

**STRATEGIC TECHNICAL ALIGNMENT FOR  
RESULTS (STAR) PROCESS**

**CENTRAL ASIA REGION (CAR)**

**Regional Operational Plan**

**(ROP) 2017**

**Strategic Direction Summary**

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## 1.0 Goal Statement

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In this 2017 Regional Operational Plan (ROP), the Central Asia Regional (CAR) PEPFAR program plans to continue progress in advancing national programs toward achievement of the UNAIDS 90-90-90 goals and sustainable epidemic control. Over the past year, PEPFAR CAR fielded a new model of HIV case finding and linkage to treatment, supported national HIV programs to begin revisions of HIV treatment guidelines toward Test and START, and coordinated support with Global Fund (GF) to maximize impact and sustainability of HIV/AIDS investments. In Fiscal Years (FY) 18 and 19, PEPFAR CAR will continue to build on these successes and, as outlined in the PEPFAR ROP 2017 Planning Level and Strategic Direction letter, will focus on three strategic outcomes: 1) intensified harm reduction and targeted case finding among Key Populations (KP) in priority provinces; 2) increased HIV treatment uptake among people living with HIV (PLHIV) to support viral suppression in the priority provinces; and 3) strengthened government capacity to monitor, manage, and finance national HIV responses.

Accomplishing these outcomes will require a strategic, country-tailored mix of above-site support, such as national guidelines development and adoption of more efficient service delivery models, and site-level investments to ensure that national policies, guidelines, and catalytic models are implemented well and achieve the expected impact. Given that injection drug use is still estimated to account for the majority of new and prevalent HIV cases, people who inject drugs (PWID) and their sexual partners will remain the focus for prevention, case finding, and treatment efforts. PEPFAR CAR will fill critical gaps in the HIV service cascade for this underserved key population. In addition, PEPFAR CAR will use updated surveillance and program monitoring data continually to iterate toward improved performance, such as increasing HIV case finding yield of the new peer-driven case finding approach. The priority provinces chosen in the ROP15 pivot in Tajikistan, Kyrgyz Republic, and Kazakhstan remain the focus for site-level support in the 2017 ROP. Further examination of disease burden, expected national and external funding for HIV, implementing partner performance, and partner contribution to the three strategic outcomes resulted in a projected shift in resources in FY 19 to an increased proportion of funding for Tajikistan and Kyrgyz Republic, increased funding to Ministry of Health partners, and a phasing out of funding for up to 5 international mechanisms.

Over the past year, PEPFAR CAR continually supported and engaged community and civil society in multiple fora, including national strategic planning meetings, country coordination meetings, local site visits, and various PEPFAR meetings. In preparation for this ROP, PEPFAR CAR collaborated with the national HIV programs to hold stakeholder meetings in each of the three countries to disseminate the PEPFAR annual achievements and strategic objectives as well as to seek input from stakeholders on ways to improve the PEPFAR and national HIV response. Stakeholder feedback was incorporated into the ROP planning. This engagement will continue in order to ensure a cohesive approach to common goals of epidemic control.

## 2.0 Epidemic, Response, and Program Context

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### 2.1 Summary statistics, disease burden and regional profile

The PEPFAR CAR program is implemented in Tajikistan (TJ) (population 8.5 million), Kyrgyz Republic (KG) (population 6 million), and Kazakhstan (KZ) (population 17.6 million). At the end of 2015, there were an estimated 1,529,300 PLHIV in Eastern Europe and Central Asia, which accounts for 4.2% of the global number of PLHIV.<sup>1</sup> In the three countries included in PEPFAR CAR there are an estimated 47,417 PLHIV. The HIV epidemic in CAR is growing, and is primarily concentrated among PWID and their sexual partners. In all three countries, the regions and cities that align with international drug trafficking routes have higher numbers of PWID, and consequently PLHIV, with 60% of the cumulative HIV cases in this region reported among PWID.<sup>2</sup> While the HIV prevalence among the general population in the three countries is at or below 0.19%, rates among PWID range from 9.3-26.5% within the PEPFAR focus subnational units (SNU). The number of new HIV infections in Central Asia rose rapidly in the 1990s and saw another increase toward the end of the last decade. The number of new registered HIV cases across the region increased by 6% (from 4,404 in 2015 to 4,707 in 2016). Epidemiological data show that other KPs are also disproportionately affected by HIV/AIDS relative to the general population. HIV prevalence among female sex workers (FSW) ranges from 1.4% (KZ) to 3.5% (TJ) prevalence among men who have sex with men (MSM) ranges from 2.7% (TJ) to 13% (KG).

In Tajikistan 5,807 adult PLHIV are officially registered, accounting for 36.7% of the estimated adult PLHIV; in Kyrgyz Republic, 4,823 adult PLHIV are diagnosed, accounting for 60.5% of the estimated adult PLHIV; and in Kazakhstan, 19,372 adult PLHIV are diagnosed, accounting for 85% of the estimated adult PLHIV.<sup>3</sup> The antiretroviral therapy (ART) coverage is 23.7% in Tajikistan, 33% in Kyrgyz Republic, and 34.6% of estimated adult PLHIV in Kazakhstan. Utilization of KP prevention services is also low across the region, and varies by country. Condom use by PWID at last intercourse ranges from 49.9% in Tajikistan to 39.9% in the Kyrgyz Republic. The average number of needles distributed per PWID in harm reduction annually ranges from 283 in Tajikistan to 128 in Kazakhstan.

The PEPFAR priority provinces in Tajikistan (Districts of Republican Subordination, Dushanbe, and Sughd Province) account for 72% of the estimated PLHIV in the country. Similarly, the four PEPFAR priority provinces in Kyrgyz Republic (Bishkek City, Chui Province, Osh City, and Osh Province) account for 82% of the estimated PLHIV in the country. In Kazakhstan, the two PEPFAR priority provinces (East Kazakhstan and Pavlodar provinces) were purposefully selected based on the enabling policy environment, and account for 21% of the estimated PLHIV.

In all three countries the GNI per capita decreased due to a regional economic downturn. The GNI dropped from \$1,370 (2014) to \$1,280 (2015) in Tajikistan; \$1,260 (2014) to \$1,170 (2015) in Kyrgyz Republic; and \$12,090 (2014) to \$11,390 (2015) in Kazakhstan. Kazakhstan spends 4.4% of its GDP

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<sup>1</sup> UNAIDS, *AIDSInfo* 2015, <http://www.aidsinfoonline.org>

<sup>2</sup> World Health Organization, *Central Asia HIV Profile*, 2013

<sup>3</sup> Unless otherwise specified, all estimated PLHIV figures in this document refer to adult PLHIV (15 years and up)

(\$184.4 billion)<sup>4</sup> on the health sector, which includes purchasing of ARVs. Tajikistan spends 6.9% of its GDP (\$7.85 billion)<sup>4</sup>, while Kyrgyz Republic spends 6.5% of its GDP (\$6.57 billion)<sup>4</sup> on their health sectors with no funds for ARV purchases.

