



FY 2015 Central Asia Regional Operational Plan (ROP)

The following elements included in this document, in addition to “Budget and Target Reports” posted separately on www.PEPFAR.gov, reflect the approved FY 2015 ROP for Central Asia.

- 1) *FY 2015 ROP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

Note that PEPFAR summary targets discussed within the SDS were accurate as of ROP approval and may have been adjusted as site-specific targets were finalized. See the “COP 15 Targets by Subnational Unit” sheets that follow for final approved targets.

- 2) *COP 15 Targets by Subnational Unit* includes approved ROP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

Approved FY 2015 ROP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the “FY 2015 Country Operational Plan Budget and Target Report.”

Central Asia

PEPFAR Regional Operational Plan (ROP)

2015

Strategic Direction Summary

August 28, 2015

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Goal Statement

PEPFAR's goal in the Central Asia Region (CAR) is to increase the access, uptake, and quality of core prevention and treatment interventions to a saturation level for people who inject drugs (PWID) in order to increase the number of people living with HIV (PLHIV) on antiretroviral treatment (ART) and decrease new HIV infections in high burden locations in Kazakhstan, the Kyrgyz Republic, and Tajikistan. Working in partnership with host country governments and their national plans, local civil society, the Global Fund and other UN organizations, PEPFAR CAR agencies will work together at priority sites and in alignment with their comparative advantages to address gaps and barriers to epidemic control and to improve retention rates of PWID in the continuum of care in order to make substantial progress towards UNAIDS 90-90-90 goals. Localized data will be used to target implementation and monitoring of evidence-based interventions, while building sustainable long term capacity to measurably progress towards control of CAR's HIV epidemic concentrated among key populations (KP).

Expanding upon program pivots launched in ROP₁₄, PEPFAR CAR will geographically concentrate its focus to six priority sub-national units (SNUs) with great HIV burden and thereby maximize resources to impact the lives of more than 14,250 PWID via prevention activities and more than 4,180 PWID via HIV care services in the region. This strategy represents a new and exclusive focus on PWID as the largest KP group with the highest HIV prevalence and therefore the optimal group for targeted support. ROP₁₅'s program pivots include: 1) significantly expanding testing of PWID as part of prevention outreach, 2) increased community and medical support along the entire continuum of care to enable more PLHIV to start and adhere to ART, and 3) an operating model wherein PEPFAR agencies work in complementarity at program sites.

Informed by the PEPFAR 3.0 strategy, the PEPFAR CAR Targeted Technical Assistance (TTA) model uses state-of-the-art technical and normative guidance on the prevention, care and treatment of HIV and demonstrates evidence about best practices for scaling up core interventions and services. CAR's TTA approach is designed to build capacity and systems at the site, regional, and national levels to: (1) improve epidemiological and programmatic data and systems to assist in making informed program analysis and decisions; (2) increase demand, access and uptake of evidence-based HIV services by KPs; (3) strengthen linkages and referral systems and improve HIV care and treatment services to ensure PLHIV enter and remain in the HIV continuum of care; and (4) promote policy reform and support an enabling environment to mitigate the stigma and discrimination that adversely impacts access to HIV services by KPs.

As a TTA region, PEPFAR resources are modest compared with national and multilateral budgets as well as the complex challenges of addressing HIV among PWID. Thus PEPFAR CAR will maintain close collaboration with the Global Fund and national stakeholders to leverage all available resources for our shared commitment to UNAIDS 90-90-90 goals.

(Note: CAR's February 2015 award of ROP₂₀₁₄ supplemental funding for Uzbekistan will be utilized to support programming in Uzbekistan through at least September 2016. Thus, Uzbekistan is not included in this strategic direction summary.)

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

At the end of 2013, there were an estimated 1.1 million [0.98 million–1.3 million] PLHIV in Eastern Europe and Central Asia, which accounts for 3% of the global number of PLHIV. In Kazakhstan, official statistics count 18,247 PLHIV; in Tajikistan 5,561 PLHIV are officially registered, with virtually the same number in the Kyrgyz Republic (5,504),¹ although the real population sizes are estimated to be significantly larger due to under-testing of KPs. The HIV epidemic in CAR continues to grow, and is primarily concentrated among PWID and their sexual partners. The epidemiological data shows that female sex workers (FSW) and men who have sex with men (MSM) are also disproportionately affected by HIV/AIDS.²

The number of new HIV infections in Central Asia 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.³ Heterosexual transmission among PWID is known to be of significant importance, but the proportion of sexual transmission independent of drug use is not known.⁴

There are more than 29,000 officially registered PLHIV in Kazakhstan, the Kyrgyz Republic and Tajikistan. While the HIV prevalence among the general population in the three countries is at or below 0.10%, rates among KPs range from 1.0% to 13.0%. Within each country, the HIV prevalence rate, KP population size, and number of PLHIV vary significantly across oblast (region) and city. In all three countries, the regions and cities that align with international drug trafficking routes have high numbers of PWID and 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 and discriminatory laws and policies toward KPs [REDACTED]; (2) stigma and discrimination from communities, health providers and law enforcement officials that marginalizes KPs and limits access to and uptake of HIV related services; (3) incomplete epidemiological data on the size and location of these populations (especially FSW and MSM) 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.

According to the European Center for Disease Prevention and Control, overall low coverage and limited access to HIV-related services among KPs and high rates of late diagnosis limit the ability to achieve epidemic control in this region.⁵ All three countries experience challenges in reaching KPs living with HIV/AIDS and ensuring they are linked and supported through the continuum of care.

¹ Kazakhstan, Kyrgyz Republic, and Tajikistan EHCMS, respectively, 2014

² *The Gap Report*, UNAIDS, 2013 <http://www.unaids.org/en/resources/campaigns/2014/2014gapreport/gapreport>

³ *World Health Organization, Central Asia HIV Profile*, 2013

⁴ 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

⁵ *Thematic report: HIV treatment, care and support. Monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2012 progress report*. Stockholm: European Centre for Disease Prevention and Control; 2013 <http://www.ecdc.europa.eu/en/publications/Publications/dublin-declaration-treatment-care-support.pdf>, accessed 9 July 2014

Table 1.1.1
Key National Demographic and Epidemiological Data – Kazakhstan, the Kyrgyz Republic, and Tajikistan

Table 1.1.1 Kazakhstan Key National Demographic and Epidemiological Data											
	Total		<15				≥15				Source, Year
	N	%	Female	%	Male	%	Female	%	Male	%	Empty cells indicate no data available.
Total Population	17,160,774	100	2,169,014	12.64%	2,289,366	13.34%	6,706,945	39.08%	5,995,449	34.94%	https://www.stat.gov.kz, 2014
Prevalence (%)	[REDACTED]										
AIDS Death (per year)	[REDACTED]										
PLHIV	[REDACTED]										
Incidence Rate (Yr)	[REDACTED]										
New Infections (Yr)	[REDACTED]										
Pregnant Women Needing (ARVs)	[REDACTED]										
TB Cases (Yr)	12,510		497				12,013				Statistical Report on the Health of the Population and Activities of the MOH, 2013
TB/HIV Coinfection	[REDACTED]										
Key Populations											
	Total		Female				Male				Source, Year
	N	%	N	%	N	%	N	%	N	%	
Total PWID	111,840										Global AIDS Response Progress Reporting (GAPR), 2013
PWID HIV Prev.	[REDACTED]										
Total MSM	28,840										GARP, 2013
MSM HIV Prev.	[REDACTED]										
Total FSW	19,940										GARP, 2013
FSW HIV Prev.	[REDACTED]										

Table 1.1.1 Kyrgyz Republic Key National Demographic and Epidemiological Data											
	Total		<15				≥15				Source, Year
	N	%	Female		Male		Female		Male		Empty cells indicate no data available.
	N	%	N	%	N	%	N	%	N	%	
Total Population	5,776,570	100	876,454	15.17%	914,659	15.83%	2,043,571	35.38%	1,941,886	33.62%	Republican Medical Information Center, 2014
Prevalence (%)	[REDACTED]										
AIDS Death (per year)	[REDACTED]										
PLHIV	[REDACTED]										
Incidence Rate (Yr)	[REDACTED]										
New Infections (Yr)	[REDACTED]										
Pregnant Women Needing (ARVs)	[REDACTED]										
TB Cases (Yr)	5,859										TB Register, 2013
TB/HIV Coinfection	[REDACTED]										
Key Populations											
	Total		<15				≥15				Source, Year
	N	%	Female		Male		Female		Male		Empty cells indicate no data available.
	N	%	N	%	N	%	N	%	N	%	
Total PWID	25,000										RAC Semiannual report, nt'I M&E system, RAC 2013
PWID HIV Prev.		12.40%									IBBS, 2013
Total MSM	22,000										RAC Semiannual report, nt'I M&E system, RAC 2012
MSM HIV Prev.		6.30%									RAC Semiannual report, nt'I M&E system, RAC 2012
Total FSW	7,100										RAC Semiannual report, nt'I M&E system, RAC 2012
FSW HIV Prev.		2.20%									RAC Semiannual report, nt'I M&E system, RAC 2012
Table 1.1.1 Tajikistan National Demographic and Epidemiological Data											
	Total		<15				≥15				Source, Year
	N	%	Female		Male		Female		Male		Empty cells indicate no data available.
	N	%	N	%	N	%	N	%	N	%	
Total Population	8,161,100	100	1,379,100	16.90%	1,465,100	17.95%	2,657,800	32.57%	2,659,100	32.58%	Statistical Agency, President of the Rep. of TJ, 2014
Prevalence (%)	[REDACTED]										
AIDS Deaths (per year)	[REDACTED]										
PLHIV	[REDACTED]										
Incidence Rate (Yr)	[REDACTED]										
New Infections (Yr)	[REDACTED]										
Pregnant Women Needing (ARVs)	[REDACTED]										
TB Cases (Yr)	5,306	100					2311	43.60%	2995	56.40%	TB Center, 2013
TB/HIV Coinfection	[REDACTED]										

Table 1.1.1 Tajikistan National Demographic and Epidemiological Data, cont.											
Key Populations											
	N	%	Female		Male		Female		Male		Source, Year
			N	%	N	%	N	%	N	%	
Total PWID	[REDACTED]										
PWID HIV Prevalence	[REDACTED]										
Total MSM	[REDACTED]										
MSM HIV Prevalence	[REDACTED]										
Total FSW	[REDACTED]										
FSW HIV Prevalence	[REDACTED]										

Table 1.1.1 (a) Key and Priority Population Size Estimate and HIV prevalence by SNU (highlighted SNUs are targeted for scale up)

Kazakhstan													
Oblast/Region	City	Population	KP Estimate	PLHIV-Total	HIV Prevalance	PWID-PSE	PWID-HIV Prevalence	MSM-PSE	MSM-HIV Prevalence	FSW-PSE (PSI)	FSW-HIV Prevalence	Prisoners-PSE	Prisoners-HIV Prevalence
	Almaty	1,507,509	28,000	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	4,000	[REDACTED]	8,310	[REDACTED]	4,730	ND
	Astana	814,435	9,836	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	2,430	[REDACTED]	906	[REDACTED]	ND	ND
South Kazakhstan		2,733,279	33,220	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	10,000	[REDACTED]	2,720	[REDACTED]	3,174	ND
	Shymkent	682,565	ND	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	ND	[REDACTED]	ND	[REDACTED]	ND	ND
	Sary-agash	309,083	ND	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	ND	[REDACTED]	ND	[REDACTED]	ND	ND
	Sairamskii rayon	319,562	ND	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	ND	[REDACTED]	ND	[REDACTED]	ND	ND
	Zhetisai	ND	ND	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	ND	[REDACTED]	ND	[REDACTED]	ND	ND
Karagandinskaya		1,369,607	16,260	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	2,000	[REDACTED]	1,020	[REDACTED]	6,337	ND
	Karaganda	484,768	ND	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	ND	[REDACTED]	ND	[REDACTED]	ND	ND
	Temirtau	182,551	ND	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	ND	[REDACTED]	ND	[REDACTED]	ND	ND
East Kazakhstan		1,394,018	16,650	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	3,750	[REDACTED]	1,000	[REDACTED]	ND	ND
	Ust-Kamenogorsk	325,803	ND	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	ND	[REDACTED]	500	[REDACTED]	ND	ND
Pavlodarskaya		752,793	20,500	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	5,000	[REDACTED]	750	[REDACTED]	ND	ND
	Pavlodar	352,693	ND	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	ND	[REDACTED]	450	[REDACTED]	ND	ND
Zhambyl		1,084,482	11,290	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	3,790	[REDACTED]	700	[REDACTED]	ND	ND
	Taraz	351,353	ND	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	ND	[REDACTED]	ND	[REDACTED]	ND	ND
Kostanaiskaya		880,776	4,340	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	ND	[REDACTED]	340	[REDACTED]	ND	ND
	Kostanai	221,943	ND	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	ND	[REDACTED]	ND	[REDACTED]	ND	ND
				[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	30,970	[REDACTED]	15,746	[REDACTED]		
Source		Population, 2013 National Data	NGO Assessment, 2014	2014 NAC Semi-Annual M&E Report	2014 NAC Semi-Annual M&E Report	Rep. AIDS Center, 2014	IBBS, 2013	NGO Assessment, 2014	IBBS, 2013	NGO Assessment, 2014	IBBS, 2013	NGO Assessment, 2014	

Kyrgyzstan													
Oblast/Region	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	915,668	17,905	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	6,975	[REDACTED]	2,945	[REDACTED]	ND	ND
Chui		853,725	6,535	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	6,474	[REDACTED]	569	[REDACTED]	5,473	7.60%
	Tokmok City	53,087	ND	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	ND	[REDACTED]	225	[REDACTED]	ND	ND
	Soluluk Town	8,715	ND	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	ND	[REDACTED]	344	[REDACTED]	ND	ND
	Issyk-Kata (Kant Town)	21,762	ND	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	ND	[REDACTED]	ND	[REDACTED]	ND	ND
Osh		1,199,929	13,284	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	ND	[REDACTED]	ND	[REDACTED]	ND	ND
	Osh City	265,204	ND	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	ND	[REDACTED]	1,474	[REDACTED]	ND	ND
	Kara Suu City	22,900	ND	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	ND	[REDACTED]	ND	[REDACTED]	ND	ND
Jalal-Abad		1,099,193	823	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	ND	[REDACTED]	ND	[REDACTED]	655	ND
	Jalal-Abad City	89,004	ND	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	ND	[REDACTED]	444	[REDACTED]	ND	7.30%
Issyk-Kul		458,524	1,630	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	ND	[REDACTED]	1,391	[REDACTED]	ND	ND
	Karakol	63,400	ND	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	ND	[REDACTED]	1,020	[REDACTED]	ND	ND
Source		Population, 2013 National Data	NGO Assessment, 2014	2014 NAC Semi-Annual M&E Report	2014 NAC Semi-Annual M&E Report	2014 NAC Semi-Annual M&E Report	IBBS, 2013	NGO Assessment, 2014	IBBS, 2013	NGO Assessment, 2014	IBBS, 2013	NGO Assessment, 2014	NGO Assessment, 2014

