19.

Each of the three CAR countries will have a specifically tailored strategy in each technical area, since each country has its unique epidemiological situation and health sector. For example in the Kyrgyz Republic and Tajikistan, treatment scale up is highly dependent on the GF support, as they are the sole procurers of ARV drugs. In Kazakhstan, the government procures ARVs at more than ten times the price compared to their regional neighbors, and ART shortages are anticipated during FY16. PEPFAR technical assistance is supporting analyses of alternative procurement mechanisms for Kazakhstan and engagement in high-level advocacy to address this pressing issue by FY17. PEPFAR CAR will collaborate with the Principle Recipients and GF in the Kyrgyz Republic and Tajikistan and with the Government of Kazakhstan to leverage resources for achieving aggressive treatment scale-up. In addition, PEPFAR CAR is currently working with Ministries of Health (MOH) across all three countries to adopt the 2015 WHO Test and Start recommendations (ART for all PLHIV regardless of CD4 cell count), as well as new models of decentralized service delivery. In 2015, the Kyrgyz Republic and Kazakhstan adopted the 500 CD4 treatment eligibility criteria in 2015, and with PEPFAR support, Tajikistan plans to review and revise its national treatment guidelines at the end of FY 2016.

In the Kyrgyz Republic and Tajikistan, PEPFAR will support a new model for HIV case finding among PWID and their partners, instead of using the traditional outreach worker key population prevention model, which has been associated with low HIV testing yield. Beginning in FY 2016, a Peer Driven

Intervention (PDI) approach will use PWID/ PLHIV "seeds" to recruit their peers for HIV testing and is expected to recruit new, hard-to-reach PWID and the sexual partners of HIV infected PWID. Meanwhile, Kazakhstan is estimated to have diagnosed over 90% of PLHIV nationally and will not implement PDI, although only 50.3% of adult PLHIV are currently in care. Therefore, retaining/ re-enrolling PLHIV lost to follow up (LTFU) and linking them to treatment will be a focus in all three countries. In FY 2016, PEPFAR began supporting Peer Counselors in ART clinics to task shift patient adherence counseling. Home visiting nurses will work with the facility-based Peer Counselors and community-based peer navigators to promote retention in treatment. In collaboration with GF and MOH, viral load testing will be scaled up in Tajikistan and the Kyrgyz Republic by increasing the number of sites performing viral load testing and increasing the number of viral load tests performed. For ROP16, the target in PEPFAR SNUs is that 90% of adult patients on ART for one year or more will have a viral load test performed and among these, 90% will have a suppressed viral load.

In ROP15, PEPFAR CAR pivoted to the focus SNUs and began program implementation in the highest HIV burden districts (rayons) and cities within the SNUs (oblasts/capital cities). In ROP16, PEPFAR CAR will begin implementing the combined prevention, case finding, treatment and retention model in additional high and medium burden districts within the focus SNUs, using a data-driven approach to select and monitor implementation sites.

During ROP implementation, PEPFAR CAR will continue to scrutinize site yield data from HIV testing and counseling (HTC) sites and will closely evaluate the PDI approach for HIV case finding yield. Support to sites and peer networks that do not find HIV positive cases will be stopped. During ROP16 development, Expenditure Analysis data was used to look for expensive outliers in unit expenditures, in order to target resources and promote efficiency.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

At the end of 2014, there were an estimated 1.5 million [1.3 million–1.8 million] PLHIV in Eastern Europe and Central Asia, which accounts for 4% of the global number of PLHIV.[1] In Kazakhstan, 18,185 adult PLHIV are diagnosed, accounting for 92% of the estimated adult PLHIV; in Tajikistan 5,310 adult PLHIV are officially registered, accounting for 35% of the estimated adult PLHIV; while in the Kyrgyz Republic 4,339 adult PLHIV are diagnosed, accounting for 49% of the estimated adult PLHIV. The HIV epidemic in CAR is growing, and is primarily concentrated among PWID and their sexual partners. The number of new HIV infections in Central Asia rose rapidly in the 1990s then again began increasing towards the end of the last decade after having remained relatively stable for several years since 2000. Sixty percent of the cumulative HIV cases in this region have been reported among PWID.[2] Heterosexual transmission among PWID is known to be of significant importance, but the proportion of sexual transmission

[1] *UNAIDS, AIDSInfo; Central Asia HIV Profile, 2014, http://aidsinfo.unaids.org/ accessed 20 March 2016*

[2] *World Health Organization, Central Asia HIV Profile, 2013*

independent of drug use is not known.[3] The epidemiological data shows that female sex workers (FSW) and men who have sex with men (MSM) are also disproportionately affected by HIV/AIDS relative to the general population.

There are more than 29,000 officially registered PLHIV in Kazakhstan, the Kyrgyz Republic and Tajikistan. Within each country, the HIV prevalence, KP size, and number of PLHIV vary significantly across oblasts (regions) and cities. While the HIV prevalence among the general population in the three countries is at or below 0.20%, rates among PWIDs range from 7-26.5% within the PEPFAR focus SNUS. In all three countries, the regions and cities that align with international drug trafficking routes have high numbers of PWID, and consequently PLHIV. In Tajikistan, over 50% of all reported PLHIV live in five cities (Dushanbe, Vakhdat, Khujand, Penjikent and Kulyab); PWID HIV prevalence rates range from 6.4% in Kulyab to 26.5% in Dushanbe.

Countries in this region face several similar obstacles in achieving the targets set out in the UNAIDS "Fast Track – Ending the AIDS Epidemic by 2030" Initiative, including: (1) punitive laws and policies toward PWIDs, influenced by Russian models; (2) stigma and discrimination from communities, health providers and law enforcement officials that marginalizes PWID and limits access to and uptake of HIV related services; (3) incomplete epidemiological data on the size and location of these populations to help strategically target services; and (4) limited coverage and quality of an evidence-based HIV continuum of care (including harm reduction for PWID) that will ensure PLHIV achieve long-term viral suppression.

(The Purchasing Power Parity Gross National Income for Kazakhstan, Tajikistan, and the Kyrgyz Republic is 21,710; 2,660; and 3,220 international dollars per capita respectively (2014, World Bank).)

[3] European Centre for Disease Prevention and Control, World Health Organization Regional Office for Europe. Surveillance report: HIV/AIDS surveillance in Europe 2012. Stockholm: European Centre for Disease Prevention and Control; 2013 http://www.euro.who.int/__data/assets/pdf_file/0018/235440/e96953.pdf, accessed 9 July 2014

Table 1.1.1

Key National Demographic and Epidemiological Data – Tajikistan, the Kyrgyz Republic, and Kazakhstan

TAJIKISTAN											
Table 1.1.1 Key National Demographic and Epidemiological Data											
	Total		<15				≥15				Source, Year
			Female		Male		Female		Male		Empty cells indicate no data available.
	N	%	N	%	N	%	N	%	N	%	
Total Population	8,352,000	100	1,399,000	16.75%	1,493,000	17.88%	2,728,700	32.67%	2,731,300	32.70%	National Statistics Agency, As of January 01, 2015, www.stat.tj/ru/
Estimated number of PLHIV	16,350		535		535		5,920		9,360		UNAIDS SPECTRUM, 2014 http://aidsinfo.unaids.org
HIV Prevalence (%)	-	0.20%	-	0.04%	-	0.04%	-	0.22%	-	0.34%	Estimated PLHIV (SPECTRUM, 2014) / population (NSA, 2015)
AIDS Death (per year)	<1,000	-	<100	-	<100	-	<500	-	<500	-	SPECTRUM, 2014
AIDS Death (per year)	107	-	0	-	2	-	23	-	82	-	EHCMS, Feb 01, 2015 - Jan 31, 2016 for reported deaths
# PLHIV diagnosed	5,890	100	223	3.79	357	6.06	1,909	32.4	3,401	57.7	EHCMS, As of Jan 31, 2016
New Infections (Yr)	1,700										SPECTRUM, 2014 for national total
Newly diagnosed Infections (Yr)	1,038	-	51	-	71	-	378	-	538	-	EHCMS, 2015; # of newly registered/confirmed cases
Pregnant Women Needing (ARVs)	28	-	0	-	-	-	28	-	-	-	EHCMS, As of Jan 31, 2016
Notified TB Cases (Yr)	5,804	100	150	2.58%	184	3.17%	2445	42.13%	3025	52.12%	TB center, 2014 (communication with GFATM PIU TB Specialist); 2015 Global TB report essentially the same 5,807
% of TB cases that are HIV infected	61	1.05%	1		2		19		39		EHCMS, As of Jan 31, 2016; calculated % HIV infected/ registered cases.
Key Populations											
											Source, Year
Estimated Population Size of PWID	23,100	-	-	-	-	-	-	-	-	-	RAC, size estimation of PWID, 2014
PWID HIV Prev.	-	13.5%	-	-	-	-	-	-	-	-	RAC, IBBS, 2014
Estimated Population size of MSM	13,400	-	-	-	-	-	-	-	-	-	RAC, IBBS, 2015
MSM HIV Prev.	-	1.5%	-	-	-	-	-	-	-	-	RAC, IBBS, 2011
Estimated Population Size of FSW	14,100	-	-	-	-	-	-	-	-	-	RAC, size estimation of FSW, 2014
FSW HIV Prev.	-	3.5%	-	-	-	-	-	-	-	-	IBBS, 2014

KYRGYZSTAN

Table 1.1.1 Key National Demographic and Epidemiological Data

	Total		<15				≥15				Source, Year
			Female		Male		Female		Male		Empty cells indicate no data available.
	N	%	N	%	N	%	N	%	N	%	
Total Population	5,895,062	100	903,713	15.33%	944,455	16.02%	2,074,378	35.19%	1,972,516	33.46%	Republican Medical Information Center, As of January 01, 2015
Estimated number of PLHIV	9,258		176		217		3,853		5,012		UNAIDS estimate based on SPECTRUM, 2014 http://aidsinfo.unaids.org
HIV Prevalence (%)	-	0.16%	-	0.02%	-	0.02%	-	0.19%	-	0.25%	Estimated PLHIV (SPECTRUM, 2014) / population (2015)
AIDS Death (per year)	371										UNAIDS estimate for national total deaths (2014);
AIDS Death (per year)	77	-	1	-	3	-	21	-	52	-	EHCMS, Feb 01, 2015 - Jan 31, 2016 for reported deaths
# PLHIV diagnosed	4,837	100	191	3.95%	307	6.35%	1,621	33.51%	2,718	56.19%	EHCMS, As of Jan 31, 2016
Incidence Rate (Yr)	-	0.010%	-	0.0019%	-	0.0015%	-	0.012%	-	0.016%	# of new cases in the period Feb 01, 2015 - Jan 31, 2016/by total population, 2015 *100
New Infections (Yr)	853										UNAIDS SPECTRUM 2014 for National
New Infections (diagnosed/ Yr)	592	-	17	-	14	-	242	-	319	-	EHCMS, Feb 01, 2015 - Jan 31, 2016; # of newly confirmed cases officially registered
Pregnant Women Needing (ARVs)	41	-	0	-	-	-	41	-	-	-	EHCMS, As of Jan 31, 2016
Notified TB Cases (Yr)	5,898	100%	202	3.40%	236	4.00%	2415	40.90%	3045	51.60%	MOH data for 2014; Global TB report WHO 2015 = 6,390 cases
% of TB cases that are HIV infected	226	3.8%	3	1.5%	5	2.1%	47	1.9%	171	5.6%	EHCMS, As of Jan 31, 2016
Key Populations											**Source, Year**
Estimated Population Size of PWID	25,500	-	-	-	-	-	-	-	-	-	Center for Health Policy Analysis, Report on Size estimation of PWID, 2013
PWID HIV Prev.	-	12.4%	-	-	-	-	-	-	-	-	IBBS, 2013
Estimated Population size of MSM	22,000	-	-	-	-	-	-	-	-	-	Report on Size estimation of MSM, 2013 Anti-SPID, 2014
MSM HIV Prev.	-	13% in Bishkek; 0% in Osh	-	-	-	-	-	-	-	-	UNAIDS, National HIV prevalence 6.3% (2013); RAC, IBBS, 2013; Note: there were methodologic difficulties in the IBBS in Osh
Estimated Population Size of FSW	7,100	-	-	-	-	-	-	-	-	-	Report on Size estimation of FSW, 2013
FSW HIV Prev.	-	2.2%	-	-	-	-	-	-	-	-	RAC, IBBS, 2013

KAZAKHSTAN										0.0144	
Table 1.1.1 Key National Demographic and Epidemiological Data											
	Total		<15				≥15				Source, Year
			Female		Male		Female		Male		Empty cells indicate no data available.
	N	%	N	%	N	%	N	%	N	%	
Total Population	17,417,673	100	2,252,815	12.93%	2,378,762	13.66%	6,750,335	38.76%	6,035,761	34.65%	National Statistics Agency, As of January 01, 2015
HIV Prevalence (%)	-	0.12%	-	0.01%	-	0.01%	-	0.11%	-	0.21%	Estimated PLHIV (SPECTRUM, 2014) / population (NSA, 2015)
AIDS Death (per year)	< 1,000	-	-	-	-	-	-	-	-	-	AIDSinfo (http://aidsinfo.unaids.org) 2014 national AIDS-related deaths
AIDS Death (per year)	142	-	1	-	0	-	42	-	99	-	EHCMS, Feb 01, 2015 - Jan 31, 2016 for reported deaths
Estimated # of PLWH	20,288		225	1.11%	225	1.11%	7,418	36.56%	12,420	61.22%	SPECTRUM, 2014
# PLHIV diagnosed	18,627		188	1.01%	254	1.36%	7,055	37.88%	11,130	59.75%	EHCMS, As of Jan 31, 2016
Incidence Rate (Yr)	2,300	0.013%	-		-		< 1,000	< 0.015%	1,600	0.0265%	UNAIDS, AIDSinfo (http://aidsinfo.unaids.org) for 2014
New Infections (diagnosed/ Yr)	2,513	0.0144%	18	0.0008%	14	0.0006%	1,021	0.0151%	1,460	0.0242%	EHCMS, Feb 01, 2015 - Jan 31, 2016; # of newly confirmed cases officially registered
Pregnant Women Needing (ARVs)	152	-	0	-	-	-	152	-	-	-	EHCMS, As of Jan 31, 2016
Notified TB Cases (Yr)	15,244	6%	230	-	215	-	4,731	-	6,304	-	WHO 2015 Global TB report for national total; National TB program data for age/ sex disagregate
% of TB cases that are HIV infected	864	5.67%	0		3		186		675		EHCMS, As of Jan 31, 2016; calculated % using notified cases as denominator.
Key Populations											Source, Year
Estimated Population Size of PWID	127,800	-	-	-	-	-	-	-	-	-	RAC, Report on Size Estimation of PWID, 2014
PWID HIV Prev.	-	7.95%	-	-	-	-	-	-	-	-	e-IBBS, 2014
Estimated Population size of MSM	27,890	-	-	-	-	-	-	-	-	-	e-M&E, 2015
MSM HIV Prev.	-	3.16%	-	-	-	-	-	-	-	-	e-IBBS, 2014
Estimated Population Size of FSW	19,050	-	-	-	-	-	-	-	-	-	e-M&E, 2015
FSW HIV Prev.	-	1.27%	-	-	-	-	-	-	-	-	e-IBBS, 2014

Table 1.1.1 (a) Key and Priority Population Size Estimate and HIV prevalence by SNU

TAJIKISTAN

Oblast	City	Population	KP Estimate	PLHIV-Total	HIV Prevalance	PWID-PSE	PWID-HIV Prevalence	MSM-PSE	MSM-HIV Prevalence	FSW-PSE	FSW-HIV Prevalence	Prisoners-PSE	Prisoners-HIV Prevalence
Dushanbe city		788,700		6,037	0.77%	2,998	26.50%	13,400	1.50%	1,638	3.00%		11.50%
RRS		1,922,000		2,607	0.14%	784 (for only Vakhdat)	16,4% (for only Vakhdat			394 (for only Vakhdat	11,3% (for only Vakhdat		5,3% (for only Vakhdat
Soghd oblast		2,455,500		2,432	0.10%	1440 (for Khudjand, Istaravshan, Isphara cities)	5,3% (for Khudjand, Istaravshan, Isphara cities)			2072 (for Khudjand, Istaravshan, Isphara cities)	0,82% (for Khudjand, Istaravshan, Isphara cities)		
Source		National Statistics Agency, As of January 01, 2015, www.stat.tj/ru/		Estimated from EHCMS, As of Jan 31, 2016	PLHIV/Population*100	Size estimation of PWID, 2014	IBBS, 2014	IBBS, 2011	IBBS,2011	Size estimation of PWID, 2014	IBBS, 2014		IBBS, 2013

KYRGYZSTAN

Oblast	City	Population	KP Estimate	PLHIV-Total	HIV Prevalance	PWID-PSE	PWID-HIV Prevalence	MSM-PSE	MSM-HIV Prevalence	FSW-PSE	FSW-HIV Prevalence	Prisoners-PSE	Prisoners-HIV Prevalence
Bishkek city		926,512	NA	1,894	0.20%	8,050	11%	min 1151 - max 6960	13%	min 1700 - max 2500	1.6%	NA	NA
Chui oblast		870,319	NA	2,676	0.31%	3100 (only for Sokuluk)	NA	NA	NA	min 30 - max 50 (only for Sokuluk)	NA	NA	NA
Osh oblast		1,228,346	NA	1,216	0.10%	700 (only for Karasuu)	NA	NA	NA	NA	NA	NA	NA
Osh City		270,292	NA	1,359	0.50%	3,800	17%	min 349 - max 4731	0%	min 200 - max 400	2%	NA	NA
Source		Republican Medical Information Center, As of January 01, 2015		Estimated from EHCMS, As of Jan 31, 2016	PLHIV/Population*100	Report on Size estimation of PWID, 2013	IBBS, 2013	Report on Size estimation of MSM, 2013	IBBS, 2013	Report on Size estimation of FSW, 2013	IBBS, 2013		

KAZAKHSTAN

Oblast	City	Population	KP Estimate	PLHIV-Total	HIV Prevalance	PWID-PSE	PWID-HIV Prevalence	MSM-PSE	MSM-HIV Prevalence	FSW-PSE	FSW-HIV Prevalence	Prisoners-PSE	Prisoners-HIV Prevalence
East-Kazakhstan oblast		1,395,324	NA	2,489	0.18%	14,300	14.18%	3,720	6.67%	1,700	1.49%	-	5.68%
Pavlodar oblast		755,778	NA	1,658	0.22%	10,200	10.08%	1,000	1.00%	750	3.67%	-	3.79%
Source		National Statistics Agency, As of January 01, 2015		Estimated from EHCMS, As of Jan 31, 2016	PLHIV/Population*100	PSE of PWID Report, 2014	e-IBBS, 2014	e-M&E, 2015	e-IBBS, 2015	e-M&E, 2015	e-IBBS, 2015		e-IBBS, 2014

People who inject drugs (PWID): In the three countries of CAR, there are an estimated 176,400 PWID. Throughout the region, estimates suggest that HIV prevalence is significantly higher among PWID than in the general population. In Kazakhstan, the Kyrgyz Republic and Tajikistan, HIV prevalence in the general population is at or less than 0.20%, but HIV prevalence among PWID is 7.95% in Kazakhstan, 12.4% in Kyrgyz Republic and 13.5% in Tajikistan.[4] Official PWID size estimates are 127,800 in Kazakhstan, 25,500 in Kyrgyz Republic in and 23,100 in Tajikistan; however, the accuracy of these data has been controversial.[5] The SNU-level prevalence and PWID population size varies considerably across regions and cities in each of the countries, reinforcing the need for well-developed strategic information and surveillance systems to ensure targeted programming. As PWID are the largest KP group and have the highest prevalence in the region, PEPFAR CAR will focus on PWID as its target population. Recently, the countries of CAR report that HIV cases attributed to injection drug use are decreasing and sexual transmission is on the rise. However, disaggregation of HIV cases between males and females indicate that injection drug use is the primary mode of transmission of HIV among men. For example, in Kazakhstan, 68% of all HIV positive men contracted HIV through unsafe injecting equipment and 72% of all HIV positive females acquired HIV via sexual intercourse. This implies that injection drug use is the main route of HIV transmission among men, and female are at high risk of contracting HIV from their male sex partners who use injection drugs. Therefore, PEPFAR CAR will focus on PWID and their sexual partners for HIV case finding interventions.

Over the last few years, the three CAR countries have made progress in identifying more areas with large PWID populations, reaching more PWID with community-based outreach, care and support services, and piloting PWID clinical services including HIV Testing and Counseling (HTC), Methadone or Medication Assisted Therapy (MAT) and ART for PWID PLHIV. There has also been considerable progress in developing electronic HIV case management systems (EHCMS), which has improved the ability of the Republican (National) AIDS Centers in the three countries to monitor PWID throughout clinical services, understand current modes of transmission, and elucidate SNU distribution of PLHIV, including HIV-infected PWID.

Despite gains over the last few years, all three countries are experiencing significant challenges in supporting PWID throughout the continuum of care (see Table 1.1.2). Stigma and discrimination towards PWID by service providers and law enforcement agents present barriers to PWID in accessing services; high threshold approaches prevent some PWID from enrolling in and accessing MAT; and poor uptake of HTC services limits efficiency and enrollment in HIV care and treatment. Limited service delivery points and dependence on an increasingly limited set of donors (e.g. GF) also present barriers for PWID populations.

The Kyrgyz Republic is the only country in the region to have a relatively large scale implementation of MAT and to implement a "one stop" HIV/MAT services, which can play an important role in treating opioid addiction and facilitating access and retention in HIV care and treatment. In the Kyrgyz Republic, MAT has been expanded in 29 sites across the country, including eight in prisons, and the proportion of PLHIV receiving ART while on MAT is increasing. That said, in the Kyrgyz Republic, poor quality of MAT services constrains uptake of services, as does compulsory registration of PWID clients at narcology

[4] National prevalence data, Republican AIDS Center, 2015.
[5] National population size estimation data, Republican AIDS Center, 2015.

centers, which can limit employment opportunities. Tajikistan has comparatively fewer MAT sites, but these have the highest volume in the region, averaging around 100 clients per site, and some locations have a waiting list. MAT coverage does not exceed 5% in any CAR country despite evidence that MAT increases ART adherence for HIV infected PWID. While there has been progress on building political support and a lower threshold for accessing MAT across CAR countries, a host of barriers still limit access to MAT for PWID populations.