All three countries are actively preparing to implement WHO's "Test and START" ART initiation guidelines. Tajikistan and the Kyrgyz Republic have new draft clinical protocols in various stages of development. Kazakhstan drafted a new clinical protocol making all PLHIV eligible for ART regardless of CD4 or clinical stage. The new protocol was submitted to the MoH for approval in February 2017. Tajikistan drafted a new HIV testing algorithm that was submitted to the MoH for approval in December 2016. The new testing protocol allows for use of HIV rapid tests by outreach workers in community settings and removes the requirement for Western Blot for confirmation of diagnosis. Kyrgyz Republic approved a new testing algorithm that includes HIV rapid testing to provide a timely diagnosis.

CAR countries face several similar obstacles in achieving the targets set out in the UNAIDS "Fast Track – Ending the AIDS Epidemic by 2030" initiative, including: punitive and discriminatory laws and policies toward KP; stigma and discrimination from communities, health providers, and law enforcement officials that marginalize PWID and limit access to and uptake of HIV-related services; and limited epidemiological data on the size and location of these populations to help strategically target services. National governments, in close collaboration with PEPFAR, UNAIDS and other stakeholders, are working to implement new approaches to expand HIV testing and improve HIV cases detection, consistent with the Fast-Track approach.

These countries are committed to the Sustainable Development Goals, specifically related to Sustainable Goal 3 and ending the HIV/AIDS epidemic by 2030. Currently, all countries are committed to 90-90-90 implementation.

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<sup>4</sup> *Trading Economics, Kazakhstan GDP, 2017*, <http://www.tradingeconomics.com/kazakhstan/gdp>

**Table 2.1.1 Key National Demographic and Epidemiological Data – Tajikistan**

	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	8,551,200	100%	1,418,100	16.58%	1,520,700	17.78%	845,800	9.89%	877,100	10.26%	1,958,100	22.90%	1,931,400	22.59%	National Statistics Agency, 01/01/2016
HIV Prevalence (%)	-	0.19%	0.01%				-	0.09%	-	0.08%	-	0.24%	-	0.50%	Estimated PLHIV (SPECTRUM, 2015) / population (NSA, 01/01/2016)
AIDS Deaths (per year)	154	-	5	-	4	-	2	-	2	-	37	-	104	-	EHCMS, January 01 - December 31, 2016 for reported death
Estimated # of PLHIV	16185	-	360				762	-	727	-	4613	-	9723	-	UNAIDS SPECTRUM 2015 www.aidsinfoonline.org
# PLHIV	6,442	-	245	-	390	-	135	-	70	-	2008	-	3594	-	EHCMS, 31/12/2016
Incidence Rate (Yr.)	-	0.01%	-	0.00%	-	0.00%	-	0.01%	-	0.00%	-	0.02%	-	0.03%	EHCMS, 2016; Note: # of new confirmed cases/by total population*100
New Infections (Yr.)	1041	-	45	-	71	-	50	-	32	-	320	-	523	-	EHCMS, 01/01/2016-31/12/2016; # of newly confirmed cases officially registered
Pregnant women needing ARVs	32													EHCMS, 31/12/2016	
Notified TB cases (Yr)	5,106	-	150	-	164	-	575	-	792	-	1580	-	1845	-	National TB center, 2015
% of TB cases that are HIV infected	144	2.82%	6	4.00%	16	9.76%	1	0.17%	1	0.13%	32	2.03%	88	4.77%	EHCMS, 31/12/2016; calculated % using notified cases as denominator.
Estimated Population Size of MSM*	13,400													UNAIDS, 2015 www.aidsinfoonline.org	
MSM HIV Prevalence		2.70%													UNAIDS, 2015 www.aidsinfoonline.org
Estimated FSW Population Size	14,100													RAC, size estimation of FSW, 2014	
FSW HIV Prevalence		3.50%													IBBS, 2014
Estimated PWID Population Size	23,100													RAC, size estimation of PWID, 2014	
PWID HIV Prevalence		13.5%													RAC, IBBS, 2014

**Table 2.1.1 Key National Demographic and Epidemiological Data – Kyrgyz Republic**

	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	6,019,480	100%	932,465	15.49%	976,846	16.23%	531,527	8.83%	551,466	9.16%	1,574,594	26.16%	1,452,582	24.13%	National Statistics Agency, 01/01/2016
Estimated # of PLHIV	8098	-	137				318	-	365	-	2278	-	5000	-	UNAIDS SPECTRUM, 2015 <a href="http://www.aidsonline.org">www.aidsonline.org</a>
HIV Prevalence (%)	-	0.13%	0.01%				-	0.06%	-	0.07%	-	0.14%	-	0.34%	Estimated #PLHIV (SPECTRUM, 2015) /Population (NSA, 01/01/2016)
AIDS Deaths (per year)	78		1	-	5	-	0	-	0	-	19	-	53	-	EHCMS, for reported death, 01/01/2016 – 31/12/2016
# PLHIV	5312		200	-	289	-	125	-	80	-	1684	-	2934	-	EHCMS, 31/12/2016
Incidence Rate (Yr.)	-	0.01%	-	0.00%	-	0.00%	-	0.01%	-	0.01%	-	0.02%	-	0.03%	EHCMS, 2016; Note: # of new confirmed cases/by total population*100
New Infections (Yr.)	763	-	17	-	16	-	42	-	36	-	260	-	392	-	EHCMS, 01/01/2016-31/12/2016; # of newly confirmed cases officially registered
Pregnant women needing ARVs	42													EHCMS, 31/12/2016	
Notified TB cases (Yr)	5853	-	239	-	293	-	243	-	1313	-	2160	-	1605	-	National Statistical Committee of the Kyrgyz Republic, 2015
% of TB cases that are HIV infected	176	3.01%	3	1.26%	3	1.02%	2	0.82%	1	0.08%	29	1.34%	138	8.60%	EHCMS, 31/12/2016; calculated % using notified cases as denominator
Estimated Population Size of MSM*	22,000													Report of size estimation of MSM, 2013	
MSM HIV Prevalence		13% in Bishkek 0% in Osh												UNAIDS, National HIV Prevalence 6.3% (2013); RAC, IBBS, 2013; Note: there were methodologic difficulties in the IBBS in Osh	
Estimated Population Size of FSW	7,100													RAC, size estimation of FSW, 2014	
FSW HIV Prevalence		2.20%												RAC IBBS, 2013	
Estimated Population Size of PWID	25,000													UNAIDS, 2015 <a href="http://www.aidsinfoonline.org">www.aidsinfoonline.org</a>	
PWID HIV Prevalence		12.40%												IBBS, 2013	