Tajikistan														
Oblast/Region	City	Population	KP Estimate	PLHIV-Total	HIV Prevalance	PWID-PSE	PWID-PSE Quality	PWID-HIV Prevalence	MSM-PSE	MSM-HIV Prevalence	FSW-PSE	FSW-HIV Prevalence	Prisoners-PSE	Prisoners-HIV Prevalence
	Dushanbe	770,000	10,636	[REDACTED]	[REDACTED]	[REDACTED]	7,390	[REDACTED]	[REDACTED]	1.50%	[REDACTED]	[REDACTED]	2,900	[REDACTED]
	incl Vakhdat	300,100	1,178	[REDACTED]	[REDACTED]	[REDACTED]	500	[REDACTED]	[REDACTED]	ND	[REDACTED]	[REDACTED]	ND	[REDACTED]
RRP		1,853,000	ND	[REDACTED]	[REDACTED]	[REDACTED]	2,900	[REDACTED]	[REDACTED]	ND	[REDACTED]	[REDACTED]	ND	[REDACTED]
	Tursunzade	258,800	ND	[REDACTED]	[REDACTED]	[REDACTED]	1,000	[REDACTED]	[REDACTED]	ND	[REDACTED]	[REDACTED]	ND	[REDACTED]
	Rudaki	431,300	ND	[REDACTED]	[REDACTED]	[REDACTED]	650	[REDACTED]	[REDACTED]	ND	[REDACTED]	[REDACTED]	ND	[REDACTED]
GBAO		211,100	ND	[REDACTED]	[REDACTED]	[REDACTED]	2,160	[REDACTED]	[REDACTED]	ND	[REDACTED]	[REDACTED]	ND	[REDACTED]
	Khorog	28,700	749	[REDACTED]	[REDACTED]	[REDACTED]	850	[REDACTED]	[REDACTED]	ND	[REDACTED]	[REDACTED]	ND	[REDACTED]
Sughd		2,375,000	ND	[REDACTED]	[REDACTED]	[REDACTED]	4,615	[REDACTED]	[REDACTED]	ND	[REDACTED]	[REDACTED]	ND	[REDACTED]
	Khujand	(incl metro = 919K)	2,189	[REDACTED]	[REDACTED]	[REDACTED]	1,200	[REDACTED]	[REDACTED]	ND	[REDACTED]	[REDACTED]	900	[REDACTED]
	Istaravshan	236,900	819	[REDACTED]	[REDACTED]	[REDACTED]	350	[REDACTED]	[REDACTED]	ND	[REDACTED]	[REDACTED]	ND	[REDACTED]
	Panjakent	262,200	648	[REDACTED]	[REDACTED]	[REDACTED]	1,200	[REDACTED]	[REDACTED]	ND	[REDACTED]	[REDACTED]	ND	[REDACTED]
Khatlon		2,856,400	ND	[REDACTED]	[REDACTED]	[REDACTED]	9,430	[REDACTED]	[REDACTED]	ND	[REDACTED]	[REDACTED]	1,650	[REDACTED]
	Kurgan-Teppa	89,300	1,788	[REDACTED]	[REDACTED]	[REDACTED]	1,350	[REDACTED]	[REDACTED]	ND	[REDACTED]	[REDACTED]	ND	[REDACTED]
	Kulyab	192,300	2,455	[REDACTED]	[REDACTED]	[REDACTED]	1,800	[REDACTED]	[REDACTED]	ND	[REDACTED]	[REDACTED]	ND	[REDACTED]
	Farhor	146,500	ND	[REDACTED]	[REDACTED]	[REDACTED]	1,200	[REDACTED]	[REDACTED]	ND	[REDACTED]	[REDACTED]	ND	[REDACTED]
Source		Population, 2013 National Data	NGO Assessment, 2014	2014 NAC Semi-Annual M&E Report	2014 NAC Semi-Annual M&E Report	PSE used for IBBS, 2014	NGO Assessment, 2013	IBBS, 2014	* 2014 NAC Semi-Annual M&E Report; PSI Rapid Assessment, 2014	NGO Assessment, 2013	PSE used for IBBS, 2014	IBBS, 2013	NGO Assessment, 2013	IBBS, 2013

People who inject drugs (PWID): There are estimated to be over 200,000 PWID in the five countries of CAR. Throughout the region, estimates suggest that HIV prevalence is significantly higher among PWID than in the general population. This is certainly the case in Kazakhstan, the Kyrgyz Republic and Tajikistan, where HIV rates in the general population are less than 0.10% but rates among PWID are 7.9% in Kazakhstan, 12.4% in Kyrgyz Republic and 12.9% in Tajikistan.⁶ PWID size estimates are 112,000 in Kazakhstan, 25,000 in Kyrgyz Republic and 23,000 in Tajikistan.⁷ The prevalence rates 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. Because it is the largest KP group and has the most available HIV-related information (population size estimations, prevalence, and other indicators) in the region, PEPFAR CAR will focus on PWID as its target population. Moreover, this concentrated focus is designed to produce a greater impact than working with several KP groups.

Over the last few years, the three countries have made some progress in identifying more areas with high 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 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.

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 among service providers and a hostile legal and law enforcement environment [REDACTED] present barriers to PWID in accessing services; high threshold approaches prevent PWID from enrolling and accessing MAT; and poor uptake and low yield HTC services limit enrollment in HIV care and treatment. Limited service delivery points, unreasonably expensive ART and dependence on an increasingly limited set of donors (e.g. Global Fund) also present barriers for PWID populations.

The Kyrgyz Republic is the only country in the region to have moved beyond a small number of pilot MAT and “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 30 sites across the country including in seven prisons. However, MAT coverage does not exceed 5% in any CAR country. While there has been progress on building political support and a lower threshold for accessing MAT across CAR countries, there are a host of barriers that 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 likelihood of transmitting HIV and other infectious diseases, such as sharing injecting equipment, tattooing and piercing. HIV prevalence has been reported to be over 10% in some prisoner populations, which is significantly higher than in the general population.⁸ ROP15 will address HIV among PWID in prisons.

Female sex workers (FSW): FSWs are a second group disproportionately impacted by the HIV epidemic. The HIV prevalence rates for FSW are estimated to be 1.5% in Kazakhstan, 2.2% in the Kyrgyz Republic and 3.5% in Tajikistan. There is considerable variation in FSW HIV rates across regions and

⁶ National prevalence data, Republican AIDS Center, 2014.

⁷ National population size estimation data, Republican AIDS Center, 2013.

⁸ World Health Organization, *Central Asia HIV Profile*, 2013

cities in these regions. For instance, the 2014 IBBS for Tajikistan reported a HIV prevalence of FSW of 11.3% in the city of Vakhdat, which is significantly higher than the national HIV prevalence reported for FSW. 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.⁹

Behavioral risk surveys conducted by Population Services International in 2013-2014 report relatively high use of condoms with clients among FSWs in the three countries, but condom use with regular and casual partners remains relatively low. These surveys report that FSWs have more negative attitudes towards condom use with trusted partners and most feel that condoms should be used only with clients. While uptake of HIV testing and counseling by FSW is reportedly high, the surveys do indicate significant numbers of FSWs are not routinely testing for HIV.¹⁰

As with PWID, the FSW population experiences stigma and discrimination from the general population, health providers and law enforcement that can limit access and uptake of key HIV services. FSW also have a unique set of needs throughout the continuum of care and there is significant attrition as FSWs move across the continuum of HIV care and services.

While FSW are an important risk group, research indicates that FSW are a smaller population with lower HIV prevalence in the region. Moreover, data on FSW at a sub-national level can be challenging to obtain. PEPFAR CAR will focus on PWID and partners, which could include FSWs as partners. In addition, PEPFAR CAR will collaborate with other entities operating in the region, in particular the Global Fund, on this.

Men who have sex with men (MSM): MSM are also disproportionately impacted by HIV in the region, with HIV prevalence estimated to be 1.2% in Kazakhstan, 6.3% in the Kyrgyz Republic and 1.5% in Tajikistan (see Table 1.1.1). MSM are highly stigmatized in these countries, which likely results in inaccurate size estimations of this population. The IBBS data also is of limited utility in this population due to low participant numbers and limited set of sites. For example, the national HIV prevalence for MSM in the Kyrgyz Republic is 6.3%, but 13% in Bishkek. While there has been limited progress in improving the quality of the epidemiological data for MSM in the three countries, population size estimates and HIV behavioral and biological surveys (e.g. IBBS) have been limited. As a result, the estimates have limited application in driving program priorities. Where feasible, program monitoring data can be used to provide proxy data for size estimation and prevalence - but this approach likely misses MSM that are highly marginalized and are not accessing services. Where data exists, it highlights inadequate access and uptake of key HIV prevention services including HTC by MSM. For example in the Kyrgyz Republic and Tajikistan, only 11-18% of MSM (based on underrepresented population size estimations) have received an HIV test in the last 12 months. Where HTC is available, national reporting indicates poor yield of positives. As in the other two KPs, MSM experience stigma and discrimination that can limit access and uptake of key HIV services. 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 as well.

⁹ 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.

¹⁰ 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

MSM are also an important risk group, however, the population is smaller and has a lower HIV prevalence in the region. Moreover, due to the ostracizing and punitive campaigns against LGBT rights in the region, MSM are being forced to hide their sexual activity and identity, making them difficult to reach with interventions. Thus, data on MSM is becoming even more challenging to obtain. PEPFAR CAR will continue to address suppressive LGBT laws and stigma and discrimination against all KP groups, including MSM, on a national level. PEPFAR CAR will focus on PWID and partners, which could include MSM as partners. In addition, PEPFAR CAR will collaborate with other entities operating in the region, in particular the Global Fund, on this.

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 priority cities in Tajikistan, PWID coverage with prevention interventions is around 60%, but only 40% have received an HIV test within the last 12 months. Where HTC is available, national reporting indicates poor yield of positives, which indicates HTC is not being targeted to high-risk KP groups.
- Minimal Methadone Assisted Therapy: PWID populations in all three countries have the highest HIV prevalence and represent the largest KP group. However, MAT coverage among registered PWID remains less than 5% in all three countries. In the PEPFAR priority cities in Kazakhstan and Tajikistan, MAT coverage ranges from 0-3%. While progress has been made in the Kyrgyz Republic, the rate still only ranges from 5% in Bishkek City to 18% in Chui Region. Fear and distrust of MAT has constrained full rollout of successful pilots to reach scale and maximum replication. [REDACTED]
- Limited PLHIV Accessing Care: Rates of registered PLHIV in care are 77% in Kazakhstan, 50% in the Kyrgyz Republic and 40% in Tajikistan. The rate of PLHIV enrolled in care among KPs in all three countries (where information is available) is significantly lower than the overall PLHIV numbers accessing services, indicating barriers to access and uptake of care services.
- Low Coverage of Antiretroviral Treatment: [REDACTED] As in care, 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.

Table 1.1.2 Cascade of HIV Prevention, Diagnosis, Care and Treatment for Key Populations

[REDACTED]

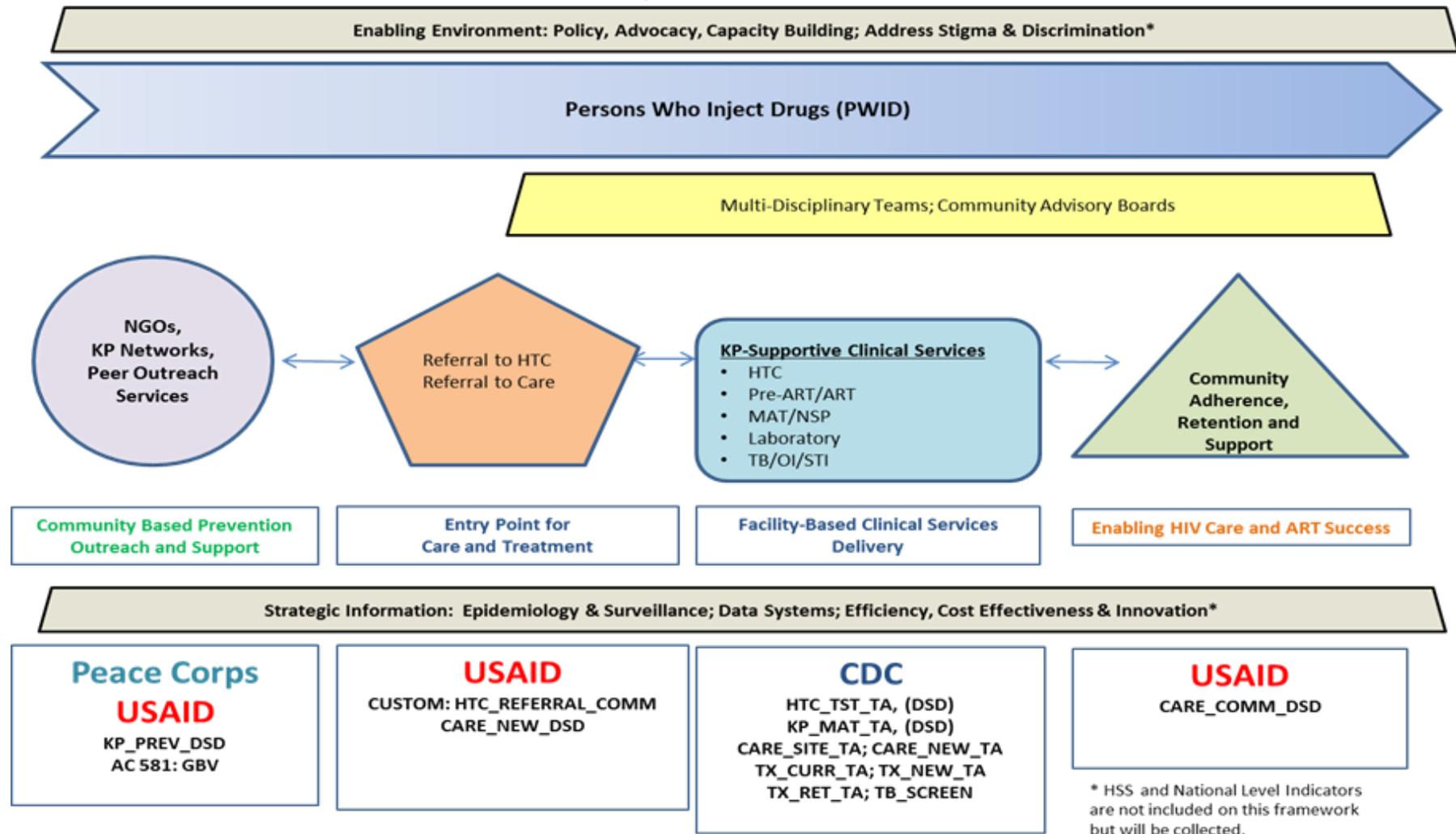
As illustrated above, one of the major barriers to accelerating epidemic control in CAR is the weak performance of the continuum of care in each country, encompassing outreach and prevention, and extending to integration of KPs into the clinical cascade of testing, care, and ART treatment, with community-based support throughout this process. *[REDACTED]*

Many factors contribute to these challenges, as described throughout this document, ranging from the Soviet legacy of vertically segregated health services to stigma and discrimination. Another factor is national guidelines for ART eligibility which were set for CD4 counts <350, although the Kyrgyz Republic, Tajikistan, and Kazakhstan recently endorsed initiating ART at the WHO recommended level of 500 CD4. It is also difficult to assess the number of individuals achieving viral suppression because of the paucity of labs capable of conducting this analysis (e.g. only one in Tajikistan).

Thus, PEPFAR CAR is pivoting to support improved continuum of care outcomes by targeting its resources in fewer high burden sites, **implementing a coordinated, all-agency support model as outlined below to increase community and facility support for adherence**, and other new and continuing interventions noted throughout this document.

Supporting the Right Things

PEPFAR CAR Continuum of HIV Prevention, Care and Treatment



1.2 National Investment Profile

Kazakhstan

As an upper middle income country (per capita GNI of \$11,550),¹¹ Kazakhstan served as the major source of financing (78%) for its \$37M annual HIV response in 2013. The rest of its response was contributed by international sources (5% by PEPFAR and 15% by the Global Fund).¹² As HIV is integrated into the national five year health strategy, the government currently procures all ARVs (excluding ARVs for migrants) and plans to increase the number of people on ART. (Meanwhile the price of ARVs in Kazakhstan is estimated to be 5-8 times higher than in other countries in the region, a major bottleneck to the scale-up of ART.¹³) Kazakhstan shoulders the majority of costs across its entire HIV response, including almost all clinical services and laboratory costs (see Table 1.2.1). It has made strong political and budgetary commitments in support of the social sector and the response to HIV. For example, a state social contracting order for \$600,000 serves as a source of financing to NGOs (including PEPFAR-trained HIV service NGOs).

Unfortunately, due to the falling price of oil and the effect of the Russian economic crisis, Kazakhstan's economy and currency is weakening and domestic budgets are at risk of cuts; like other sectors, Kazakhstan's HIV program may be affected by budget reductions.

