The Global Fund
To Fight AIDS, Tuberculosis and Malaria

EFFECTIVE TB AND HIV CONTROL PROJECT IN KYRGYZSTAN

Investing for impact against tuberculosis and HIV

SUMMARY INFORMATION			
Applicant Information			
Country	Kyrgyz Republic		
Funding Request Start Date	January 2016	**Funding Request End Date**	December 2017
Principle Recipient(s)	United Nations Development Programme in Kyrgyzstan; Ministry of Health of the Kyrgyz Republic will take over PR-ship starting 2017.		
If the programs are to be managed as separate grants:			
Funding Request Start Date for HIV	n/a	**Funding Request End Date for HIV**	n/a
Principal Recipient(s) for HIV	n/a		
Funding Request Start Date for TB	n/a	**Funding Request End Date for TB**	n/a
Principal Recipient(s) for TB	n/a		

FUNDING REQUEST SUMMARY TABLE

By Year

	Year 1	Year 2	Total
Allocation	10,083,095	9,631,394	19,714,489
Above	742,862	376,622	1,119,484
Grand Total	**10,825,956**	**10,008,016**	**20,833,972**

By Module

Module name	Allocation	Above	Full request
MDR-TB	8,499,797	1,119,484	9,619,281
Prevention programs for people who inject drugs (PWID) and their partners	2,980,588	0	2,980,588
Prevention programs for sex workers and their clients	780,281	0	780,281
Prevention programs for MSM and TGs	461,066	0	461,066
Prevention programs for other vulnerable populations (prisoners)	130,209	0	130,209
PMTCT	467,839	0	467,839
Treatment, care and support	2,561,959	0	2,561,959
Community systems strengthening	170,000	0	170,000
Removing legal barriers to access	170,000	0	170,000
HSS - Health information systems and M&E	430,000	0	430,000
TB/HIV	69,714	0	69,714
Program management	2,993,035	0	2,993,035
Grand Total	**19,714,488**	**1,119,484**	**20,833,972**

SECTION 1: COUNTRY CONTEXT

This section requests information on the country context, including descriptions of the TB and HIV disease epidemiology and their overlaps, the health systems and community systems setting, and the human rights situation.

1.1 Country Disease, Health Systems and Community Systems Context

With reference to the latest available epidemiological information for TB and HIV, and in addition to the portfolio analysis provided by the Global Fund, highlight:

a. The current and evolving epidemiology of the two diseases, including trends and any significant geographic variations in incidence or prevalence of TB and HIV. Include information on the prevalence of HIV among TB patients and TB incidence among people living with HIV/AIDS.

b. Key populations that may have disproportionately low access to prevention, treatment, care and support services, and the contributing factors to this inequity.

c. Key human rights barriers and gender inequalities that may impede access to health services.

d. The health systems and community systems context in the country, including any constraints relevant to effective implementation of the national TB and HIV programs including joint areas of both programs.

Kyrgyzstan (Kyrgyz Republic) is a country in transition in Central Asia, which gained independence after the break-up of the Soviet Union in 1991. The period of transition to the democratic society and market economy was complicated by severe economic downturn, ethnic clashes, worsened living conditions, breakdown of the social safety net and profound disintegration of the health system. The economic recovery began in late 1990s and today, Kyrgyzstan has a total population of 5.8 million and the Gross National Income (GNI) is USD 1,250 per capita.[1] The World Bank defines Kyrgyzstan as lower-middle income country. Administratively, the country comprises of 7 oblast (regions) and two administratively independent cities (Bishkek – the capital city and Osh). Each region comprises a number of rayons (districts) administered by government-appointed officials.

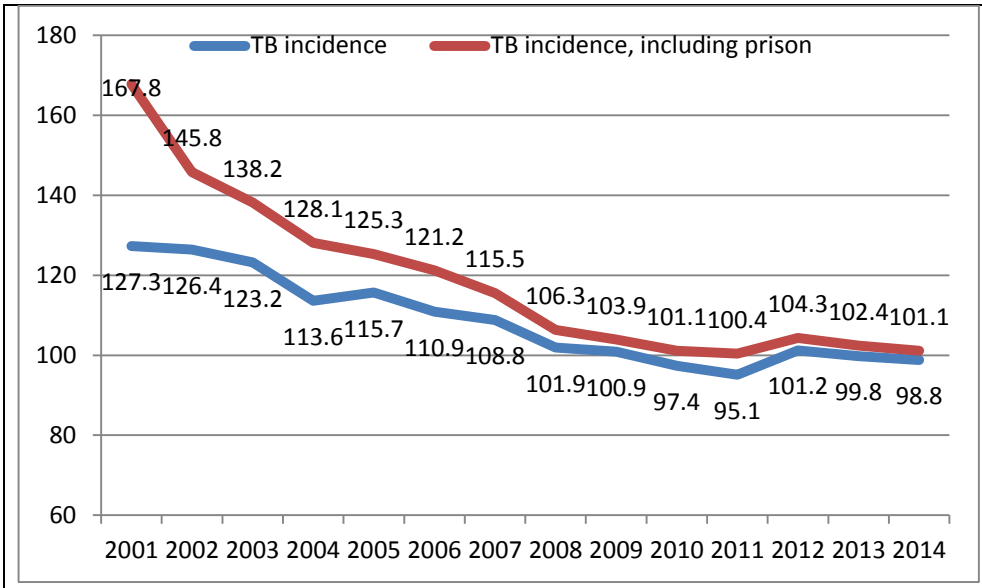
TB epidemiology

Tuberculosis re-emerged as an important public health problem after independence and its burden remains severe in the country. Kyrgyzstan is one of the 27 countries with a high burden of multi-drug resistant TB (MDR-TB),[2] and one of the 18 high-priority countries in the WHO European Region.[3] According to the WHO Global Tuberculosis Report (2014), Kyrgyzstan's incidence rate for all forms of tuberculosis has reached 141 (124-157), prevalence is 190 (88-329) and mortality is 11 (11-11) per 100,000 population.

According to NTP, the notification data (registered separately for the civilian population and prisoners) showed a steady downward trend over 2001-2009 with stabilization during 2010 – 2014. In 2014 a total of 5,784 newly TB cases have been registered (including 135 cases in the penitentiary system). The notification rate fell from 168 per 100,000 population in 2001 to 101.1 in 2014, including penitentiaries (Fig. 1).

Fig 1. TB incidence, Kyrgyzstan, 2001 – 2014

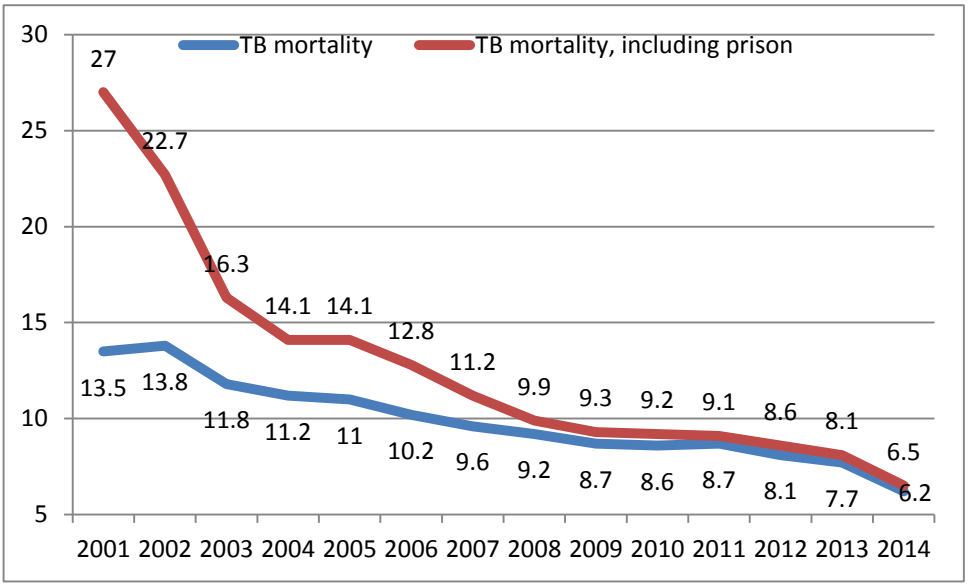
[1] World Bank development indicators, http://data.worldbank.org/country/kyrgyz-republic, accessed on 05.07.2015
[2] WHO Global Tuberculosis Report 2014, http://www.who.int/tb/publications/global_report/en/
[3] WHO Regional Office for Europe. Plan to Stop TB in 18 High-priority Countries in the WHO European Region, 2007–2015.



The highest incidence rates have been in Bishkek and the Chuy region (121.8 and 129.3 per 100,000 population respectively) due to internal labour migration. The lowest incidence rate has been registered in the Issyk-Kul oblast (64.7 per 100,000 population). While there has been an overall decrease in TB incidence among children (from 82.2 in 2002 to 24 per 100,000 population in 2013), it remains high. The incidence among adolescents also remains high: it was 82.5 per 100,000 population in 2014.

There is a constant decrease in mortality rate. In 2014, mortality was 6.5 compared with 27 per 100,000 population in 2001, including penitentiaries. The figure 2 describes the mortality trend over the last 14 years in civilian and penitentiary sectors.

Figure 2. TB mortality rates, Kyrgyzstan, 2001 – 2014.



While there are important achievements of the National TB Programme during recent years, crucial challenges remain to be addressed. As in the other former Soviet Union republics, resistance to anti-TB drugs represents a serious obstacle to effective control of the TB epidemic. According to the latest official WHO figures available, the level of MDR-TB is 26.4% among new TB cases and 55.1% among previously treated TB cases.[4] The detection rate has been increased due to

[4] WHO Global Tuberculosis Report 2014, http://www.who.int/tb/publications/global_report/en/

introduction and scale-up of molecular tests for drug resistance (e.g. Hain, Xpert). Over the past five years, the detected MDR-TB cases increased from 528 in 2010 to 1,219 in 2014 while the detection of XDR-TB cases increased from 32 patients in 2010 to 43 in 2014.

Table 1. Laboratory confirmed MDR-TB cases, Kyrgyzstan, 2009 - 2014.