**Table 2.1.1 Key National Demographic and Epidemiological Data – Kazakhstan**

	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	17,670,579	100%	2,331,571	13.19%	2,464,104	13.94%	1,257,180	7.11%	1,301,580	7.37%	5,539,347	31.35%	4,776,797	27.03%	National Statistics Agency, 01/01/2016
Estimated # of PLHIV	23,134	-	261				875	-	965	-	6,270	-	14,763	-	UNAIDS SPECTRUM, 2015 <a href="http://www.aidsinfoonline.org">www.aidsinfoonline.org</a>
HIV Prevalence (%)	-	0.13%	0.01%				-	0.07%	-	0.07%	-	0.11%	-	0.31%	Estimated #PLHIV (SPECTRUM, 2015) / Population (NSA 01/01/2016)
AIDS Deaths (per year)	167	-	2	-	1	-	-	-	-	-	50	-	114	-	EHCMS, for reported death, 01/01/2016 – 31/12/2016
# PLHIV	19,811	-	192	-	247	-	390	-	250	-	7,241	-	11,491	-	EHCMS, 31/12/2016
Incidence Rate (Yr.)	-	0.0164%	-	0.0009%	-	0.0006%	-	0.0106%	-	0.0095%	-	0.0192%	-	0.0324%	EHCMS, 2016; Note: # of new confirmed cases/by total population*100
New Infections (Yr.)	2,903	-	20	-	14	-	133	-	124	-	1,062	-	1,550	-	EHCMS, 01/01/2016-31/12/2016; # of newly confirmed cases officially registered
Pregnant women needing ARVs	170														EHCMS, 31/12/2016
Notified TB cases (Yr)	13,417	-	NA	-	National TB center, 2015										
% of TB cases that are HIV infected	772	5.75%	-	-	-	-	3	-	2	-	200	-	567	-	EHCMS, 31/12/2016; calculated % using notified cases as denominator
Estimated Population Size of MSM*	14,320														e-M&E, 2016
MSM HIV Prevalence		3.16%													UNAIDS, 2015
Estimated FSW Population Size	18,660														IBBS, 2015
FSW HIV Prevalence		1.27%													e-M&E, 2016
Estimated PWID Population Size	120,500														e-IBBS, 2016
PWID HIV Prevalence		9.28%													IBBS, 2016

**Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression**

	Epidemiologic Data				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate, (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
<b>TAJKISTAN</b>										
Total population	8,551,200	0.19%	16,185	6,442	3,842	23.74%	71.00%	509,089	1,041	1,145
Population less than 15 years	2,938,800	0.01%	360	635	570	158.33%	75.45%	NA	116	104
15-24 year olds	1,722,900	0.09%	1,489	205	174	11.69%	76.09%	NA	82	88
25+ year olds	3,889,500	0.37%	14,336	5,602	3,098	21.61%	69.37%	NA	843	953
MSM	13,400	2.70%	362	49	22	6.08%	50.00%	NA	15	10
FSW	14,100	3.50%	494	225	153	31.00%	73.91%	NA	80	69
PWID	23,100	13.50%	3,119	2,293	781	25.04%	64.29%	NA	185	236
<b>KYRGYZ REPUBLIC</b>										
Total population	6,019,480	0.13%	8,098	5,312	2,679	33.08%	64.22%	376,288	763	675
Population less than 15 years	1,909,311	0.01%	137	489	417	304.38%	66.58%	NA	33	39
15-24 year olds	1,082,993	0.06%	683	205	124	18.16%	66.96%	NA	78	59
25+ year olds	3,027,176	0.24%	7,278	4,618	2,138	29.38%	63.58%	NA	652	577
MSM	22,000	6.30%	1,386	96	50	3.61%	75.51%	NA	26	24
FSW	7,100	2.20%	156	49	16	10.24%	75.00%	NA	9	5
PWID	25,000	12.40%	3,100	2,228	825	26.61%	56.47%	NA	131	193
<b>KAZAKHSTAN</b>										
Total population	17,670,579	0.13%	23,134	19,811	7,998	34.6%	59.87%	2,894,687	2,903	2,469
Population less than 15 years	4,795,675	0.01%	261	439	407	155.9%	79.50%	NA	34	39
15-24 year olds	2,558,760	0.07%	1,840	640	235	12.8%	57.38%	NA	257	142
25+ year olds	10,316,144	0.20%	21,033	18,732	7,356	35.0%	58.81%	NA	2,612	2,288
MSM	14,320	3.16%	453	409	158	34.9%	59.18%	NA	126	68
FSW	18,660	1.27%	237	272	50	21.1%	45.45%	NA	38	13
PWID	120,500	9.28%	10,885	8,999	3,297	30.3%	58.81%	NA	842	933

## 2.2 Investment Profile

### Tajikistan

Tajikistan's investment profile is characterized by a large dependency on external support to fund most of its \$61 million HIV National Strategic Plan (NSP) (2017-2020, pending the Government of Tajikistan's (GoT) approval), with international sources funding 83.1% (PEPFAR 23.1%, GF 60%), the GoT funding 14.3%, and the private sector 2.6% in calendar year (CY) 16 (Table 2.2.1 - Tajikistan). The GF represents the majority of international investment, and currently procures 100% of ARVs and treatment commodities (Table 2.2.2 - Tajikistan). The GF allocated \$17 million for HIV under the New Funding Model (NFM) for 2015-2017. Under the NFM, 60% of the total funding allocation is for prevention activities; 38% is for care, treatment, and support activities; and 2% is allocated for strengthening health systems and civil society. In December 2016, the GF issued an allocation letter for Tajikistan that recommended a funding level of \$12.9 million USD for HIV for three years (2018-2020), which is a 43% decrease from the previous allocation.

The proposed contribution by GoT is up to \$5.38 million during the current grant period.<sup>16</sup> Despite anticipated donor and domestic contributions, the NSP anticipates a funding gap of \$18 million, representing up to 29.1% of total NSP financial needs. This gap would primarily impact allocations to prevention services, which account for 80% of the NSP Budget. Ongoing economic uncertainty in the region may negatively impact the GoT's ability to increase or maintain HIV spending in 2017 and beyond.

### Kyrgyz Republic

According to the 2013-2014 National AIDS Spending Assessment (NASA), the majority of funding for Kyrgyz Republic's HIV/AIDS response comes from international sources (Table 2.2.1 - Kyrgyz Republic). In CY 16, international donors contributed 57.9% (23.8% PEPFAR, 34.2% GF); the Government of the Kyrgyz Republic (GoKR) accounted for 40%; and private sector sources accounted for less than 1.9% of HIV expenditures.