Meanwhile, Kazakhstan is not eligible for more HIV grants under the Global Fund's New Funding Model (NFM) due to its economic status. Phase 2 of its existing \$8.2m HIV grant ends in December 2016. The Global Fund primarily supports provision of needles and syringes (NSP) in five regions, some HIV prevention outreach, condom procurement, and 10 MAT pilot sites. While the government has committed to addressing gaps in NSP and condoms in anticipation of the conclusion of Global Fund support, it is uncertain whether it will continue support for MAT [REDACTED] and for outreach by NGOs.

To address these challenges, PEPFAR is currently engaging the USAID's Supply Chain for Health Division and the USAID Economic Development Office to conduct an analysis of ARV prices and identify opportunities for lower cost ARV procurement and distribution in Kazakhstan. This would free up resources to put more PLHIV on treatment and support other program components that may face budget cuts. PEPFAR will also leverage resources from USAID's Democracy and Governance Office to support advocacy for MAT, lesbian-gay-bisexual-transgender (LGBT)-friendly policies, harm reduction, ARV price reduction, and social contracts to KP NGOs.

¹¹ "World DataBank." *The World Bank DataBank*. N.p., n.d. Web. 05 Mar. 2015. <<http://databank.worldbank.org/data/views/reports/tableview.aspx>>

¹² *National Report on the Progress Achieved in Provision of Global Measures and Response to HIV*, 2013.

¹³ "Price of ARV Drugs," Association of People Living with HIV, 2015.

Table 1.2.2 Procurement Profile for Key Commodities (2013 exp) - Kazakhstan

Commodity	Total	% PEPFAR	% GF	% Govt
ARVs	\$7,450,980	NA	NA	100%
Rapid test kits	\$323,595	NA	NA	100%
Other drugs	\$102,707	0%	100%	IQ
Lab Reagents	\$588,647	NA	NA	100%
VMMC kits	\$0	NA	NA	IQ
Condoms	\$940,260	0%	45%	55%
Other commodities (lab test systems, Lab supplies, lubricant)	\$994,158	0%	79%	21%
Total	\$10,400,347	0%	13%	87%

*Prices in Tenge converted to USD at 181 tenge/USD

n/a= not applicable, NA: Not Available, IQ = Insufficient Quality Data

ARV cost provided by Republican AIDS Center. Alt = 3,050 planned on ARV x \$1,800 annual cost/person = \$5.5M.

Table 1.2.1 Investment Profile by Program Area (2013 exp) - Kazakhstan

Program Area	Total	% PEPFAR	% Global Fund and other Int'l Donors	% Gov't
Clinical care, treatment and support	\$6,096,138	6%	0%	94%
Community-based care, treatment and support	\$109,794	100%	0%	0%
PMTCT	\$582,000	0%	10%	90%
HTC	\$2,589,560	6%	0%	94%
VMMC	\$0	n/a	n/a	n/a
Other Prevention	\$1,164,000	0%	47%	53%
Priority population prevention	\$71,846	72%	0%	28%
Key population prevention	\$6,123,018	9%	63%	28%
OVC	\$0	n/a	n/a	n/a
Lab (includes blood safety)	\$1,652,143	14%	0%	86%
SI, Surveys and Surveillance	\$1,986,276	22%	20%	58%
HSS	\$2,385,797	0%	28%	72%
M&O (PEPFAR not included)	\$18,490,000	0%	7%	93%
Grand Total	\$39,517,592	5%	17%	78%

Budget Notes

GF expenditures in 2013 were \$ 6.1 Million (15 % of the total 2013 expenditures) -GF PIU 2.25.2015

Figures are taken from the 2014 Investment Case data compiled by UNAIDS (2013 expenditures)

EA FY14 figures were used as a proxy for PEPFAR data under NASA.

PEPFAR HSS is categorized by program area.

NASA segregates funding sources by International, Donor, and Private Sector. PEPFAR Funds were subtracted out from int'l funds using EA14 data. Any discrepancies were reduced from HSS.

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives

Funding Source	Total Non-COP Resources	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
CDC Global Disease Detection	1,400,000	n/a	0	NA	NA
USAID Economic Development Office (Trade) - \$100,000 PEPFAR related	2,500,000	n/a	0	0	ARV Market Assessment
USAID Democracy and Governance	2,951,000	1,233,333	1	150,000	Advocacy/ policy
PEPFAR Central Initiatives	154,057	154,057	1		LCI
Total	7,005,057	1,387,390	2	150,000	-

The figures above are estimates.

The Kyrgyz Republic

The Kyrgyz Republic is a lower middle income country in CAR with a GNI of US\$3,080 per capita, with remittances accounting for one third of GDP.¹⁴ According to the National AIDS Spending Assessment, the Global Fund and other international donors accounted for 56% of HIV expenditures in 2013, followed by the Government of the Kyrgyz Republic at 29%, PEPFAR at 14%, and private sector sources at 1%.

As noted in Table 1.2.1 for the Kyrgyz Republic, the major source of financing for its \$ 96.5m five-year HIV NSP (2012-2016) is from international sources, estimated at 71% of total available resources. In support of the current HIV NSP and the request for funds under Global Fund's NFM, the government of the Kyrgyz Republic has increased HIV spending by 3% annually since 2012.¹⁵ Despite anticipated donor and domestic contributions, the NSP anticipates a funding gap of 16% of the total NSP budget.

The Global Fund has been the major donor for the HIV response in the Kyrgyz Republic over the past decade. It is anticipated that \$10 million in HIV grants will be available for the Kyrgyz Republic for the period of 2016-2017.¹⁶ Under the NFM, 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.¹⁷ Currently, Global Fund procures all ARVs and other treatment commodities, as noted in Table 1.2.2. In the NFM concept note submission, funding allocations for treatment are \$1.2 million in 2016 and \$1.6 million in 2017, which corresponds to a planned scale-up in the number of positives on ART: 1,700 in 2015, 2,900 at the end of 2016 (+71%) and 3,500 in 2017 (+21%).

In an effort to address uncertain funding levels from international donors as well as the national government, PEPFAR has supported strategic investments in reaching epidemic control. Using the preliminary results from the Investment Case and Allocative Efficiency Analysis, the Global Fund has prioritized its spending and as a result is focusing 99% of all prevention investments in the NFM on KPs. The preliminary results highlighted the cost efficiency of prevention activities for PWID in achieving epidemic control. These results were incorporated into the Concept Note (CN) Budget.

¹⁴ World Bank, op. cit.

¹⁵ New Funding Model Concept Note, Final Budget Jan, 2015.

¹⁶ NFM CN 2015

¹⁷ NFM CN, Final Budget 2016 - 2017

Table 1.2.1 Investment Profile by Program Area (2013 exp) - Kyrgyz Republic

Program Area	Total	% PEPFAR	% GF and other Int'l Donors	% Gov't	% Private Sector
Clinical care, treatment and support	\$2,790,690	14%	41%	38%	7%
Community-based care, treatment and support	\$284,158	100%	0%	0%	0%
PMTCT	\$775,258	0%	62%	36%	2%
HTC	\$795,767	45%	7%	48%	1%
VMMC	\$0	n/a	n/a	n/a	n/a
Other Prevention	\$621,570	0%	90%	5%	5%
Priority population prevention	\$134,030	99%	0%	1%	0%
Key population prevention	\$4,814,266	29%	65%	6%	0%
OVC	\$0	n/a	n/a	n/a	n/a
Lab *	\$5,447,970	7%	12%	81%	0%
SI, Surveys and Surveillance	\$473,171	84%	9%	6%	1%
HSS	\$7,739,563	0%	93%	5%	2%
Total	\$23,876,443	14%	56%	29%	1%

Budget Notes

GF expenditures in 2013 were 9.1 Million (38% of the total 2013 expenditures) -GF Annual Report

GF figures and Government Figures are taken from the 2014 NASA for KG (2013 Exp)

*LAB PEPFAR figures include blood safety and infection control

Does not include General Population Prevention

HSS figures for PEPFAR are spread across program areas

Subtracted PEPFAR figures from int'l org total (NASA 2014) at a rate of .2. Only 20% of PEPFAR exp were included in the NASA ROP 14 EA data is used as a proxy for FY 13 exp.

Table 1.2.2 Procurement Profile for Key Commodities (2013 exp) - Kyrgyz Republic

Program Area	Total	% PEPFAR	% GF	% Govt	% Other
ARVs	\$236,636	0%	100%	n/a	N/A
Rapid test kits	\$274,983	4%	96%	IQ	N/A
Other drugs	\$18,305	0%	100%	IQ	N/A
Lab Reagents	\$110,697	0%	100%	IQ	N/A
VMMC kits	\$0	n/a	n/a	n/a	N/A
Condoms	\$420,169	0%	100%	IQ	N/A
Other commodities *	\$2,209,745	13%	87%	IQ	N/A
Total	\$3,270,535	9%	91%	IQ	N/A

*(GF 2013 Annual Report , Page 29 #9,11,12,13,14,15,16,6,7)

ARVs reported at \$63,132 due to existing stocks. 2013 cost = # PLHIV on ART x ARV cost/person/year

n/a= not applicable, NA: Not Available, IQ = Insufficient Quality Data

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives -Kyrgyz Republic

Funding Source	Total Non-COP Resources	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID TB (\$100K towards PEPFAR goals)	4,300,000	0	n/a	n/a	TB/HIV
USAID SPA projects	15,000	0	n/a	n/a	Health education
Peace Corps	20,000	0	n/a	n/a	Health education
PEPFAR Central Initiatives	335,376	335,376	1		LCI
Total	4,670,376	335,376	1	-	-

The figures above are estimates.

Tajikistan

Tajikistan is the poorest country in CAR (\$2,300 per capita GNI¹⁸) which significantly impacts its ability to fund its HIV response. According to the National AIDS Spending Assessment, the Global Fund accounted for 45% of HIV expenditures in 2013, followed by the Government of Tajikistan at 21%, PEPFAR at 19%, other donors at 12%, and private sector sources at 2%. The Global Fund currently procures all ARVs and other treatment commodities.

Reliance on external support continues in Tajikistan's \$48.5 million, 2015-2017 HIV National Strategic Plan (NSP) with financing from international sources estimated at 77% and public resources accounting for 21% of total available resources. In support of the current HIV NSP and its request for funds under the NFM, the government plans to increase HIV spending by 5% annually.¹⁹ Meanwhile, the NSP still anticipates a funding gap of US \$10M (20.6%). This gap is anticipated to primarily impact allocations to prevention services (80% of the NSP budget). In its NFM CN, its proposed funding for treatment corresponds to an ambitious and needed planned scale-up in the number of PLHIV on ART: to 3,469 at the end of 2015, 4,221 in 2016 (+21%), and 4,838 in 2017 (+15%).

As the major donor for the HIV response in Tajikistan over the past decade, drastic changes in Global Fund support of Tajikistan would have significant implications for Tajikistan's NSP and potentially on PEPFAR's support of this plan. The Global Fund allocated \$17M under the NFM for the period 2015-2017 (60% for prevention and 38% for care, treatment and support activities, with 2% for health system strengthening and strengthening civil society).²⁰ The CN has prioritized prevention spending, focusing on KPs as epidemic drivers as the optimally efficient investment as concluded by the PEPFAR-supported Investment Case and Allocative Efficiency Analysis for Prevention Activities, and is focusing 98% of all prevention investments in the NFM grant on KPs (testing and counseling directed at KPs, MAT, and NSP). As in Kazakhstan, PEPFAR will also leverage resources to support advocacy for MAT, LGBT-friendly policies, and harm reduction for PWID.

¹⁸ US\$13,000 per capita GDP in 2013, World Bank, op cit

¹⁹ "National HIV/AIDS Strategic Plan (2015-2017)," Republic of Tajikistan, 2014

²⁰ New Funding Model Concept Note, Final Budget Jan, 2015

Table 1.2.1 Investment Profile by Program Area (2013 exp) - Tajikistan

Program Area	Total	% PEPFAR	% GF and other Int'l Donors	% Gov't	% Private Sector
Clinical care, treatment and support	1,369,783	24%	51%	25%	0%
Community-based care, treatment and support	279,521	64%	0%	36%	0%
PMTCT	803,603	0%	41%	58%	0%
HTC	729,750	25%	23%	52%	0%
VMMC	0	n/a	n/a	n/a	n/a
Other Prevention	2,631,563	0%	82%	18%	0%
Priority population prevention	79,432	100%	0%	0%	0%
Key population prevention	2,929,891	54%	39%	6%	1%
OVC	2,000	0%	100%	0%	0%
Lab (Includes Blood Safety)	746,581	38%	0%	26%	36%
SI, Surveys and Surveillance	403,273	99%	1%	0%	0%
HSS	723,416	0%	100%	0%	0%
M&O (GF and Govt only)	3,458,515	0%	63%	36%	1%
Total	15,865,833	19%	57%	21%	2%

Budget Notes

GF expenditures in 2013 were \$6.8m (45% of the total 2013 expenditures)- NSP

GF figures and Government Figures are taken from the 2014 NASA for TJ (2013 Exp)

EA FY 14 figures were used as a proxy for PEPFAR data under NASA

PEPFAR HSS is categorized by program area

NASA segregates funding sources by International, Donor and Private Sector. PEPFAR funds were subtracted out from Int'l funds using EA 14 data . Any discrepancies were reduced from HSS

Table 1.2.2 Procurement Profile for Key Commodities (2013 exp) -Tajikistan

Program Area	Total	% PEPFAR	% GF	% Govt	% Private Sector
ARVs	\$506,000	n/a	100%	n/a	N/A
Rapid test kits	\$250,248	n/a	100%	IQ	N/A
Other drugs	\$87,752	n/a	100%	IQ	N/A
Lab Reagents	\$155,389	n/a	100%	IQ	N/A
VMMC kits	\$0	n/a	n/a	n/a	N/A
Condoms	\$476,114	n/a	100%	IQ	N/A
Other commodities	\$975,734	35%	65%	IQ	N/A
Total	\$1,945,236	18%	82%	IQ	IQ

ARV cost estimated: # PLHIV on ART x ARV cost/person/year due to IQ.

n/a= not applicable, NA: Not Available, IQ = Insufficient Quality Data

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives- Tajikistan

Funding Source	Total Non-COP Resources	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID TB (\$100K toward PEPFAR goals)	4,000,000	0	0	n/a	TB/HIV advocacy/policy
USAID Democracy and Governance	3,145,000	1,650,000	1	225,000	Advocacy
PEPFAR Central Initiatives	838,428	838,428	4	75,000	(CCI, Gender Challenge, LCI)
Total	7,983,428	2,488,428	5	300,000	

PEPFAR Central Initiatives: Funds included are Total funds received since 2012

The figures above are estimates.

1.3 Sustainability Profile

While PEPFAR CAR was not required to complete a Sustainability Index and Dashboard exercise, PEPFAR CAR is working along with other key stakeholders to enhance the sustainability of these countries, which share common elements of a sustainability profile.

Institutionalized Data Availability

- *Epidemiological and Health Data:* Systems providing HIV and related data at the appropriate operational level are often paper-based and data is often not easily accessible or shared broadly with the public. PEPFAR support of EHCMS introduction in each priority country has started to improve national capacities in this area.

Domestic Program and Service Delivery

- *Access and Demand:* Low coverage of MAT and HTC services is a critical problem for PWID, impacting their ability to reduce HIV risks and access care. Other critical service issues are described throughout this document, including high levels of stigma against PLHIV and discrimination by healthcare providers. Support to these key areas is a major component of PEPFAR CAR's work.
- *Human Resources for Health:* Low health care provider salaries and frequent staff turnover 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 treatment systems. NGO prevention providers have been trained to identify KPs and support them through the continuum of care. Government and donor financing to NGOs could be reduced in some countries due to decreasing HIV/AIDS budgets. PEPFAR supports institutionalization of policies, practices, technical training, mentorship and development of PLHIV-NGO staff capacity.
- *Commodity and Supply Chain:* CAR countries have faced problems with maintaining HIV-related supply chains and commodity distribution. Stock outs of ARVs and supplies are experienced regularly especially in Tajikistan and the Kyrgyz Republic. Kazakhstan faces fewer disruptions. PEPFAR CAR supports electronic forecasting of ARVs and other supplies to prevent stock outs.