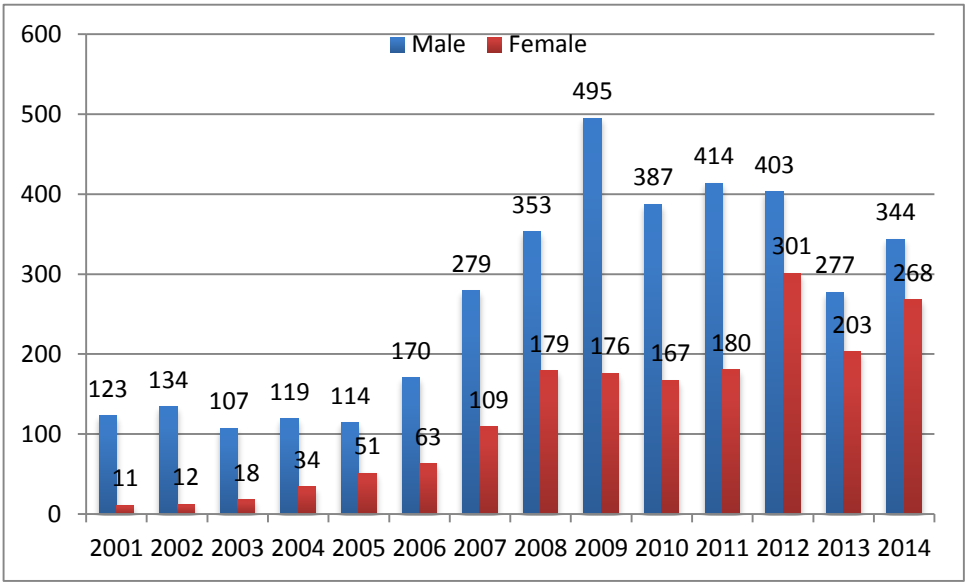
Year	Laboratory confirmed cases of MDR-TB	
	MDR-TB	XDR-TB
2010	528	32
2011	679	14
2012	958	18
2013	1,590	63
2014	1,219	43

HIV epidemiology

Kyrgyzstan has a concentrated HIV epidemic, with an estimated HIV prevalence in adult general population of 0.3% (Source: UNAIDS, 2013 Report on the Global AIDS Epidemic). Although the burden of HIV in Kyrgyzstan has been comparatively low, it is probably underestimated, in particular due to difficulties in accessing key affected populations (KAP), i.e. people who inject drugs (PWID), sex workers (SW) and their clients, men who have sex with men (MSM) and prisoners. The estimated number of people living with HIV (PLHIV) in Kyrgyzstan is 9,496 (UNAIDS estimates for 2015 based on SPECTRUM).

According to national statistics, by January 1, 2015, a total of 5,505 HIV cases were officially registered in Kyrgyzstan. Of them, 694 persons developed AIDS and 343 of them died. The annual number of people newly diagnosed with HIV increased from 134 in 2001 to 612 in 2014 with stable newly registered HIV cases over past years around 600 cases per year (Figure 3). Cases of HIV-infection have been registered in all administrative-territorial regions and towns. The highest HIV cumulative number of cases has been registered in the following districts and cities: the Chuy region - 1,646 cases (29.9%), the Osh region - with 1,078 cases (19.6%), the city of Osh - 927 cases (16.8%), Bishkek - 826 cases (15%) and Jalal-Abad - 621 cases (11%). All together they count for 81.3% of all HIV registered cases in Kyrgyzstan. The remained regions (Talas, Naryn, Issyk-Kul and Batken) count for 7% or 406 registered cases.

Figure 3. Registration of HIV infections by sex in the Kyrgyz Republic, 2001-2014.



Out of the total number of the PLHIV 79.4% are men, 20.6% - women. Among newly diagnosed HIV cases, men are still predominant; however during recent years an increase in the number of HIV

infected women is observed (see Figure 3). The predominant mode of HIV transmission is sharing of injecting equipment among people who inject drugs (55%), however transmission through heterosexual sex is increasing and currently accounts for 36% of cumulative cases; the majority of PLHIV are in the age group 25-49 years.

The HIV epidemic in Kyrgyzstan continues to be concentrated among key affected populations, mostly people who inject drugs in civilian and prison sectors, sex workers and men having sex with men. In 2014, the Republican AIDS Centre together with technical partners conducted the first size estimation, which indicated a population of 25,000 (20,300 – 29,200) PWID, 7,100 (6,890-7317) SW and 21,800 MSM.

Key populations

People who inject drugs. Based on 2013 Integrated bio-behavioural surveillance (IBBS) in key populations, the HIV prevalence among PWID is 12.4% in Kyrgyzstan, showing a decrease (from 14.3%) compared to previous IBBS conducted in 2010. PWID also have the highest prevalence of HCV (45.2%) and syphilis (8.0%) compared to other key affected populations. The IBBS has been conducted in 8 sentinel sites (Bishkek, Tokmok, Osh, Jalal-Abad, Kyzyl-Kia, Kochkor, Karakol and Talas). The highest HIV prevalence has been noticed in the Osh region – 16.8% and Jalal-Abad – 20%. Based on 2013 IBBS, only 55% of people who inject drugs report using sterile injecting equipment the last time they injected; only 40% report the use of a condom at last sexual intercourse. In the previous 12 months, 5% of PWID reported having commercial sex; majority reported use of a condom at last sexual intercourse with a commercial sex partner (81%). At the same time, only 28.2% of PWID reported participating in prevention programs in the previous year: this figure was higher in the Osh oblast than for any of the other 8 sites surveyed.

Men having sex with men. HIV prevalence among MSM increased from 1.1% in 2010 to 6.3% in 2013. The condom use during last anal sex with a male partner is 82%. The IBBS indicated a high proportion of MSM (20%) engaged in commercial sex in the previous six months, which suggests that the sample included a sizeable proportion of male sex workers. The median number of sexual partners reported by MSM in the previous 6 months was 6. About 76.3% reported having received HIV prevention services in the previous year and 40% had HIV test in the past 12 months. The prevalence of HCV is 1.6% and syphilis – 7.9%.

Sex workers. The prevalence of HIV in SW is 2.2%, whereas prevalence of HCV is 3.3% and syphilis is 23.6%. The 2013 IBBS showed that condom use with clients at last sex was 90.6% while the median number of clients reported by SW in the previous month was 59. Condom use with non-commercial sex partner at last sex was much lower (36%). About two third of SW (65%) reported participation in preventive programs and about 56% reported HIV testing during the last 12 months. The relative high HCV prevalence suggests that some female sex workers are also PWID. An alarming issue is the high prevalence of syphilis, which indicates inappropriate sexual behaviour.

Prisoners. The average annual number of detainees in the penitentiary system of Kyrgyzstan was about 7,953 in 2014 with about 3,500 annual turnover. The TB incidence is 1,918 per 100,000 population or 19 times higher compared to civilian sector; however this is less compared to 2001. The high prevalence of HIV (7.6%) and HCV (34.5%) among prisoners may indicate to injection drug issue in prison. The 2013 IBBS indicated that half of PWID in prison (47.9%) would use their own syringe and 8% would use a common one. Prevalence of syphilis was 14%. About 22% of respondents reported coverage with minimum three services (condoms, syringes and informational materials). About 41% of respondents reported HIV testing during the last 12 months. Awareness about prevention programs and use of condoms is still low in this group.

Two rounds of second-generation sentinel surveillance in key affected populations have been conducted based on the same methodology. Comparative results are presented in the Table 2 below.

Table 2. HIV prevalence among key affected populations, IBBS 2010 and 2013, Kyrgyzstan

	PWID		SW		MSM		Prisoners	
	2010	2013	2010	2013	2010	2013	2010	2013
HIV prevalence	14.3	12.4	3.5	2.2	1.1	6.3	13.7	7.6

Migrants. Labour migrants represent a substantial share of the total country population, although its exact size is difficult to determine. According to the World Bank, the net migration was -131,593 in 2010 and involves primarily working-age population. The NTP documented that about 10.4% of newly diagnosed TB cases in 2013 have been in migrants (compared to 9% in 2009). Over last five years, about 2,530 people diagnosed with TB came from abroad; majority are from southern regions of Kyrgyzstan.

Table 3. TB incidence among migrants in the Kyrgyz Republic by region from 2009-2013.

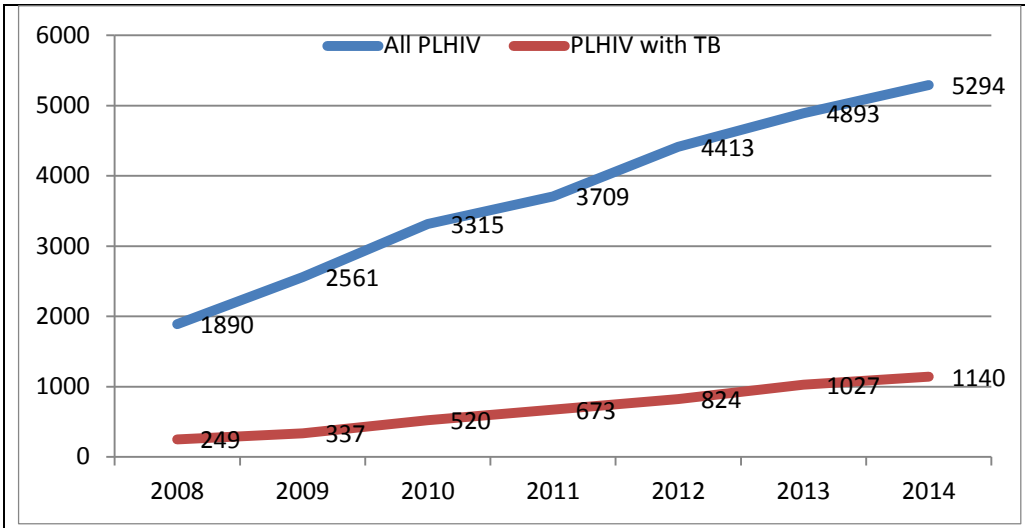
Region	Absolute number					% of newly diagnosed people				
	2009	2010	2011	2012	2013	2009	2010	2011	2012	2013
Republic	**490**	**488**	**510**	**449**	**593**	**9.0**	**9.2**	**9.7**	**7.9**	**10.4**
Batken region	55	34	44	108	97	15.4	9.5	12.5	26.3	23.2
Jalal-Abad region	111	132	30	134	160	12.9	15.5	3.5	14.8	18.2
Issyk-Kul region	24	19	18	31	32	8.1	6.4	6.0	9.8	10.0
Naryn region	5	3	3	1	3	2.0	1.1	1.2	0.4	1.2
Osh region	194	13	123	147	158	17.6	3.3	12.4	14.1	13.7
Talas region		-		-	-	-		2.0	-	-
Chuy region	37	66	61	56	72	3.2	5.7	5.6	4.7	6.4
City of Bishkek	53	82	189	46	58	5.7	9.2	20.3	4.4	5.3
City of Osh	11	17	37	26	13	4.3	7.9	16.8	10.5	6.0

Based on the above-mentioned, the current Concept Note to the Global Fund is focused primarily on people who inject drugs, men having sex with men, sex workers and prisoners as the most affected populations in Kyrgyzstan and most vulnerable TB patients, including migrants.

TB/HIV co-infection

As of 01.07.2015 the cumulative number of PLHIV who have been screened for TB was 2,014. This represents 43.62% of the cumulative number (4,617 alive) of PLHIV registered in the country, 222 were detected with TB and HIV co-infection, 112 enrolled for TB/HIV treatment, 95 PLHIV provided IPT, which increased twice against with 2014. Among them, 492 (43.2%) are known to have died because of TB, showing that the overall life expectancy for persons with dual disease is very meagre in Kyrgyzstan. In most cases (366 - 74,3 % of those who died), TB was the cause of death. The cumulative number of TB/HIV infected cases regularly increased over the last 7 years (Figure 4).

Figure 4. Cumulative number of TB/HIV cases, Kyrgyzstan, 2008-2014



The proportion of TB/HIV cases who started antiretroviral therapy during TB treatment raised from less than 50% in 2011 to 82.3% in 2014. According to data from the statistical unit of the national TB program, the absolute majority of new TB patients are tested for HIV. According to registered information, the prevalence of HIV is 3.1% in 2013 (see Table 4 below).