The GF, at 34.2% of total funding, is the largest single external donor for HIV programming in Kyrgyz Republic, and GF grant activities procure all ARVs and treatment commodities (Table 2.2.2 - Kyrgyz Republic). Prevention activities for PWID account for 50.3% of the total GF funding allocation; prevention of sexual transmission account for 19.4%; and care, treatment and support activities equal 17.6%. The remaining 12.7% is allocated toward management and operations, health system strengthening and the reduction of legal barriers for access to services of key populations<sup>17</sup> The GF focuses 99% of all prevention investments on KP, following the PEPFAR-funded 2015 Investment Case and Allocative Efficiency Analysis prioritized spending guidance.

Based on the GF Board's decision in November 2016 on the allocation of resources for 2017-2019, \$23,470,014 has been allocated for HIV, TB, and building resilient and sustainable systems for health. HIV is 48%, or \$11,266,362, of the total funding envelope. Disease burden and income level influenced

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<sup>16</sup> GF Allocation Letter to Tajikistan, December 2016

<sup>17</sup> National Plan of Transition to Domestic Funding, 2017

allocation amounts for all countries. Kyrgyz Republic is also among a handful of countries eligible to apply for additional catalytic investment funds. For 2017, the GoKR committed to co-finance over \$20 million for TB and HIV, and it will be expected to increase this amount by an additional \$3.5 million over the next three years of the next grant.

## Kazakhstan

The major source of financing for Kazakhstan's \$37 million annual HIV response is from domestic sources at 85.4%; international sources provide 14.6% (13.5% PEPFAR, 1.1% GF) (Table 2.2.1 - Kazakhstan), based on CY 16 expenditures. The Government of Kazakhstan (GoK) made strong political and budgetary commitments publicly in support of the social sector's role in the response to HIV/AIDS and kept the social sector expenditures unchanged in the 2015 budget (European Bank for Reconstruction and Development Transition Report 2015-16). The GoK procures all ARVs and pledged in the 5-year Health Strategy *Densaulyk* (2016-2019) to provide \$10.9 million in 2016, \$12.6 million in 2017, and \$12.7 million in 2018 for the procurement of ARVs. PEPFAR CAR provides support for updating the HIV drug formulary to utilize fixed dose combination drug therapies, which are less expensive than drugs on the current formulary. PEPFAR CAR will continue to advocate for and support the government to procure WHO prequalified ARVs through low cost UN mechanisms.

**Table 2.2.1 Investment Profile by Program Area – Tajikistan**

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
Clinical care, treatment and support	\$2,250,395	7.2	77.7	15.1	n/a
Community-based care, treatment, and support	\$471,009	57.2	21.3	21.5	n/a
HTS	\$996,272	16.8	45.1	38.1	n/a
Priority population prevention	\$745,951	n/a	100	n/a	n/a
Key population prevention	\$4,215,939	8.3	86.6	4.3	0.7
PMTCT	\$525,335	n/a	10.2	89.1	0.7
OVC	n/a	n/a	n/a	n/a	n/a
Laboratory	\$562,733	17.4	n/a	35	47.6
SI, Surveys and Surveillance	\$831,860	67.9	32.1	n/a	n/a
HSS	\$1,087,903	100	n/a	n/a	n/a
<b>Total</b>	<b>\$11,687,396</b>	<b>23.1%</b>	<b>60%</b>	<b>14.3%</b>	<b>2.6%</b>

**Table 2.2.2 Procurement Profile for Key Commodities - Tajikistan**

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	\$1,323,357.00	n/a	100	n/a	n/a
Rapid test kits	\$660,657.00	n/a	100	n/a	n/a
Other drugs	\$566,031.00	n/a	100	n/a	n/a
Lab reagents	\$297,503.00	n/a	100	n/a	n/a
Condoms	487,308	n/a	100	n/a	n/a
Viral load commodities	n/a	n/a	n/a	n/a	n/a
MAT	n/a	n/a	n/a	n/a	n/a
Other commodities	\$303,906	26.2	73.8	n/a	n/a
<b>Total</b>	<b>\$3,638,762</b>	<b>2.2%</b>	<b>97.8%</b>	<b>0%</b>	<b>0%</b>

**Table 2.2.1 Investment Profile by Program Area – Kyrgyz Republic**

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
Clinical care, treatment and support	\$1,767,288	9.8	19.21	60.8	10.3
Community-based care, treatment, and support	\$1,564,892	30.7	69.3	n/a	n/a
HTS	\$432,910.30	48.2	0	51.2	0.5
Priority population prevention	\$42,171	n/a	96.1	3.9	n/a
Key population prevention	\$3,024,602	24.5	66.6	8.9	0.1
PMTCT	\$432,910	n/a	32.1	65	2.9
OVC	n/a	n/a	n/a	n/a	n/a
Laboratory	\$4,539,956	3	n/a	97	0.04
SI, Surveys and Surveillance	\$811,248	95.9	n/a	3.7	0.5
HSS	\$4,074,484	33.6	53.8	937	2.9
<b>Total</b>	<b>\$17,004,563</b>	<b>23.7</b>	<b>34.2</b>	<b>40.2</b>	<b>1.9</b>

**Table 2.2.2 Procurement Profile for Key Commodities - Kyrgyz Republic**

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	\$239,872	n/a	100	n/a	n/a
Rapid test kits	\$354,009	2.8	97.2	n/a	n/a
Other drugs	n/a	n/a	n/a	n/a	n/a
Lab reagents	\$122,428	n/a	100	n/a	n/a
Condoms	n/a	n/a	n/a	n/a	n/a
Viral load commodities	n/a	n/a	n/a	n/a	n/a
MAT	\$70,139	n/a	100	n/a	n/a
Other commodities	\$1,013,369	20.9	79.1	n/a	n/a
<b>Total</b>	<b>\$1,799,816</b>	<b>12.3</b>	<b>87.7</b>	<b>n/a</b>	<b>n/a</b>

**Table 2.2.1 Investment Profile by Program Area – Kazakhstan**

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
Clinical care, treatment and support	\$7,726,810	2.1	n/a	97.9	n/a
Community-based care, treatment, and support	\$333,178	100	n/a	n/a	n/a
HTS	\$3,361,443	5	n/a	95	n/a
Priority population prevention	\$26,343	n/a	n/a	100	n/a
Key population prevention	\$2,790,470	10.2	8.7	81.2	n/a
PMTCT	\$688,860	n/a	n/a	100	n/a
OVC	n/a	n/a	n/a	n/a	n/a
Laboratory	\$2,057,699	9.2	n/a	90.8	n/a
SI, Surveys and Surveillance	\$2,238,926	32.2	n/a	67.8	n/a
HSS	\$3,493,412	34.9	n/a	65.1	n/a
<b>Total</b>	<b>\$22,717,140</b>	<b>13.5%</b>	<b>1.1%</b>	<b>85.4%</b>	<b>n/a</b>