Government Accountability and Transparency

- *Oversight and Stewardship:* [REDACTED] PEPFAR has invested in support of governance and oversight capabilities, e.g. to strengthen Country Coordinating Mechanisms (CCMs), to support compliance with Global Fund eligibility and performance assessment requirements, and to develop a transition plan for CCMs in preparation for reduction in Global Fund support.
- *Public transparency:* CAR governments respond to information requests from the Global Fund and the international HIV/AIDS community; however, the quality of 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)). PEPFAR support of CCMs also fosters a platform for continued dialogue between government and NGOs and further government accountability.

Political Will and Commitment

- *Enabling Policy and Legal Environment:* PEPFAR is working to foster sustained political will and to improve the policy and legal environment for a sustainable response to HIV. PEPFAR CAR will work to identify champions from the public sector and civil society to sustain equitable services for KPs.

Health Financing and Strategic Investments

- *Insufficient Domestic Resources:* Tajikistan and the Kyrgyz Republic are dependent on Global Fund support for ART, lab supplies, and other commodities, with an estimated \$10M in HIV grants available for Tajikistan and \$17M for the Kyrgyz Republic in 2016-2017. PEPFAR endorses Global Fund CN requirements for increased national expenditures on the HIV response to which CAR countries have agreed.
- *Reliance on International Donors:* Global Fund is the major donor in CAR, with over US\$126 million in current HIV active grants. After the 2017 NFM grants end for the Kyrgyz Republic and Tajikistan, it is unclear what level of support the Global Fund will maintain, however PEPFAR is supporting these national governments to maintain grant eligibility in order to increase the opportunity for continued funding. Meanwhile, in December 2016, Global Fund resources for HIV are planned to transition out of Kazakhstan, which has strong domestic funding. PEPFAR CAR is supporting this transition plan.
- *Allocative Efficiency:* PEPFAR CAR has also 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.

1.4 Alignment of PEPFAR Investments Geographically to Disease Burden

In ROP15, PEPFAR CAR is further aligning program activities and funding with the mandate of PEPFAR 3.0 to implement “...a data-driven approach that strategically targets geographic areas and populations where HIV/AIDS is most prevalent, and in which we can achieve the greatest impact for our investments.”²¹ To achieve this goal, PEPFAR CAR conducted thorough analyses of available epidemiological data from annual bio/behavioral surveys and population size estimations for PWID, MSM and FSW conducted by the Republican AIDS Center, as well as data collected by NGOs providing services to KPs.

In ROP15, PEPFAR CAR refined the selection of high-burden SNUs from 12 SNUs to six SNUs (two in each country) and will support a comprehensive continuum of HIV services framework in these SNUs. (See *PEPFAR CAR Continuum of Prevention, Care and Treatment Diagram in Section 1.1*)

While PEPFAR CAR has historically targeted SNUs with high burden of HIV, some SNUs are currently receiving assistance in certain elements of the continuum (e.g. outreach and referral), but not in all. In ROP14, PEPFAR CAR also supported several SNUs with lower prevalence due to existing agreements with the Republican AIDS Center or existing implementing mechanisms that specified geographic coverage. Several of these small scale activities will need to continue through the end of ROP15 in order to honor previous agreements with national partners. ROP15 will ensure strong linkages to a full continuum of referral, prevention, care and treatment to support PWID.

PEPFAR CAR Fiscal Year 2014 Expenditure Analysis

Several of the ROP14 strategic pivots described above are not fully reflected in FY14 expenditure reporting, as ROP14 activities are implemented in FY15. However, the FY14 Expenditure Analysis (EA) does provide several critical pieces of information that PEPFAR CAR utilized during the preparation of ROP15.

PEPFAR CAR reviewed FY14 EA data on spending by SNU and program area (e.g., care and treatment) and in other contexts. In most cases, FY14 EA data reflects a program in each country that is moving

²¹ The Office of the U.S. Global AIDS Coordinator. (2014) PEPFAR 3.0 – Controlling the Epidemic: Delivering on the Promise of an AIDS Free Generation. <http://www.pepfar.gov/documents/organization/234744.pdf>

towards an appropriate balance of TA and service delivery investments at the national, regional and high-burden sub-national levels and targets PWID with a set of interventions designed to support accelerated and sustained epidemic control.

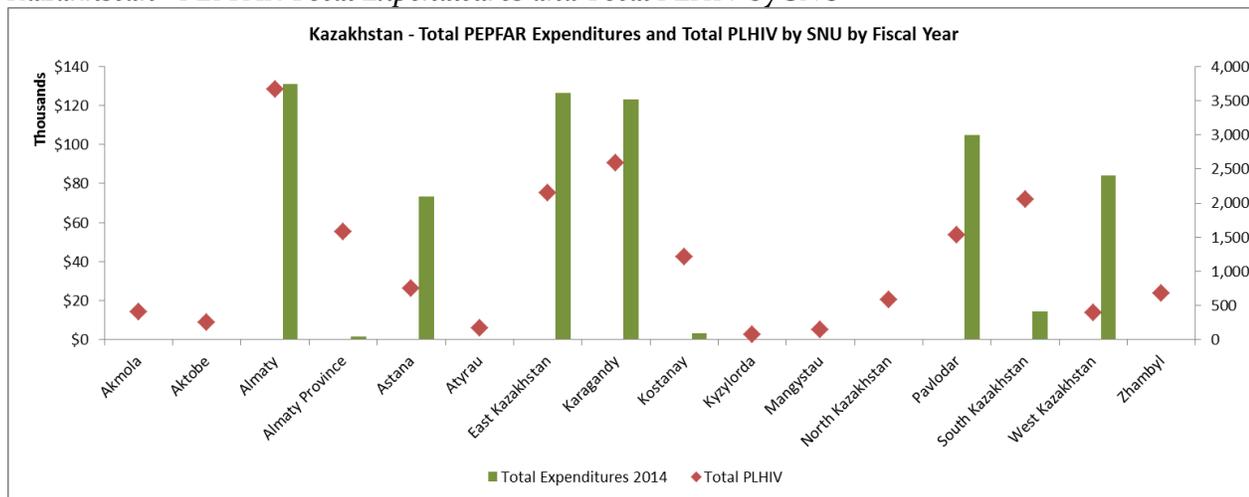
Total PEPFAR Spending and Total PLHIV: As noted in the tables below, PEPFAR CAR resources have been largely focused in the locations with the largest number of PLHIV. However, there were some regions of program activity in which fewer PLHIV are located (e.g. Astana and West Kazakhstan in Kazakhstan). PEPFAR CAR will transition out of these regions and increase activities in the other high-burden locations currently supported by PEPFAR. In the Kyrgyz Republic, as a result of more focused targeting, PEPFAR CAR will provide more support (and expenditures) in Bishkek City and Osh City and high burden cities in Osh and Chui Regions and will transition out of Jalalabad and Issuk Kul regions. In Tajikistan, more support toward saturation will be provided in Dushanbe (plus Vakhdat) and Khujand, and the program will transition out of Gorno-Badakhshan Autonomous (GBA) Region, Sughd Region, Districts of Republican Subordination, and other cities in Khatlon Region.

Spending by SNU: The largest expenditures per PLHIV in Kazakhstan were in West Kazakhstan Region (\$215), Astana City (\$97), Pavlodar Region (\$68), East Kazakhstan Region (\$59), and Karaganda Region (\$47). In the Kyrgyz Republic, the largest PEPFAR expenditures per PLHIV occurred in Bishkek City (\$597), Issyk-Kul Region (\$482), Chui Region (\$369), and Osh Region (\$356). Finally, in Tajikistan, expenditures were the greatest in Gorno-Badakhshan Autonomous (GBA) Region (\$961), Khatlon Region (\$812), Sughd Region (\$749) and Dushanbe City (\$417). 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.

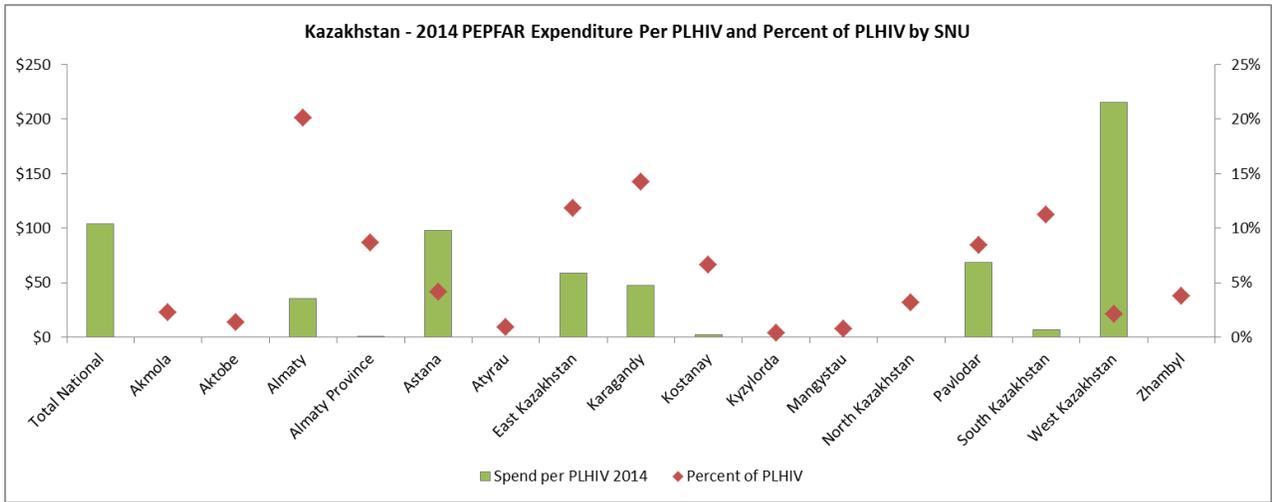
PEPFAR CAR looks forward to deepening its EA analysis in ROP15.

Figures 1.4.1 (Note: all locations noted in charts are regions)

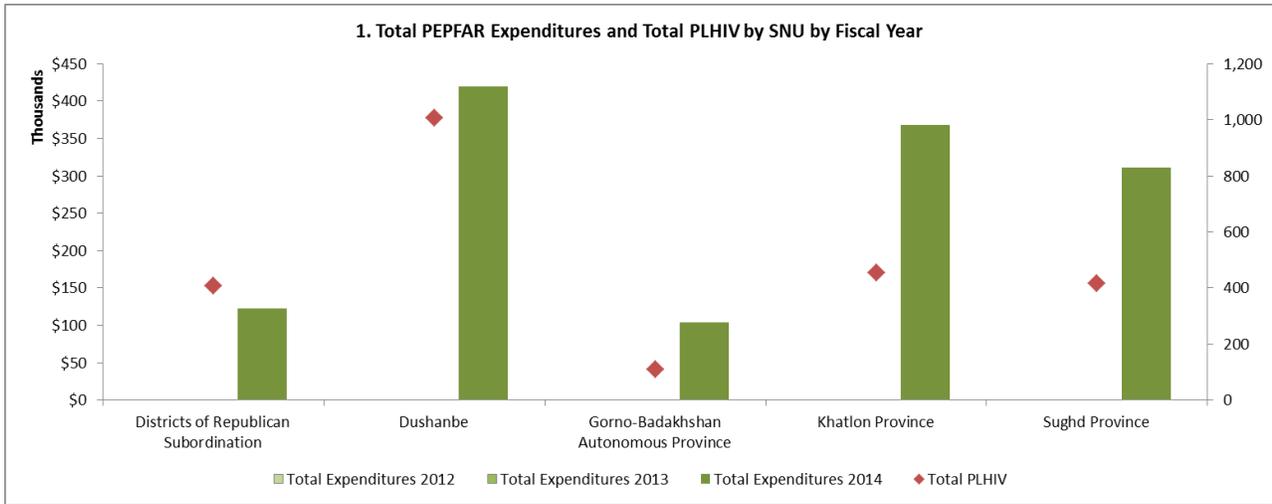
Kazakhstan - PEPFAR Total Expenditures and Total PLHIV by SNU



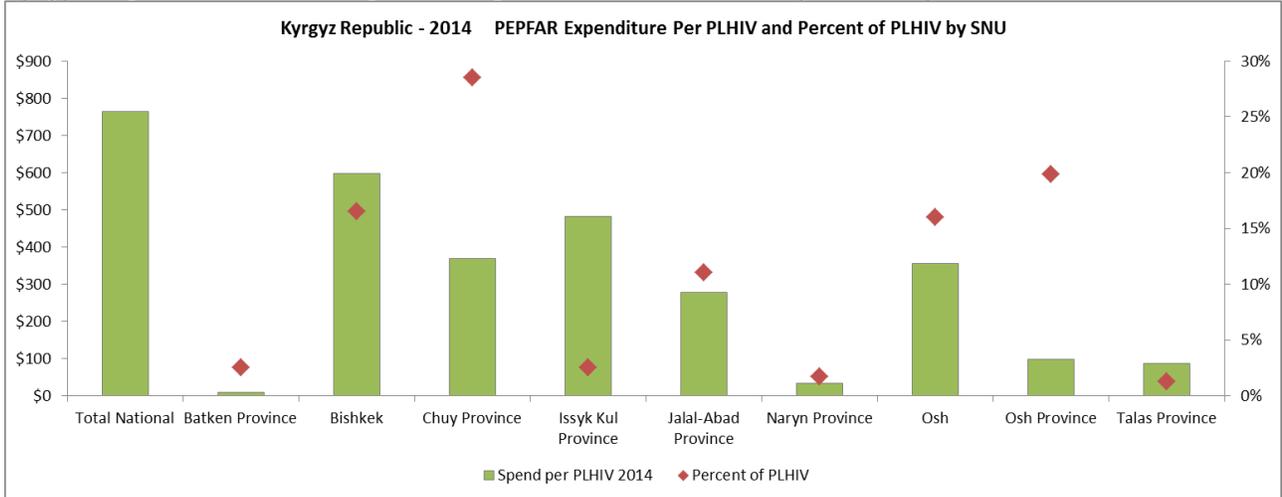
Kazakhstan - PEPFAR Expenditure per PLHIV and Percent of PLHIV by SNU



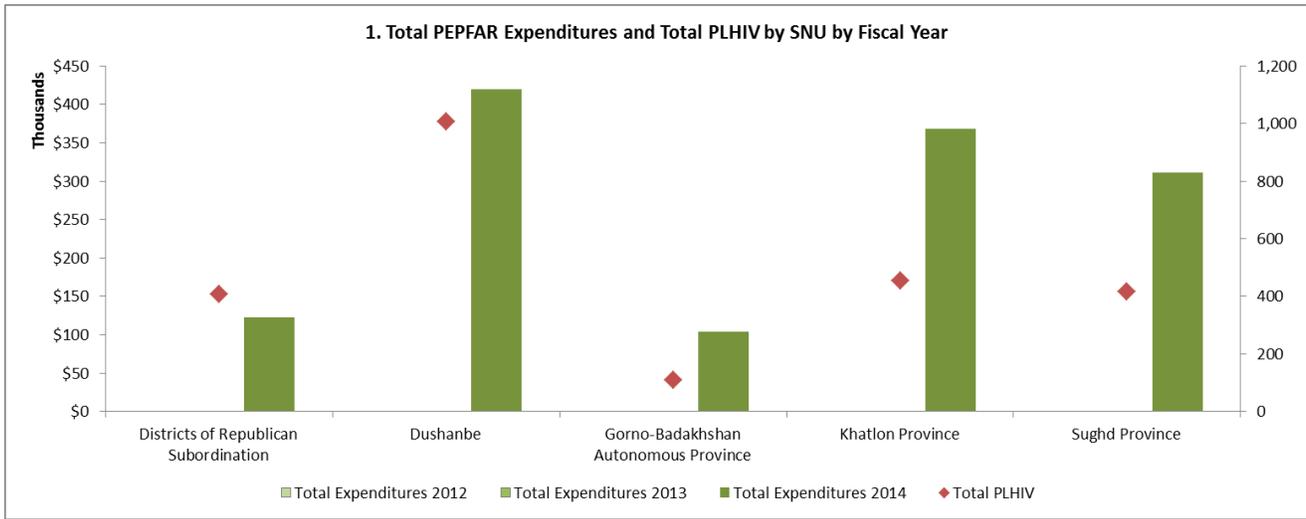
Kyrgyz Republic - PEPFAR Total Expenditures and Total PLHIV by SNU