Table 4. TB/HIV co-infection in Kyrgyzstan, 2009-2013

Year	TB cases	Tested for HIV	# HIV positive	% of HIV positive
2009	6,358	6,358	88	1.4
2010	6,595	6,595	183	2.8
2011	6,666	6,666	153	2.3
2012	6,916	6,916	151	2.2
2013	7,209	7,209	227	3.1

Among the 227 new individuals with HIV associated TB in 2013, 26 (11.4%) had documented MDR-TB. While this proportion is worrisome for the extremely high case fatality rate in these patients, it is not higher than that observed among HIV negative individuals. Data on TB treatment outcomes for TB/HIV co-infected patients are not available. However, the NTP has data on treatment outcome for MDR-TB in HIV infected patients during the period 2007 to 2011: among 54 patients treated and with known outcome 40 (74%) had defaulted, failed, or died.

Human rights and gender inequalities

In Kyrgyzstan, substantial effort has been made during the last decade in combating violence against children and women and bridging gender inequalities. The country adhered to key international conventions and agreements related to human rights, including the Convention on the Elimination of All Forms of Discrimination against Women, and the Convention on the Rights of the Child. The provisions of these conventions have been reflected and further elaborated in respective National Laws guaranteeing the rights of women and children. The Constitution of the Kyrgyz Republic guarantees equal rights for all regardless of sex, nationality and social status, and generally protects key affected populations from discrimination. The Law on HIV/AIDS provides for non-discrimination and the development of prevention programs for key populations. The Law on tuberculosis provides rights, obligations and social protection of people with tuberculosis and defines the way in which TB interventions are organized and legally regulated. Gender-sensitive approaches are increasingly used during development of different national policies, regulations and programmes, including disease specific. According to the legislation, the access to health services guaranteed by the state is equal for all citizens independently of gender; epidemiological data recorded and reported by the NAP and NTP include disaggregates by sex and age at all levels. At the same time, the CCM included into NFM project specific activities in addressing potential legal barriers to care, communication and de-stigmatization through innovative patient-centred approaches described below. However, some challenges that impact access to prevention,

treatment and care services remain to be addressed. Despite favourable legal framework, there are still some evidences on harassment of key populations on behalf of law enforcement officials (e.g. forced testing of sex workers, presence of law enforcement officers in OST and HR sites etc.)

Health system in Kyrgyzstan

The Government has made substantial progress in rationalizing public health facilities and health care staff, developing treatment protocols, training personnel, and introducing new forms of organization and financing. The country has developed three major health reform programmes after becoming independent: Manas (1996–2006), Manas Taalimi (2006–2010) and Den Sooluk Health Reform Program (2012-2016). These reforms introduced comprehensive structural changes to the health care delivery system with the aim of strengthening primary health care, developing family medicine and restructuring the hospital sector. The health reforms were supported by a number of international financial institutions.

Major service delivery improvements have included the introduction of new clinical practice guidelines, improvements in the provision and use of pharmaceuticals, quality improvements in the priority programmes for mother and child health, cardiovascular diseases, tuberculosis and HIV/AIDS, strengthening of public health and improvements in medical education. A Community Action for Health programme was introduced through new village health committees, enhancing health promotion and allowing individuals and communities to take more responsibility for their own health. The rationalization of health services limited the services provided free of charge, while guaranteeing a basic package of services to the entire population. The Law "On Health Protection of the Citizens of the Kyrgyz Republic" recognizes that social fairness, equity and accessibility to health services are the main principles of the state policy in the health sector. Also, important steps have been taken to introduce market economy and allowing privatization of some health care providers.

The Ministry of Health has ultimate responsibility for the management of the health system, but it has limited means to influence general health care providers at the local level. Although efforts have been undertaken to shift the focus from hospital provision to primary care, progress has been slow. At the ambulatory facility level, a shift towards comprehensive individual or family care, coordinated by one provider, is most visible in the regions. However, in both urban and rural areas, it is unusual to see consistent and efficient patient-flow processes at primary care facilities. The main goal of the health system - to provide universal access to health services for all citizens - is hampered by severe lack of funding and high out of pocket payments, resulting in limited access to services for large parts of the population.

Kyrgyzstan introduced a purchaser – provider split and established a "single payer" for health services under the state-guaranteed benefit package. Responsibility for purchasing health services has been consolidated under the Mandatory Health Insurance Fund (MHIF), which pools general revenue and health insurance funding. Funds have been pooled at national level since 2006, replacing the previous pooling at oblast level. The transition from oblast-based pooling of funds to pooling at the national level allowed the MHIF to distribute funds more equitably for the SGBP and the Additional Drug Package. Although utilization of both primary care and hospital services declined during the 1990s and early 2000s, it is increasing again. There is increasing equality of access across regions, improved financial protection and a decline in informal payments, but more efforts are required in these areas in the future.

While there are notable improvements in the health system, such as increasing investments in the health sector infrastructure and the expansion of the package of free services, Kyrgyzstan public health care system continues to face challenges in contracting and increasing government funding for non-governmental sector involved in HIV/AIDS prevention, and care for key affected populations and PLHIV and those involved in tuberculosis control. This is a key weakness of the health system that affects the performance and outcome of HIV and tuberculosis control efforts. Tuberculosis and HIV/AIDS issues in the Kyrgyz Republic remain of the highest priority. The related policy is based on multi-sectoral approach, implying cooperation between governmental and non-governmental sectors as well as the interaction between various organizations within a nationwide

response.

Community systems in Kyrgyzstan

Traditionally, in the Eastern Europe and Central Asia (EECA) region the health and social systems were heavily centralized with little participation of community in service provision and human rights advocacy. The Kyrgyz Republic is not an exception. Only after getting independence from the USSR in 1991 some elements of the Community Systems Strengthening (CSS) started to be implemented in the country with participation of international organizations. All initiatives were focused on provision of financial, technical and other kinds of support to organizations and agencies that work directly with and in communities (home care services to vulnerable populations including mentally disable people, elderly and others, lately HIV/AIDS communities and most recent TB community as well).

The major partners working in these areas are local NGOs that comprise and/or provide services to people living with HIV, tuberculosis patients, members of vulnerable populations, and individuals who otherwise have sub-standard access to vital health services. However, these initiatives are still developing and improving in Kyrgyzstan. The local NGOs are grouped in networks and need further attention. `The public and civil society partnership also needs further development. The community based and non-governmental organizations as a whole need to participate more in program planning, design, implementation and monitoring. The Law "On state social service commissioning" provides formal cooperation with civil society organizations and support through the state budget. However, it has not yet been implemented within the health care system.

At the same time, there is a commitment in the country to increase accessibility, uptake and effective use of services to improve health and wellbeing of communities. However, the non-government civil society organizations do not sufficiently participate in promoting general accountability to communities, including government accountability to its citizens and donors to the communities they aim to serve. These systemic weaknesses impact upon HIV and tuberculosis control and to a greater extent they define and shape the specific challenges for the national programs. It is anticipated that further strengthening of community participation will contribute to improved outcomes of disease specific interventions.

The Global Fund programs started to address the issues by development of the role of key affected populations and of non-governmental organizations in the design, delivery, monitoring and evaluation of services and activities related to prevention, treatment, care and support of people affected by HIV. The current proposal to the Global Fund will further boost the CSS activities, including involving national mechanisms created in previous programs (ex. NGOs networks) and prepare them to sustainable development.

Barriers to access health services

Access to high quality diagnosis, prevention, treatment and care services for the most at risk for HIV people has been limited by the lack of availability of these services in areas outside the capital city and by the limited reach of targeted programs into key affected populations. Stigma, discrimination and the fact that the main risk behaviours are illegal (injecting drug use, commercial sex) have kept these people from coming forward to ask for services in large numbers. There is a poor coordinated referral system and underdeveloped responsibility at the local level to channel people diagnosed with HIV into on-going prevention, treatment and care services.

The main barrier to service delivery for key affected populations in Kyrgyzstan is the stigmatization of drug use, sex work and sex between men. Health services, especially TB and HIV services are those who receive a significant proportion of people who are most at risk. Similarly, services dealing with drug users, sex work and the criminal justice system encounter a significant proportion of people who have become infected with HIV and/or TB. The need to attend multiple services acts as a barrier in providing adequate treatment to people who are most in need in the country. Currently TB and HIV services and services for key affected populations in Kyrgyzstan are functioning separately and are not integrated, as they should be.

The many social and health service barriers in accessing prevention and care services in Kyrgyzstan result in lengthy delays in seeking health care. The care provision is further complicated by lower levels of adherence to prescribed treatments. Daily drug use, alcohol dependence and depression are associated factors that complicate care and treatment. Stigma against people who inject drugs, sex workers and MSM among health workers, law enforcement personnel and social service workers also contributes to poor outcomes, such as the forced registration of people who inject drugs within mandatory drug treatment programs. There is lack of information about women who inject drugs, their approaching to health facilities than men who inject; further studies are needed to indicate that females who inject drugs may have suboptimal access to HIV care and may be less likely to receive antiretroviral therapy than male populations.

In addition, there are a number of specific barriers in TB service delivery that need to be addressed in order to ensure appropriate TB control including halting the development and spread of drug-resistant TB:

- The NTP ensures universal access to diagnosis of TB and DR-TB, with high coverage by drug-susceptibility testing (DST). However, rapid diagnostic methods are not used to the extent needed; this results in late diagnosis of the full resistance profile, which prevents from proper separation of patient flows and initiation of a correct treatment regimen according to the resistance status, and, ultimately, contributes to amplification of resistance and transmission of DR-TB strains.
- Inherited from the Soviet times, the TB care delivery system in Kyrgyzstan holds to a hospital-based treatment model, when the majority of TB cases are hospitalized for intensive phase of treatment. In the absence of appropriate measures for infection control in TB hospitals, this amplifies the risk of nosocomial transmission of TB, including MDR and XDR forms. Besides this threat in terms of DR-TB burden, excessive TB inpatient infrastructure leads to unnecessary hospitalizations and extended duration of the hospital stays, which creates substantial inefficiencies in the utilization of resources in the system.
- There is a stringent need to expand full outpatient treatment of TB patients, including DR-TB cases, as this is seen as a key to interrupting further increase of M/XDR-TB burden and, at the same time, as the means for improving efficiency and facilitating implementation of patient-centred TB care.
- Important regulatory and/or institutional barriers exist that limit access to appropriate TB, DR-TB and TB/HIV care for vulnerable and high-risk population groups (such as mobile KAP and migrants), which need to be tackled, inter alia, through multidisciplinary and multisectoral approaches.

The Global Fund NFM Concept Note took into consideration all the country epidemic specifics and existing barriers. The Concept Note has been developed under comprehensive country dialog in strict accordance to the above-mentioned legal documents and it is an integral part of the national disease programmes.

1.2 National Disease Strategic Plans

With clear references to the **current** TB and HIV national disease strategic plan(s) and supporting documentation (including the name of the annexed documents and specific page reference), briefly summarize:

a. The key goals, objectives and priority program areas under each of the TB and HIV programs including those that address joint areas.

b. Implementation to date, including the main outcomes and impact achieved under the HIV and TB programs. In your response, also include the current implementation of TB/HIV collaborative activities under the national programs.

c. Limitations to implementation and any lessons learned that will inform future implementation. In particular, highlight how the inequalities and key constraints and

barriers described in question 1.1 are currently being addressed.

d. The main areas of linkage with the national health strategy, including how implementation of this strategy impacts the relevant disease outcomes.

e. Country processes for reviewing and revising the national disease strategic plan(s). Explain the process and timeline for the development of a new plan and describe how key populations will be meaningfully engaged.