**Table 2.2.2 Procurement Profile for Key Commodities - Kazakhstan**

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	\$10,900,00	n/a	n/a	100	n/a
Rapid test kits	\$976	100	n/a	n/a	n/a
Other drugs	n/a	n/a	n/a	n/a	n/a
Lab reagents	n/a	n/a	n/a	n/a	n/a
Condoms	\$112,726	n/a	100	n/a	n/a
Viral load commodities	n/a	n/a	n/a	n/a	n/a
MAT	\$141,111	n/a	100	n/a	n/a
Other commodities	\$229,326	9	91	n/a	n/a
<b>Total</b>	<b>\$11,384,139</b>	<b>0.19%</b>	<b>4.06%</b>	<b>95.75%</b>	<b>n/a</b>

**Table 2.2.3 USG Non-PEPFAR Funded Investments and Integration**

<b>Funding Source</b>	<b>Total USG Non-PEPFAR Resources</b>	<b>Non-PEPFAR Resources Co-Funding PEPFAR IMs</b>	<b># Co-Funded IMs</b>	<b>PEPFAR COP Co-Funding Contribution</b>	<b>Objectives</b>
USAID MCH	\$2,000,000 (TJ)				
USAID TB	\$8,907,788*				
USAID Nutrition	\$2,750,000°				
USAID Malaria					
Family Planning					
NIH					
CDC (Global Health Security)					
Peace Corps					
DOD Ebola					
MCC					
<b>Total</b>	<b>\$13,657,488</b>				

### 2.3 National Sustainability Update

The primary gaps in ensuring a sustainable HIV response across Central Asia are 1) low levels of government funding to the national HIV/AIDS program; 2) inefficient funding allocations; 3) high personnel turnover resulting in low institutional knowledge on the HIV technical response; and 4) inadequate collaboration between the public health sector and civil society to access vulnerable populations and ensure key populations receive appropriate high-quality HIV prevention and treatment services.

In Tajikistan, PEPFAR provides direct technical assistance to the Republican AIDS Center to support coordination of activities and maximize resources. To address HIV funding gaps in Kyrgyz Republic, PEPFAR advocates for inclusion of HIV-related services in the national health insurance plan. In Kazakhstan PEPFAR advocated for a low-cost ARV procurement system to maximize domestic resources allocated to HIV. To address inefficient funding allocations, PEPFAR advocated a KP-focused targeted HIV testing strategy in all countries.

The lack of institutional memory and technical capacity within the state-run HIV responses across the region is the focus of PEPFAR’s support for data systems, quality assurance, and policy development. PEPFAR is addressing stigma on multiple levels, from promoting civil society advocacy for the elimination of the punitive drug-user registration to training on discrimination for site-level personnel. PEPFAR is also building the capacity of civil society to advocate for accountable HIV national responses and promoting social contracting to ensure sustainable partnerships between civil society and government institutions.

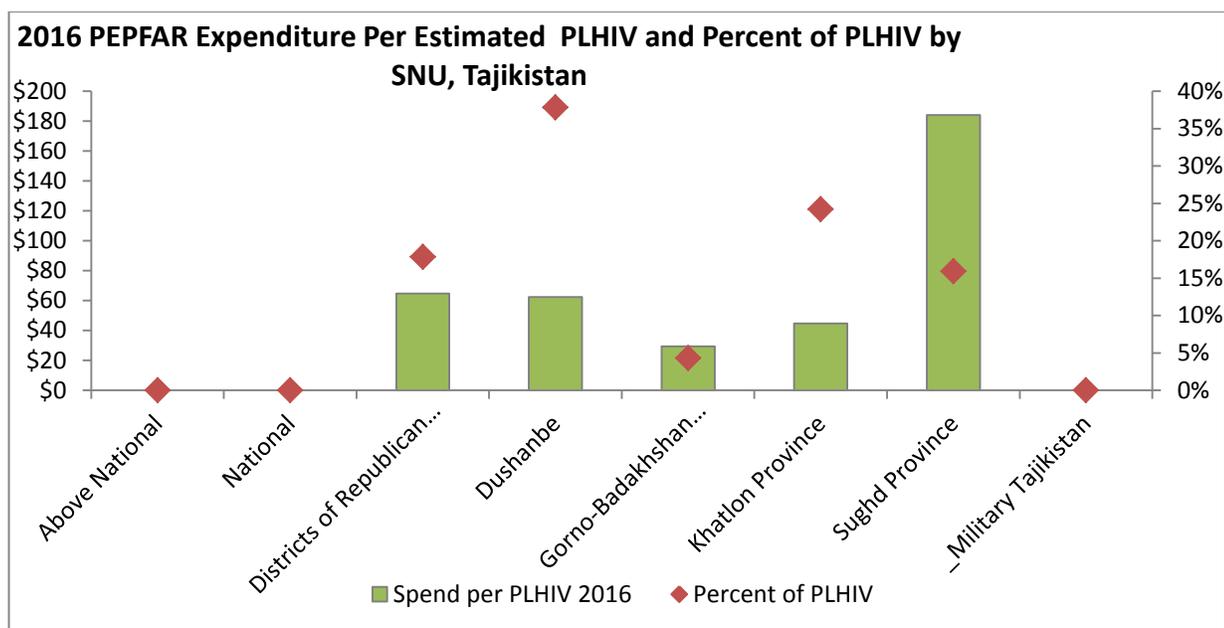
\* Breakdown of TB funds by country: \$4,000,000 for TJ; \$4,300,000 for KG; \$607,488 for regional TB funds