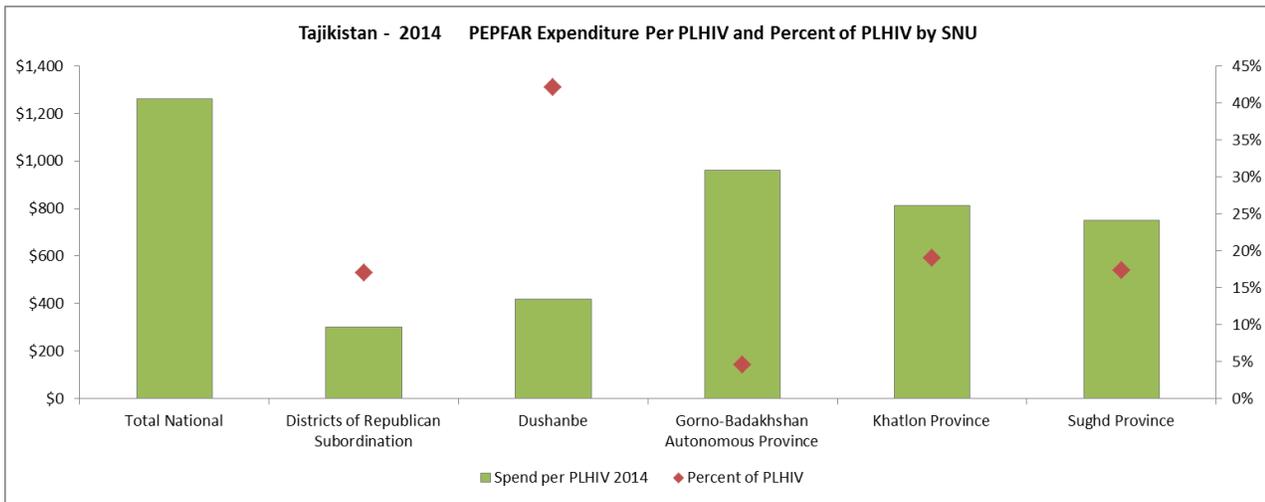
Kyrgyz Republic - PEPFAR Expenditure per PLHIV and Percent of PLHIV by SNU



Tajikistan - PEPFAR Total Expenditures and Total PLHIV by SNU



Tajikistan - PEPFAR Expenditure per PLHIV and Percent of PLHIV by SNU



Figures 1.4.2 Total PLHIV and ART Coverage per SNU

Figures 1.4.2 were compiled based on S/GAC guidance, including required components. Review of the figures outlining total PLHIV and ART coverage per SNU shows relatively consistent ART coverage on a national basis across geographic regions, with higher than average coverage in SNUs where the HIV epidemic originated (such as Osh Region in the Kyrgyz Republic and Sughd Region in Tajikistan). The coverage rates also reflect the fact that national guidelines have indicated initiation of treatment at CD4 counts <350, with coverage clearly falling far short of 80% of all PLHIV.

Kazakhstan - Total PLHIV and ART Coverage per SNU

[REDACTED]

Kyrgyz Republic - Total PLHIV and ART Coverage per SNU

[REDACTED]

Tajikistan - Total PLHIV and ART Coverage per SNU

[REDACTED]

Spending by Program Area: FY14 EA data by program area accurately reflects PEPFAR program priorities of HIV prevention, care and treatment among KPs.

Figure 1.4.4 PEPFAR CAR expenditures by Program Area

	Kazakhstan	Kyrgyz Republic	Tajikistan
Key Population Prevention	22%	27%	44%
HIV Counseling and Testing	9%	11%	6%
Care & Treatment	24%	20%	17%
MAT-related TA and support for PWID	9%	15%	8%
Strategic Information	23%	11%	12%

In addition to the geographic pivots noted above for ROP15, PEPFAR CAR made several adjustments in ROP14 to more strategically align program activities and investments with epidemic control needs. These adjustments included further reducing pipeline; consolidating the activities of several program mechanisms into single awards for improved efficiency and impact; intensifying analysis and use of available epidemiological data; and selecting a set of sub-national units (regions and cities/districts) for targeted program activities and TA. In addition, PEPFAR CAR also increased efforts to support and implement evidence-based programming related to the organization and delivery of services to KPs most heavily impacted by HIV/AIDS.

1.5 Stakeholder Engagement

Coordination and strategic communication with external partners was an important element of CAR's ROP15 planning. PEPFAR CAR convened national stakeholder engagement meetings in the Kyrgyz Republic, Tajikistan, and Kazakhstan (respectively) with members of civil society, host country governments, and multilateral partners.²² Having conducted program and expenditure analyses, key population analyses and review of the national continuums of care, PEPFAR country teams presented previous year results, the PEPFAR 3.0 strategy including a vision for programming in the next year (in the framework of "the right people, the right place, the right thing, and the right time"), periodic stakeholder engagement plans and the types of data to be requested in the future. Participants shared their perceptions about the strategic challenges facing each country in its fight for epidemic control and provided feedback on PEPFAR CAR's strategic direction both via discussion and a written questionnaire. Stakeholders supported the goal of more frequent meetings to foster improved coordination and most government partners requested more information from PEPFAR about its plans, activities, and results. Moreover, participants noted the need to improve the performance of the continuum of care. Implementing partners, multilateral organizations, and national governments discovered opportunities for increased program collaboration and acknowledged the need to do mapping to avoid duplication of effort. Common concerns expressed focused on the Global Fund downsizing in the region, repressive legislation targeting KPs, how to ensure institutionalization and retention of capacity developed through training, debates on the potential generalization of the epidemic, and in Kazakhstan the high price of ARVs. On the whole, a fruitful dialogue was held and next steps were identified.

²² Participants included Republican AIDS Center Directors, Republican Narcology Center Directors, Global Fund Primary Recipient Managers, Country Coordinating Mechanism Representatives, National Representatives from UNAIDS and WHO, Heads of national civil society organizations working both with PEPFAR and the Global Fund and serving and representing the interests of KPs and PLHIV, National Blood Center and Laboratory Representatives, PEPFAR agency representatives, others.

In a very positive parallel development, the Global Fund has proposed joint program planning with PEPFAR in Tajikistan and possibly other countries. This will be an excellent opportunity to ensure our resources are targeted for maximum impact, to avoid duplication, and to provide mutual support. The support of the Global Fund, UNAIDS, and UNODC will be critical to achieving desired results across the countries during implementation.

Future periodic meetings with civil society, government, and multilateral stakeholders will be planned around Global Fund CCM meetings/topics, and other national counterpart convenings. At these meetings, PEPFAR will also share the results of its quarterly monitoring reviews. In some cases smaller group meetings may be appropriate, such as for KP groups who may sometimes appreciate forums without government partners present.

2.0 Core, Near-Core and Non-Core Activities

As noted previously, PEPFAR CAR made several adjustments in ROP₁₄ to more strategically align program activities and investments with epidemic control needs. In ROP₁₅, PEPFAR CAR will further align program activities and funding with Ambassador Birx's charge to focus on the “... *right people, in the right places, with the right things, at the right time.*” 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 Kazakhstan, the Kyrgyz Republic and Tajikistan.

“Right People”

For ROP₁₅, core activities will target the PWID population in the three focus countries, which estimates reveal is the largest KP group and is also experiencing the highest rates of HIV. Programs will also focus on PWID in prisons. PEPFAR CAR will transition support for activities that focus on MSM and FSW populations to partners, while maintaining surveillance to improve data collection on these two KP groups to understand how the dynamics of the epidemic evolve among these groups. PEPFAR will also provide limited support to advocacy against suppressive LGBT laws.

“Right Place”

For ROP₁₅, geographic focus was further refined to a set of SNUs (regions/cities) with high HIV prevalence among PWID, large numbers of PLHIV, and large total PWID estimates. PEPFAR CAR will support core activities in these SNUs, including prioritizing improved uptake, access and quality of HIV services in the community and in facilities for these populations. SNUs not included in the priority regions and SNUs will be deemed near-core or non-core. PEPFAR CAR will transition near-core activities to other organizations by the end of FY16, and will suspend support for non-core activities in these SNUs by the end of 2015. Given that the Global Fund will end its HIV funding to Kazakhstan since it has now been designated by the World Bank as a “middle income” country, it will transition Global Fund programs to direct government funding after 2016. PEPFAR will support time-limited capacity building initiatives to improve the quality and capacity of the Kazakhstan HIV program as it transitions to local funding.

“Right Things”

PEPFAR CAR will scale up core targeted technical assistance 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 outreach workers and facility-based service providers implement effective interventions that respond to the unique needs of PWID. Specific core priority activities will include: (1) identifying and referring PWID to increase access to and uptake of HIV testing and registration for care; (2) ensuring that PWID are provided with high quality HIV care, ART, MAT, and TB screening and services and (3) strengthening community based service providers skills in adherence and retention systems that promote viral suppression. Activities not directly linked to the continuum of care framework will be deemed near-core or non-core and transitioned or eliminated in FY16.

“Right Time”

For the set of core activities that PEPFAR will support at the national and sub-national level, the “right time” is “right now” to expand proposed SNU activities in ROP₁₅. Key core activities in this area include supporting the adoption and implementation of guidelines related to PWID service delivery modalities, countering punitive policies that undermine current gains in reaching KPs, implementation of algorithms designed to increase access to HCT by PWID, and expansion of quality assurance for HIV laboratory

diagnostic and clinical services. Activities not directly related to the scale-up and improvement of the HIV continuum of care for KPs at the sub-national and national levels are deemed near-core and non-core in ROP15 and will be transitioned or eliminated.

3.0 Geographic and Population Prioritization

PEPFAR CAR utilized the most recent epidemiological data (e.g. IBBS and Population Size Estimates for PWID, MSM and FSWs) 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. Once the high-burden SNUs were selected, existing programmatic and available epidemiological data was utilized to select a set of cities that had the highest HIV prevalence among PWID, high density of PWID, and large numbers of PLHIV. Current coverage of combination community-based prevention 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.

PEPFAR CAR's strategy is to prioritize activities within high-burden cities (and in limited cases, a suburb whose epidemic is connected to that of the main city) where most new HIV infections are likely to originate. Prioritizing and scaling up program activities in these cities provides PEPFAR the highest probability of supporting the three countries to achieve epidemic control through saturation by 2017. In addition to the selected cities, 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 priority locations will be conducted with Global Fund, Global Fund sub-recipients, and other stakeholders to avoid duplication of effort and maximize impact.

Table 3.1 HIV Burden in PEPFAR Priority SNUs

Country	PEPFAR Priority SNUs	% of est. total PWID per country	Est'd % of PLHIV in country
Kazakhstan	2 SNUs out of 16 regions: Ust-Kamenogorsk and Pavlodar	10%	18%
Kyrgyz Republic	2 SNUs out of 9 regions: Bishkek and Osh	63%	47%
Tajikistan	2 SNUs out of 5 regions: Dushanbe (with Vakhdat suburb) and Khujand	39%	44%

The prioritization illustrated in Table 3.1 above has resulted in transitioning out of the sites noted below.

- Kazakhstan: Almaty, Aksu, Ekibastuz, Karaganda, and Timurtau (Pavlodar region); Uralsk (West Kazakhstan Region); Shymkent (South Kazakhstan Region)
- Kyrgyz Republic: Jalalabad (Jalalabad Region); Karakol (Issyk-kul Region); Naryn (Naryn Region); Batken (Batken Region); Talas (Talas Region); Panfilov Rayon (Chui Region); and Uzgen District (Osh Region)
- Tajikistan: Kulyab District, Qurghonteppa (also called Kurgan-Tube) District, Farkhor District, Vose District (Khatlon Region); Gissar District (DRS); Khorog and Rushan (GBA District); and Penjikent (Sughd Region)

Maps 3.1.1, 3.1.2 and 3.1.3 provide PWID HIV Prevalence and size estimates by location. Due to the limited epidemiological data on MSM and FSW, maps were not generated for these populations. Available data for MSM and FSW by SNU is included in Table 1.1.1(a).

3.1.1 Kazakhstan PWID HIV Burden Mapping and Selected Priority SNUs

Priority SNU

Ust-Kamenogorsk City

Pavlodar City

In E. Kazakhstan Region

In Pavlodar Region

[REDACTED]

3.1.2 Kyrgyz Republic PWID HIV Burden Mapping and Selected Priority SNUs

Priority SNU	Priority City
--------------	---------------

Bishkek	Bishkek City
---------	--------------

	Bishkek City
--	--------------

	Sokuluk and Issyk Ata
--	-----------------------

Osh	Osh City
-----	----------

	Osh City
--	----------

	Kara-Suu
--	----------

[REDACTED]

3.1.3 Tajikistan PWID HIV Burden Mapping and Selected Priority SNUs

Priority SNU	Including
Dushanbe	Dushanbe
Khujand	Including Vakhdat Khujand

[REDACTED]

(Note: Afghanistan is located directly south of Tajikistan)

4.0 Program Activities for Epidemic Control in Priority Locations and Populations

4.1 Targets for priority locations and populations

To derive targets by program area, the PEPFAR CAR team utilized a variety of approaches appropriate for a TTA model country supporting acceleration of progress toward epidemic control. Targets for community-based indicators were based on available size estimation data in priority SNUs and projections for appropriately ambitious impact as outlined in CAR's Bangkok Regional Review session. Targets for facility based indicators were based on data from the EHCMS and an analysis of national targets and projections for appropriately ambitious impact as outlined in CAR's Bangkok Regional Review session. As a TTA country, CAR PEPFAR will impact many of these targets through TA provided, i.e. indirectly, but may also be required to integrate more components from the direct service delivery (DSD) model, i.e. contribution to some staffing in priority facilities and purchase of "scale-up" commodities that cannot be covered by the relevant government institution, in order to realize the targets and demonstrate the impact of the model.

National HIV plans in CAR pose challenges for use in target setting. No subnational or site-level targets are set with the national HIV plans of Kazakhstan, the Kyrgyz Republic, or Tajikistan. National HIV plans are often less-detailed components of larger national health plans, such as Kazakhstan's 2013-2015 National Health Plan "Salamatty Kazakhstan." As their next triennial health plan has not yet been developed, there is no national plan for PEPFAR CAR to use for targeting now. PEPFAR CAR attempted to develop approximated SNU targets with government partners, but they were not fruitful. In addition, the Global Fund does not require such targeting in CAR, while they do collect performance data on a sub-national level. Finally, the Kyrgyz Republic and Tajikistan have written ambitious plans as part of their Global Fund CNs, i.e. in the Kyrgyz Republic "by 2017, 80% of registered PLHIVs who require treatment will receive ART." However, their national plan already anticipates a 16% budget gap. Moreover, the current ART initiation level of $CD4 \leq 350$ poses a barrier to achieving this 80% PLHIV coverage. While all countries have recently endorsed ART initiation at $CD4 \leq 500$, implementation will unlikely be immediate. And finally, there are questions regarding whether sufficient staffing and institutional capacity are in place for such an upsurge of clients, for example at the Family Medical Centers to which HIV services have been decentralized in the Kyrgyz Republic.

Since PEPFAR CAR activities will be consolidated within a fewer priority geographic sites with the goal of saturation and due to other program pivots, coverage of HIV testing will increase from 25 to 50% of PWID. In addition, coverage of TB testing and referrals will increase considerably (from 4,430 (APR FY14) to 8,758). Community-based care coverage will also rise significantly (from 2,340 (APR FY14) to 4,268 PWID). Outreach targets are somewhat smaller than last year, due to the shifting efforts to more comprehensive and targeted services. In ROP15, ART targets increase from 1,820 in ROP14 to 3,410 PLHIV on treatment (including 1,608 PWID), and 1,205 PLHIV newly on treatment (including 730 PWID). Although some current projects are being phased out and an agency's HIV Flagship project will be launching, the trend for increasing coverage of prevention, care and treatment activities will remain the same.