The legal framework and health policies demonstrate the country's political commitment in responding to the HIV and tuberculosis epidemics, including those related to general health policy and HIV/AIDS and tuberculosis issues. HIV and tuberculosis control is an integral part of the national disease programs (strategic plans), which are foreseen for the control of HIV and tuberculosis epidemics. The Den Sooluk Health Reform Program (2012-2016) includes HIV and tuberculosis as two of its four priorities.

The National HIV and tuberculosis multi-sector coordination has improved over past several years after establishment of the Country Coordination Mechanism (CCM) in 2003. In 2015 the CCM initiated a revision of bylaws and upgrade of its operational procedures, new members shall be trained in program monitoring and evaluation, and most importantly civil sector membership was renewed. The enhanced CCM, together with well-equipped M&E framework and necessary funding will further play a key role in improving and scaling up national response to HIV/AIDS and tuberculosis in Kyrgyzstan.

Tuberculosis control. Kyrgyzstan's National TB Control Programme (NTP) for 2015-2017 is a strategic document outlining the policy and priorities of the Ministry of Health (MOH) and the Government of Kyrgyzstan, which is aimed at overcoming the country's tuberculosis epidemic (Annex 1. National TB Control Programme). It was prepared on the basis of the Den Sooluk National Health Care System Development Programme for 2012-2016 and the harmonized Tuberculosis IV program for 2013-2016 (Annex 2. National Health Care System Development Programme). The National TB Control Programme is an addition to these documents and defines the strategic direction and political priorities of the MOH KR for TB control. The document was updated in accordance with the country's needs and epidemiological situation during the plan's implementation.

The National TB Control Programme aims at enhancing the integration of tuberculosis care at the primary health care level and improving the quality of medical services. The priority areas of the NTP are to improve the quality of TB and MDR-TB detection, laboratory diagnosis and treatment and to strengthen TB control measures and the outpatient treatment model. In general, all efforts will be aimed at improving the effectiveness of the existing tuberculosis service. The restructuring of tuberculosis clinics will generate savings, which can then be used to strengthen primary TB services, improve access to treatment and prevent the emergence of resistant forms of TB. The aim of the National TB Control Programme 2015-2017 is to prevent the spread of drug resistance and further reduce TB incidence and mortality in Kyrgyzstan.

The improvement of TB diagnosis and treatment (including drug-resistant forms of TB) in the civilian and prison health care sectors are the priority objectives of the National TB Control Programme. The NTP objectives are the following:

1. To improve the detection of new bacteriologically-confirmed cases of tuberculosis by improving access to rapid diagnostic methods;
2. To improve the treatment success rate for new bacteriologically-confirmed cases of tuberculosis;
3. To provide universal access to treatment for people with drug-resistant forms of tuberculosis;
4. To improve the treatment success rate for people with drug-resistant forms of tuberculosis;
5. To reduce TB mortality among people living with HIV (PLHIV) through the implementation of international guidelines on the diagnosis and treatment of TB/HIV co-infection;

6. To reduce the risk of nosocomial infections in TB organizations (TBO) and strengthen infection control measures at the primary health care level;
7. To implement the phased expansion of outpatient treatment throughout the country;
8. To involve a broad cross-section of society in TB control and raise public awareness.

The NTP is aimed at the early diagnosis and treatment of all population groups, but has a particular focus on the groups most vulnerable to TB infection, including PLHIV, prisoners, migrants, the homeless, people who use drugs and others. The involvement of a broad cross-section of society in TB control will be aimed specifically at improving the access of vulnerable populations to TB diagnosis, treatment, care and support.

The WHO mission report (2014) noted that since the previous Program report in 2010, Kyrgyzstan has made significant progress in several areas and in addressing the main recommendations, including with regard to MDR-TB, infection control, and tuberculosis in children.[5] The legal framework for tuberculosis services has been revised, infrastructure has been improved, staff capacity has been strengthened, the quality of TB diagnosis and treatment has improved, and TB incidence and mortality rates have dropped. The mortality rate decreased from 22.7 in 2002 to 8.2 per 100,000 population in 2013. A positive trend can also be observed in TB incidence rates (decrease from 127 in 2001 to 101 per 100,000 population in 2014), while notifications of TB cases are growing. The detection of resistant forms of tuberculosis has also ameliorated as a result of training and improved diagnosis. The waiting list for MDR-TB treatment was eliminated for the first time in 2014 and the treatment of XDR-TB patients has been initiated.

The year 2014 also saw improvements in the treatment success rate for new (smear-positive) cases of tuberculosis from 78.4% in 2011 to 82.4% in 2013, the coverage of MDR-TB treatment in accordance with the approved protocol from 61.2% in 2011 to 91.4% in 2013, and the coverage of drug susceptibility testing for all TB patients with a positive sputum culture from 26% in 2011 to 72% in 2014. In accordance with WHO guidelines, tuberculosis services are being restructured with a view to preventing the nosocomial transmission of TB and improving the effectiveness and accessibility of tuberculosis. In keeping with the plan, the number of beds in the country has been reduced by 439, and will be reduced by another 319 TB beds by the end of 2015 in an effort to cut them from 3,172 in 2013 to 2,272 in 2017.[6] Also, to boost further activities, the MOH and partners work together on the National TB/HSS Roadmap to be approved in December 2015 (Annex 3. National TB-HSS Roadmap for 2016-2021, draft).

The TB laboratory network is being optimized in view of new diagnostic technologies (Xpert, HAIN testing), the total number of culture laboratories has been reduced, and measures are underway to provide the country's regional tuberculosis facilities with Xpert MTB/RIF platforms. Based on situation analysis, a system for the transportation of pathology material for Xpert MTB/RIF testing has been developed and is being implemented.

Since 2014, Kyrgyzstan has been expanding its outpatient model for TB treatment. This approach was initially introduced in the Chuy region, the city of Bishkek and the Kara-Suu area of the Osh region. At present, 12% of all TB cases in the country are treated entirely on an outpatient basis. There are approved clinical guidelines for TB in children, TB diagnosis and treatment in primary health care (PHC) organizations and DR-TB management and infection control, as well as palliative care for TB patients and the treatment of TB/HIV co-infection in adults and adolescents. The introduction of clinical protocols was an important step in improving the treatment and management of tuberculosis patients, as well as for the further expansion of the outpatient model throughout the country. The country's TB monitoring and epidemiological surveillance system is being improved.

In 2014, National TB Centre and the MOH developed a complete and comprehensive set of

[31] Final conclusions and recommendations of the WHO Review of Tuberculosis Prevention, Control and Care in the Kyrgyz Republic, Bishkek, 30 June-5 July 2014, p. 2.
[32] On the restructuring of tuberculosis organizations working in the Single Payer system. Joint decree of the MoH KR dated 11.01.2015 and MHIF No. 10 dated 15.01.2015.

evidence and reporting forms in accordance with the latest international standards, as well as an M&E plan for TB control activities. Intensive work is currently underway to improve the electronic database for TB with subsequent installation planed up to the district-level. Kyrgyz State Medical University has included in its curriculum courses on TB control activities.

Joint TB/HIV programming is taking place, and almost all TB patients are screened for HIV in inpatient and outpatient treatment facilities in accordance with the national protocols. There is a national strategy in place for Advocacy, Communication and Social Mobilization (ACSM), and 12 currently functioning patient support groups in place in four regions of the country. With support from MSF, introduction of new anti-TB drugs and innovative treatments has begun in the Karasu district of the Osh region of Kyrgyzstan. In order to implement these measures across the country, further support and financing are required.

HIV/AIDS Control. The National HIV/AIDS Programme (NAP) for 2012-2016 provides for universal access to prevention, treatment, care and support services for key populations in accordance with the goals of the 2011 UN Political Declaration (Annex 4. National HIV/AIDS Programme). The Program describes a multi-sectoral approach with the involvement of the Ministry of Health, the Government of the Kyrgyz Republic, other ministries, departments, government agencies at various levels, and the civilian sector. The Programme is clearly focused on priorities aimed at stabilizing the epidemic in the context of a concentrated HIV epidemic. The main beneficiaries of NAP are key populations with high-risk behaviour, including people who use drugs, sex workers, MSM, and prisoners. Another important focus of NAP is access to ART, with particular emphasis on TB/HIV co-infection. The issues of strengthening communities and health care systems and program management and funding are also among the National HIV/AIDS Programme's key strategic areas.

The National HIV/AIDS Programme also includes five strategic areas and 16 objectives. The strategies are outlined in a manner that reflects the area's priority level and the level of impact on the HIV epidemic. The aim of the Program is to stabilize and subsequently reduce the HIV prevalence rate in the Kyrgyz Republic by 2016. The objectives of NAP are outlined within its strategic areas.

Strategy 1. To reduce the vulnerability of people who inject drugs to HIV.

Objective 1. To stabilize the spread of HIV among people who inject drugs, including female drug users.

Strategy 2. To prevent the sexual transmission of HIV.

Objective 2.1. To restrict the spread of HIV among sex workers and their clients.

Objective 2.2. To reduce the vulnerability of men who have sex with men (MSM) to HIV.

Objective 2.3. To provide high-risk groups with access to STI prevention and treatment services.

Strategy 3. To provide access to treatment, care and support for people living with HIV.

Objective 3.1. To provide access to highly active antiretroviral therapy.

Objective 3.2. To provide PLHIV with universal access to diagnosis, treatment and prevention of opportunistic infections, including tuberculosis and the hepatitis C virus.

Objective 3.3. To provide HIV-positive pregnant women with a range of services for the prevention of mother-to-child transmission.

Objective 3.4. To provide HIV-positive women, children and family members with access to care and social support.

Objective 3.5. To develop the potential of the PLHIV community to ensure universal access to services.

Objective 3.6. To promote tolerance of PLHIV and high-risk groups.

Strategy 4. To strengthen and ensure sustainability of the health care system in response to HIV.

Objective 4.1. To integrate high-quality HIV services at all levels of health care.

Objective 4.2. To prevent the nosocomial transmission of HIV.

Strategy 5. To improve the strategic coordination and management of public policy.

Objective 5.1. To improve the strategic coordination and management of public policy.

Objective 5.2. To ensure the sustainable funding of the State Program.

Objective 5.3. To improve the monitoring and evaluation system.

The Program evaluation implemented by the World Health Organization in 2014 has shown achievement and positive results for all areas of intervention, including improving policies; creation of legal and social supportive environment; reducing the risk of HIV infection among key affected populations, prevention of transmission through blood transfusion; counselling and testing for HIV; prevention of HIV transmission from mother to child; treatment, care and support; TB/HIV; better M&E system etc. It also identified a list of shortfalls, which have been taken into consideration by the new National HIV/AIDS Program developed during a comprehensive and inclusive country dialog process.

Harm reduction programs are the most important prevention interventions in Kyrgyzstan and are embedded into the HIV Law. Harm reduction has been initiated and piloted in 2000 in Bishkek. Since then, with the launch of the Global Fund project, harm reduction interventions entered a new phase of development, the services have been expanded to regional and local sites throughout the country, the quality of services strengthened and the package of services standardized to the maximum extent across regions. Still, the coverage remains moderate to date, especially in MSM (See Table 5). The package of services made available by non-government organizations and government services to key populations are suitable for each specific key population. NGOs have proven to be the key link to HIV prevention, testing, treatment, care and support for key populations. However, more can be done through closer collaboration between the NGOs and government services.