The interaction of injecting drug use with sex work and imprisonment is further accelerating the spread of HIV in CAR. Estimates indicate 9 out of 10 PWID are imprisoned at some stage in their lives. In prison, they are exposed to and engage in high-risk behaviors that increase the likelihood of transmitting HIV and other infectious diseases, such as sharing injecting equipment, tattooing and piercing, and unprotected sex. HIV prevalence has been reported to be over 10% in some prisoner populations, which is significantly higher than in the general population.[6] In ROP16, PEPFAR CAR will continue to address factors contributing to HIV vulnerability among PWID in prisons and upon their release, and will provide support to PLHIV prisoners.

Female sex workers (FSW): FSW are also disproportionately impacted by the HIV epidemic. HIV prevalence for FSW is estimated to be 1.3% in Kazakhstan, 2.2% in the Kyrgyz Republic and 3.5% in Tajikistan. There is considerable variation in FSW HIV prevalence across subnational regions and cities in these countries. Overlapping risk behaviors of sex work and injecting drug use exacerbate the HIV risk across the three countries. For example, in Central Asia, a survey published in 2013 found HIV prevalence to be 20 times higher among FSW who reported injecting drug use than FSW who did not.[7] While uptake of HIV testing and counseling by FSW is reportedly high, surveys indicate that significant numbers of FSW are not routinely tested for HIV.[8]

While FSW are an important risk group, research indicates that FSW are a smaller population with lower HIV prevalence than PWID in the region. Moreover, data on FSW at a sub-national level can be challenging to obtain. PEPFAR CAR will continue to evaluate the available data on FSW population size, prevalence estimates, and case reports to determine whether future PEPFAR focus should be extended to this KP group.

Men who have sex with men (MSM): MSM are another KP disproportionately impacted by HIV in the region, with HIV prevalence estimated to be 3.16% in Kazakhstan and 1.5% in Tajikistan. In the Kyrgyz Republic, an IBBS among MSM was conducted in Bishkek, and HIV prevalence was estimated to be 13% (see Table 1.1.1). In Almaty, an IBBS among MSM found an estimated prevalence of 20.2%.[9] Stigma likely results in inaccurate size estimations of this population in case surveillance data. The IBBS data also is of limited quality in this population due to low participant numbers and limited set of survey sites. Where

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[6] *World Health Organization, Central Asia HIV Profile, 2013*

[7] Baral S, Todd CS, Aumakhan B, Lloyd J, Delegchoimbol A, Sabin K. HIV among female sex workers in the central Asian republics, Afghanistan, and Mongolia: contexts and convergence with drug use. Drug Alcohol Depend. 2013;132(Suppl 1):S13–S16. doi:10.1016/j.drugalcdep.2013.07.004.

[8] HIV and TB TRAC study understanding risk behaviors associated with HIV transmission and utilization of HIV prevention services among female sex workers in Kazakhstan, the Kyrgyz Republic, and Tajikistan, 2013-2014. Population Services International., http://psi.softdeco.net/eng/publications_and_resources/project_publications/research_reports/#go

[9] Berry M, Wirtz A, et al. Risk Factors for HIV and Unprotected Anal Intercourse among Men Who Have Sex with Men (MSM) in Almaty, Kazakhstan. PLoS One (2012) 7(8): e43071. doi:10.1371/journal.pone.0043071

data are available, it highlights inadequate access and uptake of key HIV prevention services, including HTC, by MSM. Where HTC is available, national reporting indicates poor yield of HIV positives, which points to the challenges in reaching those MSM at highest risk of infection. MSM experience stigma and discrimination that can limit access and uptake of key HIV services and force them to hide their sexual activity and identity. For example, the Kyrgyz Republic's Parliament is currently considering a bill that would introduce criminal or administrative sanctions for acts aimed at forming "a positive attitude towards non-traditional sexual relations." Similar legislation is being considered in other CAR countries.

While MSM are an important risk group, the population is smaller and has a lower HIV prevalence in the region compared to PWID. PEPFAR CAR will continue to evaluate the available data on MSM population size, prevalence estimates, and case reports to determine whether future PEPFAR focus should be extended to this KP group also.

In reviewing the available data, the PEPFAR CAR team identified several common challenges in serving KPs across all three countries:

- *Low Uptake/Referral/Yield of HIV Testing and Counseling:* The percent of KPs receiving HIV counseling and testing is significantly lower than the percent of KPs reached with prevention interventions. For example, in 2014, 40% of PWID in the Kyrgyz Republic were reached with prevention interventions, but only 22% of them received an HIV test. In the PEPFAR focus cities in Tajikistan, PWID coverage with prevention interventions is around 70%, but only 40% have received an HIV test within the last 12 months. Where HTC is available, national reporting indicates low testing yield, which indicates HTC is not being effectively targeted to high-risk KP groups. In FY16 and in ROP16, PEPFAR will focus on significantly improving HIV case finding among PWID and their partners.

- *Minimal Uptake of Methadone Assisted Therapy:* MAT coverage among the estimated population of PWID remains less than 5% in all three countries. While progress has been made in the Kyrgyz Republic, the rate still only ranges from 5% in Bishkek to 18% in Chui Region. Fear and distrust of MAT has constrained full rollout of successful pilots to reach scale and maximum replication. Russian models also discourage MAT uptake. PEPFAR CAR will continue to support high level advocacy for MAT, demonstrating the linkage to improved ART adherence, thereby leading to lower HIV transmission, as well as the social benefits of treatment.

- *Low Coverage of Antiretroviral Treatment:* ART coverage in Kazakhstan, the Kyrgyz Republic and Tajikistan is low: 30.4%, 16.6% and 15.2%, respectively. Available case reporting data indicates that access to ART for KPs is lower than the overall rate, with rates of KPs enrolled in ART ranging from 11-22% across the three countries (though case reports may under-estimate the number of KP enrolled).

- *Low Viral Load Suppression Levels:* Only 2% of estimated PLHIV in Tajikistan, 9.3% in the Kyrgyz Republic and 14.5% in Kazakhstan reported viral load suppression. In Taijikstan and the Kyrgyz Republic, this is largely due to limited availability of viral load testing, leading to low rates of documented viral load suppression.

Table 1.1.2 Cascade of HIV Prevention, Diagnosis, Care and Treatment, and viral suppression (12 months) (for patients 15 and above)

TAJIKISTAN

				HIV Testing			Care and Treatment				Enabling ART Success				
	Total Population Size Estimate(#) (15+)	Estimated PLHIV (#) 15+	HIV Prevalence (%)	Tested (#) in 2015	Diagnosed HIV+ (#) and alive 15+ as of Jan 31, 2016	Diagnosed HIV+ (#) in the period from Feb 01, 2015 to Jan 31, 2016	Newly Enrolled in Care (#) in the period from Feb 01, 2015 to Jan 31, 2016	In Care (#) (CARE_CURR As of Jan 31, 2016)	Initiated on ART (#) in the period from Feb 01, 2015 to Jan 31, 2016	On ART (#) As Of Jan 31, 2016	Retained in ART (12 mos) As of Jan 31,2016 (Those patients who on ART 12 months and more)	Viral Supression (12 mos) in accordance with the new updated MER guide_num	Viral Supression (12 mos) in accordance with the new updated MER guide_denom	% Viral Supression	Sources
Total Population	5,460,000	15,280	0.10%	598,814	5,310	916	875	2,566	1,235	2,323	1,117	300	357	84%	EHCMS
PWID	23,100	3,118	13.5%	18,192	2,204	182	222	574	302	541	288	58	75	77%	EHCMS; Size estimation 2014; IBBS, 2014
MSM	13,400	201	1.5%	3,173	39	8	8	13	8	15	7	1	2	50%	EHCMS; size estimation 2015; IBBS, 2011 (only in Dushanbe)
FSW	14,100	493	3.5%	8,883	141	57	52	84	49	78	29	10	11	91%	EHCMS; Size estimation 2014; IBBS, 2014

KYRGYZSTAN

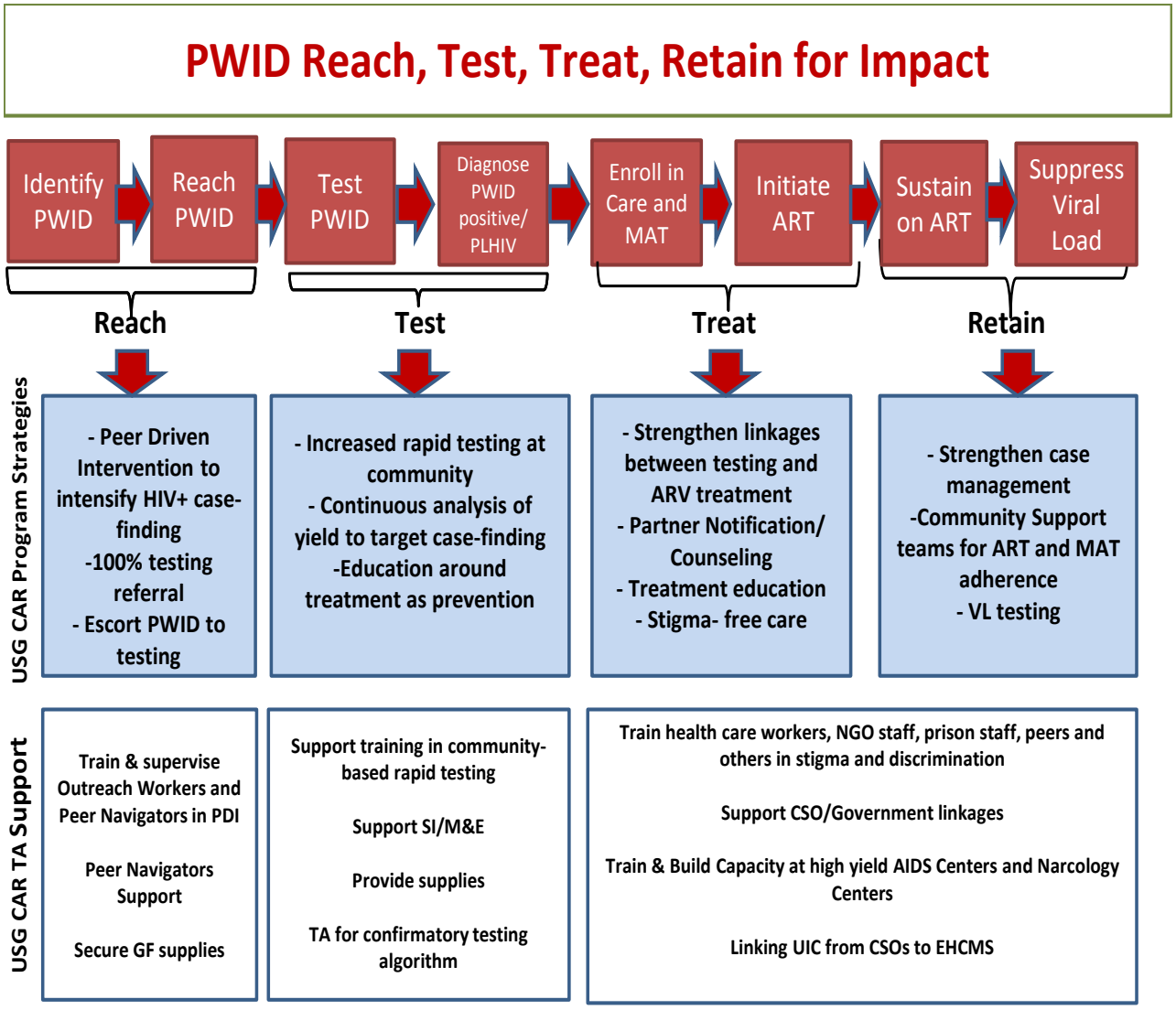
				HIV Testing			Care and Treatment				Enabling ART Success				
	Total Population Size Estimate(#) (15+)	Estimated PLHIV (#) 15+	HIV Prevalence (%)	Tested (#) in 2015	Diagnosed HIV+ (#) and alive 15+ as of Jan 31, 2016	Diagnosed HIV+ (#) in the period from Feb 01, 2015 to Jan 31, 2016	Newly Enrolled in Care (#) in the period from Feb 01, 2015 to Jan 31, 2016	In Care (#) (CARE_CURR As of Jan 31, 2016)	Initiated on ART (#) in the period from Feb 01, 2015 to Jan 31, 2016	On ART (#) As Of Jan 31, 2016	Retained in ART (12 mos) As of Jan 31,2016 (Those patients who on ART 12 months and more)	Viral Supression (12 mos) in accordance with the new updated MER guide_num	Viral Supression (12 mos) in accordance with the new updated MER guide_denom	% Viral Supression	Sources
Total Population	4,046,894	8,865	0.11%	399,979	4,339	561	491	1,786	425	1,470	1,120	825	1,351	61%	EHCMS
PWID	25,500	3,162	12.40%	3,704	2,054	134	136	723	93	437	454	275	504	55%	EHCMS; IBBS, 2013
MSM	22,000	1386	6.30%	661	70	22	21	36	16	26	10	18	27	67%	EHCMS; IBBS, 2013
FSW	7,100	156	2.20%	1,225	42	6	5	18	6	12	6	5	12	42%	EHCMS; IBBS, 2013

KAZAKHSTAN															
				HIV Testing			Care and Treatment				Enabling ART Success				
	Total Population Size Estimate(#) (15+)	Estimated PLHIV (#) 15+	HIV Prevalence (%)	Tested (#) in 2015	Diagnosed HIV+ (#) and alive 15+ as of Jan 31, 2016	Diagnosed HIV+ (#) in the period from Feb 01, 2015 to Jan 31, 2016	Newly Enrolled in Care (#) in the period from Feb 01, 2015 to Jan 31, 2016	In Care (#) (CARE_CURR As of Jan 31, 2016)	Initiated on ART (#) in the period from Feb 01, 2015 to Jan 31, 2016	On ART (#) As Of Jan 31, 2016	Retained in ART (12 mos) As of Jan 31,2016 (Those patients who on ART 12 months and more)	Viral Supression (12 mos) in accordance with the new updated MER guide_num	Viral Supression (12 mos) in accordance with the new updated MER guide_denom	% Viral Supression	Sources
Total Population	12,786,096	19,838	0.14%	2,711,990	18,185	2,481	2,197	9,982	2,314	6,031	3,579	2,894	5,164	56.0%	EHCMS
PWID	127,800	10,160	7.95%	31,376	9,078	811	733	4,611	1011	2,797	1,639	1273	2345	54.3%	EHCMS; IBBS, 2014 (HIV prev)
MSM	27,890	881	3.16%	1,018	305	84	70	193	52	99	46	51	81	63.0%	EHCMS; IBBS, 2015 (HIV prev)
FSW	19,050	241	1.27%	9,533	256	46	28	97	19	47	26	23	42	54.8%	EHCMS; IBBS, 2015 (HIV prev)

One of the major barriers to accelerating epidemic control in CAR is the drop off of clients at each stage of the continuum of care in each country, from outreach and prevention, to integration of KPs into the clinical cascade of testing, care, ART treatment, and adherence with community-based support throughout this process. As noted in Table 1.1.2, in Tajikistan 15.2% of 15,280 estimated adult PLHIV (15+) were on ART in 2015; only 2% of estimated PLHIV in Tajikistan had documented viral load suppression, largely due to limited availability of viral load testing. Viral load testing is low because only one laboratory in the country currently performs viral load testing. A similar situation can be seen in the Kyrgyz Republic in which only 16.6% of 8,865 estimated adult PLHIV (15+) were on ART as of February 1, 2016, and 9.3% with documented viral load suppression. In Kazakhstan, only 30.2% of 19,938 estimated adult PLHIV (15+) were on ART as of February 1, 2016, and 14.5% with documented viral load suppression. Retention of PWID in the continuum of care is lower than for general population. As noted in the prior section, PWID and their sexual partners are the main drivers of the HIV epidemics in all three countries. Almost half (49%) of PLHIV in PEPFAR-supported SNUs are in Tajikistan, and 32% are in the Kyrgyz Republic, reflecting PEPFAR CAR's focus on these two countries in the Central Asia OU.

Many factors contribute to the relatively low treatment rates, as described throughout this document, ranging from the Soviet legacy of vertically segregated health services to stigma and discrimination. Another factor is that national guidelines for ART eligibility are currently set for CD4 counts of less than 350 (cells/ mm_3) in Tajikistan and less than 500 CD4 (cells/ mm_3) in the Kyrgyz Republic and Kazakhstan. However, Kazakhstan still operates at the level of CD4≤ 350 due to the sporadic lack of ARVs. In 2017, Kazakhstan plans to purchase ARVs through UNICEF to cover all PLHIV with CD4≤ 500. In Tajikistan, providers are able to give ART to patients with CD4 counts of 350 (cells/ mm_3), if the patient agrees. In all countries, all HIV infected TB patients and pregnant women are eligible for ART, as well as the HIV infected partner in sero-discordant couples.

Thus, PEPFAR CAR has pivoted to support improved continuum of care outcomes in PEPFAR focus SNUs by targeting its resources in fewer high burden sites, implementing a coordinated support model as outlined below to increase community and facility support for treatment and adherence, and other new and continuing interventions noted throughout this document. PEPFAR CAR will continue to work at the above-site level on critical interventions such as national treatment guidelines update to adopt Test and Start and roll out new models of service delivery and advocacy for increased access to ART and MAT for KPs, as noted below.



1.2 Investment Profile

Tajikistan

Tajikistan is the poorest country in the region, with a Gross National Income (GNI) of $2,660 per capita.[10] A significant portion of Tajikistan's Gross Domestic Product (GDP) comes from remittances sent by Tajikistan citizens working in Russia, however with the falling oil prices and depreciation of the ruble, remittances declined by 42% in 2015.[11] This has caused GDP growth to fall from 6.7% in 2014 to 5% in 2015, and is projected to decline further to 4.5% in 2016.[12]

Due to these economic issues Tajikistan remains reliant on external support for a majority of the financing of its $48.6 million, three-year HIV National Strategic Plan (NSP), with international sources accounting for roughly 84% of total available resources. The Government of Tajikistan provides 14% of the remaining resources, with the final 2% coming from the private sector. The GF represents the majority of international investment, at 60% of all available resources, and currently procures 100% of ARVs and treatment commodities (Table 1.2.2.). The GF has allocated $17 million under the New Funding Model (NFM) for the period 2015-2017. Under the NFM, GF-supported prevention activities account for 60% of the total funding allocation, followed by care, treatment and support activities at 38%. A remaining 2% is allocated towards health system strengthening and strengthening civil society.[13] The GF has prioritized prevention spending, using the results from the Investment Case and Allocative Efficiency Analysis for Prevention Activities, and is focusing 98% of all prevention investments in the NFM on KP (KP testing and counseling, MAT, and Needle and Syringe Exchange Programs). In the NFM concept note submission, funding allocations under treatment are $2.8 million in 2016 and $3.1 million in 2017, which corresponds to a planned scale-up in the number of positives on ART: to 4,221 in 2016, and to 4,838 in 2017.

In support of the current HIV NSP per its NFM grant, the Government of Tajikistan planned to increase HIV spending by 9.6% in 2015, 19.4% in 2016 and 14.7% in 2017.[14] Despite anticipated donor and domestic contributions, the NSP anticipates a funding gap of $5m - $ 16m representing up to 32% of total NSP financial needs. This gap would primarily impact allocations to prevention services, which account for 84% of the NSP Budget. The Government of Tajikistan is now drafting the National HIV/AIDS Program (NAP) 2016-2020, which has been submitted for initial review. The NAP is a much more comprehensive and ambitious document than the NSP. The NSP was written primarily as the basis for the GF NFM concept note, and before the UNAIDS 90-90-90 goals and WHO 2015 Test and Start guidelines came out. The new draft NAP has fully adopted the UNAIDS 90-90-90 goals, and includes targets of 90% of KP reached, 90% of estimated PLHIV tested, 90% of those on ART, and 90% retained on treatment with viral load suppression. Although it has not yet been costed, it is very likely that the funding gap for the NAP will be much larger than for the NSP, indicating more donor resources needed to reach expanded outreach and ART scale-up targets. Of note, due to the current economic environment in Tajikistan, the somoni has depreciated by 31% in the past year. This depreciation, along with the ongoing economic uncertainty in the region and projected decline in GDP growth, may have negative effects upon the

[10] World Bank Data Base, 2014, http://data.worldbank.org/indicator/NY.GNP.PCAP.PP.CD/countries accessed March 14, 2016
[11] European Bank for Reconstruction and Development Transition Report 2015-16
[12] Regional Economic Prospects in EBRD Countries of Operation: Nov. 2015
[13] New Funding Model Concept Note, Final Budget 2015-2017
[14] New Funding Model Concept Note, p. 24-25

Government of Tajikistan's ability to increase or maintain HIV spending in 2016.The GF NFM grant is currently procuring all commodities for outreach and prevention for KP (for a target of only 63% of PWID to be reached, for example, by the end of 2017). In order to reach expanded targets under the PEPFAR program, a Memorandum of Understanding will need to be agreed on and signed with the GF Principal Recipient, UNDP, to increase procurement of commodities to meet the increased demand.