To support CAR governments to initiate more PLHIV on ART most efficiently, PEPFAR CAR will provide TTA to Republican AIDS Centers in updating their HIV treatment protocols to start ART as early as possible according to new WHO Treatment Guidance ($CD4 \leq 500$). These updated national treatment

protocols will have a large impact on increasing coverage for people on ART. Increased testing of KPs will also significantly contribute to initiating more new patients on ART in ROP15. The interventions which are anticipated to aid the most in ART adherence are analysis of the care and treatment cascade through the EHCMS, quarterly mentoring visits by PEPFAR CAR partners, and SIMS visits.

Resource needs for ROP15 were determined by using EA and APR data to develop unit expenditures for elements across the continuum of care and by multiplying expenditures to estimate total cost across targets. Previous outlay information was also integrated into the planning process for TTA-focused expenses.

CAR anticipates a variety of potential challenges to reaching its targets, as described throughout this document. In addition, CAR experiences significant data limitations in terms of assessing SNU and KP epidemic impact, which can pose programmatic challenges. National plans do not include sub-national or facility targets and PEPFAR also did not request such targets previously. It has been difficult to collect service data from governments on a KP basis and detailed age basis. At national stakeholder meetings, PEPFAR CAR asked partners to share information on a more detailed basis and more frequently, especially those targets which will be reviewed quarterly.

Table 4.1.1 ART Targets in Priority SNU for Epidemic Control

Kazakhstan											
					National Targets (2015-2016)			PEPFAR Targets (ROP 2015)			
SNU	Detail and/or Region	Total PLHIV	Current on ART (as of December 31, 2014)	Additional Patients Required for 80% ART Coverage	Target on ART, (by December 2015)	Target on ART (by December 2016)	Target for Newly Initiated on ART, 2015-2016	PLHIV: Target TX_CURR (ROP 15)	PWID: Target TX_CURR (ROP 15), >15 y.o.	PLHIV: Target TX_NEW (ROP 15), >15 y.o.	PWID: Target TX_NEW (ROP 15), >15 y.o.
Ust-Kamenogorsk	East Kazakhstan	[REDACTED]	[REDACTED]	[REDACTED]	No reliable data available: Only a national target for people on ART is available for 2013-2015 (3,050 patients/year) per National Strategy for Health "Salamatty Kazakhstan (2013-2015)" and was the same each year. The new country targets will be set in the new National Strategy for Health, 2016-2018 by the end of May 2015. Site-level targets are not set in any of the regulatory documents and depend on procurement prices and funds availability in every region.			733	512	382	267
Pavlodar	Pavlodarskaya	[REDACTED]	[REDACTED]	[REDACTED]				499	274	218	131
Total		[REDACTED]	[REDACTED]	[REDACTED]				1,233	786	601	398
Comments			Data captures all PLWH (<15, and >15) receiving ART in AIDS centers located in the selected PEPFAR priority cities or districts.								
Sources :			EHCMS, 2015	EHCMS, 2015	National Strategy for Health "Salamatty Kazakhstan"						
Kyrgyz Republic											
					National Targets (2015-2016)			PEPFAR Targets (ROP 2015)			
SNU	Detail and/or Region	Total PLHIV	Current on ART (as of December 31, 2014)	Additional Patients Required for 80% ART Coverage	Target on ART, (by December 2015)	Target on ART (by December 2016)	Target for Newly Initiated on ART, 2015-2016	PLHIV: Target TX_CURR (ROP 15)	PWID: Target TX_CURR (ROP 15), >15 y.o.	PLHIV: Target TX_NEW (ROP 15), >15 y.o.	PWID: Target TX_NEW (ROP 15), >15 y.o.
Bishkek	Bishkek City	[REDACTED]	[REDACTED]	[REDACTED]	No reliable data available: Only a national target for people on ART is available. Per the country's Concept Note to the Global Fund, the National Target on ART (by December 2016) is 2,900.						
	Issyk-Ata	[REDACTED]	[REDACTED]	[REDACTED]							
	Sokuluk	[REDACTED]	[REDACTED]	[REDACTED]							
	subtotal	[REDACTED]	[REDACTED]	[REDACTED]				561	262	163	81
Osh	Osh City	[REDACTED]	[REDACTED]	[REDACTED]							
	Kara Suu	[REDACTED]	[REDACTED]	[REDACTED]							
	subtotal	[REDACTED]	[REDACTED]	[REDACTED]				618	214	151	70
Total		[REDACTED]	[REDACTED]	[REDACTED]				1,179	476	314	151
Comments			Data captures all PLWH (<15 y.o. and ≥15 y.o.).	Data captures all PLWH (<15, and ≥15) receiving ART in AIDS centers located in the selected PEPFAR priority cities or districts. In Osh City, 94 children are on ART.	National targets were not solely relied upon because they are not realistic (lack of trained staff, budget deficit, difficulties connecting PLWH to care).						
Source:			EHCMS, 2015	EHCMS, 2015	Country Concept Note to the Global Fund, 2015						

Table 4.1.1 ART Targets in Priority SNUs for Epidemic Control, cont.

Tajikistan											
					National Targets (2015-2016)			PEPFAR Targets (ROP 2015)			
SNU	Detail and/or Region	Total PLHIV	Current on ART (as of December 31, 2014)	Additional Patients Required for 80% ART Coverage	Target on ART, (by December 2015)	Target on ART (by December 2016)	Target for Newly Initiated on ART, 2015-2016	PLHIV: Target TX_CURR (ROP 15)	PWID: Target TX_CURR (ROP 15), >15 y.o.	PLHIV: Target TX_NEW (ROP 15), >15 y.o.	PWID: Target TX_NEW (ROP 15), >15 y.o.
Dushanbe	Dushanbe City	[REDACTED]	[REDACTED]	[REDACTED]	Only the national target for people on ART is available for 2015 (3,469 PLWH on ART) and 2016 (4,221). Those targets are stated in the Country Concept note for NFM for the period 2015-2017 (with the goal of 80% PLHIV being on ART in 2017).						
	Vakhdat	[REDACTED]	[REDACTED]	[REDACTED]							
	subtotal	[REDACTED]	[REDACTED]	[REDACTED]				727	263	199	145
Khudjand		[REDACTED]	[REDACTED]	[REDACTED]				271	84	91	37
	Total	[REDACTED]	[REDACTED]	[REDACTED]				999	346	291	181
Comments:		The numbers include all PLWH (<15, and >15).	Data captures all PLWH (<15 y.o. and ≥15 y.o.) receiving ART in AIDS Centers.		National targets were not solely relied upon because they are felt to be not fully realistic (due to lack of trained staff, current AIDS plan budget deficit, difficulties connecting PLWH to care,						
Source:		RAC, 2014 annual report	EHCMS, 2014		Country Concept note for NFM for the period 2015-2017.						

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

Kazakhstan

		<i>National Reporting, 2014</i>					<i>PEPFAR Targets, ROP15</i>				
PEPFAR Priority SNUs		Total PWID PSE (per RAC KZ)	% PWID Reached with Prevention Intervention in 2014 (Target for 2013 was 66.9%)	% PWID who received HTC in last 12 months (Target for 2013 was 66.9%)	# PWID Receiving MAT as of December 31, 2014, Rep. Narc Center (by oblast)	% PWID on MAT, reported by RNC (2014)	Target KP_PWID_PREV_DSD (ROP 15)	CUSTOM: HTC_REFERRAL_COMP	Target HTC_TST_PWID (ROP 15)_DSD + TA	Target KP_MAT_DS D (ROP 15)	Target KP_MAT_PWID_TA (ROP 15)
Ust-Kamenogorsk	Ust-Kamenogorsk City	[REDACTED]	[REDACTED]	[REDACTED]	33	#VALUE!	1,750	875	875	N/A	38
Pavlodar	Pavlodar City	[REDACTED]	[REDACTED]	[REDACTED]	51	#VALUE!	1,993	996	996	N/A	55
TOTAL							3,743	1,871	1,871		93

Kyrgyz Republic

		<i>National Reporting, 2014</i>					<i>PEPFAR Targets, ROP15</i>				
PEPFAR Priority SNUs	PEPFAR Priority Cities	Total PWID PSE (Per NAC KG)	% PWID Reached with Prevention Intervention in 2014 (Target for 2016 was 60%)	% PWID who received HTC in last 12 months (Target for 2016 is 44.5%)	Receiving MAT (by oblast) as of December 31, 2014, Rep. Narc Center (Target for	% PWID on MAT, reported by RNC (2014)	Target KP_PWID_PREV_DSD (ROP 15):	CUSTOM: HTC_REFERRAL_COMP	Target HTC_TST_PWID (ROP 15)_DSD + TA	Target KP_MAT_DS D (ROP 15)	Target KP_MAT_TA (ROP 15)-ICAP
Bishkek	Bishkek	[REDACTED]	[REDACTED]	[REDACTED]	403	#VALUE!	3,903	1,951	3,951	85	177
	Sokuluk&Issyk-Ata	[REDACTED]	[REDACTED]	[REDACTED]	544	#VALUE!					
Osh	Osh City	[REDACTED]	[REDACTED]	[REDACTED]	85	#VALUE!	1,575	788	1,988	40	80
	Karasuu	[REDACTED]	[REDACTED]	[REDACTED]	210	#VALUE!					
Total							5,478	2,739	5,940	125	257

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

Tajikistan

		<i>National Reporting, 2014</i>					<i>PEPFAR Targets, ROP15</i>				
PEPFAR Priority SNUs	PEPFAR Priority Cities	Total PWID PSE	% PWID Reached with Prevention Intervention in 2014 (Target for 2016 was 60%)	Receiving HIV test and received results in the last 12 months, RAC Target (Target	# PWID Receiving MAT as of December 31, 2014, Rep. Narc Center (by oblast)	MAT, reported by RNC (2014) (Target for 2016 is 3.7%)	Target KP_PWID_PREV_DSD (ROP 15)	CUSTOM: HTC_REFERRAL_COMP	Target HTC_TST_PWID (ROP 15)_DSD + TA	Target KP_MAT_DS D (ROP 15)	Target KP_MAT_TA (ROP 15)
Dushanbe	Dushanbe, incl Vahdat	[REDACTED]	[REDACTED]	[REDACTED]	140	#VALUE!	2,762	1,381	1,921	216	412
Khujand	Khudjand	[REDACTED]	[REDACTED]	[REDACTED]	53	#VALUE!	420	210	459	0	57
Total							3,182	1,591	2,380	216	469

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 in the following core prevention interventions to accelerate epidemic control in priority SNUs: increased outreach and uptake of core KP prevention services (including strengthened linkages to HTC) and increased uptake and access to low threshold MAT services for PWID (See Appendix A for more detail).

Based on the state and sub-national level epidemiology data showing increased sexual transmission of HIV, PEPFAR CAR will also address HIV prevention among sexual partners of PWID. Activities will include: outreach with prevention education and couple's counseling, referrals to HTC, and follow-up with those who tested positive for HIV to link them to care and treatment services. Outreach will also include education about STI and referrals to STI diagnostic and treatment services for partners of PWID. PEPFAR CAR will also continue to support prevention programming and care and support services in several prisons with large numbers of PWID and high HIV burden. Core activities will include increasing access to and uptake of HTC and MAT services as well as referrals to care and treatment services for prisoners, post-release. Finally, PEPFAR CAR will continue to support time-limited technical assistance with modest resources to the Republican Blood Centers to ensure 100% screening of the blood supply, due to past incidents of contaminated blood and remunerated donors who are often from high risk groups.

As a result, more than 14,252 PWID will receive a prevention intervention with PEPFAR CAR's support.

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 the large numbers of tests reported disproportionately target pregnant women rather than key populations. Only 2% out of the 2 million HIV tests conducted in Kazakhstan were conducted among KPs; similarly 3.8% of the 500,000 tests in Tajikistan, and 1% of the 400,000 tests in the Kyrgyz Republic. And only 0.1% of these were HIV positive in all three countries.²³ 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; and the exclusive use of ELISA-based testing places undue burden on an already weak laboratory system. Blood based rapid testing can only be provided by health care workers. Saliva based rapid testing has been piloted in the Kyrgyz Republic at community-based settings but is expensive and requires a facility-based confirmatory test.

In ROP15, PEPFAR CAR will provide TTA to the MOH to develop and implement rational 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 program. PEPFAR CAR will work with the Republican AIDS Centers to bring mobile rapid testing to NGOs and community based settings where PWID live, play and congregate (e.g. shooting galleries) to increase uptake of HIV 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. Referrals to HTC will be expanded and strengthened via the use of mobile technology (such as SMS reminders) as well as increased use of 'peer-navigators.' It is intended to shift funding from prevention to HTC to ensure that these interventions are sufficiently supported and scaled.

²³ Republican AIDS Center Annual Reports for Kazakhstan, Tajikistan, Kyrgyz Republic, 2013

As a result, more than 11,450 PWID will be tested for HIV at PEPFAR CAR-supported sites, among the 348,420 total tests expected to be administered at these sites.

4.6 Facility & Community Based Care & Support

In ROP15, PEPFAR CAR will provide TTA and DSD support for both facility- and community-based interventions to improve retention in care and adherence to ART among PWID in high-burden priority regions where their numbers are the greatest. This TTA will incorporate evidence-based interventions (both clinical and non-clinical) to optimize outcomes and address barriers to quality service delivery for KPs.

PWID will be prioritized for care, treatment and support through a community based system in which health providers, peer navigators and social workers provide a spectrum of critical services to PWID assigning a UIC. Adherence support to strengthen the retention of pre-ART, ART, TB, PHDP, and MAT services will be provided through peer-based groups, such as community advisory groups (which are comprised of patient-groups based at AIDS and narcology centers), and peer-based support groups located at NGOs and community settings). The multi-disciplinary team (MDT) approach (which involves a team including HIV physicians, TB specialists, nurses, psychologists, social workers, peer consultants, and narcologists) will be scaled up to all DSD and TTA 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.²⁴ Home-based visits by outreach workers, as well as increased use of 'peer navigators' who can help enroll patients in key services, will strengthen patient access to quality care and treatment services. Meanwhile, USG will also provide TTA support in treatment facilities in the form of intensive supportive mentoring to health providers, which will result in improving key care services such as OI treatment, CTX prophylaxis for PWID who are eligible, regular clinical and laboratory monitoring of CD4 count and viral load, per country guidelines and screening for active TB, and support for intensified and accurate case finding, with referral for diagnosis and treatment.

As a result, 7,654 PLHIV will receive facility-based support (with 1,128 newly supported) to remain in care, among whom 3,493 will be PWID and 691 will be PWID newly in care. Moreover, 4,268 PWID will receive community-based support to remain in care in ROP15.

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, remains essential.

In ROP15, PEPFAR CAR will accelerate use of MDTs to better serve co-infected patients. A UNAIDS analysis of the MDT approach in Kazakhstan demonstrated that clients of MDTs are 1.6 times more likely to complete TB treatment, and the time it takes for PLHIV to obtain their TB diagnosis results is highly reduced (21 days compared to 84 days).²⁵ PEPFAR CAR will also emphasize strengthening national policy regulations on HIV-TB integrated care; improve active TB screening among PLHIV; ensure timely

²⁴ D.O.Kamaldinov, G.M. Akhmetova " Assessment of effectiveness of the multidisciplinary approach to adherence to treatment among PLHIV," Almaty 2014

²⁵ D.O.Kamaldinov, G.M. Akhmetova " Assessment of effectiveness of the multidisciplinary approach to adherence to treatment among PLHIV," Almaty 2014

initiation of TB treatment; and provide treatment adherence support to patients. 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. PEPFAR CAR will leverage USAID TB-earmarked funds to assist CAR MOHs to scale up rapid testing using GeneExpert 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.

As a result, 6,201 PWID and 2,557 PLHIV will complete a referral and be tested for TB and 5,874 PLHIV and 3,144 PWID will be screened for TB symptoms in AIDS or Family Medicine Centers with PEPFAR CAR's support.