Table 5. Coverage by preventive services

As of 1 January 2015	Reached	*PSE*	% reached
PWID	11,254	25,000	45%
SW	3,653	7,100	52%
MSM	1,626	21,800	8%
Prisoners	12,698	8,000	%

The package of services for people who inject drugs includes distribution of needles and syringes, information and education materials, condoms, water for injection, post-injection plaster, alcohol swabs and containers for used syringes. Free medical and psychosocial counselling is also available as well as linkages to HCT services and the OST programme. This package of services is similar to the comprehensive package recommended by WHO for addressing HIV among PWID. Compare to other countries in the region, the coverage of PWID with preventive services is better, however additional efforts are needed to boost it up to at least 60%. The coverage level is attributed to the expansion of services over years in new geographical areas. In addition, the number of client workload per outreach worker has been increased, and outreach workers were trained in appropriate techniques.

The package of services for men who have sex with men includes free STI treatment drugs and linkage to HCT centres and mobile units. Distribution of condoms and lubricants is ensured along with information and education materials. Psychosocial and medical consultations are also provided free of charge. The package of services for SW includes distribution of condoms and linkages to VCT services, STI and HIV treatment and care, distribution of information and education materials and referral to medical and psychosocial counselling services. Similarly to PWID, the increase in the number of SW reached during last years was due to expansion of services to new

geographical areas and recruitment of new outreach workers.

Psychological services for prisoners are provided in thirteen prisons and correctional settings. IEC materials are distributed and information sessions are regularly held. VCT services are continuously available in all prisons and correctional facilities. In parallel, a total of 4,000 prisoners have been provided with HIV testing. Diagnostic and treatment services for prisoners is under the responsibility of Prison Department and its Medical Commission is in charge of ARV selection and treatment regimens. The Republican AIDS Centre performs confirmation tests and provides technical expertise for HIV treatment.

HIV testing and counselling is provided based on the updated guide to HIV counselling and testing. At the moment, client and provider initiated counselling and testing services for target populations are provided by about 20 NGOs and 63 health facilities across the country. As mentioned above, testing for key populations has increased since the introduction of rapid testing in November 2012, a measure that has proven to be effective intervention in increasing the numbers of key population reached with these services. However, the coverage still remains low (see Table 6).

Table 6. HIV testing for key affected populations, 2013, Kyrgyzstan.

2013	HIV Test	% of PSE Tested	% Tested of Reached
PWID	5,560	22	49
SW	2,254	32	62
MSM	1,034	0.1	64

Opioid substitution treatment (OST) started in 2002 triggered by the Law on Law on legal circulation of narcotic substances, psychotropic drugs and precursors. The first OST site was opened at the National Narcological Center (NNC). The total number of patients involved in OST is 1605 and this number remains low compared to the estimated need. There are still certain statements remaining of concern in the Crime Code that serve as legal and structural barriers for accessing preventive and treatment services and these will be primarily targeted under the National HIV/AIDS Program.

In 2014, 93% pregnant women and 100% children received antiretroviral therapy to reduce the risk of mother to child transmission. While there is a good coverage with preventive treatment, PMTCT program needs specific attention by the health system. Also, blood safety has received significant attention from the government. The donated blood is being tested for HIV, hepatitis B & C and for syphilis. Kyrgyzstan reached 100% blood testing. Based on the last five-year data HIV prevalence among blood donors is only 0.01%. While achievements regarding safe blood supply are obvious, the situation regarding infection prevention within clinical setting receives attention under the new National HIV/AIDS Program. Also, blood safety programs will be further supported through domestic sources and no Global Fund resources are requested; PMTCT programs will be taken gradually by the Government.

Since 2006, Kyrgyzstan has made important steps in establishing and delivering curative services for PLHIV through the Republican AIDS Centre and its 5 multi-disciplinary teams (with involvement of PLHIV) and through the medical service in penitentiary system. According to Republican AIDS Centre data, 1,718 people have been started ART by January 01, 2015. The enrolment in ART almost doubled over last years. Although substantial scale-up of ART, and no waiting lists, by the end of 2014 only 28% of PLHIV in need of ART received treatment (see Table 7; based on SPECTRUM estimations). Treatment compliance increased: in 2013 about 83% of PLHIV were compliant with ART for more than 12 months.

Table 7. Coverage by ART, 2014, Kyrgyzstan

	2014
Estimated # of HIV positive people (based on SPECTRUM)	9102
Total in need of ART (based on SPECTRUM)	6038
Total in ART	1718
ART with coverage (%)	28%

While more people are able to access ART, there is need for improvement of the treatment outcomes, close coordination and collaboration between curative facilities and NGOs delivering outreach or care & support services in order to increase number of those seeking care and improve adherence to ART. Also, ART is provided according to the national protocol based on WHO new guidelines (approved by MOH Order #29 from January 2015). Treatment initiation is recommended when CD4 count falls below 500, in children and in pregnancy, in patients with stage III-IV disease, hepatitis B co-infection, and among discordant couples and TB/HIV co-infection. Patients are monitored every 6 months if they are not on ART, but every 3-4 months if they receive ART.

TB/HIV collaborative activities. TB/HIV collaborative activities have been evaluated by WHO in 2014 (Annex 5. TB/HIV WHO evaluation report). TB and HIV services are run as vertical programs. Even if Kyrgyzstan has a capillary system for primary health care (the Family Medicine Clinics), TB and HIV service delivery is poorly integrated even at grass-root level. Service delivery for TB patients who have HIV infection is an underdeveloped area within the TB program. It was noticed that HV services need further monitoring procedures for TB diagnosis and/or TB care.

In 2013, Bishkek AIDS centre opened a pilot project (called “the one-stop-shop strategy”) for integrated TB/HIV/OST care with UNDP support. Beyond this pilot project, the integration of TB and HIV care is still limited in the country. The referral system between the two services is insufficiently developed, sill there are no formal procedures for referral, and the outcome of referral cannot be monitored or evaluated. Provisions of TB expertize at HIV centres and HIV expertise at TB centres happen on occasional circumstances, but there is no explicit plan to ensure that consultations from the two diseases will converge on the same patient at the right time. At the same time, a single high level coordination mechanism for TB and HIV have been established under leadership of Deputy Minister of Health to improve and strengthen integration of TB and HIV services (MOH Order #396 as of 15 July 2015).

The HIV testing procedures for TB patients are well defined and organized and coverage of HIV testing is high. However, there are some evidences that the patients are poorly oriented on the benefits of testing, the implication of a positive test in terms of care options, quality of life and life expectancy. Also, the procedures are cumbersome and lengthy. Early diagnosis of TB among PLHIV is particular important. The WHO-recommended questionnaire tool is adopted and forms are available to assist in clinical care and recording and reporting at AIDS centres. However, data on this indicator are not available yet. There are challenges for effective early diagnosis of TB among PLHIV in relation to referral system between HIV services and TB diagnostic sites. However, some pilot interventions funded by USAID to improve referral system between TB and HIV services have been initiated. Also, to cover the policy gap, the MOH coordinated the preparation and approved the clinical protocol for TB/HIV management in 2014.

There is a substantial number of HIV associated TB cases among the prisoners (approximately 70 cases in 2013). Clinical prevention and treatment standards are reported to be the same as in the civil sector. However, referral of patients between the prison and the civilian setting is still challenging: MSF/ICRC implement a joint program for facilitating referral of TB patients discharged from the prison. In addition, with AFEW support programs for further integration the HIV patients when released from prison. There are plans to scale-up and replicate these lessons learned and best practices at the national scale.

HIV testing is offered to all persons entering the prison system for 6 months or longer. The testing is performed by the laboratory of the Ministry of Interior. Also, there are some pilots for rapid testing on saliva samples. The TB screening in prisoners is based on fluorography. Prisoners with positive fluorography or respiratory symptoms undertake microscopy. Culture is available and performed on smear positive cases, at two prisons, in Osh and Bishkek. There is one Xpert MTB/RIF machine available: the test is performed on smear positive cases. Some programs are co-financed by MSF and MDR-TB cases undergo second line DST at supranational laboratory in Borstel, Germany. The prison system uses an electronic database for TB patients and one for MDR-TB patients. M&E for HIV is based on paper forms shared by the MOH.

Taking into account the specifics of the epidemic, response analysis and lessons learned from the implementation of the previous and current HIV/AIDS and tuberculosis programs (described above), the Government of Kyrgyz Republic lead the process of designing a complex framework to guide the national diseases response. During the country dialog process, the Ministry of Health in collaboration with the prison medical department and with involvement of all local and international technical partners, non-governmental organizations and people living with diseases will develop next cycle of the National HIV/AIDS and Tuberculosis programmes.

1.3 Joint planning and alignment of TB and HIV Strategies, Policies and Interventions

In order to understand the **future** plans for joint TB and HIV planning and programming, briefly describe:

a. Plans for further alignment of the TB and HIV strategies, policies and interventions at different levels of the health systems and community systems. This should include a description of i) steps for the improvement of coverage and quality of services, ii) opportunities for joint implementation of cross-cutting activities, and iii) expected efficiencies that will result from this joint implementation.

b. The barriers that need to be addressed in this alignment process.

MOH identified the HIV/AIDS program as the effector of the health response to the HIV epidemic, and the TB Program as the effector of the response to the TB epidemic. Both programs have the mandate to deliver the respective interventions through the PHC system (the Family Medicine Centres – FMC – network). There are approximately 800 FMC in the country, as compared with seven TB dispensaries and nine HIV clinics located in the major urban centres. By adopting this strategy, Kyrgyzstan is on its way for a decentralized, capillary, and integrated health delivery system.

However, the TB and HIV programs still operate as vertical programs and even at FMC levels TB/HIV co-infected patients have no access to integrated care. This is caused by several co-factors. First, the TB and HIV programs implement weak interventions for training and supervision of FMC. Secondly, delivery of high quality HIV and TB care at FMC appears to be faced by specific challenges: a) a high level of stigma, for both TB and HIV; b) the limited number of staff and high staff attrition; c) health system weaknesses in the implementation of referral activities between services (for example, patients with presumptive TB identified at FMC services need to be referred to TB centres for the diagnostic procedure); d) the weakness of the recording and reporting system which prevents collection of high quality data at peripheral level. All this is of concern, considering that 50% of all PLHIV are cared for at FMCs, including delivery of ART.

In terms of the response to TB, in its latest programmatic plan of development (Den Sooluk), the MOH Kyrgyzstan acknowledges the importance of the on-going TB epidemic and the still increasing incidence of MDR-TB. The National Tuberculosis Centre (NTC) runs the NTP, with the NTC director being also the NTP coordinator directed by the Ministry of Health. This arrangement will be further tuned, because the mission of the NTC is to coordinate secondary and tertiary care rather that getting involved into primary health care. As a consequence, the NTC/NTP lacks functional links to TB activities at FMCs, which is a problem in the context of the current decentralization strategy adopted by the Country.