Table 1.2.1 Investment Profile by Program Area - Tajikistan

Program Area	Total Expenditure	% PEPFAR(1)	% GF(2)	% Host Country(3)	% Other(4)
Clinical care, treatment and support	$2,458,729	15.1	71.1	13.8	0
Community-based care, treatment, and support	$607,477	66.8	16.5	16.7	0
PMTCT	$525,335	0	10.2	89.1	0.7
HTS	$941,847	12	47.7	40.3	0
VMMC	n/a	n/a	n/a	n/a	n/a
Priority population prevention	$745,951	0	100	n/a	n/a
Key population prevention	$5,288,289	26.9	69.1	3.4	0.6
OVC	$9,399	100	n/a	n/a	n/a
Laboratory	$705,734	34.2	n/a	27.9	37.9
SI, Surveys and Surveillance	$363,803	26.7	73.3	n/a	n/a
HSS	$124,609	100	n/a	n/a	n/a
Total	$11,771,173	23.7	59.6	14.2	2.6

(1)PEPFAR Data taken from 2015 EA Data
(2)GF 2014 Expenditure Data
(3)(4) 2014 National AIDS Spending Assessment

Table 1.2.2 Procurement Profile for Key Commodities - Tajikistan

Commodity Category	Total Expenditure	% PEPFAR(1)	% GF(2)	% Host Country	% Other
ARVs	$1,323,357	n/a	100	n/a	n/a
Rapid test kits	$660,657	n/a	100	n/a	n/a
Other drugs	$566,031	n/a	100	n/a	n/a
Lab reagents	$297,503	n/a	100	n/a	n/a
Condoms	$487,308	n/a	100	n/a	n/a
Viral Load commodities	n/a	n/a	n/a	n/a	n/a
VMMC kits	n/a	n/a	n/a	n/a	n/a
MAT	n/a	n/a	n/a	n/a	n/a
Other commodities	$303,906	26.1	73.8	n/a	n/a
Total	$3,638,762	2.2	97.8	n/a	n/a

(1)PEPFAR Data taken from 2015 EA Data
(2)GF 2014 Expenditure Data

Table 1.2.3 USG Non-PEPFAR Funded Investments and Integration – Tajikistan * Draft FY16 funding levels

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	$2,000,000*	n/a	n/a	n/a	Improve MCH and Nutrition in select regions
USAID TB	$4,000,000*	n/a	n/a	n/a	Improve access to and quality of TB services. Where applicable, will ensure coordination of activities with PEPFAR IMs
CDC FETP TJ	$1,000,000	n/a	n/a	n/a	
Total	**$7,000,000**				

Kyrgyz Republic

The Kyrgyz Republic is a lower middle income country with a GNI of $3,220 per capita.[15] GDP growth was 3.6% in 2014, declining from 10.9% in 2013, mainly due to the economic slowdown in Russia; a weakened ruble; depressed Kyrgyz exports; as well as remittance flows from Kyrgyz citizens working in Russia.[16] During the first half of 2015, GDP growth increased to 7.3% largely due to recovery in the gold sector, but with the worsening economic downturn brought on by vastly lower remittances from Russia and the increasingly difficult export environment, this growth is expected to settle around 5%.[17] GDP growth is projected to decline further to 3.9% in 2016 due to the continued regional economic turmoil brought on by the fall of the ruble and lower oil prices. Accession to the Eurasian Economic Union is expected to create only limited opportunities in the short run, but growth is expected to pick up to 4% in 2017, assuming recovery of exports to Russia and other neighboring countries and growth of remittances to support domestic consumption.[18]

As shown in Table 1.2.1, the majority of funding for the Kyrgyz Republic's HIV/AIDS response comes from international sources, with PEPFAR, the GF, and the private sector contributing an estimated 57% of the total resources. ("Private sector" includes both out-of-pocket expenses and private health insurance coverage.) The GF, at 37%, is a key donor to the HIV response in the Kyrgyz Republic and currently procures all ARVs and treatment commodities (Table 1.2.2.). Under the NFM, GF prevention activities account for 53% of the total funding allocation, followed by care, treatment and support activities at 33%. The remaining 14% is allocated towards management and operations, health system strengthening and the reduction of legal barriers for access to services of KPs.[19] The GF has prioritized spending, using the results from the Investment Case and Allocative Efficiency Analysis conducted by UNAIDS in late 2015, and is focusing 99% of all prevention investments in the NFM on KP.

In support of the current HIV NSP and the request for funds under the NFM, the Government of the Kyrgyz Republic has increased HIV spending by 3% annually since 2012.[20] In the current economic environment, the Kyrgyz currency has devalued by around 30% between early 2014 and early 2016. This devaluation, along with projected further slowing of economic growth in 2016 and 2017, raises some concerns regarding the levels of investment the Government of the Kyrgyz Republic may be able to provide in the coming years. The Government of the Kyrgyz Republic accounted for 43% of HIV expenditures, followed by the GF and other international donors at 37%, PEPFAR at 18%, and private sector sources at 2%.

Key stakeholders raise serious questions about the future sustainability of HIV prevention, care and treatment services (including MAT in at community level and in the penitentiary system) in the Kyrgyz Republic, especially as the GF announced the decision to reduce its financial contribution to the region and gradually hand over funding for those services to national governments. To address this challenge, with technical assistance from PEPFAR, the Kyrgyz multi-sectorial working group consisting of representatives of the MOH and Ministry of Finance, the Mandatory Health Insurance Fund, civil society

[15] World Bank Data Base, 2014, http://data.worldbank.org/indicator/NY.GNP.PCAP.PP.CD/countries accessed March 14, 2016
[16] World Bank Economic Update No.1 | Spring 2015, *Kyrgyz Republic: Adjusting to a Challenging Regional Environment.*
[17] European Bank for Reconstruction and Development Transition Report 2015-16
[18] Ibid.
[19] New Funding Model Concept Note, Final Budget 2015-2017
[20] Kyrgyz Republic Ministry of Health, 2015

and international development partners has started working on development of a Road Map for gradual transitioning from donor funding to state funding for HIV/AIDS programming by 2020.

Table 1.2.1 Investment Profile by Program Area – Kyrgyz Republic

Program Area	Total Expenditure	% PEPFAR(1)	% GF(2)	% Host Country (3)	% Other (4)
Clinical care, treatment and support	$1,954,538	18.4	17.4	54.9	9.3
Community-based care, treatment, and support	$1,432,290	24.3	75.8	n/a	0
PMTCT	$432,910	0	32.1	64.9	2.9
HTS	$667,649	42.1	n/a	57.3	0.6
VMMC	n/a	n/a	n/a	n/a	n/a
Priority population prevention	$42,170	0	96.1	3.9	0
Key population prevention	$3,747,999	39.1	53.7	7.2	0.1
OVC	n/a	n/a	n/a	n/a	n/a
Laboratory	$4,544,136	3.1	n/a	96.9	0.04
SI, Surveys and Surveillance	$172,563	80.6	n/a	17.2	2.2
HSS	$2,777,091	2.6	78.9	14.2	4.3
Total	$15,771,346	17.8	36.8	43.3	2.1

(1) PEPFAR data taken from 2015 EA Data
(2) GF data from 2014 United Nations Development Programme Annual Report
(3)(4)Taken from 2014 NASA (2013 expenditures)

Table 1.2.2 Procurement Profile for Key Commodities – Kyrgyz Republic

Commodity Category	Total Expenditure	% PEPFAR (1)	% GF (2)	% Host Country	% Other
ARVs	$239,872	0	100	n/a	n/a
Rapid test kits	$354,009	2.8	97.2	IQ	n/a
Other drugs	n/a	n/a	n/a	n/a	n/a
Lab reagents	$122,427	n/a	100	IQ	n/a
Condoms	n/a	n/a	n/a	IQ	n/a
Viral Load commodities	n/a	n/a	n/a	n/a	n/a
VMMC kits	n/a	n/a	n/a	n/a	n/a
MAT	n/a	n/a	n/a	n/a	n/a
Other commodities	$1,013,368	20.9	79.1	IQ	n/a
Total	$1,729,677	12.8	87.2	IQ	n/a

(1)PEPFAR data taken from 2015 EA Data
(2)2014 United Nations Development Programme Annual Report

Table 1.2.3 USG Non-PEPFAR Funded Investments and Integration – Kyrgyz Republic * Draft FY16 funding level**s**

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	n/a	n/a	n/a	n/a	
USAID TB	$4,300,000*	n/a	n/a	n/a	Improve access to and quality of TB services. Where applicable, will ensure coordination of activities with PEPFAR IMs
CDC Flu	$300,000	n/a	n/a	n/a	
Total	**$4,600,000**				

Kazakhstan

The Republic of Kazakhstan is an upper middle income country with a GNI of $21,710 per capita.[21] The current recession in Russia and fall of the ruble, in addition to continued low oil prices, has led to GDP growth in Kazakhstan of only 1.2% in 2015. This muted economic growth is projected to continue into 2016, with an expected GDP growth of only 1.5%. The Kazakhstani tenge has also been severely affected by both the weakened economic sector as well as the switch from an exchange rate fixed to the USD to a floating exchange rate, and in the past year has depreciated by 46% to the USD.[22] The government of Kazakhstan is the major contributor to the national HIV/AIDS response, and provides 78% of the overall programmatic funding and 97.4% of commodities. Unfortunately due to lower oil prices, the Government has had to revise its 2016 budget, and this combined with the tenge devaluation has put Kazakhstan's HIV program at risk of budget reductions.

The major source of financing for Kazakhstan's $37m annual HIV response is from domestic sources at 78%, followed by international sources at 22% (15% PEPFAR, 7% GF) (Table 1.2.1). The Government of Kazakhstan has publicly made strong political and budgetary commitments in support of the social sector, including the response to HIV/AIDS, and despite economic uncertainty kept the social sector expenditures unchanged in 2015's budget.[23] Kazakhstan's 5 year Health Strategy *Salamatty Kazakhstan* (2011-2015) ended in 2015, and a new *Salamatty Kazakhstan* is being developed for 2016-2020 which includes an updated component for HIV. The government of Kazakhstan procures all ARVs and has pledged in the new strategy to provide 10.9 million USD in 2016, 12.6 million USD in 2017, and 12.7 million USD in 2018 for the procurement of ARVs.[24] Meanwhile, the price of ARVs in Kazakhstan is estimated to be between ten times greater than in other countries of CAR, and remains a major impediment to scale-up of ART.[25] PEPFAR CAR will provide support for updating the HIV drug formulary to utilize more common combination drug therapies which are much less expensive than the medications on the current formulary. PEPFAR CAR will also continue to advocate for and support the government to procure ARVs through UN mechanisms, rather than the current procurement through a parastatal company, that will lead to large cost savings which can be used to put more PLHIV on treatment.

Kazakhstan in not eligible for consideration of further HIV grants under the GF's NFM due to its economic status. The current GF HIV grant is planned to end in December of 2016, and is mainly focused on prevention efforts for KPs, specifically PWID, providing roughly a quarter of the overall funds in that programmatic area. The other significant portion of its expenditures is focused on health system strengthening.

[21] World Bank Data Base, 2014, http://data.worldbank.org/indicator/NY.GNP.PCAP.PP.CD/countries accessed March 14, 2016
[22] European Bank for Reconstruction and Development Transition Report 2015-16
[23] European Bank for Reconstruction and Development Transition Report 2015-16
[24] Salamatty Kazakhston 2016-2020
[25] *Kazakhstan ARV Pricing and Supply Chain Review. Kanatbek Moldokulov, SCMS, July 2015*

Table 1.2.1 Investment Profile by Program Area - Kazakhstan

Program Area	Total Expenditure	% PEPFAR(1)	% GF(2)	% Host Country(3)	% Other
Clinical care, treatment and support	$8,393,280	9.9	0	90.1	n/a
Community-based care, treatment, and support	$502,228	100	0	0	n/a
PMTCT	$688,859	0	0	100	n/a
HTS	$3,378,565	5.5	0	94.5	n/a
VMMC	n/a	n/a	n/a	n/a	n/a
Priority population prevention	$26,342	0	0	100	n/a
Key population prevention	$4,871,180	26.9	26.7	46.4	n/a
OVC	n/a	n/a	n/a	n/a	n/a
Laboratory	$2,257,553	17.3	0	82.7	n/a
SI, Surveys and Surveillance	$1,835,260	17.3	0	82.7	n/a
HSS	$2,938538	6.9	15.6	77.5	n/a
Total	$23,375,715	15	7.1	77.9	n/a

*(1)*PEPFAR data taken from 2015 EA Data
(2)2014 GF Enhanced Financial Reporting for KAZ-H-RAC Grant
(3)Country Expenditures estimated using UNAIDS 2014 data on total domestic expenditure, and distributed according to 2014 NASA distribution of funds across programmatic areas

Table 1.2.2 Procurement Profile for Key Commodities - Kazakhstan

Commodity Category	Total Expenditure	% PEPFAR(1)	% GF(2)	% Host Country(3)	% Other
ARVs	$7,450,980	n/a	n/a	100	n/a
Rapid test kits	$324,571	0.3	n/a	99.7	n/a
Other drugs	$167,613	n/a	100	n/a	n/a
Lab reagents	$588,647	n/a	n/a	100	n/a
Condoms	n/a	n/a	n/a	n/a	n/a
Viral Load commodities					
VMMC kits	n/a	n/a	n/a	n/a	n/a
MAT	n/a	n/a	n/a	n/a	n/a
Other commodities	n/a	n/a	n/a	n/a	n/a
	$54,063	38	62	n/a	n/a
Total	$8,384,740	0.25	2.34	97.41	n/a

Table 1.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP - Kazakhstan

Funding Source	Total PEPFAR Non-COP Resources	Total Non-PEPFAR Resources	Total Non-COP Co-funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
Other PEPFAR Central Initiatives Other Public Private Partnership	$200,000 (est.)	$200,000 (est.)	n/a	n/a	n/a	USAID central funding to support introduction of new TB drugs & regimens for DR TB.
Total	**$200,000 (est)**	**$200,000 (est.)**				

Table 1.2.3 USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
DTRA	2, 741,534	n/a	n/a	n/a	
GDD	2,243,959	n/a	n/a	n/a	
Flu	543,491	n/a	n/a	n/a	
Total	**$5,528,984**				

1.2 National Sustainability Profile

While PEPFAR CAR was not required to complete a Sustainability Index and Dashboard exercise as a Regional OU, the PEPFAR team has analyzed the elements of sustainability and plans to address key barriers to sustainability in ROP16, as outlined below and in Section 6 (Program Support Necessary to Achieve Epidemic Control). PEPFAR CAR must work with other key stakeholders to address the sustainability of these countries' national HIV programs, which share common characteristics within a sustainability context.

Governance, Leadership and Accountability

- Planning and Coordination – Strength/Priority for Increased Focus. Throughout CAR, national governments have developed budgeted, national AIDS plans with the participation of diverse stakeholders (NGOs, international donors, and others), largely in preparation for GF Concept Note (CN) submission. Kazakhstan includes its HIV/AIDS program within its national health plan. PEPFAR and the GF are developing national activity coordination plans (organized according to each stage of UNAIDS 90-90-90 strategy) to ensure optimal investment and outcomes, non-duplication, and coverage of all focus locations and activities; national governments, multilateral partners and other non-governmental stakeholders are in support of this initiative. In each CAR country, regional AIDS care institutions are accountable for their contribution toward achievement of the national plan.

- Policies and Governance – Some Vulnerabilities/Priority for Increased Focus. HIV/AIDS service policies and laws are in place in CAR countries. ART initiation policies are improving from previous WHO 2013 Guideline levels (for details, see section 4.8 – Adult Treatment). For example, in accordance with the draft National HIV/AIDS Program 2016-2020,Tajikistan has recently expressed its intention to embrace WHO's Test and Start guidelines, anticipated at the June 2016 High Level UNAIDS Meeting in New York. The steep economic decline in CAR countries over the past year makes these goals more ambitious. PEPFAR CAR will continue its strong advocacy for national adoption of Test and Start guidelines, along with the GF and local partners, and support capacity development to enable implementation. Low coverage of MAT (in Kazakhstan and Tajikistan) and HTC services for PWID in all three CAR countries is also a critical issue, impacting PWID ability to reduce HIV risks and access care, despite the fact that national policies prohibit discrimination in access to HIV/AIDS services. To initiate more PWID into the clinical cascade, PEPFAR CAR will implement PDI to access untapped PWID networks and motivate and expedite their linkage to testing and treatment.

Civil society has a strong voice in the AIDS epidemic within each CAR country. NGOs play the largest role in educating PLHIV about their rights and reducing discrimination, as stigma and discrimination indices show that PLHIV experience the greatest discrimination or stigmatization in healthcare facilities. A targeted program will address stigma and discrimination among HIV providers and training to mitigate stigma and discrimination will continue to be included in all PEPFAR-supported training programs. The government has recently made a significant step forward by endorsing a normative document on delivering HIV express testing services at the community level in Tajikistan. PEPFAR will continue to support enabling policy environments and strengthening of vital civil society groups such as the Central Asia Regional Network of PLHIV and its member NGOs. And a GIZ-supported initiative in the Kyrgyz Republic will complement PEPFAR efforts by working in 2016-2017 to support regional NGOs to more effectively perform their role as members of GF CCMs. NGO contracting mechanisms are utilized by the government of Kazakhstan to provide HIV services and efforts are underway in the Kyrgyz Republic to promote social contracting.

- Public Access to Information – Vulnerability. CAR governments disseminate information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as high level fiscal information related to HIV/AIDS (often in the context of GF CNs). Not all HIV/AIDS information is shared with the public, however. CAR governments respond to information requests from the GF and the international HIV/AIDS community; however, the information provided and used for decision making could be improved. Thus PEPFAR supports improved data systems (via EHCMS and the expansion of unique identifier codes (UIC)) in ROP16 and improved KP PSEs in order to better target interventions and project for testing and treatment needs. PEPFAR support of CCMs has also fostered a platform for continued dialogue between governments and NGOs and further government accountability. Efforts are being made by governments to share data, via print, press conferences, etc. Ongoing POART and related results dissemination may increase public access to information.

National Health System and Service Delivery

- Service Delivery, including Lab Capacity - Vulnerability/Priority to Address. CAR national governments deliver clinical services in high burden HIV locations themselves, and are responsible for responding to demand for services. To date, demand for services, especially by KPs, has been supported by international donors and implemented by NGOs. Domestic financing for service delivery has been high in Kazakhstan and low in Tajikistan and the Kyrgyz Republic, due to endemic poverty in these countries. Lab capacity for viral load testing remains a weakness, with only a handful of testing machines available in each country (e.g. Tajikistan is increasing from one to two/three PCRs over the next year; the Kyrgyz Republic has one active PCR machine, with another expected to serve the southern region of the country in 2017). Lab development is another priority area within ROP16.

- Human Resources for Health – Vulnerability/Priority to Address. Low health care provider salaries and frequent staff turnover (in Tajikistan and the Kyrgyz Republic) contribute to varying levels of technical expertise among health care providers in government HIV/AIDS treatment centers in CAR. PEPFAR CAR provides intense mentoring and training support to build the capacity of staff and testing and treatment systems, including NGO prevention providers. Government and donor financing to NGOs could be reduced in some countries due to decreasing HIV/AIDS

budgets; advocacy is being conducted to increase NGO involvement in care and task shifting in facilities is also being utilized to help improve the efficiency of deployment of staff resources. Moreover, PEPFAR CAR is refining its community-facility support model to utilize NGO support most effectively, and it is anticipated that protocols will be developed with HIV care facilities, to strengthen community-facility linkages, and allow NGOs to provide improved support across the continuum of care.

- Commodity Security and Supply Chain – Vulnerability/Priority to Address. All CAR countries have faced problems with maintaining HIV-related supply chains and commodity distribution, in particular of ARVs. PEPFAR CAR supports electronic forecasting of ARVs and other supplies to prevent stock outs. However, funding and/or supply systems for ARV distribution are not sufficient, and lead to a rationing mentality which often results in exclusion of PWID from treatment. PEPFAR CAR will engage the Procurement and Supply Management (PSM) Project to assist the countries of the region, especially Kazakhstan, to strengthen the domestic commodities supply chain system. In Kazakhstan, the financial crisis from the past year has resulted in limited purchases of ARVs which is expected to continue in the following year (please see health financing section below for PEPFAR CAR's proposed approach to resolve this). Meanwhile, Kazakhstan's ARV drug formulary has been found to be prohibitively complex, outdated, and in need of simplification in order to economize, and ensure that sufficient quantities of drugs are available to AIDS Centers when and as needed. This will be another area of support in ROP16.

Strategic Investments, Efficiency, and Sustainable Financing

- Domestic Resource Mobilization – Vulnerability/Priority to Address. Tajikistan and the Kyrgyz Republic are dependent on GF support for ARVs, lab supplies, and other commodities, with an estimated $15.6M in HIV grants available for Tajikistan and $17M for the Kyrgyz Republic in 2016-2017. PEPFAR endorses GF Concept Note requirements for increased national expenditures on the HIV response, to which CAR countries have agreed. PEPFAR is supporting these national governments to plan for increasing domestic spending on HIV/AIDS in order to maintain grant eligibility and increase the likelihood for continued funding after the 2017 NFM grants end for the Kyrgyz Republic and Tajikistan.

  Meanwhile, over the past year, Kazakhstan has been hit by a financial crisis caused by the falling price of oil, which has led to decreased government revenues and a loss of half of the purchasing power of the local currency (see next paragraph). In December 2016, GF resources for HIV are planned to transition out of Kazakhstan. PEPFAR CAR is advocating for a smooth implementation of the transition plan, with maintenance of service levels by the government.

- Allocative/Technical Efficiency – Vulnerability/Priority to Address. PEPFAR CAR has supported allocative efficiency analysis in CAR through the UNAIDS Investment Case activity, which includes strategies such as promoting prioritized use of existing funds, given declining national budgets. As a result, it was identified that Kazakhstan has been paying on average 10 times more than international prices for ARVs, exacerbated by its complex drug formulary. The government has requested PEPFAR CAR support in addressing these two issues and for procuring through UNICEF which is already enabled by decree. PEPFAR CAR will address this with the PSM Project support in ROP16. In the Kyrgyz Republic, the government is increasing its national investment in its HIV response, and is working to include coverage for HIV services under its national health insurance program. Meanwhile, PEPFAR CAR will also work with CAR governments and the stakeholder community to implement technical innovations that have been proven to decrease

the cost of HIV services, such as task shifting, integrating services into primary care services (as in the Kyrgyz Republic), and strengthening coordination and improving integration of HIV and TB services; and dosage spacing. TB and HIV services still function largely independently with referrals between services, but policies and approaches are improving and can still be enhanced to provide more coordinated, person-centered care.

Strategic Information

- Epidemiological and Health Data – Strength. General population and KP surveillance are led by the government, with technical assistance provided by PEPFAR CAR and other international experts; funding for surveillance implementation comes from the government and international donors, including PEPFAR on a limited basis. Integrated Bio-behavioral Surveys (IBBS) are most often conducted by NGOs in cooperation with national authorities on a biannual basis. The quality of implementation of IBBSs has considerable variability over time and across the region, frequently resulting in unstable estimates, particularly PWID population size estimates. Viral load data is not as available/comprehensive as desirable, due to the small number of PCR machines in each country. PEPFAR has supported the implementation of an electronic EHCMS in CAR countries which has significantly enhanced national capacities in this area. In ROP16, PEPFAR will work to ensure that the EHCMS is fully utilized by each health system as the source of unified patient information in facilities. Meanwhile, PEPFAR CAR will also work to connect the community-based unique client ID system that has been developed in NGOs, for community-based support of treatment and care outcomes to clinical health facilities along the continuum of care.