4.8 Adult treatment

While Tajikistan and Kyrgyz Republic reflected the 2013 WHO revised treatment guidelines into their recently submitted Global Fund CNs, none of the PEPFAR CAR supported countries have fully scaled up treatment per their existing eligibility requirement (i.e., CD4<350). The reported national coverage rate for those who are eligible according to the existing criteria is 69.7% in Kazakhstan, 56.4% in the Kyrgyz Republic and 82% in Tajikistan. [REDACTED] Access to ART for KPs is lower than the overall rate, with national reported rates of KPs enrolled in ART ranging from 11-22% across the three countries. While retention data for those enrolled is limited, Kazakhstan and the Kyrgyz Republic have better retention rates for PLHIV than does 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 Chui and Osh regions, which have the highest HIV prevalence in the country. 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 5-8 times higher than in other countries in the region where UNDP is procuring the ARVs as the Global Fund Principal Recipient.

In ROP 2015, 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 by 2017. 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 PWID friendly community-clinical MDT model in select sites); and identify and support implementation of efficiencies and quality improvement activities to allow increased uptake of services at same/lower costs. 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 strengthen adherence. PEPFAR CAR will 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.

As a result, more than 2,338 PWID among 4,615 PLHIV will be on ARVs with PEPFAR CAR's support; 730 PWID out of 1,205 PLHIV will have initiated ART newly in ROP15.

5.0 Program Activities for Other Locations and Populations

Transition plans for redirection PEPFAR support to priority locations and populations

In ROP 2015, PEPFAR will transition away from non-core activities and non-priority locations as described below.

*Non-Priority Areas/Low Burden SNU*s (see Section 3)

KP Outreach, HIV Testing and Counseling, including KP Trust Points (Tajikistan) Central Support Sites
Over the next 6-12 months, DSD activities outside of priority areas will be transitioned or phased out, as they cannot all be terminated due to existing agreements with national authorities. Where there is ongoing need (i.e. significant demand/yield for services), PEPFAR CAR will work with the national AIDS programs to take over financing and/or partner with the Global Fund with the aim to ensure essential services are maintained.

Laboratory and Blood Safety Central Support Sites

Over the next year, technical assistance for blood safety and laboratory activities that do not directly support the priority geographic areas will be phased out. PEPFAR CAR is currently working with the National Blood Centers and National AIDS Programs in these non-priority areas to identify other means of support.

Prevention Activities Among General Populations

In ROP15, Peace Corps will discontinue its focus on general prevention education activities among youth, and instead provide shorter term “Response” volunteers who will work with NGOs and government facilities to build their capacity to serve PLHIV and PWID. NGOs will be located in priority SNU

s in the Kyrgyz Republic.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Laboratory strengthening

PEPFAR CAR program activities support Republic AIDS Centers in Kazakhstan, the Kyrgyz Republic and Tajikistan to strengthen their laboratory systems and networks in a sustainable manner to provide quality diagnostic testing for HIV prevention, treatment, and care to HIV-infected persons. In ROP15, PEPFAR CAR will prioritize laboratory strengthening activities in the selected high-burden SNU and priority cities to achieve the greatest impact for these investments. Key laboratory strengthening goals in ROP15 include:

- 1) Expanding quality assurance/proficiency testing programs for HIV rapid tests and other core HIV-related diagnostic and clinical monitoring tests;
- 2) Supporting laboratory CQI projects to provide higher standards of quality-assured diagnostics, care, and treatment to HIV/AIDS patients;
- 3) Continuing ROP14 laboratory accreditation for national reference laboratories and laboratories located in the high-burden SNUs; and
- 4) Supporting and improving treatment, care and prevention programs by developing country-specific viral load implementation and scaling up strategies and networks systematically implementing viral load testing.

PEPFAR CAR currently supports the national HIV/AIDS reference laboratory in all three countries, and provides additional technical support for a select set of oblasts HIV/AIDS laboratories that conduct high volume of diagnostic and clinical monitoring tests. PEPFAR CAR will also continue providing technical assistance and build capacity in the high-burden SNUs to ensure that all blood is screened for HIV in laboratories with strong quality assurance programs. With the support of headquarters technical assistance, PEPFAR CAR plans to transition these activities to the national program within 18-24 months.

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. IM ID	7. SID	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			N/A	8. HIV Test	9. (LTC)	10. ART uptake	11.*Other Combination prevention
Technical Support/Capacity Building to nat'l and subn'l level labs in high-priority SNUs to strengthen QA,	Report on situational analysis on HIV EQA/PT practices conducted with	Address recs from assessment/regulatory barriers (transport; data sharing)	[REDACTED]	[REDACTED]	[REDACTED]	n/a	x	x	x	x	x

develop and participate in EQA/PT schemes to strengthen quality of core HIV-related diagnostic and clinical monitoring tests.	recommendations provided.	re: EQA/PT. Draft guidelines/job aids on HIV RTK QA/PT and conduct TOT in priority SNU.									
TA to HIV and blood transfusion national labs and labs in high-burden SNU to implement robust quality management system (QMS)	Focused QMS training and mentorship activities in selected labs. Enrolled into QMS impln activities / audits conducted.	Provide focused QMS training and mentorship activities in selected labs.	[REDACTED]	[REDACTED]	[REDACTED]	n/a	x	x	x	x	x
Techn support @ priority SNU HIV labs to achieve intnat'l accreditn, to serve as centers of excellence for EQA/PT schemes and training center(s) to disseminate skills on HIV advanced lab testing technologies.		TA to achieve international accreditation. Lab (s) will achieve intermediate level in preparation for accreditation in 2016.	[REDACTED]	[REDACTED]	[REDACTED]	n/a	x	x	x	x	x

Support devt of a multifaceted approach to ensure quality of HIV molecular testing by providing subject matter expertise, mentorship and training for designated national and subnational labs	Assessment of current HIV molecular testing practices conducted / recommendations provided /training conducted.	Continue training lab providers in the VL testing network; conduct on-the-job mentoring activities to implementation of new procedures/sy stems	[REDACTED]	[REDACTED]	[REDACTED]	n/a	n/a	x	x	x	x
Support strengthening LIMS through dev't and pilot implementation of lab modules of EHCMS in high-priority SNU HIV labs	Lab module developed and integrated into EHCMS – the overall patient electronic MIS	EHCMS lab module piloted in selected labs	[REDACTED]	[REDACTED]	[REDACTED]	n/a	n/a	x	x	x	x
Continue to provide TA support to ensure 100% screening of blood supply in priority SNUs, support for tracing and referral systems for HIV-reactive donors and to develop and	Provided TA to implement blood service information system in 7 labs.	Continue providing TA to implement blood service information system in 7 labs.	[REDACTED]	[REDACTED]	[REDACTED]	n/a	x	x	n/a	n/a	n/a

implement QMS and blood service info systems.											
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6.2 Strategic information (SI)

While the availability of epidemiological data for KPs has improved for PWID over the last several years, data for MSM and FSW is still sparse. For example, IBBS is only conducted in the capital cities in the Kyrgyz Republic and Tajikistan. While all three countries conduct annual KP bio-behavioral surveys, the representativeness of the surveys is limited due to small number of sites and size of the pool of respondents. The limited availability of data continues to make it challenging to tailor program activities to the “right place.” In ROP15, PEPFAR CAR will continue to provide TTA to the Republican AIDS Centers in all three countries to increase capacity, quality and representativeness of the IBBS and size estimations. PEPFAR CAR will work to improve the protocols to collect data, and train staff at the Republican AIDS Centers to analyze data and ensure that it is of high-quality and utility to better understand trends in the micro-epidemics of these KPs and guide program decision making.

As a core priority, PEPFAR CAR will focus on strengthening the Management Information System (MIS) including UIC, which collects data that in turn informs decision making for the HIV prevention program. In ROP15, PEPFAR CAR will support efforts to integrate the UIC with information management at the AIDS Centers (including EHCMS) to promote data integration and combined analysis across the continuum of care. In addition, behavioral surveys with KPs conducted by NGOs will track behavior change among these groups. The data collected from these studies will enhance understanding of the socio-demographic characteristics of these KPs including health seeking behaviors, determinants of risky behavior, and knowledge about health products/services. This information will be used to sharpen targeting of KP groups with the right interventions, in the right place and at the right time to impact epidemic control. These assessments will be used to identify “losses” of KPs in the continuum of care and PEPFAR CAR will identify the gaps in uptake and quality of services and update size estimations for KPs in prioritized geographic areas and respond accordingly.

PEPFAR CAR will also continue to provide TTA related to the EHCMS in all three countries so that the Republican AIDS Center can collect quality data to inform decision making on services for people officially registered with HIV. The EHCMS includes PLHIV social and demographic characteristics, laboratory tests (ELISA, CD4 and viral load, HCV, HBV, resistance to ARVs), epi data including risk factors, clinical data (stage of HIV, OIs, treatment of opportunistic infections, ART and adherence to it, TB, MAT), and an ARV forecasting tool.

TTA for the Electronic MAT Register (EMR) will also continue. This online system allows the Republican Narcology Center to collect and analyze the social and demographic, laboratory and clinical data for patients on MAT. Finally, PEPFAR CAR will continue supporting the Electronic Monitoring and Evaluation (e-M&E) System, which will help the MOHs in CAR to gather, analyze and use program data to promote strategic allocation of resources.

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. IM ID	7. SID Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			N/A	8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention
MIS strengthening and UIC	Database and plan for linking UIC to AIDS Center data systems	Database and plan for linking UIC to AIDS Center data systems	[REDACTED]	[REDACTED]	[REDACTED]	n/a	x	x	x	x	x
Behavioral surveys with KPs (PWID, CSW and MSM), Prisoners and PLHIV	Programmatic report with recommendations to adjust interventions based on findings	Programmatic report recommendations are implemented	[REDACTED]	[REDACTED]	[REDACTED]	n/a	x	x	x	x	x
Assessments of cascade for KPs to identify gaps in quality of services	Programmatic reports with identified 'losses' of KPs throughout the cascade plus recommendations	Programmatic report recommendations are implemented	[REDACTED]	[REDACTED]	[REDACTED]	n/a	x	x	x	x	x

Size estimation (hot spot study) for PWID, SW and MSM	Programmatic reports with quantitative data and analysis on estimated 'hotspots'	Programmatic report recommendations are implemented	[REDACTED]	[REDACTED]	[REDACTED]	n/a	x	x	x	x	x
Electronic IBBS among KPs (PWID, CSW, MSM, and Prisoners)	Reports on dynamics, risk behavior, KP size and HIV prevalence ongoing	Reports on dynamics, risk behavior, KP size and HIV prevalence ongoing	[REDACTED]	[REDACTED]	[REDACTED]	n/a	x	n/a	n/a	n/a	n/a
EHCMS	High quality demo, epi, lab, clinical data on HIV cases at each A/C and some FMCs + ART forecasting module	High quality demo, epi, lab, clinical data on HIV cases at each A/C and some FMCs + ART forecasting module + development of Lab module	[REDACTED]	[REDACTED]	[REDACTED]	n/a	x	x	x	x	x
EHCMS	Preparatory work on linking UIC to AIDS Center data systems	Incorporation of UIC into EHCMS	[REDACTED]	[REDACTED]	[REDACTED]	n/a	x	x	x	x	x

Electronic MAT Register (EMR)	Quality data on MAT clients to monitor tx effectiveness	Quality data on MAT clients to monitor tx effectiveness	[REDACTED]	[REDACTED]	[REDACTED]	n/a	x	x	x	x	x
Electronic Monitoring and Evaluation (e-M&E)	Software to help MoHs gather, analyze, and use ntl and UNGASS indicators	Software to help MoHs gather, analyze, and use ntl and UNGASS indicators	[REDACTED]	[REDACTED]	[REDACTED]	n/a	x	x	x	x	x
IBBS	TA to RAC/TJ in developing protocol	Conduct IBBS	[REDACTED]	[REDACTED]	[REDACTED]	n/a	x	x	x	x	x
M&O	SI advisor	% health scientist (USDH) and SI advisor	[REDACTED]	[REDACTED]	[REDACTED] a	n/a	x	x	x	x	x

6.3 Health System Strengthening

Optimizing Funding. PEPFAR CAR will focus on providing TTA to MoH and Finance to mobilize advocacy on health financing and optimize funding to address the epidemic. With support from PEPFAR CAR, UNAIDS conducted Investment Case Assessments in 2014 and found that the budget allocations to optimally prevent new cases of HIV and AIDS related deaths required shifts. The key areas include: increased government funding for ART, reduced pricing of ART through more efficient and transparent procurement processes, and reduced total allocations for HTC for general populations. Findings further suggest that the HIV budget should not include activities targeting HIV prevention among the general population where prevalence is less than 1%. PEPFAR CAR will further disseminate and use Investment Case analyses for advocacy, decision making for increasing government budgets at the national and SNU level for targeted HIV programs in the geographical “hot spots.” In ROP 2015, PEPFAR CAR will support TTA to the MoH and key decision makers to improve allocation efficiency in areas where KPs live, play and congregate. PEPFAR CAR will also collaborate with UNODC to conduct cost-effectiveness analyses related to MAT.

CCM Support for NFM. PEPFAR CAR will support CCMs to accelerate implementation of policies and systems to meet and comply with eligibility criteria and/or implement guidelines under the Global Fund’s NFM. This builds on the Investment Case work to ensure MOHs lobby Ministries of Economy/Planning to mobilize required counterpart funding under the NFM. In Tajikistan, PEPFAR CAR will provide support to the CCM to assist with policy implementation under the NFM. PEPFAR CAR will conduct an assessment of the CCM in the Kyrgyz Republic to identify additional needs for TTA for the CCM. In Kazakhstan, TTA will be provided to assist in sustaining the operational and governance structure once the current grant ends in 2016. Thus, CAR PEPFAR will continue to play an active role to support the MOH’s desire to sustain the successful CCM model as it transitions to a nationally funded HIV program.

Countering Punitive Policies. Over the past 12 months, restrictive policies against KPs, heavily influenced by Russia, have resurfaced in CAR and threaten human rights-based gains made in combatting the concentrated epidemic in the region. PEPFAR will work with UNODC at the national level to cultivate “MOH champions” to help create and protect an enabling environment for countering punitive policies (e.g. MAT/NSP) that negatively impact programming. We will also create a strong alliance with UNODC to mobilize other key stakeholders to advocate for reversing or neutralizing policies that criminalize KP behavior, driving KPs further underground and away from services critical to stem the epidemic. At the SNU and community level, PEPFAR CAR will support local NGOs’ efforts to counter punitive policies and practices that negatively impact KPs’ access to critical services. PEPFAR CAR will provide small grants to HIV NGOs to track and react to punitive policies; advocate against stigma and discrimination promote KP access to HIV prevention, care and treatment; and intensify efforts to find KPs and link them to ART and MAT. These grants will also include advocacy through alliances with human rights groups and the use of social media to support LGBT rights and social contracting/funding to NGOs which target KPs.

1. Brief Activity Description	Deliverables		Budget Code and Allocations		6. IM ID	7. SID Score	Impact on epidemic				
	2. 2015	3. 2016	4. 2015	5. 2016			N/A	8. HIV Testing	9. Linkages to Care	10. ART Uptake	11. Other Comb. prevention
Technical Assistance to support health financing and allocative efficiency	MOH allocates optimized HIV financing.	MoH allocates optimized HIV financing. Price reduction for ARVs.	[REDACTED]	[REDACTED]	[REDACTED]	N/A	X	X	X	X	X

High level policy and advocacy for harm reduction for PWID and prisoners	Implementation plan for harm reduction developed	Implementation of activities to reverse harmful policies	[REDACTED]	[REDACTED]	[REDACTED]	N/A	X	X	X	X	X
TA to CCM (or successor entity) to meet GF eligibility requirements	CCMs in TJ and KG change policies to meet eligibility criteria. In KG, CCM needs are assessed for eligibility criteria	CCM in KG changes policies to meet eligibility criteria. Training on the updated policies are conducted for CCM members	[REDACTED]	[REDACTED]	[REDACTED]	N/A	X	X	X	X	X
TA to roll out and implement the transition plan for the CCM (KZ) post Global Fund	CCM agrees on the transition plan and gets approval from the Govt	CCM is funded and championed/supported by the MOH	[REDACTED]	[REDACTED]	[REDACTED]	N/A	X	X	X	X	X
Capacity building in advocacy and policy for KP NGOs to countering the punitive policies	NGOs trained in advocacy and policy dialogue for issues such as MAT scale-up and LGBT laws changed	Policy dialogue events conducted to changed restrictive policies	[REDACTED]	[REDACTED]	[REDACTED]	N/A	X	X	X	X	

7.0 Staffing Plan

PEPFAR CAR's staffing is already largely aligned with critical program priorities in the three focus countries for ROP15. Currently, staff percent time and number of local staff are aligned with the high priority programmatic areas identified for 'core' activities. The placement of staff within the three countries of focus is also strategically positioned to leverage priority activities. PEPFAR CAR staff will adjust time and travel schedules to undertake additional responsibilities related to conducting SIMS visits and expenditure analysis. Visits will be combined with routine project monitoring required by agency standards, whenever possible, to maximize efficiency and to reduce costs. Additional funding for these visits across the focus countries are included in the Cost of Doing Business section for staff to meet SIMS, EA and reporting requirements.