The Ministry of Health of Kyrgyzstan supports the view that hospitalization of people with non-severe and/or non-infectious TB is unnecessarily expensive compared with outpatient care, unethical from a patient perspective and even dangerous by exposing patients to the risk of super-infection by multidrug-resistant M. tuberculosis strains. It recognizes that most of the people with TB may effectively receive their TB treatment on an ambulatory basis, at FMC services, even during the intensive phase of treatment. The policy to expand out-patient TB care was initially piloted with the assistance of technical partners (USAID, KNCV and MSF) but it is still not expanded nation-wide notwithstanding very positive results in terms of treatment outcome. The Kyrgyzstan CCM participated in endorsement of the Regional EECA TB and Health System Strengthening project (TB-REP) recently reviewed and approved by TRP and intends to join its efforts for further health system transformation for better TB control.

In terms of the response to HIV, despite the limited number of individuals affected by HIV Kyrgyzstan started early a process of decentralization of care. ARV is prescribed to patients by AIDS Centres, and dispensed either by AIDS Centres or FMCs. The dispensing institution is also eventually responsible for monitoring of treatment. In addition, the civil society greatly contributes to this process in partnership with the public health system. However, there are concerns for an effective HIV response in some key population (including law that criminalizes homosexuality, foreign agency law etc.)

There is an intention to coordinate the efforts in order to build next cycles of TB and HIV national programs together. This exercise is planned for 2016, lead by MOH in closed collaboration with CCM and local and international partners. It is expected that the new programs will take into account all facets of the provision of quality integrated TB and HIV control services. Particularly, the health workers at TB and HIV treatment and care facilities shall receive integrated training on HIV diagnosis and care and clinical and laboratory diagnosis of TB with a view to better treatment of co-infection cases. Subsequently, the MOH will include the TB/HIV component in basic training curricula. Multi-skilled TB and HIV community actors (TB Coalition) will support care at the community level by monitoring patient compliance with treatment, tracing patients lost to follow-

up, and providing integrated prevention services for the populations most exposed to risk.

The joint TB/HIV semester supervision visits will help improve the provision of high-quality integrated services and ensure that information and decisions are unified. In addition, joint annual evaluations of the integrated TB/HIV activities will be proposed in the two national programmes to be carried out at the central and regional levels, as well as a mid-term review involving the components of TB/HIV cooperation which will lead to the development of aligned TB and HIV strategic plans from 2017 onwards for these collaborative activities.

In terms of community systems strengthening, during the implementation of the TB and HIV/AIDS national programs, necessary synergy and common actions will be developed using the same community actors (NGOs). The latter will be additionally trained on tracing TB and HIV patients lost to follow-up, treatment compliance, psychosocial support and mobilizing and raising the awareness of the target groups. The two programs also plan to capitalize on the existing national networks in order to carry out the community activities. All these actions will further increase programs effectiveness in terms of maximizing impact and boost coverage in terms of the provision of TB/HIV testing and treatment services, improve the provision and quality of services and care, and save resources (financial, human, etc.).

There are some risks that CCM will take into account during the alignment process. The TB and HIV/AIDS national programmes planning cycles have never been synchronized. As part of the alignment process, the NTP and NAP will process together the assessment results. These results will enable the national programmes to adjust, taking into account the above-mentioned gaps while taking collaborative TB/HIV interventions/activities into account. Also, another identified risk is the shortage of trained staff, which may create further barriers to the implementation of integrated activities. CCM will consider building the capacities of all TB and HIV care providers and the staff of both programs in the future.

SECTION 2: FUNDING LANDSCAPE, ADDITIONALITY AND SUSTAINABILITY

To achieve lasting impact against the diseases, financial commitments from domestic sources must play a key role in a national strategy. Global Fund allocates resources that are insufficient to address the full cost of a technically sound program. It is therefore critical to assess how the funding requested fits within the overall funding landscape and how the national government plans to commit increased resources to the national disease program and health sector each year.

2.1 Overall Funding Landscape for Upcoming Implementation Period

In order to understand the overall funding landscape of the TB and HIV national programs and how this funding request fits within these, briefly describe:

a. The availability of funds for each program area and the source of such funding (government and/or donor). Highlight any program areas that are adequately resourced (and are therefore not included in the request to the Global Fund).

b. How the proposed Global Fund investment has leveraged other donor resources.

c. For program areas that have significant funding gaps, planned actions to address these gaps.

The public expenditure for health has been increasing since 2000 and was 4.3% of the GDP along with significant level of private spending up to 39.9% of total health expenditure in 2012 (see Table 8.) The spending for health in the general government budget was 12.2% in 2012. This indicators show that in comparison with other countries of the region in Central Asia there is relatively strong

government commitment to distribute fair share of the government budget to the health system. It is important to note, however, the official GDP per capita is very low in the country that makes the public expenditure on health per capita to be very low as well.

Table 8. Trends in health expenditures, Kyrgyzstan, 1995-2012

Indicators	1995	2000	2005	2010	2011	2012
Total health expenditure percent of GDP	6.0	4.7	5.8	6.7	6.2	7.1
GGHE as percent of GDP	3.1	2.1	2.4	3.7	3.7	4.3
GGHE as percent of GGE	10.7	12.0	11.9	11.9	11.6	12.2
External resources on health as percent of THE	1.1	6.0	12.7	11.4	10.8	12.2
GGHE as percent of THE	51.2	44.3	40.9	55.7	59.9	60.1
PvHE as percent of THE	48.8	55.7	59.1	44.3	40.1	39.9
Out of pocket expenditure as percent of PvHE	92.6	89.3	94.7	87.3	86.0	87.2
Out of pocket expenditures as percent of THE	45.2	49.8	56.0	38.7	34.5	34.8
GGEH (current USD per capita)	9.9	5.7	11.6	33.3	42.5	50.6
PvHE (current USD per capita)	9.5	7.2	16.8	26.5	28.4	33.7
GDP (current USD per capita)	324.9	276.5	487.9	898.8	1 147.0	1 182.8

GDP = Gross Domestic Product
GGE = General Government Expenditure
GGHE = General Government Health Expenditure
PvHE = Private Health Expenditure
THE = Total Health Expenditure
USD = United States Dollar
Data source: WHO National Health Accounts 2013

The national health system of Kyrgyzstan is based on a purchaser-provider split since 1997 when the mandatory health insurance system was introduced. In 2009 the MHIF was separated from the MOH and subordinated directly to the Kyrgyz Government. The MHIF is pooling the funds for health services from local and central resources and acts as a single public payer of health services and administers the State Guaranteed Benefit Package (SGBP) and the Additional Drug Package. The MOH coordinates and ensures hierarchal top-down controls through coordination commissions on health management and owns the facilities of the territorial hospitals. The purchasing is based on a contractual relationship between the MHIF and providers of health services. The contracts are updated on annual basis, and the MHIF pays for services with output-based payment mechanisms. Priority health programmes such as TB are not fully integrated in the general health system although the MHIF started integrating the financing of TB services.[7]

At the first glance, the expenditure for TB, reported in the 2013 WHO data collection form, in share of the public expenditure for health was 4.1% of the public expenditure on health without the donations from the international donors and other grants in 2012 (see Table 9). If we add the donation from international donors, funded especially by the Global Fund, then the public expenditure for TB was in fact 6.9% of the public expenditure on health in the same year.

Table 9. Expenditures (in USD) for TB Programme, Kyrgyzstan, 2013

Budget items	Government	Global Fund	Other Grants	Total	Percent
First-line TB drugs	0	282 591	488 744	771 335	4.06
TB staff wages	5 725 991	189 665	125 160	6 040 816	31.80
NTP management and supervision	14 404	0	24 261	38 665	0.20
Laboratory supplies and	0	166 051	342 071	508 122	2.68

[7] Ibraimova A, Akkazieva B, Ibraimov A, Manzhieva E, Rechel B. Kyrgyzstan: Health system review. Health Systems in Transition, 2011

equipment					
PAL	0	0	0	0	0
PPM (Public-Public, Public-Private Mix - DOTS)			13 840	13 840	0.07
Collaborative TB/HIV activities	0	0	236 197	236 197	1.24
Second-line drugs for MDR-TB	0	2 939 931	0	2 939 931	15.48
Management of MDT-TB (excluding second-line drugs)	0	0	36 837	36 837	0.19
Community involvement	0	0	51 846	51 846	0.27
ACSM	0	21 809	33 712	55 521	0.29
Operational research	0	0	0	0	0.00
Surveys to measure TB burden and impact on control	0	0	4 678	4 678	0.02
All other budget lines for TB	5 660 235	2 520 456	115 437	8 296 128	43.68
Total	*11 400 630*	*6 120 503*	*1 472 783*	*18 993 916*	*100*
Percent	*60.02*	*32.22*	*7.75*	*100*	

ACSM = advocacy, communication and social mobilization
DOTS = directly observed therapy short course
MDR = multi-drug resistant
PAL = Practical Approach to Lung Health
PPM = Private-Public Mix
TB = Tuberculosis
USD = United States Dollar
Data source: WHO Data Collection Form, 2013

In 2012, the expenditures reported through the WHO data collection form included the first- and second-line drugs (19.5%) as well as the wages of medical professionals and staff (32%). The share for programme management and supervision activities was reported as 0.2% of the total expenditure for TB, which seems to be very low. From the total expenditures on TB, 60% was funded by the Government that pays mainly the wages, the management and supervision cost as well as other budget lines for the providers. At the same time, 40% of the expenditures were funded by the external donors and grants. The Global Fund solely covered the second-line of drugs for MDR-TB. There was no government contribution to laboratory supplies and equipment. Food costs are covered by the hospitals although the money allocated for meals, which was reported as 76 KGS/day (1.4 USD), appears to be a low amount. It was reported that TB services are available free of charge for the patients, but suspected cases have to pay for services if they are not diagnosed (100 KGS/x-ray). This practice may adversely impact contact tracing and case finding.

In the annual national report of the NTP the distribution of expenditures for TB along with the health care functions and cost per patient are not calculated even if Kyrgyzstan was one of the first countries in the WHO region that compiled a TB specific health account in 2007. Therefore, the NTC experts estimated the distribution of the expenditures between the different healthcare functions within the NTP. The estimated amount is almost fully aligned with the reported amount in the 2013 WHO TB Data Collection Form (see table 10), which indicates that there is a possibility for reliable, coherent and effective data collection on health finance in the NTP.

According to the estimate of the NTC presented in the Table 10 below, the expenditure for outpatient services apart from case finding, is only 5.2% of the total expenditure for TB which is a low share compared with the spending for in-patient services (52.3%). According to MOH and the NTC the planned TB hospital rationalisation is on-going in line with health sector reforms. A total of 439 TB beds have been reduced and 319 are to be reduced by the end of 2015 with the final aim to cut from 3,172 in 2013 to 2,272 in 2017. To boost these activities further, the Government will approve the National TB/HSS Roadmap for 2016-2021 by December 2015.

The agreement between the Mandatory Health Insurance Fund administration and MOH provides that the funds saved from the TB bed rationalisation will remain in the TB system and be allocated for TB control. The MHIF introduced a case-based payment method for TB care in 2013 the implementation of which is still going on. Since 2014 the strict rule of line item budget has been

relieved and the flexibility of the financial management of the providers has been increased. Outpatient services including the primary health care are financed based on per capita that includes the finance for TB services. In a pilot region, Issyk-Ata, incentives are applied to increase performance in active case finding (100 som per detected case).