1.4 Alignment of PEPFAR investments geographically to disease burden

In ROP15, PEPFAR CAR reduced the number of SNUs from 12 to six high prevalence areas, after careful analysis of disease burden, KP size estimates and services then available. Over the course of the year, phase out was achieved in the former sites, with support transitioned to the host country governments. PEPFAR CAR also began implementation of the "handshake" model of comprehensive support to PWID and PLHIV across the continuum of care through coordinated activities by USG agencies. In ROP16, PEPFAR CAR will have completed this geographic transition and will continue to consolidate and strengthen care across the continuum in these locations.

PEPFAR CAR Fiscal Year 2015 Expenditure Analysis

The pivot described above was underway in FY15, with support to some areas having phased out over the course of the year. Therefore, the FY15 expenditure reporting shows some funding to geographic areas which will are not focus SNUs moving forward (e.g. Jalalabad Oblast in Kyrgyz Republic and Almaty, Karaganda and West Kazakhstan in Kazakhstan).

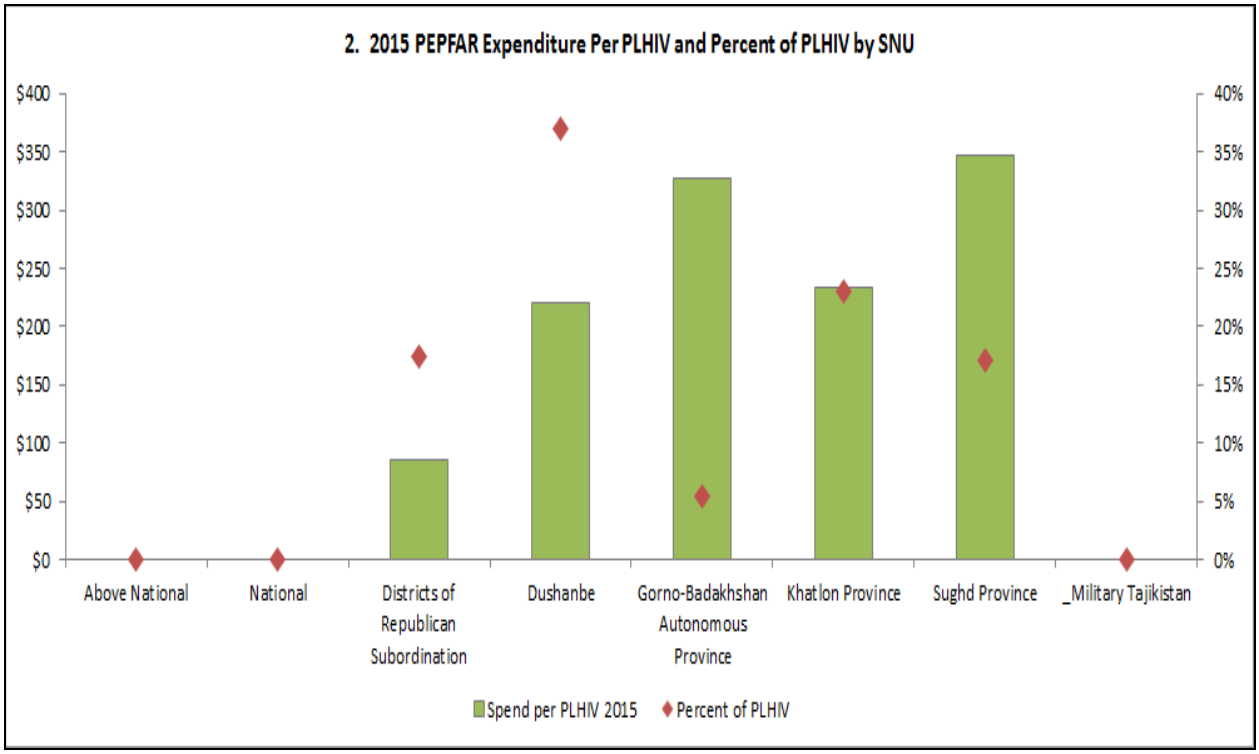
Total PEPFAR Spending and Total PLHIV: As shown in the following tables, PEPFAR CAR resources were largely focused in the areas with the highest HIV burden and proportionate to the number of PLHIV. By the end of FY15, PEPFAR CAR had transitioned out of lower prevalence regions and increased activities in the other high-burden locations currently supported by PEPFAR. In the Kyrgyz Republic, as a result of more focused targeting, PEPFAR CAR now provides more support and expends more funding

in Bishkek City and Osh City and high burden cities in Osh and Chui regions and has transitioned out of Jalalabad and Issyk-Kul regions. In Tajikistan, more support toward saturation is now being provided in Dushanbe (plus Vakhdat and Districts of Republican Subordination) and Sughd Region, and the program has transitioned out of Gorno-Badakhshan Autonomous (GBA) Region, and other cities in Khatlon Region.

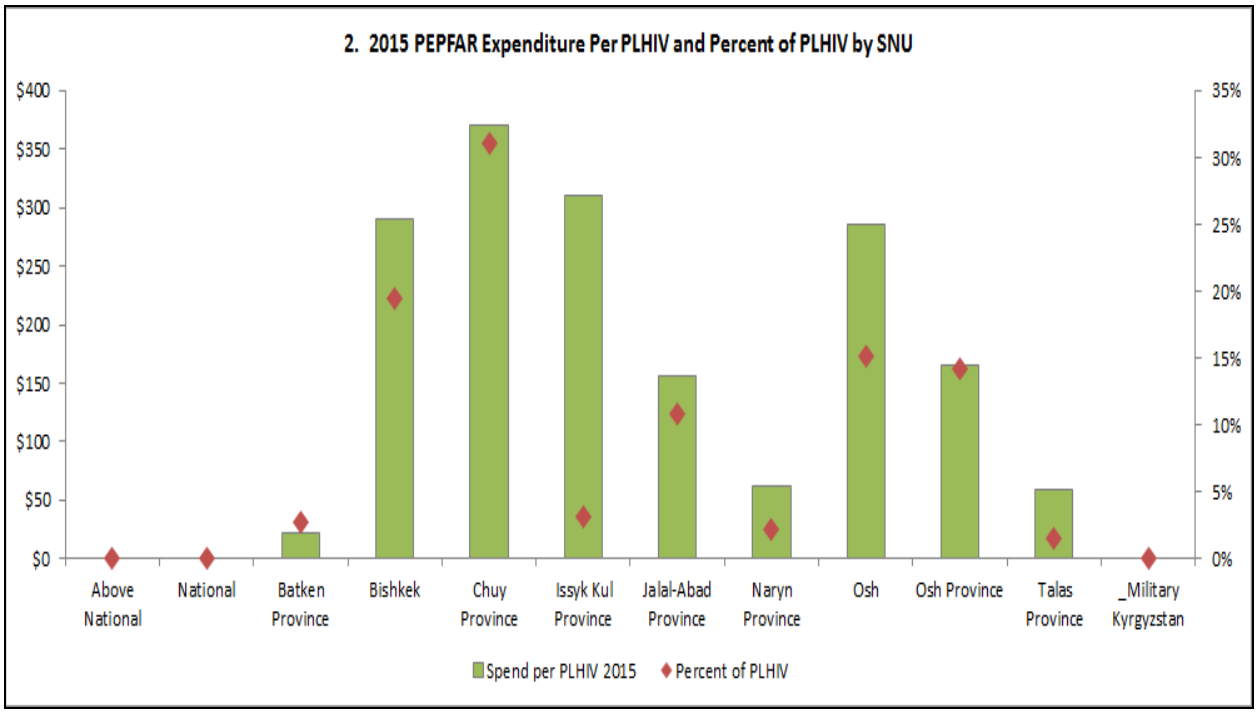
Spending by SNU: The largest expenditures per PLHIV in Tajikistan were in Sughd Region ($347) and Gorno-Badakhshan Autonomous (GBA) Region ($327). In the Kyrgyz Republic, the largest PEPFAR expenditures per PLHIV occurred in Chuy Province ($371) and Issyk-Kul Region ($310). Finally, in Kazakhstan, expenditures were the greatest in West Kazakhstan Region ($469), which was much higher than the next two regions, Pavlodar Region ($152) and East Kazakhstan Region ($175). The significant variance is due to dramatically different costs of operating in each country and in central vs. peripheral geographic zones. An outlier in terms of higher costs per PLHIV can be seen in GBA Region, which has a smaller number of PLHIV because of its small size but a high prevalence due to its geographic location on a drug trade route out of Afghanistan. The GBA Region is no longer a PEPFAR-focus SNU.

Figures 1.4.1 - PEPFAR Expenditure per PLHIV and Percent of PLHIV by SNU (2015)

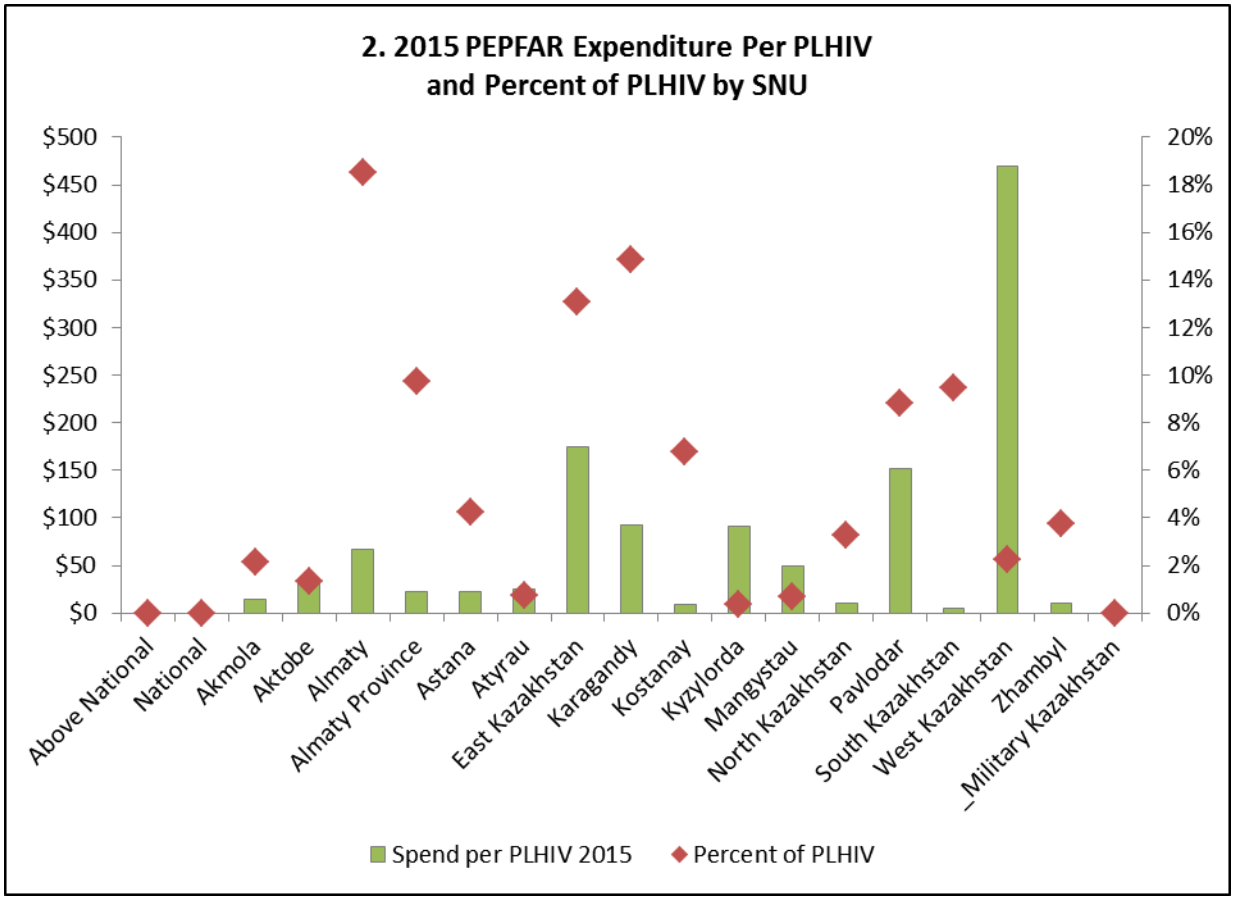
Tajikistan



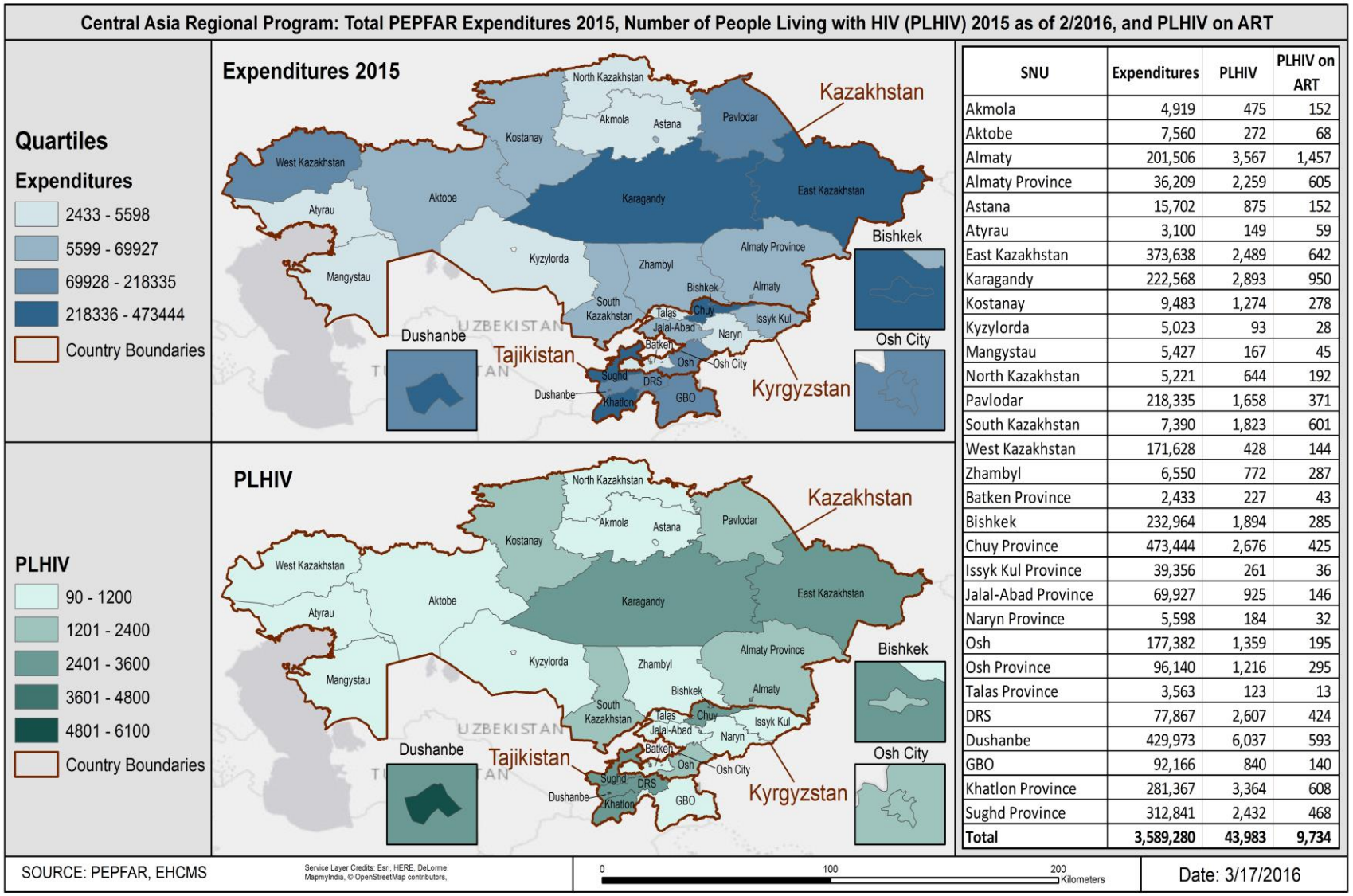
Kyrgyz Republic



Kazakhstan



Figures 1.4.2 - PEPFAR Total Expenditure, PLHIV, and PLHIV on ART by District (2015)



SNU	Expenditures	PLHIV	PLHIV on ART
Akmola	4,919	475	152
Aktobe	7,560	272	68
Almaty	201,506	3,567	1,457
Almaty Province	36,209	2,259	605
Astana	15,702	875	152
Atyrau	3,100	149	59
East Kazakhstan	373,638	2,489	642
Karagandy	222,568	2,893	950
Kostanay	9,483	1,274	278
Kyzylorda	5,023	93	28
Mangystau	5,427	167	45
North Kazakhstan	5,221	644	192
Pavlodar	218,335	1,658	371
South Kazakhstan	7,390	1,823	601
West Kazakhstan	171,628	428	144
Zhambyl	6,550	772	287
Batken Province	2,433	227	43
Bishkek	232,964	1,894	285
Chuy Province	473,444	2,676	425
Issyk Kul Province	39,356	261	36
Jalal-Abad Province	69,927	925	146
Naryn Province	5,598	184	32
Osh	177,382	1,359	195
Osh Province	96,140	1,216	295
Talas Province	3,563	123	13
DRS	77,867	2,607	424
Dushanbe	429,973	6,037	593
GBO	92,166	840	140
Khatlon Province	281,367	3,364	608
Sughd Province	312,841	2,432	468
Total	**3,589,280**	**43,983**	**9,734**

1.5 Stakeholder Engagement

After the ROP 15 programmatic and geographic pivot, PEPFAR teams conducted stakeholder meetings at the six SNUs with local government and MOH officials, leadership from city and oblast level AIDS Centers, local NGOs and implementing partners to disseminate information about the ROP15 pivot and new activities. These stakeholder engagement meetings involved sharing the 90-90-90 goals and treatment targets for each SNU. Five out of six of these meetings were held after site-level SIMS visits related to treatment and MAT. Therefore, the stakeholder meetings included objective feedback for areas of improvement and further collaboration based on the SIMS assessments. All stakeholders were involved with discussing barriers and challenges as well as sharing opportunities to scale up of testing, treatment and improving diagnostics. Based on these meetings, PEPFAR was able to tailor interventions for ROP15 implementation with implementing partners at these SNUs by Oct 2015. Also, memorandums of understanding were signed in each SNU at the treatment facilities, which included treatment targets. Due to the success of these stakeholder meetings, the PEPFAR team plans to replicate this approach in each SNU after ROP16 is approved.

Engagement with the GF and other multilaterals was strengthened throughout the ROP16 planning period. As new guidelines for Test and Start have just been released, PEPFAR has engaged with GF, WHO, UNAIDS, and other multilaterals to plan advocacy efforts and engagement with the governments on changing national guidelines and policies and planning for rapid scale up of treatment. PEPFAR also engaged significantly with UNODC on advocacy around MAT scale up in all three countries at the national and local levels and in December 2015, methadone was registered in Kazakhstan.

In February 2016, PEPFAR participated as a stakeholder in the first round table meeting hosted by Global Health Research Center for Central Asia (Columbia University affiliate) in Kazakhstan on developing implementation and research strategies for overcoming barriers meeting the 90-90-90 goals in Central Asia specifically around stigma and discrimination. During this meeting PEPFAR shared ROP15 goals and targets as well as implementation activity plans for ROP 16. The findings from the PEPFAR-supported Stigma Index Survey were presented and the discussion among participants highlighted significant barriers of stigma and discrimination at the community and facility levels as well as significant barriers to access of ARV and MAT. PEPFAR will continue to participate in these roundtable meetings, as they will occur regularly throughout the coming year, and incorporate the information into ROP16 implementation.

During ROP16 planning in Tajikistan and the Kyrgyz Republic, efforts were made to ensure that there is no overlap in funding or activities, particularly with the GF-supported UNDP activities around PWID case-finding and linkage to treatment. This emerged as a potential issue due to the delay in funding for the USAID HIV Flagship project, during which time UNDP was approved to implement prevention activities through the new 2-year GF grant, which was just awarded to Tajikistan in fall 2015. This was most crucial in Tajikistan, where low PWID population size estimates and limited numbers of PWID NGOs make overlap more likely. PEPFAR CAR has worked intensively to identify a solution in close collaboration with all stakeholders in Tajikistan, holding several meetings with the UNDP, MOH and RAC staff, representatives of the GF Country Coordinating Mechanism and local NGOs and GF representatives. Through these discussions the PEPFAR team proposed a plan for conducting Implementation Research on the PDI model in 2016, while jointly working on a plan with UNDP, MOH and NGOs to prepare to transition PWID case-finding and testing activities to PEPFAR in the focus SNUs

in 2017. PEPFAR CAR is engaged to further advocate for this resolution, and awaits concurrence from the Tajikistan MOH and CCM.

In Kyrgyz Republic, population size estimates for PWID are much larger, PWID are dispersed over larger, under-served areas, there are several NGOs which have a history of working with PWID, and the GF grant cycle is at a point that gives flexibility so programmatic overlap is more easily avoidable. PEPFAR CAR has met with all relevant stakeholders in Kyrgyz Republic to map a plan to avoid overlap, including ensuring the consistent use of UICs and screening questions.

2.0 Core, Near-Core and Non-Core Activities

In preparation for ROP16, as an interagency team PEPFAR CAR reviewed the national programs and the 2015 PEPFAR program role in the national response during our January 27- 28 PEPFAR Review meetings. During the interagency review of 2016 Technical Considerations, proposed activities were evaluated for alignment with the updated technical considerations as well as through a core, near-core and non-core lens for focus impact countries. Core activities are those that are critical for savings lives and preventing new infections, and the USG is uniquely qualified to render. The critical activities for saving lives and preventing new infections that are not well done by host country or other partners were considered near core. The ROP16 program activities and funding align with Ambassador Birx's charge to focus on the "… *right people, in the right places, with the right things*." Core, near-core, non-core analyses are briefly summarized below. Appendix A includes a detailed matrix of core, near-core and non-core activities for Tajikistan, the Kyrgyz Republic and Kazakhstan.

"Right People"

For ROP16, core activities will target the PWID population in the three focus countries, which is the largest KP group and has the highest prevalence of HIV. Programs will also focus on PWID in prisons. PEPFAR CAR transitioned support for activities that focus on MSM and FSW populations to partners, while maintaining some surveillance activities to improve current HIV prevalence and population size estimates on these two KP groups to understand how the dynamics of the epidemic evolve among them. PEPFAR will also provide limited support for advocacy promoting human rights of KP and PLHIV. PEPFAR and the GF will perform complementary efforts to address factors that constrain KP access to HIV/AIDS services.