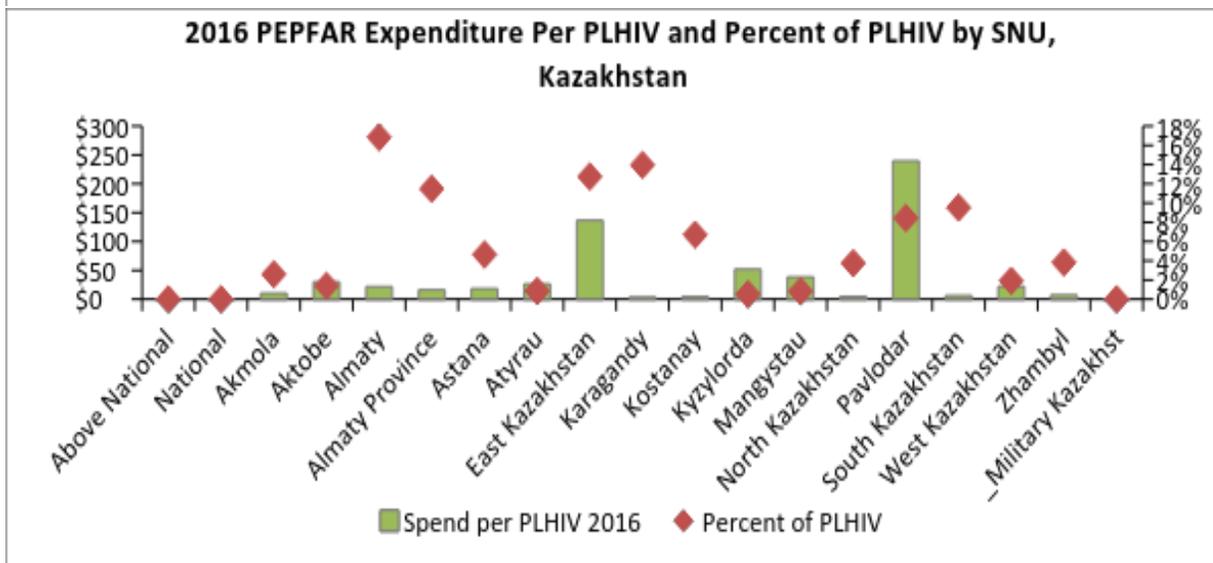
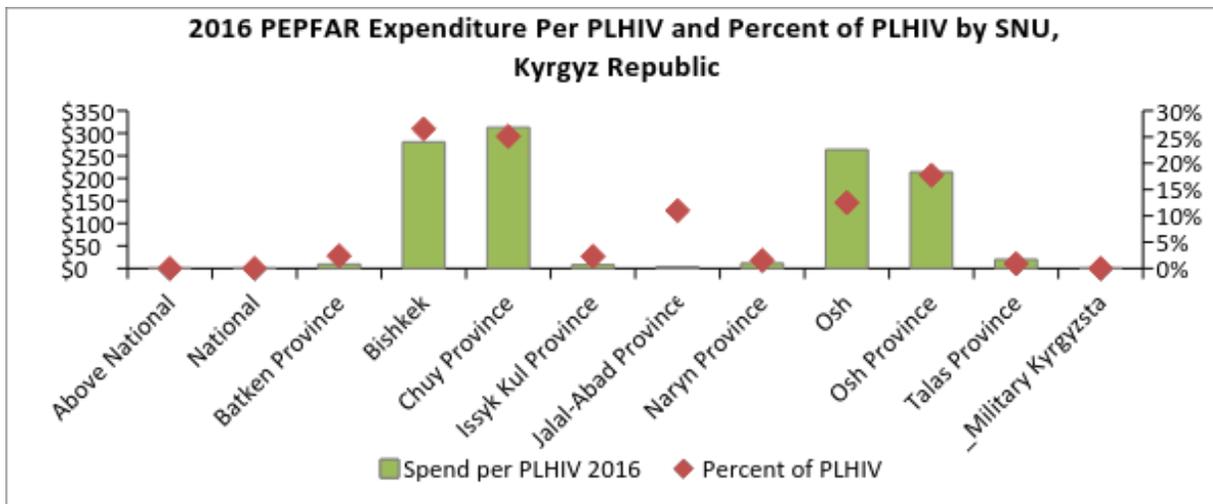
° Breakdown of nutrition funds by country: \$1,750,000 for TJ; \$1,000,000 for KG.

In Tajikistan and Kyrgyz Republic, the proposed National HIV/AIDS plans have the 90-90-90 strategy as their cornerstone, include HIV treatment benchmarks, incorporate domestic funding sources for the first time, and institutionalization of MAT into the national health program. Kazakhstan’s plan, mostly self-financed, includes adopting Test and START by 2019, reaching 90-90-90 targets by 2020, and institutionalizing MAT services.

#### 2.4 Alignment of PEPFAR investments geographically to disease burden

PEPFAR expenditures per estimated PLHIV in 2016 aligned with the PEPFAR priority provinces. The distribution of PEPFAR expenditures per PLHIV and disease burden measured by proportion of PLHIV by sub-national unit varies by each country. In Kyrgyz Republic, expenditures are well aligned with disease burden, while in Tajikistan, expenditures per PLHIV were relatively low in the highest burden subnational unit of Dushanbe due to significant delays in PEPFAR-supported community-based case detection and adherence support implementation. In Kazakhstan, expenditures per PLHIV varied significantly across supported provinces due to similar site-level expenditure in implementation despite lower disease burden in Pavlodar. To improve overall alignment of PEPFAR investments to disease burden in Central Asia, planned investments in Tajikistan will increase as its PEPFAR focus SNU represent 49.5% of the disease burden in the entire operational unit.





## 2.5 Stakeholder Engagement

Quarterly meetings with implementing partners and country stakeholders disseminate PEPFAR program results, collect feedback, and ensure better coordination of activities among stakeholders. The PEPFAR team conducted stakeholder meetings in each country during ROP17 strategy development. The teams met with local government and MoH officials, leadership from National AIDS and Narcology Centers, local NGOs, GF representatives, other implementing partners, and representatives of civil society and key populations to disseminate information from the FY 16 annual progress report, and to discuss the strategic direction for FY 18.

Stakeholders were very engaged in expressing their feedback on PEPFAR results and program activities and opportunities to improve coordination and collaboration to increase the efficiency and effectiveness of the HIV response. Dynamic discussions with all stakeholders gave a deeper understanding of the accomplishments and strategies moving forward, and solicited input.

When possible, feedback was integrated into the operational plan.

PEPFAR teams also meet regularly with GF and other external partners to streamline activities and

avoid duplication. There is consistent PEPFAR representation on GF Country Coordinating Mechanisms, who meet regularly and are currently assisting in the development of new GF applications to submit in March or May 2017. The PEPFAR team also actively engages in the strategic country meetings and with bodies that address National AIDS Programs and funding transition issues. These meetings support cross-sectional stakeholder investment and coordination platforms throughout the year.

## 3.0 Program Activities for Epidemic Control

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### 3.1 Description of strategic outcomes

Strategic outcomes for the 2017 ROP include: 1) intensified harm reduction and targeted case finding among KP in priority provinces; 2) increased HIV treatment uptake among PLHIV to support viral suppression in the priority provinces; and 3) strengthened government capacity to monitor, manage, and finance national HIV responses. The first two strategic objectives encompass activities to reach the UNAIDS 90-90-90 targets, and the third relates to the long term sustainability of the national HIV responses.

PWID remain the highest prevalence KP across all three CAR countries. All KP are relatively underserved by government funded programs across the region and are subject to intense stigma and discrimination. Given the low proportion of estimated PLHIV who know their status in Tajikistan (37% of estimated adult PLHIV are diagnosed) and Kyrgyz Republic (61% of estimated adult PLHIV are diagnosed), intensified case finding and linkage to treatment is essential in order to rapidly achieve treatment saturation. PEPFAR CAR will therefore continue to intensify site-level case finding in the priority provinces for PWID and their sexual partners to accelerate treatment scale up in focus provinces in Tajikistan and Kyrgyz Republic, while in Kazakhstan the focus will be on linking PLHIV who have been lost to follow up (LFTU) to care. Stigma and discrimination is a cross-cutting issue which is addressed in PEPFAR community, facility and above-site activities.