Table 10. Estimated expenditures for TB services, Kyrgyzstan, 2012

Services	Payment mechanisms	Som (thousands)	USD (thousands)	Percent
Outpatient				
Case finding	P4P pilot	149 442 500	2 988 850	15.6
Pharmaceuticals	Procurement	190 406 800	3 808 136	19.9
Outpatient services	Per-capita	50 000 000	1 000 000	5.2
BCG vaccination	Per-case	1 600 000	32 000	
Laboratory, diagnostics	Procurement	62 800 000	1 256 000	0.2
Inpatient				
Hospital services	Per-case	500 000 000	10 000 000	52.3
Total expenditure		*954 249 300*	*19 084 986*	*100*

BCG = Bacillus Calmette–Guérin
P4P = Pay for Performance
USD = United States dollar
Data source: NTP estimations (per request of the Review Mission)

Total funding of the National HIV programme has increased greatly over the last few years, and TGF is by far the largest international donor contributing with more than 50% of all international funding for the national HIV programme in Kyrgyzstan. Domestic funding for HIV more than doubled from 2011 to 2012 (1.441.565 in 2011 to 3.886.526 USD in 2012), but still accounts for less than 15% of total national HIV programme expenditure and finances basically only staffing, infrastructures and maintenance of AIDS centres and some elements of blood services. Funding from TGF has also increased significantly since 2010: the total annual TGF budget for HIV was 5.836.715 USD in 2010 and 11.829.864 USD in 2013.[8] Still, ARV and TB drugs, HIV and TB diagnostics, NSP and OST programmes, HIV prevention services for SW, MSM and prisoners, care and support to KAP are greatly funded by TGF. The MOH and partners work on a plan to increase financial support over years for priority areas in order to express their commitment.

In addition, there are technical partners active in the country such as WHO, MSF, USAID/Project Hope, USAID/KNCV, Abt Associates, ICRC, FIND, KfW and UNDP. A new technical TB control project funded by USAID and implemented by Abt Associates was launched in the autumn of 2014. The project is scheduled for five years and includes several technical components such as the expansion of outpatient treatment, MDR-TB, infection control, epidemiological surveillance and other.

While the NTP more or less covers the operating costs associated with the running of TB services (salaries, social insurance contributions, utility costs etc.), donors play a crucial role in covering essential needs. Despite the predicted increase in the national budget for the NTP in 2015-2017 and a revision of the cost structure in the context of reduced bed capacity and expansion of the outpatient treatment model, it is expected that the donor community and technical partners will continue to play a significant role in covering the current budget deficit, which, taking into account TGF funding already allocated for 2015, stands at around US$ 19 million. Some operational costs, including laboratory reagents and consumables, sample transportation, infection control measures, motivational support for patients and health care workers are covered to a small extent by the international NGO Médecins Sans Frontières. The construction of new infrastructure (laboratories and hospitals) and the provision of laboratory equipment are covered by the German Development Bank (KfW).

[8] UNDP annual report on the implementation of grants provided by the Global Fund to fight AIDS, Tuberculosis and Malaria in Kyrgyzstan. 2013

Despite considerable donor support, only MSF supports procurement of drugs and covers other essential treatment-related expenses, including TB/HIV. However, MSF is only present in one oblast at district level and treatment coverage in 2014 was just over 100 TB patients. A new PEPFAR project implemented by Abt Associates is also covering a small amount of diagnosis and treatment expenditure. The International Red Cross is working to prevent and treat TB in prisons, including in 2015, but has not yet confirmed whether it can fund TB programs in 2016-2017. According to preliminary estimates, contributions from other donors, including USAID and WHO projects that focus predominantly on the provision of technical support, will total US$ 4.6 million for 2016-2017.

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) works through Government of Kyrgyzstan to support a sustainable, integrated, and country-led response to HIV/AIDS. This is implemented through a comprehensive, multispectral approach that expands access to prevention, care and treatment and promote sustainable country programs. In Kyrgyzstan, PEPFAR activities aim to control the HIV epidemic in high burden locations by increasing access, uptake and quality of evidence-based prevention and treatment interventions for key populations, primarily PWID and PLHIV, thereby increasing the number of PLHIV on ART and decreasing new HIV infections. PEPFAR adopted an epidemic driven approach to key populations and support capacity building of MOH to reach 90/90/90 in line with UNAIDS and PEPFAR goals.

The PEPFAR activities include working at the community and clinic level across the continuum of care to reach, refer, treat and improve adherence for key populations, PWID and PLHIV in the country. PEPFAR works closely with the MOH and civil society to increase access to information and services and, with the Global Fund, in the provision of life saving commodities critical for key populations. PEPFAR uses a technical assistance approach designed to build capacity and systems at the site, regional, and national levels; improve epidemiological and program data and systems to assist in making informed program analyses and decisions and increase demand for, access to, and uptake of evidence-based HIV services by key populations. It also aims to strengthen linkages and referral systems, improve HIV care and treatment services to ensure PLHIV enter and remain in the HIV continuum of care, promote policy reform and support an enabling environment to mitigate the stigma and discrimination that adversely impacts access to HIV services by key populations.

The Soros Foundation-Kyrgyzstan supports projects aimed at reforming the public health care system and increasing access to health care services for vulnerable groups by engaging representatives of civil society in decision-making. The Foundation also works on civil society capacity building and promotes legal aspects associated with HIV as part of educational programs at the Academy of the Ministry of Internal Affairs and programs on health law for medical and law faculties. Since 2010, it has been working to promote palliative care and treatment for the hepatitis C virus.

The UN agencies provide technical support in accordance with the mandate of each organization. UNAIDS is responsible for the overall coordination of UN agencies' work in this area. Beginning in 2013, UNAIDS launched a regional program focusing on two components: (1) strengthening the routine epidemiological surveillance of HIV; and (2) improving maternal and child health. As part of these components, efforts to institutionalize the training of health care workers, introduce standard operating procedures for the laboratory diagnosis of HIV and monitor infection control within maternal and child health care organizations are being improved. Early diagnosis of HIV in infants born to HIV-positive mothers and the support of eight multidisciplinary teams for the treatment, care and support of PLHIV have been introduced with support of UNICEF. UNFPA is working with young people on HIV and reproductive health; UNICEF is supporting PMTCT, as well as the prevention and treatment of HIV in children; UNODC is supporting HIV prevention programs for people who use drugs; and WHO is developing policies and standards with regard to health care, prevention, treatment and care, health care aspects of HIV and blood safety, STI and tuberculosis control. UNDP is implementing a program entitled “Support for the Government in Response to the HIV/AIDS Epidemic”.

Based on 2013 experience, the external financial support for HIV programs amounted about 75% of the total funding (TGF constituted about half of external funding and supported about 40% of the

total funding for HIV/AIDS program in the country.[9] The government of Kyrgyzstan is committed to fighting the TB and HIV epidemics and allocated over past years increasing amounts of financial, human and infrastructural resources for this purpose, particularly to cover the substantial costs of staff, medical interventions and facility expenses. At the same time the government has made serious steps in overtaking funding for essential services as are TB first line drugs, some HIV diagnostic, diagnosis of opportunistic infections and treatment, STIs diagnostic, etc. However, some priority areas of the National TB and HIV/AIDS Programmes are still financed only by the Global Fund , including diagnosis, treatment, preventive interventions in KAP (PWID, SW, MSM, prisoners) and community-based care and support for people with diseases.

Understanding the importance of sustainability and continuation of consistent, evidence-based and impact oriented national TB and HIV responses, the Government of Kyrgyzstan is committed to further increase the level of domestic funding in order to bridge the gaps and take over the funding of all priority interventions included in the National TB and HIV/AIDS Programmes. Starting 2016, the Government is committed to fully finance TB treatment with first line drugs, blood safety, management of opportunistic infections, STIs testing and treatment and laboratory operation. During the Project period, the Government plans gradual transition from external to domestic funding for prevention of vertical HIV transmission.

As mentioned above, the MOH and partners initiated an investment plan to gradually take over funding for TB and HIV/AIDS programs. In this respect, several strategies have been put forward, including to further increase effectiveness of TB and HIV/AIDS programmes, consider further hospital sector restructuring (especially in relation to TB control), increase coverage of the Mandatory Health Insurance Fund and include services related to diagnosis and treatment of TB and HIV/AIDS, prioritize MOH funding under public health programmes focusing on priority TB and HIV/AIDS interventions. The investment framework, will be streamlined with the Global Fund investment guidance for EECA and plans for a well-defined, time bound transfer of key interventions from external to domestic funding taking into account gradual transition of the following:

- Prevention among key affected populations
- Preventing mother-to-child transmission
- Prevention programs for general population
- HIV testing and counselling and TB screening
- Quality TB and HIV diagnosis
- TB and ARV treatment and monitoring
- Care and support to people with diseases
- Development of necessary practices for targeted TB and HIV/AIDS interventions
- Monitoring and evaluation and integration of TB and HIV into health information system
- Capacity building activities and training
- Program planning and administration.

The Concept Note to the Global Fund and respective funding request aims at filling the gaps and assisting the National TB and HIV/AIDS Programmes in transition towards Government funding for major intervention such as:

- Ensure case detection and universal coverage with DR-TB diagnosis and treatment
- Uphold and scale-up needle and syringe programs (NSP) and opioid substitution therapy (OST) as part of programs for PWID and their partners
- Uphold and scale-up behavioural change as part of programs for sex workers and their clients
- Promotion of behavioural change as part of programs for MSM
- Uphold and scale-up behavioural change as part of prevention programs for prisoners
- Scale-up HIV and viral hepatitis testing and counselling for key affected populations

[51] Assessment of national health accounts, Bishkek, 2014, p.

- Ensure universal antiretroviral therapy (ART) and monitoring
- Ensure prevention of vertical HIV transmission
- Provide counselling and psycho-social support, as part of care and support programs for PLHIV
- Create enabling environment for targeted evidence-base interventions
- Operationalization of routine reporting including second generation surveillance
- Strengthen and involve communities in disease response and provide legal services to key affected populations
- Improve NTP and NAP management.

2.2 Counterpart Financing Requirements

Complete the Financial Gap Analysis and Counterpart Financing Table (Table 1). The counterpart financing requirements are set forth in the Global Fund Eligibility and Counterpart Financing Policy.

a. For TB and HIV, indicate below whether the counterpart financing requirements have been met. If not, provide a justification that includes actions planned during implementation to reach compliance.

Counterpart Financing Requirements	Compliant?	If not, provide a brief justification and planned actions
i. Availability of reliable data to assess compliance	☒Yes ☐ No	n/a
ii. Minimum threshold government contribution to disease program (low income-5%, lower lower-middle income-20%, upper lower-middle income-40%, upper middle income-60%)	☒Yes ☐ No	n/a
iii. Increasing government contribution to disease program	☒Yes ☐ No	n/a

b. Compared to previous years, what additional government investments are committed to the national programs in the next implementation period that counts towards accessing the willingness-to-pay allocation from the Global Fund. Clearly specify the interventions or activities that are expected to be financed by the additional government resources and indicate how realization of these commitments will be tracked and reported.

c. Provide an assessment of the completeness and reliability of financial data reported, including any assumptions and caveats associated with the figures.

This proposal has been developed in line with the counterpart financing requirements of the Global Fund, which are set forth in the Policy on Eligibility Criteria, Counterpart Financing Requirements, and Prioritization. The Government of Kyrgyz Republic is committed to uphold financial sustainability of priority public health interventions, as it is key to ensuring continuity of impact. Over the last years, the Government has increased financial allocations to TB and HIV control interventions, while the contributions of external partners in this area started to decrease during this period of time. At the moment, the Global Fund is the main external source of support to TB and HIV control in the country.