"Right Place"

For ROP15, geographic focus was refined to a set of six SNUs (6 provinces and 3 embedded cities) with large numbers of PLHIV, high HIV prevalence among PWID, and large total PWID estimates. In ROP16, PEPFAR CAR will continue to support a comprehensive set of core activities in these PEPFAR focus SNUs in both the community and facilities. In FY16, initial implementation focused on the districts within the PEPFAR focus provinces with highest burden of PLHIV. ROP16 plans to expand further in the focus SNUs to cover virtually all ART treatment sites and districts with significant number of PLHIV.

"Right Things"

PEPFAR CAR will scale up core activities to community and facility-based service providers to help them to identify, refer and enroll PWID to effective, comprehensive, and high-quality HIV services. This includes supporting all stages of the continuum of HIV prevention, care and treatment (including adherence) and ensuring both community-based peer navigators and facility-based service providers implement effective interventions that respond to the unique needs of PWID. Specific core priority activities will include: (1) identifying PWID through a new peer driven network approach to increase HIV case finding and linkage to treatment; (2) ensuring that PWID PLHIV are provided with high quality HIV treatment, MAT, and TB services and (3) strengthening providers' skills in adherence, retention, and viral load testing in order to promote viral suppression. Given the absence of other technical implementing agencies, PEPFAR inputs are critical for promoting adoption of national Test and Start Guidelines, new models of service delivery, a more robust system for promoting adherence and retention, countering punitive policies that undermine current gains in reaching KPs, and expansion of quality viral load testing. Site level activities not directly linked to the continuum of care framework have be deemed non-core and will be transitioned or eliminated in FY16.

3.0 Geographic and Population Prioritization

In ROP15, PEPFAR CAR utilized the most recent epidemiological data from the Republican AIDS Centers in Kazakhstan, the Kyrgyz Republic and Tajikistan to select a set of SNUs that have the highest burden of HIV/AIDS. In both Tajikistan and the Kyrgyz Republic, the PEPFAR focus SNUs include over 70% of the national total of adult PLHIV. PWID are the focus population since they are the single largest group of KP and have the highest HIV prevalence. Once the high-burden SNUs were selected, existing programmatic and available epidemiological data was utilized to select a set of cities and districts that had the highest HIV prevalence among PWID, high density of PWID, and large numbers of PLHIV (Table 3.1). Community-based combination prevention coverage and unmet need for HIV care and treatment services were also analyzed to select cities within high-burden SNUs that had the best probability of increasing site yield and cost effectiveness of programming. For ROP16, epidemiologic data were updated, but the SNUs selected in ROP15 and focus populations (PWID and PLHIV) will not change.

Table 3.1 HIV Burden in PEPFAR Priority SNUs

Country	PEPFAR Focus SNUs	% of est. total PLHIV per country
Kazakhstan	2 SNUs out of 16 regions: 1) East Kazakhstan 2) Pavlodar	20.9%
Kyrgyz Republic	2 SNUs out of 9 regions: 1) Chui Oblast including Bishkek city 2) Osh Oblast including Osh city	80.6%
Tajikistan	2 SNUs out of 5 regions:	72.5%

	1)Dushanbe city and surrounding Districts of Republican Subordination 2)Sughd Oblast	

* Since the estimated number of PWID did not include the entire oblast, this percentage is low.

To estimate number of PLHIV in each SNU, PEPFAR CAR used the national estimation of PLHIV from the most recent SPECTRUM analysis for each country and the most recent national case reporting data (EHCMS, Feb 2016) on ever-diagnosed PLHIV per SNU in order to distribute the national PLHIV figure across all SNU. PEPFAR CAR realizes that case-finding efforts are stronger in some provinces; therefore, this method for estimating the SNU distribution of PLHIV will overestimate the number of PLHIV in areas with stronger case finding efforts and will under-estimate the number of PLHIV where case-finding is low. PEPFAR CAR is working with an Atlanta-based surveillance advisor on a more refined Bayesian methodology for SNU-level estimation of PLHIV. Within each province, prevention program data on PWID and the HIV case reporting data with mode of transmission was used to estimate distribution of PWID PLHIV in the districts and cities in order to prioritize activities within the SNUs.

PEPFAR CAR's strategy is to prioritize activities within highest-burden cities and districts where most new HIV infections are likely to originate. Prioritizing and scaling up program activities in these cities and districts provides PEPFAR the highest probability of supporting the three countries to aggressively achieve epidemic control. Improved case finding efforts, such as the peer network approach, is expected to improve understanding of SNU level distribution of PLHIV and PWID. In addition to the selected cities and districts, PEPFAR CAR will also continue supporting activities in a number of prisons with high KP populations and high HIV burden. Activity mapping and other coordination efforts for focus locations has been conducted with GF, GF sub-recipients, and other stakeholders to avoid duplication of effort and maximize impact.

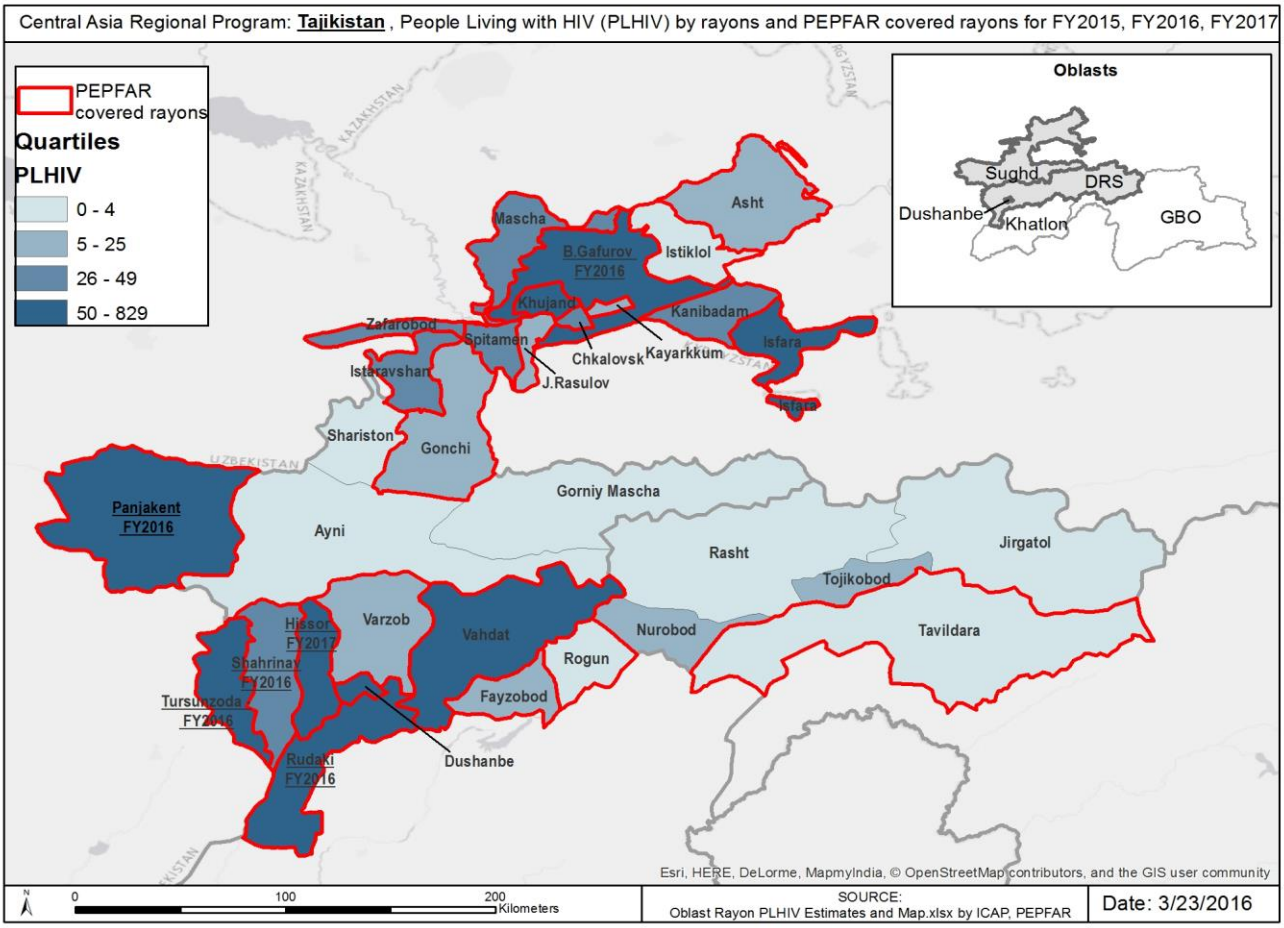
Adult treatment coverage is low across all SNUs and all countries in CAR. In the PEFAR focus SNUs, treatment coverage is lowest in Dushanbe, Tajikistan (10.2%) and highest in Eastern Kazakhstan (25.8%). Across CAR, the total treatment coverage gap is 14,130 adults who need to be added to achieve 80% treatment coverage, though some SNU's have further to go in order to achieve saturation. Availability of ART and projected procurement through host government and GF sources are currently insufficient to cover the saturation treatment targets; therefore, PEPFAR CAR will 1) promote with host country governments and GF to increase budget allocation for ARVs and 2) target an aggressive doubling of adult treatment coverage for each SNU until saturation is achieved while staying within the current expected GF procurement envelope. In Tajikistan and the Kyrgyz Republic, since the percent of PLHIV identified is low, case finding is a prerequisite for treatment scale up. In the Tajikistan SNUs, particularly in Dushanbe, additional ART sites will need to be opened and additional clinical staff trained in order to scale up by over a factor of 10 times the current achievement.

Table 3.2 Adult HIV Treatment coverage by SNU and number needed to achieve saturation

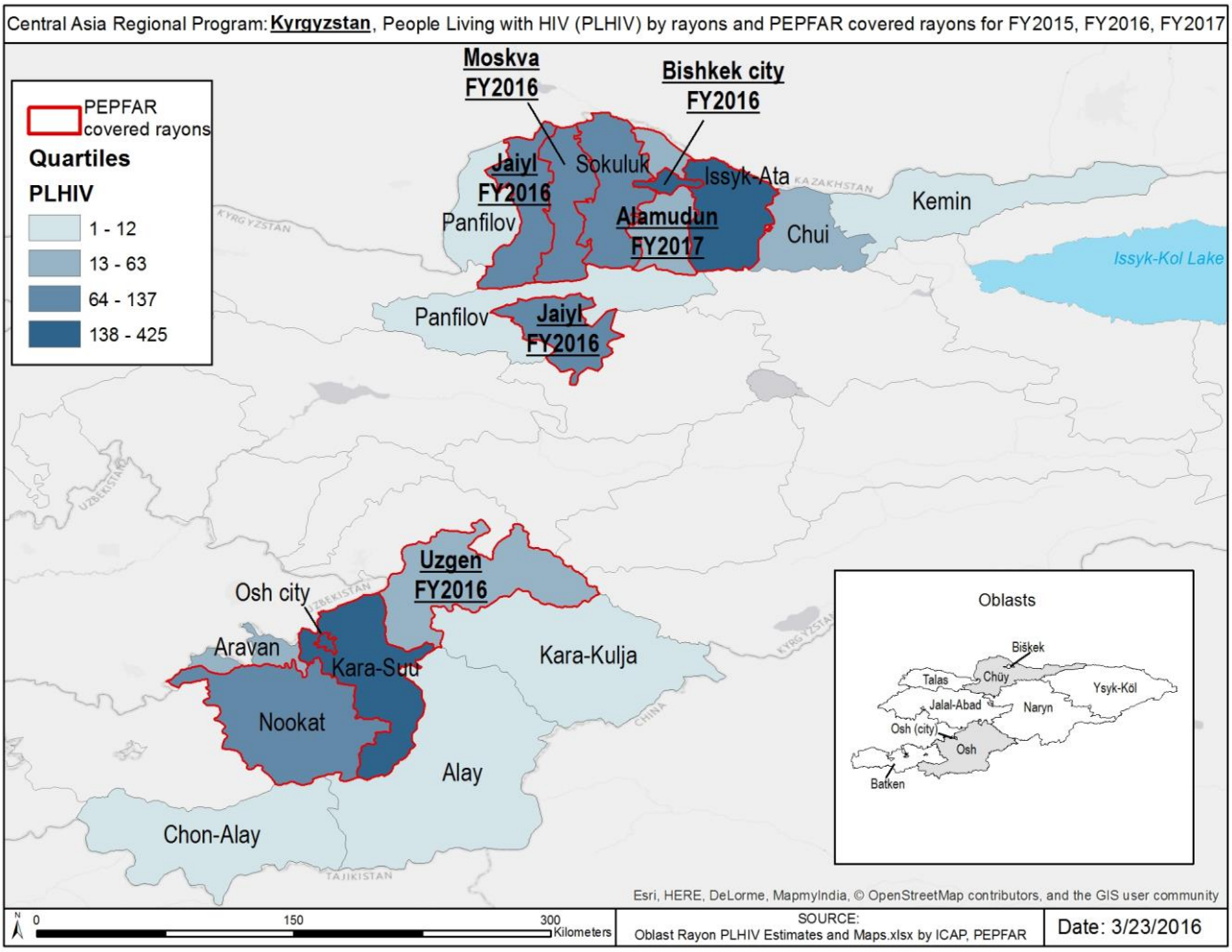
Country	PEPFAR Focus SNUs	TX_CURR (2/1/16)	Estimated Adult PLHIV	Adult ART coverage	# on ART for 80% coverage
Kazakhstan	East Kazakhstan Oblast	642	2,489	25.8%	1349
	Pavlodar Oblast	371	1,658	22.4%	955
Kyrgyz Republic	Bishkek	275	1,894	14.5%	1240
	Chui Oblast	426	2,676	15.9%	1715
	Osh	196	1,359	14.4%	891
	Osh Oblast	304	1,216	25%	669
Tajikistan	Districts of Republican Subordination	443	2,607	17%	1643
	Dushanbe	616	6,037	10.2%	4214
	Sughd Oblast	491	2,432	20.2%	1454

PEPFAR is focusing its resources in the districts within each focus SNU that have the greatest HIV burden, as visualized in red on the country maps 3.1.1, 3.1.2, and 3.1.3 below.

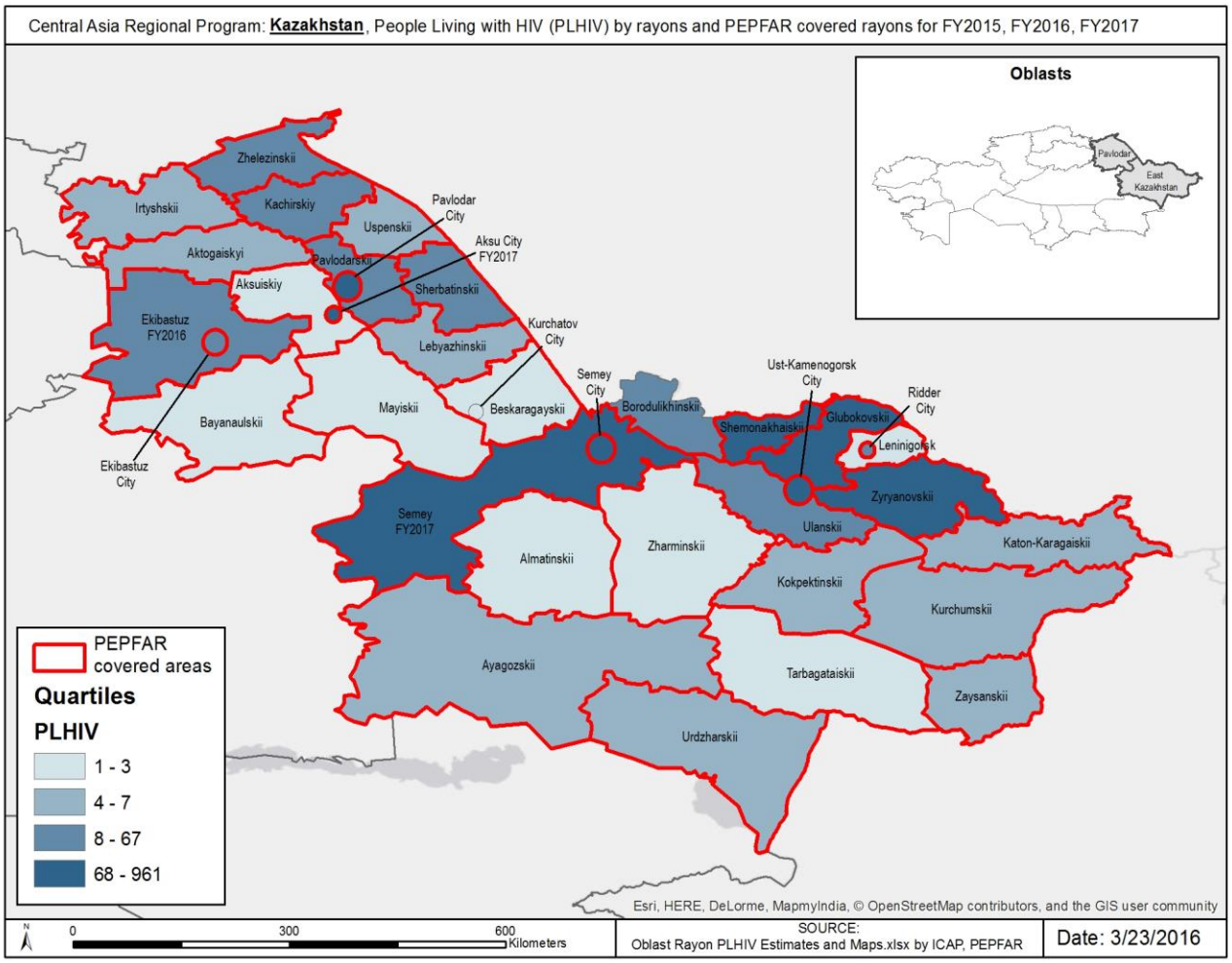
Map 3.1.1 Tajikistan PWID HIV Burden Mapping and Selected Focus SNUs



3.1.2 Kyrgyz Republic PWID HIV Burden Mapping and Focus SNUs



3.1.3 Kazakhstan PWID HIV Burden Mapping and Focus SNUs



4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations

4.1 Targets for focus locations and populations

To derive targets by program area, the PEPFAR CAR team utilized the most current available data to measure and project the acceleration of progress toward achieving 90/90/90 within PEPFAR focus SNUs. Targets for facility based indicators were developed using the Data Pack utilizing data from the EHCMS, SPECTRUM national PLHIV estimates and other relevant epidemiological data, where available. On review of data, three key challenges emerged: 1) the current ART coverage rates in the PEPFAR focus SNUs are extremely low (ranging from 10.2% in Dushanbe to 25.8% in Eastern Kazakhstan oblast), 2) the percent of PLHIV currently in care in the PEPFAR-focus SNUs in Tajikistan and the Kyrgyz Republic is

low, and 3) the available host government and GF supported budgets for ARVs are insufficient for scaling up to saturation in 2017. After consultations with the review team during the DC Management Meeting, it was decided that all PEPFAR CAR focus subnational units would be designated as "aggressive scale-up" with a goal of doubling ART coverage every year until saturation is achieved. This approach should result in achieving saturation in four sub-national units by the end of FY18 (Eastern-Kazakhstan Oblast, Pavlodar Oblast, Osh City, and Osh Oblast). The remaining subnational units, following the same aggressive scale up of doubling the number of PLHIV on ART annually, should achieve treatment saturation by the end of FY19. Based on improved service delivery models for retention, we assumed a 12 month retention of 80% of PLHIV on treatment. We targeted that 90% of PLHIV on ART for 1 year or more would have a viral load test and that 90% of those tested would have a suppressed viral load. We assume that 90% of newly diagnosed PLHIV will initiate treatment, this will be contingent upon the adoption of the most recent WHO guidelines and ART availability.

Programmatic achievement is highly dependent on GF's support in the Kyrgyz Republic and Tajikistan as they are the sole procurers of ARV drugs. In Kazakhstan, the government procures ARVs at more than ten times the price compared to their regional neighbors. The government of Kazakhstan has allocated a total budget for ARVs that should be sufficient to cover their treatment needs based on global pricing; however, due to the high per patient ART prices and devaluation of the tenge, ART shortages are anticipated during FY16, limiting the number of PLHIV initiating treatment. PEPFAR technical assistance is supporting analyses of alternative procurement mechanisms for Kazakhstan and engagement in high-level advocacy to expediently address this pressing issue. We anticipate a new procurement mechanism to be in place by FY17. PEPFAR CAR will collaborate with the Principal Recipients and GF in the Kyrgyz Republic and Tajikistan and with the Government of Kazakhstan to leverage resources for achieving treatment targets.

The current National HIV Strategic Plans within CAR do not include subnational or site-level HIV treatment targets. In Kazakhstan activities to combat HIV/AIDS are a part of government's "Den Saulyuk" program for health development for 2016-2019. In the Kyrgyz Republic and Tajikistan the plans tend to be focused primarily on prevention and outputs related to the GF Concept Notes. With PEPFAR support, Tajikistan is currently drafting the next iteration of the National AIDS Program (2016-2020) and the programmatic goals and targets reflect the UNAIDS 90/90/90 targets. In the Kyrgyz Republic, the development of a costed new national HIV/AIDS and Tuberculosis multi-year program (2017-2019) is under discussion and the MOH and Republican AIDS Center aim to be ambitious, especially if support for ART scale-up is available from the GF in addition to national resources.

As explained in further detail in the Treatment section (4.8), national adult treatment guidelines in the Kyrgyz Republic have endorsed ART initiation at CD4≤ 500. While Kazakhstan and Tajikistan have allowed clinicians to initiate ART at CD4≤ 500, there has not been any official *prikaz* ("decree") to mandate treatment initiation above a 350 CD4 count. All countries are currently considering revising national guidelines to adopt Test and Start; however, there are concerns about available resources from the GF to support treatment scale up in the Kyrgyz Republic and Tajikistan within the current GF concept note. The Government of Kazakhstan has sought PEPFAR technical assistance to model the economic and epidemiological benefits of Test and Start to inform their decision about whether to adopt these guidelines. To support CAR governments to initiate more PLHIV on ART most efficiently, PEPFAR CAR will provide support to Republican AIDS Centers in three countries in updating their HIV treatment

protocols to start ART as early as possible according to the new WHO Treatment Guidance and pilot new models of service delivery, including decentralization in Tajikistan and Kazakhstan. These updated national treatment protocols will have a significant impact on increasing coverage for people on ART. Increased testing of KPs and efforts to identify, reach and test KPs at elevated risk of infection will also significantly contribute to initiating more new patients on ART in ROP16.