Treatment coverage is low across the region: 24% in Tajikistan, 33% in Kyrgyz Republic, and 35% in Kazakhstan. However, all three countries have committed to rapid treatment scale up in political declarations and national strategic plans. For all diagnosed PLHIV across the region, immediate treatment initiation, retention, and adherence support are expected to improve viral suppression in the priority provinces and serve as catalytic models for national scale up. In the current year, the national HIV programs are expected to approve treatment guidelines embracing HIV treatment for all PLHIV regardless of CD4; therefore, PEPFAR support will focus on training, roll out, and monitoring of the expanded treatment eligibility guidelines. With the large proportion of diagnosed PLHIV patients and a sufficient supply of ARVs, Kazakhstan is poised for a rapid scale up of treatment coverage. PEPFAR will support ART clinics in priority provinces to address clinic infrastructure, human resource needs, and patient flow bottlenecks, as well as implement new models of service

delivery to provide treatment more efficiently. Harm reduction, including MAT, is a critical component of keeping HIV-negative PWID uninfected, and in supporting HIV-infected PWID to be adherent to HIV treatment and achieving high viral suppression rates. Above-site activities will maintain the goal of ensuring an enabling environment for an effective, evidence-based HIV response, increasing government ownership in the three countries. Because the PEPFAR focus provinces account for over 70% of all PLHIV in Tajikistan and Kyrgyz Republic, progress in PEPFAR priority regions will substantially improve the national performance towards sustainable epidemic control.

Below is a high-level rationale and narrative description of both site-level and above-site investments for the first two strategic outcomes. Specific details of each activity, milestones and sustainability plans are included in the Focused Outcome and Impact Table (FOIT).

### **3.2 and 3.3 Site level and above site investments for achieving epidemic control**

#### **Strategic Outcome # 1: Intensified harm reduction and targeted case finding among KP in priority geographic areas**

*Rationale:* In Tajikistan and Kyrgyz Republic, site level activities for case finding and harm reduction among PWID will fill a critical gap in services to the highest prevalence KP. Kazakhstan has nearly achieved the first 90: 85% of estimated adult PLHIV know their status. However, many of these have been LTFU; therefore, the focus in Kazakhstan will be on bringing LTFU PLHIV back into care rather than case finding. Above site support will focus on rolling out new HIV testing protocols, which allow for HIV rapid testing by non-health workers in community settings thus increasing the accessibility of HIV testing for KPs. In addition, the new HIV testing algorithms are expected to reduce time for diagnosis since Western Blot testing will no longer be required.

Harm reduction for PWID remains a critical element in the HIV strategy to prevent new infections, as evidenced by the low HIV seroconversion rate among PWID in CAR harm reduction programs. MAT coverage does not exceed 5% of the estimated PWID in any CAR country, and so site-level support will fill critical gaps in services to PWID. Site-level support will also demonstrate effective models of low threshold, high volume MAT, and new models of successful referral of PWID to MAT by strengthening community-facility collaboration and increased retention in MAT through investments in evidence-based psychosocial support models.

*Site-Level Activities:* PEPFAR CAR will continue to conduct case finding among PWID at the community level through peer-driven outreach (PDO) and in select prisons through peer navigators within the priority provinces, continuously assessing network and yield data to improve outcomes. Initial HIV Flagship PDO activities demonstrated an average HIV positive yield of approximately 2%, (ranging from 0 – 6%) in Tajikistan and Kyrgyz Republic. Given the high HIV prevalence among PWID, network maps were analyzed in order to ascertain new methods to increase yield, such as using only HIV positive PWID to initiate peer networks and limiting the continuation of networks that

found no HIV positive cases. These changes have been recently implemented, and HIV Flagship is collecting new performance data. In addition, sub-recipient NGOs with particularly low testing yields will be visited by PEPFAR staff and more closely monitored. Previously, newly diagnosed PLHIV were referred to care and treatment services, yet many were LFTU. HIV Flagship peer navigators will now escort newly diagnosed PLHIV through confirmatory testing and initiation of treatment, providing active case management for the first six months of treatment to ensure ART adherence. They will also screen PWID and PLHIV for TB, and refer to TB services as needed.

In Quarter 1, 2017, the Tajikistan Republican Narcology Center (RNC) initiated two new MAT sites with PEPFAR support in order to fill a critical lack of MAT services in Tajikistan, and the site-level MAT support is expected to continue scaling up in FY 18 and 19. The MAT sites are co-located with HIV treatment facilities in order to increase access of HIV infected PWID to MAT. Across the region, PEPFAR will track and attempt to increase successful referral of PWID in prevention services to MAT services. In addition, a “MARS”<sup>18</sup> peer support model will be implemented in PEPFAR supported sites in Tajikistan and Kyrgyz Republic Narcology Centers in order to increase retention on MAT. PEPFAR CAR will continue to coordinate with the GF and other partners to ensure that HIV negative key populations receive harm reduction services and commodities, such as needle exchange and condoms, and community level peer navigators will refer clients to these services, escorting them when necessary.

Given the epidemiology of the concentrated epidemic in Central Asia, 90-90-90 will not be reached with work among PWID alone. While PWID make up over 50% of PLHIV, the scant available data indicate that MSM are likely also an important risk group, with prevalence estimates as high as 13% in some areas. MSM in Central Asia are extremely stigmatized and are largely unwilling to openly seek services. There is currently limited active case-finding being done with MSM, so PEPFAR CAR will use supplemental funds to test the implementation of peer-driven outreach case finding among MSM in Bishkek, Kyrgyz Republic and Dushanbe, Tajikistan. The goals of this work are (1) to test the potential impact and acceptability of this outreach model among MSM in Central Asia and (2) to develop population size and HIV prevalence estimates for MSM in these areas.

In Central Asia, traditional community level work has focused on provision of harm reduction services to relatively stable populations over time. This was effective in reducing incidence among those KPs participating in harm reduction but did not actively reach out to more hidden populations. The peer-driven outreach is an innovative model for the region which attempts to reach into networks who are not reached through traditional models. In order to examine the cost-effectiveness of this model, PEPFAR CAR will use supplemental funds to compare the cost of case-finding through each model in Kyrgyz Republic, where the two methodologies are implemented side-by-side. A simple calculation of the cost of scale-up will be done in Tajikistan.