[REDACTED]

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

Core Focal Areas	Near-Core Focal Areas	Non-Core Focal Areas
Site Level		
Key populations-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 and methadone-assisted therapy.	Support to the Republican Blood Centers in high-burden oblasts to conduct 100% HIV screening of blood and quality assurance of blood services laboratories.	Prevention activities conducted in low-burden and low-yield sites.
Key populations-focused community-based care activities 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.	Support expansion of laboratory quality assurance/proficiency testing for HIV testing and clinical monitoring at PEPFAR priority sites.	Care activities conducted in low-burden and low-yield sites.
HIV care and treatment-related targeted technical assistance and supportive mentoring/supervision to health facilities (e.g. AIDS Centers, Family Health Centers) in high-burden oblasts in cities with sizable populations of KP with high HIV prevalence and large numbers of PLHIV.		Clinical-services related technical assistance being provided in low-yield sites in sites that are not located in PEPFAR "priority" SNU.
Targeted technical assistance and limited support for service delivery in a sub-set of prisons with high HIV KP (and specifically PWID) populations with high prevalence of HIV.		Direct financial support to a set of "Government Trust Points" for Key Populations in low-burden SNU (Tajikistan).
Supportive mentoring to Republican AIDS Program, Republican Narcology Centers and NGOs at PEPFAR Priority sites to collect and analyze epidemiological and program data to improve resource prioritization and quality improvement activities.		General prevention activities among youth
Technical assistance and support for the development and expansion of a "unique identifier code" system for key populations to strengthen adherence across the HIV continuum of prevention, care and treatment.		Technical support activities at HIV laboratories to achieve international accreditation in non-priority SNU which will transition to completion.

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.	Support to the Republican Blood Centers in high-burden oblasts to conduct 100% HIV screening of blood and quality assurance of blood services laboratories.; train staff on use of blood service software related to tracking HIV and other bloodborne pathogens.	Purchase of test kits and other commodities for Oblast Republican Blood Centers.
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, care and treatment services.	Continued support on HIV rapid testing validation, HTC algorithm development, and KP cascade assessments.	
Targeted technical assistance to the Oblast Republic AIDS Centers, Oblast Republic Narcology Centers, and Non-Governmental Organizations in high-burden PEPFAR Priority SNU on expanding and supporting high-quality HIV/AIDS prevention activities, strengthening referral systems for HTC, NSP/MAT, and HIV care and treatment.	Training to Oblast MOH staff on the multi-disciplinary team (MDT) approach.	
Provide technical assistance to Oblast National AIDS Center to develop and implement laboratory quality assurance programs for HIV rapid testing, clinical chemistry, 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 key populations of core HIV prevention interventions, including HTC and NSP/MAT, support effective referral programs, 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 Global Fund CCMs.		

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

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.	Technical support to low-yield and low-burden HTC sites.
Support to strengthen the policy/legislative environment for HTC 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 key populations 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 (Kyrgyzstan).		
Supportive mentoring to HTC staff 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.	Direct financial support to a set of "Government Trust Points" for Key Populations in low-burden SNU's (Tajikistan and Kyrgyzstan).
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 mgmt).	
Expand Multi-Disciplinary Team approach to selected sites to support adherence to ART and TB among PLHIV. Train MDT members on case management, pre-ART, services for PLHIV, stigma and discrimination prevention, and communication skills.		
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 by social workers 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 proper HIV care and treatment (including 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	Implementation of Blood Center software for automated work (compliance with ISBT-128) and implementation of M&E system
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 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		
Capacity building of Oblast Republican AIDS Program in PEPFAR priority sites to develop and implement a quality management program for HIV care and treatment.	Provide technical assistance to clinical service providers at sites outside PEPFAR priority SNU's	Financial support to "Club 25" to promote recruitment of voluntary blood donors.
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.		
Targeted technical assistance to develop, expand and improve quality of unique identifier code and electronic HIV/AIDS case management reporting systems.		
Provide supportive supervision to clinical service providers at PEPFAR priority sites.		
Training of service providers on harm reduction, stigma/discrimination and interpersonal communication.		

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.		
Lab		
Technical Support/Capacity Building to national and subnational level laboratories in high-priority 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-priority 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 support activities at HIV laboratories to achieve international accreditation in non-priority SNUs which will transition to completion.
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	
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 priority sites.		
Technical support to strengthen the use and quality of the Electronic HIV/AIDS Case Management Registry and Electronic Methadone Registry (Kyrgyzstan), 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 Priority 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

Location from which activity will be transitioned	Transitioning Activities	Type of Transition (i.e. to which entity)	Funding in COP15	Estimated funding in COP16	# of IMs	Transition End Date
Aksu (Kazakhstan)	HIV Care and Treatment site TA	Government	\$0	\$0	12872	1/1/2016
Ekibastuz (Kazakhstan)	HIV Care and Treatment/MMT site TA	Government	\$0	\$0	12872	1/1/2016
Uralsk (Kazakhstan)	HIV Care and Treatment/MMT site TA	Government	\$0	\$0	12872	1/1/2016
Almaty (Kazakhstan)	HIV lab accreditation TA in non-priority SNU's	Government	\$10,000	\$0	13970	3/31/2016
Panfilov district (Kyrgyz Republic)	HIV Care and Treatment/MMT site TA	GFATM	\$0	\$0	12872	1/1/2016
Jalalabad City (Kyrgyz Republic)	HIV Care and Treatment/MMT site TA	GFATM	\$0	\$0	12872	1/1/2016
Uzgen (Kyrgyz Republic)	HIV Care and Treatment/MMT site TA	GFATM	\$0	\$0	12872	1/1/2016
Batken (Kyrgyz Republic)	Blood Safety TA	Government	\$10,000	\$5,000	13971	1/1/2017
Chui, Naryn, Talas, Osh, Jalalabad, Issyk-Kul regions (Kyrgyz Republic)	General population prevention by Peace Corps Volunteers	Non-PEPFAR PCVs will continue gen pops activity with different funding	0\$	0\$		9/30/2015
Djalalabad (Kyrgyz Republic)	HIV Prevention/outreach to PWID	GFATM	\$0	\$0	12859	9/1/2015
Karakol (Kyrgyz Republic)	Care and Treatment/Community advisory board	Government	\$0	\$0	12746	9/30/2015
Naryn (Kyrgyz Republic)	Blood Safety TA	Government	\$10,000	\$5,000	13971	1/1/2017
Talas (Kyrgyz Republic)	Blood Safety TA	Government	\$10,000	\$5,000	13971	1/1/2017
Farkhor (Tajikistan)	HIV Prevention Trust Points for PWID	Government or NGO	\$18,868	\$0	12799	3/31/2016
Farkhor (Tajikistan)	HIV Prevention Point for PWID	Government	\$0	\$0	12799	3/31/2016
Gissar (Tajikistan)	HIV Prevention Trust Points for PWID	Government or NGO	\$18,868	\$0	12799	31-Mar-16

Gissar (Tajikistan)	HIV Prevention Point for PWID	Government	\$0	\$0	12799	3/31/2016
Khorog in GBAO (Tajikistan)	HIV Prevention/outreach to PWID	GFATM	\$0	\$0	12859	9/1/2015
Khorog in GBAO (Tajikistan)	HIV Care and Treatment/MMT site TA	Government	\$0	\$0	12872	1/1/2016
Qurghonteppa (Tajikistan)	HIV Prevention/outreach to PWID and SW	GFATM	\$0	\$0	12859	9/1/2015
Qurghonteppa (Tajikistan)	HIV Care and Treatment/MMT site TA	Government	\$0	\$0	12872	1/1/2016
Qurghonteppa (Tajikistan)	HIV Prevention Point for PWID	Government	\$0	\$0	12799	3/31/2016
Qurghonteppa (Tajikistan)	HIV Prevention Trust Points for PWID	Government or NGO	\$18,868	\$0	12799	3/31/2016
Rushan (Tajikistan)	HIV Care and Treatment/MMT site TA	Government	\$0	\$0	12872	1/1/2016
Rushan (Tajikistan)	HIV Prevention Trust Points for PWID	Government or NGO	\$18,868	\$0	12799	3/31/2016
Vose (Tajikistan)	HIV Prevention Trust Points for PWID	Government or NGO	\$18,868	\$0	12799	3/31/2016
Vose District (Tajikistan)	HIV Prevention Point for PWID	Government	\$0	\$0	12799	3/31/2016

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
\$0	\$15,800,000	\$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	\$186,418
IDUP	Injecting and Non-Injecting Drug Use	\$2,989,504
HMBL	Blood Safety	\$280,905
HMIN	Injection Safety	\$74,681
CIRC	Male Circumcision	
HVCT	Counseling and Testing	\$2,246,909
HBHC	Adult Care and Support	\$2,625,591
PDCS	Pediatric Care and Support	
HKID	Orphans and Vulnerable Children	
HTXS	Adult Treatment	\$898,940
HTXD	ARV Drugs	
PDTX	Pediatric Treatment	
HVTB	TB/HIV Care	\$504,626
HLAB	Lab	\$1,007,610
HVSI	Strategic Information	\$1,763,390
OHSS	Health Systems Strengthening	\$761,628
HVMS	Management and Operations	\$2,459,798
TOTAL		\$15,800,000

B.2 Resource Projections

To determine resource requirements, unit costs were developed from the expenditure analysis and APR results and used where possible to project future spending. For new activities or activities where unit costs cannot be calculated, projections were developed based on standard government estimates and historical costs.

Central Asia Region COP15 Targets by Oblast: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Kazakhstan/ Akmola Oblast	-	-	-	-	-
Kazakhstan/ Aktobe Oblast	-	-	-	-	-
Kazakhstan/ Almaty	-	-	-	-	-
Kazakhstan/ Almaty Oblast	-	-	-	-	-
Kazakhstan/ Astana	-	-	-	-	-
Kazakhstan/ Atyrau Oblast	-	-	-	-	-
Kazakhstan/ Baikonur Oblast	-	-	-	-	-
Kazakhstan/ Eastern-Kazakhstan Oblast	34,679	66	3,506	382	1,315
Kazakhstan/ Jambyl Oblast	-	-	-	-	-
Kazakhstan/ Karaganda Oblast	-	-	-	-	-
Kazakhstan/ Kostanay Oblast	-	-	-	-	-
Kazakhstan/ Kyzylorda Oblast	-	-	-	-	-
Kazakhstan/ Mangystau Oblast	-	-	-	-	-
Kazakhstan/ North Kazakhstan Oblast	-	-	-	-	-
Kazakhstan/ Pavlodar Oblast	31,924	42	2,120	218	902
Kazakhstan/ South-Kazakhstan Oblast	-	-	-	-	-
Kazakhstan/ Western-Kazakhstan Oblast	-	-	-	-	-
Kyrgyzstan/ Batken Oblast	-	-	-	-	-
Kyrgyzstan/ Bishkek	60,588	123	968	98	628
Kyrgyzstan/ Chui Oblast	40,040	84	632	66	421
Kyrgyzstan/ Issyk-Kul Oblast	-	-	-	-	-
Kyrgyzstan/ Jalalabad Oblast	-	-	-	-	-
Kyrgyzstan/ Naryn Oblast	-	-	-	-	-
Kyrgyzstan/ Osh	27,914	79	1,036	134	689
Kyrgyzstan/ Osh Oblast	3,050	10	526	16	401
Kyrgyzstan/ Talas Oblast	-	-	-	-	-
Tajikistan/ Districts of Republican Subordination	20,846	60	313	28	295
Tajikistan/ Dushanbe	55,643	480	2,086	171	1,169
Tajikistan/ Gorno-Badagakshan Oblast	163	-	-	-	-
Tajikistan/ Khatlon Oblast	670	-	-	-	-
Tajikistan/ Sughd Oblast	73,362	184	1,025	92	552
Uzbekistan/ Andijan Oblast	-	-	-	-	-
Uzbekistan/ Bukhara Oblast	-	-	-	-	-
Uzbekistan/ Fergana Oblast	-	-	-	-	-
Uzbekistan/ Guliston Oblast	-	-	-	-	-
Uzbekistan/ Jizzakh Oblast	-	-	-	-	-
Uzbekistan/ Namangan Oblast	-	-	-	-	-
Uzbekistan/ Navoiy Oblast	-	-	-	-	-
Uzbekistan/ Nukus Oblast	-	-	-	-	-
Uzbekistan/ Qarshi Oblast	-	-	-	-	-
Uzbekistan/ Samarkand Oblast	-	-	-	-	-
Uzbekistan/ Tashkent	-	-	-	-	-
Uzbekistan/ Termez Oblast	-	-	-	-	-
Uzbekistan/ Urgench Oblast	-	-	-	-	-
Total	348,879	1,128	12,212	1,205	6,372

Central Asia Region COP15 Targets by Oblast: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Kazakhstan/ Akmola Oblast	-	-	-
Kazakhstan/ Aktobe Oblast	-	-	-
Kazakhstan/ Almaty	-	-	-
Kazakhstan/ Almaty Oblast	-	-	-
Kazakhstan/ Astana	-	-	-
Kazakhstan/ Atyrau Oblast	-	-	-
Kazakhstan/ Baikonur Oblast	-	-	-
Kazakhstan/ Eastern-Kazakhstan Oblast	-	-	-
Kazakhstan/ Jambyl Oblast	-	-	-
Kazakhstan/ Karaganda Oblast	-	-	-
Kazakhstan/ Kostanay Oblast	-	-	-
Kazakhstan/ Kyzylorda Oblast	-	-	-
Kazakhstan/ Mangystau Oblast	-	-	-
Kazakhstan/ North Kazakhstan Oblast	-	-	-
Kazakhstan/ Pavlodar Oblast	-	-	-
Kazakhstan/ South-Kazakhstan Oblast	-	-	-
Kazakhstan/ Western-Kazakhstan Oblast	-	-	-
Kyrgyzstan/ Batken Oblast	-	-	-
Kyrgyzstan/ Bishkek	-	-	-
Kyrgyzstan/ Chui Oblast	-	-	-
Kyrgyzstan/ Issyk-Kul Oblast	-	-	-
Kyrgyzstan/ Jalalabad Oblast	-	-	-
Kyrgyzstan/ Naryn Oblast	-	-	-
Kyrgyzstan/ Osh	-	-	-
Kyrgyzstan/ Osh Oblast	-	-	-
Kyrgyzstan/ Talas Oblast	-	-	-
Tajikistan/ Districts of Republican Subordination	-	180	-
Tajikistan/ Dushanbe	-	380	-
Tajikistan/ Gorno-Badagkshan Oblast	-	200	-
Tajikistan/ Khatlon Oblast	-	600	-
Tajikistan/ Sughd Oblast	-	490	-
Uzbekistan/ Andijan Oblast	-	-	-
Uzbekistan/ Bukhara Oblast	-	-	-
Uzbekistan/ Fergana Oblast	-	-	-
Uzbekistan/ Guliston Oblast	-	-	-
Uzbekistan/ Jizzakh Oblast	-	-	-
Uzbekistan/ Namangan Oblast	-	-	-
Uzbekistan/ Navoiy Oblast	-	-	-
Uzbekistan/ Nukus Oblast	-	-	-
Uzbekistan/ Qarshi Oblast	-	-	-
Uzbekistan/ Samarkand Oblast	-	-	-
Uzbekistan/ Tashkent	-	-	-
Uzbekistan/ Termez Oblast	-	-	-
Uzbekistan/ Urgench Oblast	-	-	-
Total	-	1,850	-