Targets for community-based indicators were based on available size estimation data in focus SNUs and projections for appropriately ambitious impact as outlined in CAR's Washington DC Planning Meeting. Kazakhstan reports reaching the 1st 90 with more than 90% of total estimated PLHIV in Kazakhstan having been diagnosed. The KP_PREV indicator will be reported in Tajikistan, Kyrgyz Republic and Kazakhstan of 8,371, 9,137 and 775 PWID reached respectively. PEPFAR CAR activities in 2016 will be revised from the traditional outreach to a Peer Driven Intervention (PDI) approach through networks of PWID, especially PLHIV/PWID. Peer navigators will ensure 100% testing for all contacted PWID and will provide risk reduction education and referrals to prevention commodities. For all PWID tested positive, linkage to treatment will be provided, and their networks will be further reached for additional case identification. In Kazakhstan, PEPFAR will focus on PLHIV who are not yet on ART and examine their networks for HIV testing and re-enrollment of those previously lost to follow-up. In all three focus countries, the PEPFAR CAR team will provide community-based support to PLHIV who are on ART, including PLHIV in prisons and post-release, through education about ART and its side effects and through self-support groups with participation of PLHIV stable on ART, to support adherence.

Resource needs for ROP16 were determined by using EA and other fiscal data to develop an evidence-based lump sum budget with extensive support, guidance, and engagement from our assigned EA advisors. PEPFAR CAR will continue to collaborate with GF and their PRs in order to increase synergy in programmatic support and harmonize targets. The PEPFAR-supported EHCMS is the basis of national reporting of HIV indicators in Kazakhstan and the Kyrgyz Republic and is expected to become the system for reporting GF targets in Tajikistan.

Table 4.1.1 ART Targets in Scale-up Sub-national Units for Epidemic Control

SNU	Total PLHIV	Expected current on ART (APR FY 16)	Additional patients required for 80% ART coverage	Target current on ART (APR FY17) *TX_CURR*	Newly initiated (APR FY 17) *TX_NEW*	ART Coverage (APR 17)
Kazakhstan/Eastern-Kazakhstan Oblast	2,489	835	1,349	1,567	981	67%
Kazakhstan/Pavlodar Oblast	1,658	541	955	1,041	641	65%
Kyrgyz Republic/Bishkek	1,894	336	1,240	672	403	35%
Kyrgyz Republic/Chui Oblast	2,676	426	1,715	852	511	32%
Kyrgyz Republic/Osh	1,359	400	891	800	480	59%
Kyrgyz Republic/Osh Oblast	1,216	304	669	522	348	50%
Tajikistan/Districts of Republican Subordination	2,607	553	1,643	977	638	42%
Tajikistan/Dushanbe	6,037	649	4,214	1,274	774	22%
Tajikistan/Sughd Oblast	2,432	607	1,454	1,072	700	50%
Total	22,368	4,651	14,130	8,777	5,476	**39%**

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY17)	FY17 Target
PWID			
Dushanbe	3,000	165.4%	**4,962**
DRS	1,200	79.5%	**954**
Sughd Oblast	3,000	81.8%	**2,455**
Chui Oblast	3,100	130%	**4,038**
Bishkek	8,050	28.2%	**2,273**
Osh Oblast	700	165%	**1,154**
Osh City	3,800	44%	**1,672**
East Kazakhstan	14,300	3.4%	**480**
Pavlodar	10,200	2.9%	**295**
Total	47,350	38.6%	**18,283**

Kazakhstan

			National Reporting, 2015			
SNU	**PEPFAR Priority Cities**	**Total PWID PSE**	**% PWID Reached with Prevention Intervention**	**% PWID who received HTC in last 12 month**	**# PWID Receiving MAT as of December 31, 2015, Rep. Narc Center (by oblast)**	**% PWID on MAT As of Dec 31, 2015**
East-Kazakhstan oblast		14,300	39.01%	57.68%	64	0.45%
	Ust-Kamenogorsk city	7,700	38.46%	56.78%	39	0.51%
Pavlodar oblast		10,200	27.81%	75.29%	22	0.22%
	Pavlodar city	6,600	21.00%	74.75%	63	0.95%
		Report on Size Estimation of PWID, 2014	IBBS, 2014	IBBS, 2014	Electronic MAT Register (EMR)	EMR, RNC

Kyrgyz Republic

			National Reporting, 2015			
SNU	**PEPFAR Priority Cities**	**Total PWID PSE**	**% PWID Reached with Prevention Intervention in 2015**	**% PWID who received HTC in last 12 month**	**# PWID Receiving MAT as of December 31, 2015, Rep. Narc Center (by oblast)**	**% PWID on MAT As of Dec 31, 2015**
Bishkek	Bishkek	8,050	41.0%	62.4%	340	4.2%
	Sokuluk	3,100	28.0%	64.6%	39	1.3%
	Issyk Ata	NA	NA	NA	43	NA
Osh Oblast	Osh City	3,800	29.0%	61.0%	109	2.9%
	Karasuu	700	34.0%	62.7%	41	5.9%
	Nookat	NA	NA	NA	NA	
		Report on Size estimation of PWID, 2013	IBBS, 2013	IBBS, 2013	RNC	RNC

Table 4.1.4 (a) PWID for Prevention Interventions to Facilitate Epidemic Control in Priority SNUs

Tajikistan

			National Reporting, 2015			
SNU	**PEPFAR Priority Cities**	**Total PWID PSE**	**% PWID Reached with Prevention Intervention in 2015**	**% PWID who received HTC in last 12 month**	**# PWID Receiving MAT as of December 31, 2015, Rep. Narc Center (by oblast)**	**% PWID on MAT As of Dec 31, 2015**
Dushanbe city	Dushanbe	2,998	75.70%	61.10%	133	4.44%
RRS						
	Vakhdat	784	50.10%	29.00%		
Soghd oblast						
	Khudjand city	887	83.90%	22.70%	65	7.33%
	Istaravshan city	353	39.30%	23.20%		
	Isphara	200	92.10%	72.50%		
					RNC	RNC
		Size estimation of PWID, 201	IBBS, 2014	IBBS, 2014		

4.2 Priority population prevention

Based on available epidemiological and programmatic data for PWID at the region/city level and the core, near-core and non-core analysis, PEPFAR CAR will invest resources and prioritize activities targeted toward PWID to accelerate epidemic control in focus SNUs. SPECTRUM estimates suggest that many cases of HIV still remain undiagnosed within the region. This is acutely true for Tajikistan and the Kyrgyz Republic. While Kazakhstan has diagnosed more than 90% of all estimated PLHIV, intensive case finding is required in the Kyrgyz Republic and Tajikistan where only 49% and 35% of estimated cases respectively have been diagnosed.

To strengthen HIV case finding, the following activities will be conducted in CAR: 1) increased case identification through PDI of PWID/PLHIV and strengthened linkages to HTC including community-testing where permitted; 2) Expansion of rapid HIV testing in places most likely to be visited by KPs (MAT sites and Trust Points), and also 3) utilization and implementation of mobile HIV testing units. Rapid HIV testing for KP is one of the core elements of the prevention portfolio that will be strengthened in ROP 16. In the Kyrgyz Republic, NGOs are allowed to perform rapid HIV tests; however, capacity of NGO staff needs to be expanded and strengthened. In Tajikistan and Kazakhstan, PEPFAR will provide technical assistance to create an enabling environment and approved policies, where needed, for expansion of rapid HIV tests including allowing the legal use of rapid HIV tests in non-medical facilities.

PEPFAR community-based prevention activities in 2016 will be revised from the traditional outreach to a Peer Driven Intervention (PDI) approach through networks of PWID, especially PLHIV/PWID. Peer Navigators will ensure 100% testing for all contacted PWID and will provide risk reduction education and referrals to prevention commodities. For all PWID tested positive, linkage to treatment will be provided, and their networks will be further reached for additional case identification. The PDI approach will be implemented in both the Kyrgyz Republic and Tajikistan, with the latter starting as an implementation science evaluation in 2016.[26] Prevention support for PWID will also be provided through referrals to NSPs and condoms (funded by the GF) by Peer Navigators. Risk reduction education will be provided, including information about prevention by using clean needles and condoms, HIV treatment as prevention, and about MAT programs and their importance in both prevention and treatment adherence. PEPFAR CAR will continue to support prevention programming and care and support services among PWID in several prisons with the focus on SNUs with large numbers of PWID PLHIV. Core activities will include increasing access to and uptake of HTC and MAT services as well as referrals to care and treatment services for PLHIV prisoners, including post-release.

The implementation of MAT remains challenging in CAR. Coverage of PWID with MAT is low, accounting for less than 4% of estimated PWID in the Kyrgyz Republic and Tajikistan, and less than 1% in

[26] PEPFAR and the GF currently have been committedly working to ensure non-duplication of services in Tajikistan; a solution has been proposed to the MOH and is awaiting confirmation. The key elements are: (1) In 2016, USAID's HIV Flagship program will carry out an Implementation Science evaluation to demonstrate the efficacy of a peer-driven outreach network model to increase HIV-positive case-finding among PWID and their sexual partners in PEPFAR focus SNUs. In 2017, GF will transition provision of PWID outreach, prevention and testing services and PLHIV adherence support to PEPFAR in PEPFAR focus SNUs. (2) In 2017, GF will use funds freed up from transition of PWID prevention and PLHIV support activities to increase scale-up of ART in line with UNAIDS 90-90-90 goals.

Kazakhstan. There is a critical need to advocate for MAT in all three countries, which are highly influenced by Russia where MAT is not legal. PEPFAR CAR will provide technical assistance to Kazakhstan, Tajikistan and the Kyrgyz Republic on the following activities: 1) creating an enabling policy environment to promote low-threshold MAT inclusion criteria to increase site volume; 2) increasing MAT clinical capacity to improve the quality of services through mentorship, training; 3) support advocacy among the general public, medical community, and high level decision makers to increase the scale of MAT in Kazakhstan and promote sustainability in the Kyrgyz Republic and Tajikistan; and 4) provision of the "one window" approach to promote client friendly services for PWID who are on ART/TB/MAT and to increase the coverage and retention rates among PLHIV on ART and MAT.

As a result of PEPFAR CAR's prevention activities among PWID, 18,283 individuals will receive prevention interventions in the region.

4.5 HTC

Despite the large number of HIV tests performed annually in each of the countries, HIV testing is primarily limited to public sector facilities, is generally provider-initiated, and is disproportionately targeted to pregnant women rather than KP. Only 2% out of the 2 million HIV tests conducted in Kazakhstan were conducted among KPs; similarly 2.3% of the 600,000 tests in Tajikistan, and 2.5% of the 420,662 tests in the Kyrgyz Republic. Only 0.1% to 0.15% of all HIV tests were HIV positive in all three countries.[27] Although development partners have advocated for approval and expansion of testing sites (including community-based testing), HIV testing coverage of KPs remains low. National reporting for HTC demonstrates a poor yield of positives, which indicates this critical intervention is not being sufficiently targeted to high-risk KP groups.

HIV rapid testing is not part of the routine HIV testing algorithm in Kazakhstan and Tajikistan, though blood-based rapid test screening can be provided by health care workers. Saliva-based rapid testing has been piloted in the Kyrgyz Republic at community-based settings since 2013 and has expanded country wide to date. Out of 13,851 tested KPs to date with a saliva-based test, 400 (2.9%) KP tested HIV positive. However many of these are re-enrollment cases, which were detected, registered, and then lost to follow-up in the past. Rapid HIV testing using capillary blood for testing PWID partners was introduced by the Kyrgyz Republican Narcology Center together with PEPFAR. Because of recent multi-step testing algorithm (at least two Elisa and one immune-blot), the time from first HIV test to confirmation of positive result reportedly takes up to 1.5 months. By February 2016, with PEPFAR and WHO support, the Kyrgyz Republic revised its national policy on HIV laboratory testing algorithm that will shorten the time between taking the blood sample and delivering HIV positive test results through simplification of the diagnostic algorithm. PEPFAR CAR is working with the MOH in Tajikistan and Kazakhstan to approve a similar new diagnostic algorithm using rapid HIV tests to shorten the time interval to confirmed HIV diagnosis. In ROP17, PEPFAR CAR will assist the MOH to develop and implement national algorithms for facility- and community-based rapid testing for the region, as well as support quality assurance for rapid testing and expansion of proficiency testing and External Quality Assurance programs.

PEPFAR CAR will work with the MOH and NGOs to bring rapid testing to community-based settings where PWID live and congregate (e.g. shooting galleries) to increase uptake of HIV testing. PWID are a

[27] Republican AIDS Center Annual Reports for Kazakhstan, Tajikistan, Kyrgyz Republic, 2013

difficult group to reach and recruit for testing. In each of the three CAR countries, there are many PWID who have not been tested (Tajikistan and the Kyrgyz Republic) or who have tested positive for HIV and then lost to follow up (Kazakhstan). As noted in Section 4.2 - Priority Population Prevention, PEPFAR CAR will introduce a new PDI to find these unreached PWID and their partners, reaching further into PWID networks than traditional outreach was able to do using NGO-based peer navigators. As a result, more than 33,518 PWID and their partners will have a screening test for HIV at PEPFAR CAR-supported sites through direct service delivery and 595,508 individuals will be tested at sites which receive PEPFAR technical assistance support.

Available SIMS data indicated that across the region service delivery points that provide HTC do not have a standardized system for successful referral of HIV-infected clients to HIV treatment services (i.e., the facilities do not know if the patient or client was successfully linked to HIV care and treatment services). PEPFAR CAR will improve/modify community testing procedures to ensure follow up and enrollment into treatment after a positive HIV diagnosis. With the new PDI, HIV reactive PWID will be escorted to treatment sites to ensure complete referrals for confirmatory testing. Stigma and discrimination training will continue to be provided to health providers within facilities operating at core sites to ensure that KP-friendly services are provided, and PWID feel welcomed in the care and treatment sites.

4.6 Facility- & Community-Based Care & Support

In ROP16, PEPFAR CAR will support both facility- and community-based interventions to improve retention in care and adherence to ART among PWID in PEPFAR focus SNUs. Taking into consideration the high percent of LTFU patients among all diagnosed PLHIV, PEPFAR CAR support will also be aimed at finding and bringing such patients back to care and treatment. This retention support will incorporate evidence-based interventions (both clinical and non-clinical) to optimize outcomes and address barriers to quality service delivery for KPs. In addition, the support services will be tailored and continuously adjusted throught the ROP period based on the gaps in the services identified during SIMS visits to the sites being supported. The available SIMS data shows that across the region there are issues related to patients rights, stigma and discrimination; TB infection control measures in the ART sites; data quality assurance; data reporting consistency; tracking of pre-ART and ART patients; routine STI screening of PLHIV; monitoring of nutrition status; weakness of documenting referral and follow up of PLHIV with presumptive TB; and integration of family planning services into routine HIV care.

PWID will be prioritized for community-based treatment support with a variety of services. Peer navigators will provide intensive post-test counseling to newly identified PLHIV and will work with AIDS Centers to offer community support to newly identified PLHIV, including treatment enrollment. (Non-disclosure memorandums will be signed to ensure confidentiality.) Pre-ART counselling will include education about ART and its side effects and will encourage health seeking behaviors if side-effects arise. Self-support groups with participation of PLHIV who are stable on ART will help PLHIV who are newly enrolled into ART to overcome side effects and adhere to treatment. Peer navigators will also assess the need for other services that will help adherence such as STI screening and treatment, family planning services, TB diagnosis and treatment (see Section 4.7 – HIV/TB) and other social services such as assistance with getting or restoring one's identification/passport. PEPFAR CAR will also engage PLHIV NGOs with AIDS Centers to offer assistance to PLHIV who missed doctor appointments, to avoid loss to

follow up. In rural districts where NGOs are not available, PEPFAR CAR will help create community treatment support groups of PLHIV to provide adherence support through self-support groups and/or individual counselling.

This support will be provided within the context of enhanced coordination of the community-based organizations working with PWID and PLHIV with the facilities that provide HIV testing, care and treatment, as well as linkage between different clinical services. Under this arrangement, health providers, peer navigators, and home visiting nurses will work together and provide a spectrum of critical services to PWID.

In addition to community-based adherence support to strengthen the retention on pre-ART, clinical support groups for integrated medical/clinical management will be located at medical sites and include physicians, nurses, and peer educators providing services to PWID and PLHIV. The clinical support groups use a multi-disciplinary team (MDT) approach (which involves a team including HIV physicians, TB specialists, nurses, psychologists, social workers, and narcologists) which will be scaled up to sites to strengthen integrated service provision across the continuum of patient needs to ensure quality care and treatment adherence. A UNAIDS assessment of the MDT model in Kazakhstan demonstrated the success of this approach. According to the study, 68% of MDT clients were initiated on ART, as opposed to 33% of non-clients in the same sites; and 95.5% of clients of MDTs retained on ART during the last 12 months in comparison to 75.3% of non-clients.[28] Home-based visits by peer navigators, as well as increased use of peers who can help enroll patients in key services, will strengthen patient access to quality care and treatment services. Also, PEPFAR CAR will mentor health providers in order to adhere to standards of care services for opportunistic infection (OI) prophylaxis and MAT for PWID who are eligible, as well as appropriate laboratory monitoring with viral load per country guidelines, screening for active TB, and support for intensified and accurate case finding, with referral for diagnosis and treatment. To absorb the expected increased number of HIV patients, USG will also support additional physicians in treatment facilities and also will promote task shifting from physicians to nurses and peer counselors. In Tajikistan and Kazakhstan, where all HIV-related services are provided through a limited network of AIDS Centers, which further limits patients coverage, PEPFAR will assist the MOH to start integration of HIV related services into primary health care services. PEPFAR will also promote optimization of the service delivery models for PLHIV with different characteristics, including patients presenting well, with advanced disease, stable and unstable on ART.

As a result, 8,777 PLHIV will receive facility-based support (with 5, 476 newly supported) to remain in care, among whom approximately 50% will be PWID. Community-based care will also be provided to 5,876individuals.

4.7 HIV/TB

Across CAR HIV testing for all TB patients is mandatory, thus according to official statistics almost 100% of TB patients know their HIV status. Yet, TB testing for PLHIV is extremely low: 44% of PLHIV are tested for TB in the Kyrgyz Republic, 35% in Tajikistan, and 46% in Kazakhstan. Efforts to improve treatment and care for HIV-TB co-infected patients, especially among PWID, remain essential.

[28] D.O.Kamaldinov, G.M. Akhmetova " Assessment of effectiveness of the multidisciplinary approach to adherence to treatment among PLHIV," Almaty 2014

In ROP16, PEPFAR CAR will continue community support for PLHIV to educate about TB and to improve access to TB diagnosis and treatment services. All PLHIV clients of the PEPFAR CAR community-based adherence support services will be offered sessions about TB and its symptoms, referral to TB diagnosis services and support during TB treatment. PEPFAR CAR will work closely with TB centers in the focus SNUs to provide community support to PLHIV during TB treatment at the continuation phase after treatment in hospitals. Emphasis will also be placed on strengthening national policy regulations on HIV-TB integrated care; improving active TB screening among PLHIV; ensuring timely initiation of TB treatment; and providing treatment adherence support to patients co-infected with both HIV and TB. PEPFAR CAR will support home-visits to PWID PLHIV on TB treatment to ensure adherence; pilot the use of mobile phone reminders for doctor's appointments and taking medicine; and work with family members to strengthen DOTS. USAID TB-earmarked funds will be leveraged to assist CAR MOHs to scale up rapid testing using GeneXpert technology to dramatically reduce the time it takes for clients to receive test results. This will accelerate identifying HIV patients who are infected with TB and increase TB-related adherence support for TB/HIV co-infected PWID.

Under ROP16, 5,876PLHIV will complete a referral and be tested for TB with PEPFAR CAR's support.

4.8 Adult treatment

All three PEPFAR CAR supported countries are in the process of the revising national treatment protocols which allow for an increasing number of PLHIV on ART. Currently, the Kyrgyz Republic and Kazakhstan national adult treatment guidelines reflect the 2013 WHO revised treatment guidelines, and only the Kyrgyz Republic has fully scaled up treatment per the CD4<500 eligibility requirement. Tajikistan is in line with the previous ART eligibility requirement (i.e. CD4<350) with some flexibility if the CD4 is between 350 and 500, and doctor and patient agree to start ART. In all countries, all PLHIV who have TB co-infection or who are pregnant are eligible for ART, regardless of CD4 count. Both Kazakhstan and the Kyrgyz Republic are willing to move to the WHO 2015 Test & Start Recommendation. The main concern for Kazakhstan is lack of sufficient ARVs during this current financial crisis, as ARVs are procured from the state budget; and for the Kyrgyz Republic the main concern is uncertain ART supply after their GF grant ends in 2017. Tajikistan plans to revise their national treatment guidelines in FY 2016 to at least a CD4 < 500, but they have the same concern of ARV supply after the current GF grant ends in addition to a fragile health infrastructure and weak human resource capacity. ART coverage in Kazakhstan, the Kyrgyz Republic and Tajikistan is 30.4%, 16.6% and 15.2%, respectively. Access to ART for KPs is lower than the overall rate, with national reported rates of KPs enrollment in ART ranging from 14-28% across the three countries. While retention data for those enrolled is limited, Kazakhstan and the Kyrgyz Republic have better retention rates for PLHIV than Tajikistan (*See Table 1.1.2*)

Currently, ART is delivered by the network of local AIDS Centers in Kazakhstan and Tajikistan. In the Kyrgyz Republic, the MOH is moving forward with plans to integrate care and treatment services into primary health centers of the PEPFAR-focus Chui and Osh regions, which have the highest HIV prevalence in the country; thus the Kyrgyz Republic has mixed system of ART delivery: centralized (distribution of ARVs via AIDS centers) and decentralized – through primary health centers. Both

Kazakhstan and Tajikistan want to decentralize ART provision to government polyclinics, realizing that successful treatment scale up will require additional clinicians and facilities. Tajikistan, with PEPFAR support in FY 2016, will begin decentralizing ART services in Dushanbe, which has an estimated PLHIV population of over 6,000 adults and currently only two small ART centers. All three countries face challenges in the availability of ARVs in their combination forms. In Kazakhstan, coverage is further hindered by limited competition in ARV procurement which results in unit costs that are ten times higher than in other countries in the region where UNDP is procuring the ARVs as the GF Principal Recipient.