*Above-Site Activities:* The planned above-site activities will aim to enhance the effectiveness of case

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<sup>18</sup> MARS – Medicated-Assisted Recovery Support – is a peer-based model designed to provide peer recovery support to persons whose recovery from opiate addiction is assisted by medication

finding and harm reductions services by addressing key national policy and system barriers to HIV diagnosis and MAT services. In all three countries, PEPFAR is supporting HIV testing guidelines revision and roll out of quality assured HIV rapid testing in community settings by non-health workers, which will improve the accessibility of HIV testing in the PDO model and reduce time to confirmatory HIV diagnosis. PEPFAR CAR will continue to advocate for increased government scale up and funding of MAT services. For example, with PEPFAR and UN Office on Drugs and Crime (UNODC) support, the Minister of Health recommended that the Government of Kazakhstan institutionalize MAT nationally. PEPFAR and UNODC persuaded the Government of Tajikistan to allow MAT services in prisons. UNODC will continue to work on addressing critical policy barriers and an enabling environment with police. In addition PEPFAR CAR will continue to support the RNCs to adopt policies that increase access to MAT, such as take-home doses of methadone and provision of methadone without officially registering as an injection drug user. PEPFAR will continue to work with MOHs and Republican AIDS Centers (RAC) to develop systems to track KPs across the full cascade of services.

**Strategic Outcome # 2: Increased HIV treatment uptake among PLHIV to support viral suppression in priority geographic areas**

*Rationale:* The PDO model will increase new HIV case finding and linkage to treatment services in Tajikistan and Kyrgyz Republic. Across the three countries, adoption of Test and START guidelines will increase the number of PLHIV eligible for treatment, resulting in rapid scale up of site-level treatment uptake. In Kazakhstan, the recent agreement to purchase ARVs through the UNICEF bulk procurement process resulted in a doubling of the amount of ARVs available at sites, with further increases in ARV availability expected in 2018. Across the regional priority provinces, rapid scale up will stress the existing staff and infrastructure unless more efficient models of differentiated service delivery are adopted, and PEPFAR CAR will work at the above site level to adopt new models of service delivery into national guidelines, and at site level to ensure that the new models are implemented. Retention and adherence support are lacking at government HIV treatment sites throughout the region, leading to low 12 month retention (75% in KZ and 80% in KG), and low national viral suppression rates for those on ART (71% in TJ, 64% KG, 60% KZ). PEPFAR CAR will pilot additional methods of adherence and retention support through community peer navigators and facility based home visiting nurses to improve retention, adherence, and viral suppression rates. Increasing MAT uptake and adherence is a critical component of PEPFAR support for improving ART adherence and increasing wellbeing among PWID PLHIV.

*Site-Level Activities:* The PEPFAR CAR supported International Center for AIDS Care and Treatment Programs (ICAP) and RAC implementing mechanisms will increase treatment initiation at sites through training workers on the new national ART eligibility guidelines, clinical mentoring of clinicians, and intensively monitoring site level performance, with performance based incentives for meeting targets. The HIV Flagship will provide newly identified PLHIV intensive support for the first six months of treatment, including active linkage to MAT and TB services when applicable, and case management in communities to ensure treatment adherence and viral suppression. Case management

includes escorting to facilities for routine appointments and tests, treatment education, community support groups, TB screening and referral, psychosocial support and other services. HIV Flagship peer navigators in the community will continue to work closely with ICAP patronage nurses and HIV treatment clinics to find PLHIV who are LTFU and bring them back to treatment. These activities fill important gaps that are not currently sufficiently addressed by government strategies and will demonstrate the feasibility of these approaches for national scale up. ICAP will address gaps in TB/HIV services and Infection Prevention in PEPFAR-supported facilities. To monitor whether treatment successfully reduces viral load to undetectable levels, the PEPFAR program will work with RACs to improve capacity in and expand access to quality viral load testing, especially in Tajikistan where only 20% of PLHIV on ART in PEPFAR provinces received a viral load test in the past 12 months. Viral load (VL) coverage was especially low (1%) in Sughd province; however, the new PEPFAR supported VL lab in Sughd is expected to increase VL testing coverage. Site-level support includes training and quality assurance of the VL labs as well as mentoring of clinicians at ART sites to order and respond appropriately to VL test results.

*Above-Site Activities:* To ensure continued progress in treatment scale up and viral suppression in priority provinces, PEPFAR CAR will continue to support the above-site work on national policy, guidelines, and advocacy for Test and START, increased access to MAT, ART procurement of sufficient quantities of WHO prequalified ARVs, and reduced stigma and discrimination. PEPFAR CAR will help national HIV programs adopt treatment guidelines for immediate initiation of ART and new models of service delivery which allow for multi-month scripting for stable ART patients. PEPFAR will work with the RACs to ensure quality of services through active monitoring of the Electronic HIV Case Management System (EHCMS) data and prompt feedback to low-performing sites, certification of sites and providers, and QA/QC programs to ensure reliability of VL lab results.

### **3.4 Description of how PEPFAR will support greater sustainability**

#### **Strategic Outcome # 3: Strengthened government capacity to monitor, manage and finance national HIV responses**

A focused, robust and sustainable national response requires that the national HIV programs have current, international standard HIV policies and guidelines, efficient and effective methods for monitoring and supervising ART sites for the quality of service delivery, efficient methods for staff capacity development and motivation, and stable, sufficient funding for the response. PEPFAR support for guideline and policy development and enhanced monitoring capacity of HIV programs to provide quality services by the RAC and RNCs were described in Sections 3.1 and 3.2. To enhance HIV service provider skill and capacity for treatment, PEPFAR CAR has implemented Project ECHO in Kazakhstan and Kyrgyz Republic, and will initiate ECHO in Tajikistan in 2017. Project ECHO operates from the postgraduate institutes and employs low-cost, web-based distance mentoring for all ART sites nationally, to mentor clinicians on illustrative cases and create a network of professionals. Since strategic information is important for evidence based programs, PEPFAR CAR will continue to work

with the national governments to collect quality program and surveillance data and to use the information for programmatic improvements.

As described in Section 2, the governments in Central Asia have varying abilities to pay for their HIV response, with Tajikistan, Kyrgyz Republic, and Kazakhstan national governments currently covering 27%, 33%, and 75% respectively. The expected trend is for GF to continue reducing HIV funding, making a 43% reduction in funding in Tajikistan over the next three years. The GF is also requiring a greater contribution by the national governments, requiring national governments to fund a greater percent of the national response. Kazakhstan and Kyrgyz Republics have national health insurance schemes, which are expected to include HIV services. All three countries have the legal basis to fund local NGOs through “social contracting,” and Kazakhstan has already been able to fund local NGOs on a limited scale. PEPFAR CAR is investing in building the capacity of local NGOs to implement case-finding, linkage to treatment and adherence support as well as to monitor services and advocate for improvements where necessary, and to reduce stigma and discrimination. Throughout the ROP period, the OU will increase efforts to work with the national governments, GF, and other partners to advocate for adoption of the findings of the Investment Case Scenarios for each country to allocate more funding for achievement of the 90-90-90 targets as well as allocate the budgets more efficiently and increase use of social contracts to ensure the most vulnerable populations continue to receive quality services.