In ROP16, PEPFAR CAR will provide HIV treatment-related technical assistance and supportive mentoring/supervision to a subset of high-burden SNUs with sizable populations of PWID, high HIV prevalence, and large numbers of PWID PLHIV with the goal of progressing to saturation as quickly as possible. The PEPFAR-supported EHCMS allows monitoring of indicators of quality of care and loss to follow-up across all three CAR countries. PEPFAR CAR's assistance will focus on finding and retaining such patients and bringing them back into care and treatment. SIMS visits to supported sites revealed issues with stigma and discrimination, lack of TB infection control, shortage of medicines for OI treatment, and gaps around documentation and quality assurance. In these sites, PEPFAR CAR will work with the National AIDS Program (and Family Medical Centers in the Kyrgyz Republic) to increase site yield/capacity for ARV, improve uptake, quality assurance, retention and adherence in care and treatment by PWID PLHIV (including supporting a clinical multi-disciplinary team model in select sites); and identify and support implementation of efficiencies and quality improvement activities to allow increased uptake of services at the same or lower costs. PEPFAR CAR will introduce simplified approaches to clinical monitoring, reduced visits for stable patients, and distribution of ARVs every 3 or 6 months, when applicable. Also, countries will consider implementation of differentiated approaches to patient management.

PEPFAR CAR will also strengthen laboratory capacity within the prioritized sites to implement and participate in quality assurance programs for HIV-related diagnostic and clinical monitoring activities, and train and support expansion of viral load monitoring to measure effectiveness of ART provision and to strengthen adherence. PEPFAR CAR will continue to conduct quarterly SIMS visits at each of the sites to review medical charts and clinical management activities; provide mentoring support and consultations with the clinical staff on the most clinically challenging cases; and review EHCMS data to assess completeness and accuracy of entered clinical information. At clinical trainings supported by PEPFAR CAR, stigma and discrimination will be raised as an important barrier to KP access and solutions raised to make sites and providers KP-friendly.

PEPFAR CAR's target is to aggressively double adult treatment coverage in the PEPFAR focus SNUs until saturation is achieved. Please see table 4.1.1 for details.

5.0 Program Activities in Sustained Support Locations and Populations

5.1 Package of services in sustained support locations and populations

PEPFAR CAR does not have "sustained support" locations because in ROP15 all focus SNUs were designated as "scale up" SNUs which are targeted to reach 80% treatment coverage, and PEPFAR CAR has transitioned out of non-focus SNUs which now have government support. In these non-focus SNUs, the national governments provide a minimum set of services such as HIV testing and counseling, treatment provision, and viral load testing, among others. These SNUs receive support from donors such as the GF for KP-focused community outreach, community-based support, and ART in Tajikistan and the Kyrgyz Republic (with the GF exiting Kazakhstan by 2017); this support is coordinated for non-duplication with PEPFAR focus locations and populations. For all CAR countries with active GF grants, GF support also includes key commodities and harm reduction services, such as condoms, lubricants, NSPs, etc.

5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations

As noted above, through ROP15, PEPFAR transitioned away from non-core locations and non-focus activities, in particular KP outreach, testing and counseling in low burden SNUs; blood safety activities; and prevention activities among the general population. Therefore, no activities are planned to be phased out during ROP16. The program has consolidated geographically in its focus SNUs for ROP16, and will stay focused on these locations until treatment saturation is reached (80% of PLHIV know their status).

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

PEPFAR CAR analyzed programmatic gaps in the clinical cascade through a variety of sources in each country, including: review of population size estimates, HTC and yield rates, as well as treatment and adherence; stakeholder communication; investment profiles; and sustainability gaps. Two broad gaps were identified, the first related to demand for services and the second related to supply-side issues. The demand-related programmatic gap includes stigma and discrimination, shortages of ART and MAT, lack of knowledge among PWID and the difficulty in maintaining contact with this fluid population. There is overlap between some of these barriers and those which arise on the supply side, including stigma and discrimination and shortages of ART and MAT. Additionally, limited local NGO capacity and community-based rapid testing were identified as barriers.

Table 6.1.1 Key Programmatic Gap #1: Low Demand for Testing and Treatment Services Among KPs

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID
Mistrust of government facilities and staff reported by KPs	1. KPs report higher levels of trust in HCWs to maintain confidentiality 2. KPs report lower levels of stigma and discrimination from HCWs *Measurement: reassessment of stigma index in a random sample of PEPFAR-supported facilities after 3 years*	Training on stigma and discrimination included in all PEPFAR trainings	HBHC	USAID: $20,000	ICAP and HIV Flagship
		Community Advisory Boards at AIDS Centers to improve communication between patients and the physicians.	HBHC	USAID: $170,000	ICAP and HIV Flagship
		Monitoring of stigma among HCWs and other staff providing services to PWID	HBHC	USAID: $120,000	LEADER
Lack of capacity among Local NGOs (LNGO)	1. LNGOs are able to meet aggressive PEPFAR targets *Measurement: Performance based metrics for NGO successful attainment of community level attainment of KP_Prev and HTC_TST targets and efficient use of resources (MER and EA reporting timeline)*	Conduct trainings for PEPFAR-supported LNGOs on peer network models of recruiting and innovative ways to reach and retain clients	IDUP	USAID: $130,000	HIV Flagship
		Monitor and support LNGOs throughout implementation (ongoing)	IDUP, HBHC	USAID: $80,000; $60,000 Flagship, $20,000 REACT	HIV Flagship and USG (SIMS)
Lack of treatment (ARV and MAT)	1. Sufficient ARVs are available in SNUs Increased access to MAT in SNUs *Measurement: For ARVs, no reported stock-outs and consistently green scores on the facility supply chain CEEs for SIMS assessments. (Ongoing routine SIMS assessments) For MAT, presence of policies that institutionalize MAT nationally without capitation on available treatment slots in Kazakhstan. (Three year benchmark) For Tajikistan and the Kyrgyz Republic, national MAT treatment plans goals for number of individuals receiving MAT in line with WHO guidance on MAT coverage to influence national HIV epidemics. (Three year benchmark)*	ARV supply is addressed in Table 6.2.1		See Table 6.2.1*	
		Peer navigators inform and educate PWID about the availability of ART	HBHC	USAID: $280,000; $200,000 (Flagship) $80,000 (REACT)	HIV Flagship
		Continue to advocate for increased MAT services	OHSS	USAID: $300,000	UNODC
Lack of knowledge among KPs (re: vulnerability, benefits and availability of testing and treatment and MAT)	1. Improved KAP levels among KPs 2. Increased uptake of services in SNUs *Measurement: The TRAC survey implemented in ROP 16 will serve as a baseline for knowledge, attitudes, and practices for PWID on testing, treatment,*	Peer navigators inform and educate PWID about benefits of testing, treatment and MAT	HVSI	USAID: $100,000	HIV Flagship and REACT
		Train HCWs in counseling KPs	IDUP	ICAP: $10,000; USAID: $20,000; $2,000 * 10 trainings (one in each SNU)	ICAP and HIV Flagship

	and MAT. The TRAC survey will be again be implemented ROP 18 to measure the hypothesized growth in knowledge of this key population group.	Conduct TRAC surveys among PWID	HVSI	USAID:$66,000	HIV Flagship
Movement of KPs limits ability to track/support adherence	1. Adherence among KPs improved 2. Prisoners remain on treatment after release *Measurement: Adherence among KPs will be routinely monitored using the TX_PVLS MER indicator. While this indicator is not disaggregated by key populations with DATIM, the program will complete this disaggregation using data from the electronic health management system (EHCMS). (MER reporting cycle) The linkage of PLHIV Prisoners to treatment following release will be tracked by REACT program data and reported during the annual reporting cycle as a custom indicator. (annually)*	Implement innovative outreach and tracking models and methods to reach and retain PWID	IDUP	USAID: $500,000	HIV Flagship
		Provide on-going support to post-release prisoners who are HIV+ to ensure linkage to care and adherence.	HBHC	USAID: $400,000	REACT
		Monitor the recruitment and tracking of PLHIV and continuously improve outreach and support activities	HBHC, HVSI	USAID: $40,000; $20,000 for Flagship, $20,000 for REACT;	HIV Flagship, REACT and USG (SIMS)

Table 6.1.2 Key Programmatic Gap #2: Lack of Enabling Environment for Testing, Treatment and Care for KPs					
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**
Attitudes toward PWID among HCWs and police	1. Improvements in stigma index results 2. Regulations in place and enforced to address discrimination and human rights *Measurement: Reassessment of stigma index in a random sample of PEPFAR-supported facilities after 3 years (see 6.1.1.) Improvement in the facility based stigma and discrimination SIMS CEEs overtime to ensure policies on stigma and discrimination are in place and appropriately enforced. (ongoing) Policy tracking conducted by UNODC on policies and practices related to the interface between law enforcement, injection drug use, and drug treatment. (annual)*	Monitoring of stigma among HCWs and other staff providing services to PWID	HBHC	Budget included in Tbl 1	LEADER
			IDUP	$50,000	ICAP
		Integrate stigma and discrimination into all PEPFAR trainings	HBHC	Budget included in Tbl 1	HIV Flagship, REACT and ICAP
		Continue to advocate for regulations which hold HCWs, police and prison staff accountable for stigma and discrimination	IDUP	USAID: $105,000: UNODC: $50,000; UNAIDS: 45,000; REACT: $10,000	UNODC, UNAIDS and REACT
			IDUP	$20,000	RNC/KG

Lack of political will to engage and support KPs	1. Availability of MAT institutionalized 2. Increased uptake of MAT in SNUs *For Kazakhstan, policy to institutionalize MAT nationally without capitation on available treatment slots. (Three year benchmark) For the Kyrgyz Republic, analysis of the "no registration as a drug user to get MAT" pilot to identify if it increased uptake of the intervention. (ROP 17) If successful, policies drafted and considered for implementation to eliminate this punitive, high threshold barrier to MAT. (Three year benchmark). For Tajikistan, analysis of the take home dosing pilot to identify if it increased uptake of the intervention. (ROP 17) If successful, policies drafted and considered for implementation increase access to MAT. (Three year benchmark)*	Continued high level advocacy for MAT		budgeted in Tbl 1*	UNODC
			IDUP	$84,000	RNC/KZ
		Pilot "no registration" for PWID at 2 sites in KG	IDUP	$10,000	RNC/KG
		Pilot take-home dosing in TJ	IDUP	$10,000	RNC/TJ
			IDUP	$15,000	HIV Flagship
		As availability of MAT increases, peer navigators link PWID to services	IDUP	$100,000	ICAP
Limited civil society engagement	CSOs actively participating in planning and implementing HIV programs *Measurement: An assessment of local capacity development will be conducted using the proportion of successfully awarded grant-based, host-country government funding, annually as applicable. With a post-hoc assessment conducted to understand factors related to success.*	CSOs (NGOs) are a part of CCMs, TWGs in countries	IDUP	$15,000; Travel to participate in the CCM meetings; $ 10,000 (Flagship) $5,000 (REACT)	HIV Flagship, REACT
		CSOs (NGOs) organize joint M&E visits with MOH and round table to present results / findings	IDUP	$30,000; Travel; $20,000 (Flagship) $10,000 (REACT)	HIV Flagship, REACT
		CSOs (NGOs) trained to apply for government grants in countries where possible (KZ, KG)	IDUP	$55,000; Training budget line in two projects; $50,000 (Flagship)	HIV Flagship, REACT
Lack of community level HIV testing for KPs	1. Rapid testing available at community in SNUs 2. KP network model driving "reach and test" in SNUs *Measurement: In Tajikistan, a revision of the HTC regulations to allow for saliva based rapid HIV testing at the community-level conducted by trained non-medical personnel.(three year benchmark) In*	Provide QA to government and NGO testing points using HIV rapid tests that increase coverage and support linkages to HIV service delivery for PWID including female friendly sites	HVCT	$50,000	RAC/TJ
		Provide QA and support to mobile testing points using HIV rapid tests that increase access and linkage to treatment facilities	HVCT	$30,000	RNC/KG

	Tajikistan and the Kyrgyz Republic, progress on the implementation of community-based testing will be monitored by the increase of the HTC_DSD community testing disaggregate overtime to indicate a higher coverage of PWID targeted testing. (MER reporting cycle).	Revise national RT guidelines; conduct RT TOT workshops; development of national policy framework for certifying HIV RT providers; Provision of on-site mentoring support for HIV RT QA measures	HLAB	RAC/KG: $115,000 RAC/KZ: $175,000 RAC/TJ: $115,000	RAC/KG; RAC/KZ; RAC TJ
		Advocate for community level rapid testing in KZ (where it is not currently allowed) and in TJ, promote further implementation of the government order endorsing community-based rapid HIV testing	HVCT	$60,000; UNAIDS: $15,000 per country; LEADER $15,000 per country	UNAIDS and LEADER
		Support community level rapid testing in KG to demonstrate feasibility	HVCT	$25,000 Training to 5 NGOs on RT ($5,000 each)	ICAP and HIV Flagship
TOTAL				$1,384,000 +*	

6.2 Critical Systems Investments for Achieving Priority Policies

Based on the programmatic gaps described above, PEPFAR CAR analyzed the systems barriers to implementation of Test and Start and New Models of Service Delivery (NMSD) using data from the Data Pack, PBAC and local sources. The barriers include ART and MAT procurement and supply and the need to update policies and training of health care workers, prison staff, community members and peers. This will be done through intensified support to advocacy for improved policies, projections, procurement mechanisms, and clinical and laboratory procedures, among other activities listed in the tables below.

Table 6.2.1 Test and Start

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID
Lack of ARVs purchased by host governments	1. Government of KZ has a rationalized ART formulary 2. Government of KZ purchases a sufficient supply of ARVs 3. Increased procurement of ARVs in TJ	Support to Govt of KZ to update ART drug list for clinical and cost effectiveness	OHSS	$150,000: HIV Flagship: $100,000; GHSCP: $50,000	HIV Flagship and Global Health Supply Chain Program (GHSCP)

	and KG increase spending on ARVs *Measurement: Revised ART formulary is developed in Kazakhstan, optimized to efficiently scale treatment. (ROP 17) Government of Kazakhstan implements an efficient procurement mechanism to purchase drugs based on the rationalized ART formulary. (ROP 17) The national HIV program plans for Tajikistan and Kyrgyz Republic include operational plans for ART procurement commensurate with treatment scale up. (Annually, as applicable) These plans are developed and supported in close coordination between Global Fund, PEPFAR, and supported in close coordination between Global Fund, PEPFAR, and UNAIDS.*	Continued advocacy and support in KZ for use of UN procurement mechanism by PEPFAR in conjunction with UNAIDS, the Central Asia Network of PLHIV and other partners	HBHC	USAID: $125,000: UNAIDS: $100,000; LEADER: $25,000	UNAIDS and LEADER
		Quality Improvement and Accreditation Unit (staffing, travel for mentoring visits, TWG for clinical protocol revision; and prekaz dissemination) NOTE: KG and TJ are cost shared with UNDP/GF	HTXS	RAC/KG:$100,000 RAC/KZ: $150,000 RAC/TJ: $50,000	RAC/KG RAC/KZ RAC/TJ
		Support ARV forecasting and advocacy at local level to include ARVs in local budget	HVSI	$30,000	ICAP
		Support to CCM in TJ to become Principal Recipient of Global Fund	OHSS	$200,000	GHSCP
		Support to TJ, KG and KZ supply chain to ensure accuracy of projections and efficiency of procurement and distribution	OHSS	$200,000	GHSCP
		Advocate with host governments and GF Principal Recipients in TJ and KG to increase budget and targets for ARVs	HBHC	USAID: $90,000: UNAIDS: $60,000; LEADER: $30,000	UNAIDS and LEADER
Lack of adoption of national policies on Test and Start	1. Guidelines in 3 countries support Test and Start 2. Prekaz in 3 countries support Test and Start *Measurement: Policies supporting Test and Start are in place in the Kyrgyz Republic (2017), Kazakhstan (2018), and Tajikistan (2017-policy/2018-implementation pending new GF note).*	Continued advocacy in 3 countries for Test and Start	HBHC	$10,000	UNAIDS and LEADER
		Quality Improvement and Accreditation Unit (staffing, travel for mentoring visits, TWG for clinical protocol revision; and prekaz dissemination) NOTE: KG and TJ are cost shared with UNDP/GF	HTXS	Budget above	RAC/KG RAC/KZ RAC/TJ
		High level advocacy round tables with parliament, MOH, MOE, WHO, UNAIDS, GF, WB, USAID on WHO Test and Start Strategy	HTXS	$45,000	RAC/KZ; RAC/KG; RAC/TJ
HCWs don't understand/support Test and Start	1. HCWs trained in new Test and Start Guidelines 2. HCWs implement new Test and Start	Conduct trainings/mentoring of HCWs on evidence base for Test and Start	HTXS	$25,000	ICAP

	Guidelines *Measurement: Monitoring of TX_NEW MER indicators relative to the HTC_POS achievements to ensure that newly diagnosed patients are receiving treatment in a timely fashion. (MER reporting cycle)*	Include stigma and discrimination in training of HCWs	HTXS	Included in trainings	All partners
		Monitor implementation of Test and Start	HTXS	$20,000	ICAP and SIMS
Lack of prioritization by government in the context of a financial crisis	1. Host governments (Ministries of Finance and Health) understand and support 90/90/90 *Measurement: Coordinated stakeholder engagement in developing national HIV programs that endorse the UNAIDS 90/90/90 goals and includes financing commitments.*	Continued advocacy for and education about Test and Start in the context of 90/90/90		Budgeted above	
		High level advocacy round tables with parliament, MOH, MOE, WHO, UNAIDS, GF, WB, USAID on WHO	HTXS	Budgeted above	RAC/KZ; RAC/KG; RAC/TJ
		Disseminate allocative efficiency study	OHSS	UNAIDS: $60,000; LEADER: $15,000	UNAIDS and LEADER
		Conduct further modeling to make a compelling case for Test and Start	HTXS	$30,000	RAC/KZ; RAC/KG; RAC/TJ
TOTAL				$1,515,000 + *	

Table 6.2.2 New and efficient service delivery models					
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**
Current National Guidelines don't include or support new models of service delivery and care (NMSD)	National Guidelines revised to allow for NMSD: 1. Primary Health Care physicians able to provide treatment to stable patients 2. Decentralization of HTC and ARV provision 3. Multi-month scripting allowed (at least in pilot areas) 4. Updated procedures for lab tests *Measurement: Treatment guidelines are revised to account for alternate service delivery models. These changes are expected to be completed to through multiple policy actions. Kyrgyz*	Quality Improvement and Accreditation Unit (staffing, travel for mentoring visits, TWG for clinical protocol revision; and prekaz dissemination) *NOTE: KG and TJ are cost shared with UNDP/GF*	HTXS	*Budget in table 6.2.1	RAC/KG RAC/KZ RAC/TJ
		Technical Assistance to MOH to revise clinical protocols; training for managers and clinicians on implementation of new protocols	HTXS	$100,000	ICAP
		HCWs trained in new case management including multi-month scripting for stable patients	HTXS	$20,000	ICAP

	Republic- lab tests, multi-month scripting (2017). Tajikistan- lab tests, multi-month scripting, decentralization (2019). Kazakhstan- decentralization (2018), multi-month scripting (2019), updated lab test procedures (2019)	Continued advocacy for NMSD by USG, UNAIDS, GF, UNDP, the Central Asia Network of PLHIV and other partners	OHSS	UNAIDS: $20,000; LEADER: $45,000	UNAIDS and LEADER
		Training of NGO staff in rapid testing, where this is allowed	HVCT	$10,000	ICAP and HIV Flagship
		Linkages established between facilities and NGOs for community level HTC	OHSS	$70,000	ICAP and HIV Flagship
Inefficient laboratory testing entrenched in practice	1. Viral load testing scaled up 2. CD4 and unnecessary lab testing reduced 3. External and internal quality assurance for HIV laboratories are part of national standards *Measurement: Viral load scale up will be measured by growth in the MER indicator TX_PVLS. (MER reporting cycle) National external and internal quality assurance plans for HIV laboratories are implemented by the host country laboratory services across the region. (2018)*	Develop national EQA/PT providers develop national EQA/PT schemes for core HIV-related diagnostic and clinical monitoring tests including building technical and leadership capacity and support establishment of the national technical working group (TWG) to address EQA/PT regulations	HLAB	$321,000	CLSI; ICAP
		On-site / off-site (hot-line, online consultations) mentoring support to laboratorians and clinicians to ensure quality of core HIV testing, including VL (on-the job training, troubleshooting, remedial actions, referrals, etc)	HLAB	$65,000	ICAP
		Conduct regional stakeholders' workshops on VL policy /action plan development; Conduct national laboratory workshops on introduction to the DBS technology for VL testing	HLAB	$160,000	CLSI
		Support on-site introduction of POCT for VL, when operational	HLAB	$10,000	ICAP
No site-level operational guidance	Clinical SOPs developed to specify operational issues and processes *Measurement: Monitoring of ICAP monthly reports detailing specific implementation results, SOPs developed/published/implemented, and facility-level SIMS results documenting clinical performance. (ongoing)*	Conduct assessment of current PEPFAR-supported facilities and potential new sites	HTXS	$10,000	ICAP
		Provide TA for development of new guidelines, including definition of "stable on ART" and "allowable visit schedule" for PWID	HTXS	$50,000	ICAP
		Monitor sites to ensure understanding of and adherence to guidelines	HTXS	$30,000	ICAP and USG (SIMS)

		Conduct ARV facility optimization at treatment sites (AIDS Centers or family medical centers) as part of standards of care monitoring and supervisor support	HTXS	$20,000	ICAP
TOTAL				$931,000 + *	

6.3 Proposed system investments outside of programmatic gaps and priority policies.

Please include in the table below all other system investments proposed for COP16 and not included in either 6.1 or 6.2. The information should be sufficient to describe how the activity is essential in reaching the 90/90/90 targets or achieving a sustainable national HIV program.

Table 6.3 Other Proposed Systems Investments						
Systems Category* (only complete for categories relevant to country context)	**Activity**	**For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.**	**Outcomes expected after 3 years of investment**	**Budget Amount**	**Budget Code(s)**	**Associated Implementing Mechanism ID**
Laboratory						
	Provide expert mentoring support in QMS implementation (SLIPTA tool) and accreditation preparedness of PEPFAR supported lab sites *Measurement: Number of labs receiving SLIPTA accreditation. (annually)*	1,2,3,4	Quality of laboratories to diagnose and monitor HIV cases is improved	$50,000	HLAB	CLSI
	Validation of rapid (RT) in Tajikistan and the Kazakshtan. *Measurement:*	1	Rapid tests are validated and used as part of national algorithm	$50,000	HLAB	ICAP

	Validation conducted and reports prepared to inform the utilization of rapid test within the national HTC algorithms in Kazakhstan and Tajikistan. (2017)					
Strategic Information						
	Support for Electronic Health Case Management System (EHCMS) including RAC support staff to manage and maintain EHCMS *Measurement: EHCMS is fully institutionalized across each country in the region as the national system of record for HIV data with identified POCs within the national program responsible for implementation and data quality. (2017)*	4	EHCMS is completely rolled out in all countries and maintenance is supported in part or in whole by RAC	ICAP: $150,000 RAC/KG: $10,000 RAC/KZ:$10,000	HVSI	ICAP
	Establish MAT Electronic Register (EMR) System *Measurement: EMR is fully is fully institutionalized across each country in the region as the national system of record for HIV data with identified POCs within the national program responsible for implementation and data quality. (2018)*	4	All MAT in Central Asia will collect program coverage data and track retention and health outcomes in MAT program	$90,000	HVSI	ICAP

	Support for IBBS and PSE in Tajikistan *Measurement: IBBS and PSE are conducted and data is utilized for program planning and improvement. (2017)*	4	IBBS and PSE is complete and is being used to inform HIV programmatic decisions at the national level	ICAP: $50,000; RAC/TJ: $100,000	HVSI	ICAP and RAC/TJ
TOTAL				$510,000		

7.0 Staffing Plan

As PEPFAR CAR has continued its program pivot to support implementation of UNAIDS 90-90-90 goals in focus SNUs, the overall team and each agency conducted a staffing analysis, based on PEPFAR USG responsibilities for ROP16 and utilizing the PEPFAR staffing tool. As a result, each agency has adjusted its staffing on a technical, geographic, or operational basis to meet the needs of the refined PEPFAR CAR program.

Staffing shifts to respond to program technical needs started in FY16 and are proposed to continue in ROP16 to provide increased support in the areas of case-finding, treatment scale up and laboratory strengthening. CDC's Associate Director became the Kazakhstan treatment team lead and CDC's former Blood Safety Specialist in the Kyrgyz Republic has been refocused as the treatment lead there. In Tajikistan, a new CDC Prevention Specialist is planned to be hired (approved in ROP15) and will also provide collaboration and support to the Global Fund/ Principal Recipient. CDC's new Health Scientist in Kazakhstan is realizing a variety of SI and technical duties within the CDC PEPFAR team and CDC has recently agreed to dedicate 20% of the Health Scientist's time to interagency SI support duties. In addition, a new CDC locally engaged laboratory specialist is being proposed in the Kyrgyz Republic to focus on viral load scale up and HIV testing support to MOH.

PEPFAR CAR also proposes to increase its staffing support from a geographical perspective, focusing on Tajikistan and the Kyrgyz Republic. In particular, the USAID PEPFAR team will grow to enable sufficient staffing to engage meaningfully with the national governments in their AIDS plans, and collaborate with the GF, while also providing technical guidance, implementing partner oversight (with a focus on intensifying HIV case finding), and fulfillment of PEPFAR monitoring and evaluation requirements. Thus, an additional USAID local staff member is proposed to be added to the current 1.5 person USAID PEPFAR country team for each of Tajikistan and the Kyrgyz Republic. In FY2016, CDC will also hire a new Prevention Advisor for Tajikistan (position approved in ROP15).

With these proposed new positions, PEPFAR CAR team members will have a stronger technical focus (in response to initial staffing conclusions of the PEPFAR staffing tool). These additions should result in stronger overall performance of the PEPFAR CAR team. In addition, several positions which had previously split their effort between HIV and other health issues are to be phased out of ROP16. The PEPFAR Coordination Office will combine the two positions approved in ROP16 (Deputy Coordinator and Program Assistant) into a mid-level Program Officer position who will work with the Regional PEPFAR Coordinator and Interagency SI Advisor, resulting in a reduction of one LNE State hire. The previous GF Liaison position will not be renewed while the Regional PEPFAR Coordinator position will be renewed for one year, through July 2017 (using agency pipeline), to provide coverage until the PEPFAR Coordinator LNA mechanism is anticipated to be in place. Interim support will be utilized as needed for the Coordination role starting from August 2017.

Several staffing approaches will remain the same, such as division of SIMS requirements across all technical officers, as they have the best program knowledge and are most appropriate to conduct SIMS visits. PEPFAR country team members will also continue to engage directly with the GF and multilateral counterparts (UNAIDS, WHO, UNODC) in their respective countries, while the PEPFAR Coordinator will

communicate with GF and other multilateral at the regional and strategic level, in coordination with agency leads.

The PEPFAR CAR team has a small number of long-term vacant positions (defined as 6 months or more). For example, the PEPFAR Program Assistant hiring was unsuccessful and will be combined into the one position as noted above. CDC has two positions that have been vacant for more than 6 months: the full-time Prevention Advisor position for Tajikistan (also noted above, to be hired in FY2016) and an IT Manager position partially devoted to PEPFAR, for which temporary cross-coverage has been found.

Below is a list of all new, PEPFAR-paid positions. All have space available or approved within the Embassy. None of the new positions are designated for hiring a new international specialist, e.g. PSC contract.

New PEPFAR(-paid) Position	**Location**	**Agency/Citizenship**	**% Focus on PEPFAR**
HIV Program Specialist	Tajikistan	USAID/LNE	100%
HIV Program Specialist	Kyrgyz Republic	USAID/LNE	100%
HIV Lab Specialist (position shifted from KZ)	Kyrgyz Republic	HHS/CDC/LNE	100%

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 16

Core Focal Areas	Near-Core Focal Areas	Non-Core Focal Areas
Site Level		
Key populations (KP)-focused community-based prevention (targeted technical assistance and service delivery) in "hotspots" in high-burden oblasts and cities that supports increased access and uptake of HIV rapid testing, condoms and lubricants. For PWID, support and assistance to increase access to new needles/syringes methadone-assisted therapy and treatment as prevention.	Support expansion of laboratory quality assurance/proficiency testing for HIV testing and clinical monitoring at PEPFAR priority sites.	
KP-focused community-based case-finding through peer-driven interventions (PDI) and support in "hotspots" in high-burden oblasts and cities that support strong referrals and increase uptake and access to HIV care and treatment, TB screening and treatment, and promotes adherence to care and treatment services.		
In prisons with a large number of PLHIV and PWID, TTA and support for case-finding, testing and treatment of PLHIV.		
Support for expansion of HIV treatment and quality of services through supportive mentoring/supervision to health facilities (e.g. AIDS Centers, Family Health Centers) in high-burden oblasts in cities with sizable populations of KP and large numbers of PLHIV.		
Support to PEPFAR priority sites to collect and analyze clinical and program data for quality improvement activities.		
Technical assistance and support for the development and expansion of a "unique identifier code" system for KP to strengthen adherence across the HIV continuum of prevention, care and treatment.		
Support expansion of viral load (VL) testing in Tajikistan and Kyrgyzstan, including sample transportation, quality-assurance, rapid reporting of results, and clinical use/ interpretation of VL test results.		

Sub-National Level		
Capacity building of Oblast Republican AIDS Program and NGOs that support KPs in high-burden oblasts to collect and analyze epidemiological and program data to improve resource prioritization and quality improvement activities. Support to community and facility-based HIV service providers to engage in high-quality program evaluation activities.	Continued support on HIV rapid testing validation, HTC algorithm development, and KP cascade assessments.	
Capacity building of KP NGOs and community groups to strengthen their ability to engage in advocacy for increased access to high-quality and KP-supportive HIV prevention, testing, care and treatment services.	Support to Oblast MOH staff for the clinical and community treatment support group approach.	
Targeted technical assistance to the Oblast Republic AIDS Centers, Oblast Republic Narcology Centers, and Non-Governmental Organizations in high-burden PEPFAR Priority SNUs on expanding and supporting high-quality HIV/AIDS prevention activities, strengthening referral systems for HTC, NSP/MAT, and HIV care and treatment.		
Provide technical assistance to Oblast National AIDS Center to develop and implement laboratory quality assurance programs for HIV rapid testing, clinical chemistry, and viral load.		
National Level		
Targeted technical assistance to the Ministry of Health (including the Republican AIDS Center and Republican Narcology Center) and NGOs on developing/strengthening/adopting evidence-based policies and guidelines that increase access and uptake by KP of core HIV prevention interventions, including Test and Start, HTC, and NSP/MAT, support effective referral programs, new models of service delivery, and ensure HIV care and treatment services are tailored to the unique needs of KPs.	Targeted technical assistance to MOH and NGOs on health financing and budgeting, and promoting service integration.	
Targeted technical assistance to Republican AIDS Center and Republican Narcology Center on development, dissemination of policies and guidance related to HIV clinical services, laboratory, and PWID programming.	Support Republican AIDS Center laboratories in Kazakhstan and the Kyrgyz Republic to receive international laboratory accreditation.	

Capacity building to Republican AIDS Center National Reference Laboratory to develop and implement robust quality assurance schemes for HIV testing, viral load and care laboratory assays.		
Supportive mentoring of Republican AIDS Program to oversee the periodic execution of IBBS and Population Size estimates and analyze epidemiological and program data to improve resource prioritization and quality improvement activities.		
Support to NGOs to conduct KP-focused program evaluations.		
Technical assistance to Ministries of Health to improve HIV-related drug projections, procurement and supply chain systems.		

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 16

Core Focal Areas	Near-Core Focal Areas	Non-Core Focal Areas
HTC		
Technical Assistance to Republican AIDS Centers (national) and Oblast/Site laboratories to develop and participate in quality assurance and quality management programs to ensure reliability of HIV testing.	Validation of HTC algorithms for KP.	
Support to strengthen the policy/legislative environment for HTC, including community based HTC and Rapid Testing and expand demand for testing among KP.	GBV education for KP and referrals of GBV victims to health services and escort to HTC.	
Build capacity of Republican AIDS Centers, Republican Narcology Centers and NGOs to increase referrals, uptake and access of HTC among KP most at risk of HIV acquisition.	Field test national HIV testing algorithms for KPs.	
Procurement and technical assistance to pilot HTC by NGOs at the community level. Procurement, supply and distribution of HIV rapid test kits (RTKs).		
Pilot community based HTC and mobile testing points to increase access and uptake by KPs.		
Referrals of PLHIV partners to HTC.		

Provision of HTC at mobile testing points of narcology centers (the Kyrgyz Republic).		
Supportive mentoring to HTC staff and use of peers to ensure effective linkage and referral of KP PLHIV to care and treatment services.		
Care and Treatment		
Direct service provision of MAT, ART, TB treatment adherence, and STI screening and referral support to PWID.	Support MOH approval of an HIV/TB referral algorithm.	
HIV care and treatment-related technical assistance and supportive mentoring/supervision to a sub-set of high-burden oblasts in cities with sizable populations of KP with high HIV prevalence and large numbers of PLHIV.	Train healthcare workers in transitioning sites (not included as PEPFAR priority sites) on effective HIV care and treatment.	
Provide training to Republican Narcology Centers to address low coverage rate for MAT and expanding low-threshold services to increase uptake among PWID.	Strengthen standards and protocols on MDT approach through support to the MOH.	
Conduct on-the-job training/mentoring for LMIS, ARV quantification and case management to Republican AIDS Centers in priority sites.	Capacity building for prison medical staff (coaching) and non-medical staff (on transitional client management).	
Expand Clinical and Community Treatment Support Team approach to selected sites to support adherence to ART and TB among PLHIV. Train Treatment support Team members and peers on case management, pre-ART, services for PLHIV, stigma and discrimination prevention, and communication skills.		
Capacity building of Oblast Republican AIDS Program in PEPFAR priority sites to develop and implement a quality management program for HIV care and treatment. Training of service providers on stigma/discrimination and interpersonal communication for HIV care and TB specialists.		
KP-focused community-based care activities in high-burden areas that support adherence to care and treatment services.		
Home visits to ensure adherence support. Technical assistance and operational support for self-support groups of PLHIV on ART (adherence support).		
Expand PLHIV Community Advisory Boards (patient groups located at AIDS Centers and Narcology Centers) to support adherence support and advocate for KP friendly services.		

Supportive mentoring to HTC staff to ensure effective linkage and referral of KP PLHIV to care and treatment services.		
Capacity building for prison medical staff in prisons with high numbers of PWID and PLHIV on HTC and proper HIV care and treatment (including adherence and MAT).		
Technical assistance to Republican AIDS Centers and Republican Narcology Centers in PEPFAR priority sites to establish "one stop shops" where PWID can access integrated MAT, ART, and other clinical services.		
Supportive mentoring to Republican AIDS Program, Republican Narcology Centers in PEPFAR priority sites to collect and analyze HIV care and treatment program data to and conduct quality improvement activities.		
Targeted technical assistance and direct support for provision of MAT, pre-ART, ART, TB and SIT screening and referral support to PWID, MSM and FSW.		
Prevention		
Technical assistance to Republican AIDS Centers and Republican Narcology Centers in PEPFAR priority sites to establish effective referral systems for PWID to MAT.	Technical Assistance to MOH to develop HIV testing algorithms.	
Technical assistance and operational support to NGOs for prevention and referrals to health services for KPs.		
Adopt comprehensive prevention packages, training curricula, guidelines for KPs and TOT (NGOs and Healthcare providers).		
Support NGO advocacy activities for scale- up of MAT.		
TA on MAT to Republican Narcology Centers' pilot sites via "one-stop-shop" approach.		
Direct outreach services/peer navigation for KP.		
Training of clinical service providers on harm reduction and raise awareness of stigma/discrimination issues that might impact uptake of HIV services by KPs.		

HSS		
Technical assistance to CCM to meet GF eligibility requirements/strengthening of operations & functioning, CCM roles & responsibilities.	Technical Assistance to support health financing and allocative efficiency, develop policy agenda to leverage GF investments, assist MOH in budgeting for HIV investments.	
Capacity building in advocacy and policy for KP NGOs, to strengthen engagement with government.		
Technical assistance to Ministries of Health to improve HIV-related drug projections, procurement and supply chain systems.		
Lab		
Technical Support/Capacity Building to national and subnational level laboratories in high-focus SNUs to develop and participate in external quality assessment and/or proficiency testing (EQA/PT) schemes to strengthen quality of core HIV-related diagnostic and clinical monitoring tests (e.g. HRT; HTC; viral load; clinical chemistry).	Continue technical support activities in high-focus SNU HIV laboratories to achieve international accreditation, which will enable them to serve as centers of excellence for establishing EQA/PT schemes and training center(s) to disseminate skills on HIV advanced lab testing technologies.	
Technical Assistance to HIV laboratories in high-burden SNUs to implement robust quality management system (QMS).		
SI		
Supportive mentoring of Republican AIDS Program to oversee the periodic execution of IBBS and Population Size estimates and analyze epidemiological and program data to improve resource prioritization and quality improvement activities.	Size estimation ("hot spot study) for SW and MSM.	
TTA to develop, expand and improve quality of unique identifier code and electronic HIV/AIDS case management reporting systems. Management Information Systems (MIS) system strengthening and Integrations of Unique Identifier Code (UIC) .		
Conduct behavioral studies on KP and evaluations of prevention activities in PEPFAR focus sites.		
Technical support to strengthen the use and quality of the Electronic HIV/AIDS Case Management Registry and Electronic Methadone Registry (the Kyrgyz Republic), and identify ways to utilize this system to improve clinical outcomes for KPs.		

Supportive mentoring to Republican AIDS Program, Republican Narcology Centers and NGOs at PEPFAR Focus sites to collect and analyze epidemiological and program data to improve resource prioritization and quality improvement activities.		
Assessments of clinical cascade for KPs to identify gaps in quality of services		

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP 16	Estimated Funding in COP 17	# of IMs	Transition End date	Notes
n/a						
n/a						
n/a						
Totals						

APPENDIX B

B.1 Planned Spending in 2017

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
$ 3,619,870	**$12,180,129**	**$15,800,000**

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	
HVAB	Abstinence/Be Faithful Prevention	
HVOP	Other Sexual Prevention	$332
IDUP	Injecting and Non-Injecting Drug Use	$3,587,379
HMBL	Blood Safety	
HMIN	Injection Safety	
CIRC	Male Circumcision	
HVCT	Counseling and Testing	$1,103,099
HBHC	Adult Care and Support	$2,438,955
PDCS	Pediatric Care and Support	
HKID	Orphans and Vulnerable Children	
HTXS	Adult Treatment	$1,598,919
HTXD	ARV Drugs	$26,020
PDTX	Pediatric Treatment	
HVTB	TB/HIV Care	$376,522
HLAB	Lab	$1,603,190
HVSI	Strategic Information	$1,136,414
OHSS	Health Systems Strengthening	$728,790
HVMS	Management and Operations	$3,200,380
TOTAL		$15,800,000

B.2 Resource Projections

ROP 16 budget was developed using an evidence-based, lump-sum approach. Lump-sum IM-level budgets were produced based on FY15 Expenditure Analysis (EA) data.

To determine the resource requirements for CDC SUPPORT project (ICAP Global TA IM), unit costs were developed from the EA and APR results and to project future spending. For cost categories where programmatic changes are expected to increase based on ambitious targets to reach 90-90-90increase targets (equipment, travel for mentoring-site visits, etc.), cost categories were adjusted upward based on activity-based budget projections. FY15 EA results showed that most expenditures fell into relatively fixed cost categories (personnel, project management, SI, etc.). As a result lump-sum budgeting was used to populate the PBAC, with the assumption that substantially more beneficiaries can be reached with the existing cost structure.

To determine the resource requirements for the six CDC G2G mechanisms, expenditure data results were used as the starting point for the ROP 16 budgets. For mechanisms with primarily direct service delivery, cost categories for supplies and travel increased where targets increased significantly. However, fixed costs remained the same with the assumption that substantially more beneficiaries can be reached with the existing cost structure. Three IMs did not have EA data since two are new ROP 15 awards and one IM is new for ROP 16, so lump-sum budget was projected solely on activity-level budgets which were based on standard government estimates and historical costs. CDC's Laboratory TA Support mechanism (CLSI) lump-sum budget was built primarily on activity-level budget instead of EA data because activities in each country have changed.

Initially, USAID looked at the unit costs for the Dialogue and Quality projects and assumed that the costs under the new Flagship project will be the same. However, in FY15, the unit cost in EA for the two projects were higher because they were reaching few targets as they closed out. Additionally, the two projects were combined into the new project, which allows for cost efficiencies. The Flagship project is also different in methodology and focus than the previous projects, so the unit costs could not be assumed to be the same. Therefore, lump-sum budgeting was used.

The FY15 expenditure data results were used as the starting point for the ROP 16 budget, and then adjusted based on FY16 planned activities. The largest adjustments in Flagship's budget are related to Program Management (PM) and Health Systems Strengthening (HSS) line items. PM has increased due to much higher targets, as this line item is not a fixed management cost and includes direct program cost. HSS went down overall because the focus shifted toward direct services delivery at the SNU level. For those IMs that did not have EA data, the budget was projected based on standard government estimates and historical costs.

During ROP 16 planning the Special Notification Country's allowable pipeline decreased from 12 months of pipeline to 9 months of pipeline.

The CAR interagency team completed a pipeline analysis to accommodate this new requirement. Total projected Pipeline as of FY16 Q4 (FY04-15 funds) is $18,348,125 or 14 months of pipeline. There is an excess pipeline of $6,498,125. It is broken down by agency as follows:

CDC: $1,530,298; USAID: $5,105,507; State: $0; Peace Corps: $ 162,320.

In ROP 16 the interagency will apply $3,619,871 to program activities, decreasing new ROP 16 funding request to $12,180,129. USAID will apply $3,449,871 to cover the 100% of the funding request for the PSI Flagship Award ($2,560,857), part of M&O costs ($689,013) and part of the AFEW REACT project ($200,000). After applying pipeline, USAID expects to have $1,655,636 above the 9 months of allowable pipeline. CDC will apply $170,000 in M&O. After applying pipeline, CDC expects to have $1,360,298 above the 9 months of allowable pipeline (due to the late arrival of ROP 14 supplemental funds received in October 2015); however, CDC expects to expend this amount in FY16 as budgeted in the ROP 14 supplemental request. Peace Corps closed out in Kyrgyzstan during ROP 15 implementation period. The excess pipeline of $ 162,320 will be de-obligated and will be applied to ROP 17 as the de-obligation process can take several months.

The interagency team has an excess of $6,335,805 (without Peace Corps pipeline). In ROP 14 the interagency team requested $3,000,000 additional funding above the $15,800,000 request. This funding was approved in Feb 2015 but not obligated to the country until Nov 2015 therefore only $139,702 has been outlaid. Given this, the CAR team is requesting this $2,860,298 to be reduced from the excess pipeline. CDC's portion is $1,360,298 and USAID's contribution will be $1,500,000. This leaves $155,637 above the 9 month allowable cost. These funds are currently obligated in the PSI Flagship and are planned to be outlaid in ROP 17.

Please see illustrative chart on the following page.

Appendix B.2, Resource Projections, cont.

CDC	Amount	Comments/ Justification	USAID	Amount	Comments/ Justification
COP 15 request	7,700,000		**COP 15 request**	7,700,000	
Projected pipeline FY16 Q4	7,305,298		Projected pipeline FY16 Q4	10,880,507	
Allowable pipeline (9 months)	5,775,000		Allowable pipeline (9 months)	5,775,000	
Excess	**1,530,298**		Excess	**5,105,507**	
ROP 16 applied pipeline	170,000		ROP 16 applied pipeline	3,449,871	
Not applied pipeline for justification	1,360,298	This funding is from the ROP 14 supplemental request. The funds were received in Nov 2015 and $1,100,000 have been obligated but only 139,702 has been outlaid	Not applied pipeline for justification	1,655,637	This funding is from ROP 14 supplemental request ($1,500,000). These funds were received in Nov 2015 and no funds have been obligated or outlaid. $155,637 are obligated to Flagship and are expected to be outlaid in ROP 17