The Financial Gap Analysis and Counterpart Financing Table have been completed (see Table 1 enclosed). The counterpart financing requirements have been met. As seen from Line N (and P) in the 'Financial Gap Analysis and Counterpart Financing' table, the government contribution share is higher than a minimum threshold set for lower-middle income countries (more than 60%). There is a slight increasing government contribution to both national disease programmes over the next

implementation period (figures in Line B of the 'Financial Gap Analysis and Counterpart Financing' table increase over time) of about 1% annually. Also, there is a slight increasing government contribution to the overall health sector over the next implementation period (figures in Line J of the 'Financial Gap Analysis and Counterpart Financing' table increase over time).

Over the last years government investments for the TB and HIV/AIDS control interventions were oriented to procurement of TB first line drugs, some HIV diagnostic, diagnosis of the opportunistic infections and treatment, blood security, STIs testing and treatment etc.

The information used to complete the financial gap analysis and counterpart financing table was obtained from the MOH, NTP, NAP – for domestic sources; PRs for TGF support (resources disbursed in previous period of implementation and disbursement planned for 2015; country offices or implementing organizations – for other external contributions (previous, current and anticipated). Calculations of financial needs for the National Programmes are based on the National TB Control Programme for 2015-2017 and the National HIV/AIDS Control Programme for 2012-2016. For 2017, funding needs are estimated at the same amount as for year 2016. MOH plans to coordinate the efforts in order to build, in close collaboration with the CCM and local and international partners, next cycles of TB and HIV national programs together. For the previous years (2013-2014), data on domestic resources for TB correspond with NTP reported expenditure and for HIV with data reported in the UNAIDS National AIDS Spending Matrix as part of the UNGASS Country Report for Monitoring the Declaration of Commitment on HIV/AIDS.

The financial data presented are considered to be largely complete and reliable; as mentioned above, the HIV needs for 2017 are estimated based on 2016 from the current strategy, therefore this was taken into account when assessing the overall reliability. In parallel, the Government and the Ministry of Health put entire effort to continuously strengthen financial data collection, e.g. introducing and strengthening the national health accounts etc.

SECTION 3: FUNDING REQUEST TO THE GLOBAL FUND

This section details the request for funding and outlines how the investment is strategically targeted to achieve greater impact on the diseases and health systems. While the investments for both the HIV and TB programs should be described, the applicant should also provide information on the expected impact and efficiencies achieved from planned joint programming for the two diseases including cross-cutting health systems strengthening as relevant.

3.1 Programmatic Gap Analysis

A programmatic gap analysis should be conducted for the six to twelve priority modules within the applicant's funding request. These modules should appropriately reflect the two separate disease programs in addition to cross-cutting modules for both programs such as Health System and Community Systems Strengthening.

Complete a programmatic gap table (Table 2) for the quantifiable priority modules within the applicant's funding request. Ensure that the coverage levels for the priority modules selected are consistent with the coverage targets in section D of the modular template (Table 3).

For any selected priority modules that are difficult to quantify (i.e. not service delivery modules), explain the gaps, the types of activities in place, the populations or groups involved, and the current funding sources and gaps in the narrative section below.

The programmatic gap tables are attached in Excel format (see Table 2 enclosed). The coverage

levels for the priority modules selected are consistent with the coverage targets in the modular template. The following priority interventions have been identified in this section:

1. Multidrug-resistant tuberculosis (MDR-TB)
2. Prevention programs for PWID and their partners
3. Prevention programs for SW and their clients
4. Prevention programs for MSM
5. Prevention program for prisoners
6. Treatment, care and support
7. TB/HIV

These interventions are considered of high priority and represent a major focus of the current funding request and are described in details in the Programmatic gap tables. Also, the Project addresses additional priority interventions such as preventing mother-to-child transmission, community systems strengthening and removing legal barriers to access, health Information System and M&E and program management for transition of PR-ship to MOH. The gap is related to testing for pregnant women and children born from HIV+ women and prophylactic treatment under the PMTCT. The identified additional needs for the community systems are related to capacity building and leadership of community organizations. Also, under health information system and M&E these are related to routine M&E supervision and reporting, and bio-behavioural surveillance in KAP.

3.2 Applicant Funding Request

Provide a strategic overview of the applicant's funding request for TB and HIV, including both the proposed investment of the allocation amount and the request above this amount. Include the specific elements related to joint programming such as health systems and community systems strengthening. Describe how the request addresses the gaps and constraints described in sections 1, 2 and 3.1. If the Global Fund is supporting existing programs, explain how they will be adapted to maximize impact.

Kyrgyzstan was invited by the Global Fund to submit TB & HIV proposal for the New Funding Model. The CCM considers that the Global Fund decision took account of the disease burden and, at the same time, was based on the recognition of the progress in TB and HIV/AIDS control in the country. The recent national efforts are still not sufficient to fully address the needs and drivers of the epidemic, therefore the Government is committed to follow the international recommendations, apply evidence-based interventions and target the Global Fund support based on national priorities for effective fight against tuberculosis and HIV/AIDS.

The overall Goal of the Effective TB and HIV Control Project is to reduce TB and HIV burden in Kyrgyzstan *through ensuring universal access to timely and quality TB diagnosis and treatment, implementing evidence based HIV preventive activities focused primarily on key affected populations, providing treatment, care and support to PLHIV, creating enabling environment and ensuring programs sustainability.* The project principles and priorities are consistent with the international policies and guidance of WHO and UNAIDS and it is integrated into the National TB Control Programme for 2015-2017 and HIV/AIDS Control Programme for 2012-2016. It is aligned with the Global Fund HIV and TB Strategy and Investment Framework for EECA 2014-2017.

The project is built on lessons learned during implementation of previous Global Fund grants (described in Section 1.2. above) as well as on the existing capacity to fully address programmatic and financial gaps. The Effective TB and HIV Control Project is an integral element to the National TB and HIV/AIDS Programmes and involve Governmental and non-governmental organizations (NGOs). The project is constructed around three main Objectives, listed below with the 12 key

Modules as following:

Objective 1: **To ensure universal access to timely and quality diagnosis and treatment of all forms of TB including M/XDR-TB**

Module 1.1. Multidrug-resistant tuberculosis (MDR-TB)

Objective 2: **To implement evidence-based HIV preventive activities focused primarily on key affected populations and provide treatment, care and support to PLHIV**

Module 2.1. Prevention programs for people who inject drugs and their partners

Module 2.2. Prevention programs for sex workers and their clients

Module 2.3. Prevention programs for MSM

Module 2.4. Prevention programs for prisoners

Module 2.5. Preventing mother-to-child transmission

Module 2.6. Treatment, care and support

Objective 3. **To create enabling environment and ensure program sustainability**

Module 3.1. Community systems strengthening

Module 3.2. Removing legal barriers to access

Module 3.3. Health information system and M&E

Module 3.4. TB/HIV activities

Module 4.1. Program management

Given the fact that the high burden of DR-TB represents the major obstacle to control the epidemic and achieve the TB control targets, 'MDR-TB module' in the modular template was selected for the majority of TB control interventions included in this proposal. At the same time, it should be noted that the NFM interventions generally cover the full spectrum of TB control issues including the overall performance of TB control services and intersectoral approaches to for TB, DR-TB and TB/HIV control with special attention to the needs of vulnerable and at-risk populations. Regarding HIV/AIDS interventions, the Project requests to uphold and scale-up needle and syringe exchange programs for PWID, preventive programs for SW and MSM, preventive programs for prisoners, HIV testing and counselling for key affected populations, quality ARV treatment and monitoring, targeted capacity building, removing barriers, M&E, etc.

The Project targets health system strengthening, by intensifying TB and HIV case finding and improving TB and HIV case management, involvement of multi-disciplinary teams, support to improving quality and performance, and strengthening patient-centred approaches in TB and HIV/AIDS care delivery. It also addresses community system strengthening through small grant programs to NGOs in both TB and HIV domains, institutional capacity building, planning and leadership. The project duration is two years starting 01 January 2016. This timeline is aligned with the country financial cycle and frames a logical continuation of the on-going TGF support. It is important to mention that all project interventions cover both civilian and penitentiary sectors.

The on-going grants will come to an end in December 2015, therefore there is no duplication or overlap of the activities between the previous round-based grants and the resources allocated by the Government to TB and HIV control. The existing grants implemented by PR UNDP have been reprogramed to better correlate the new activities starting 01 January 2016, especially related to procurement and un-interrupted supply. The correlation is reflected in the work plan and the budget. In addition, the project activities have been planned taking into account the increasing contribution of the Government in taking over some key financial needs of the programmes, including supply of first-line anti-TB drugs, PMTCT, blood safety as well as the substantial human resources and medical facility costs.

The Project will be implemented through UNDP during 2016 with transition to the Ministry of Health as Principal Recipient starting 2017. The transitional capacity development plan and implementation structure has been discussed during CCM meeting and the Principal Recipient has been nominated by the CCM in accordance with the Global Fund recommendations.

A brief description of proposed Interventions by each Objective is given below.

Objective 1. To ensure universal access to timely and quality diagnosis and treatment of all forms of TB including M/XDR-TB

Module 1.1. Multidrug-resistant tuberculosis (MDR-TB)

Intervention 1.1.1. Case detection and diagnosis. An important priority of this application is to increase coverage of needs in rapid diagnosis of TB and rifampicin resistance (close proxy of MDR-TB in Kyrgyzstan) by Xpert MTB/RIF. Rolling out Xpert in Kyrgyzstan meets the WHO recommendations for using it as the initial diagnostic test in high MDR-TB settings: *Xpert MTB/RIF should be used rather than conventional microscopy, culture and DST as the initial diagnostic test in adults presumed to have MDR-TB or HIV-associated TB (strong recommendation, high-quality evidence)*.[10] At the moment, 8 Xpert MTB/RIF instruments are functional in the country at peripheral TB units in the civilian service and penitentiary system. In Year 1, the NFM project will provide additional three instruments to equip TB units in the country, thus increasing TB suspects' access to this technology as the initial diagnostic test. The needs in Xpert testing were calculated on the basis of detailed estimates of the number of TB suspects expected by each area and setting. The need for a gradual increase in productivity is taken into consideration. Overall, it is planned to perform a total of 34,000 Xpert tests during 2016-2017.

The National TB Programme unit with additional support of donors (e.g. PEPFAR) will facilitate and accelerate implementation of Xpert technology at the peripheral TB service delivery (district) level and penitentiary system; ensure effective information exchange and stakeholder participation, coordination between different levels of care; and monitor the use. Specific tasks will be assigned to: i) integrate Xpert testing into the TB information system and ii) monitor the use of new diagnostic algorithm for better linkages to treatment including promoting full outpatient treatment of TB patients including MDR-TB cases. In addition to the Global Fund grant, a special training program on practical aspects of implementation of Xpert MTB/RIF technology at peripheral TB service level will be organized for TB specialists and laboratory staff from newly enrolled Xpert sites, as well as refresher training for all sites.

The intervention also includes support to the TB laboratories in implementing other WHO-recommended rapid diagnostic techniques: automated MGIT technology for isolation of strains in liquid culture and accelerated DST, and automated LPA technology for identification of M. TB and detection of H/R resistance. Culture and DST to 1st line drugs will be performed to all smear-positive patients (both new and previously treated cases) using rapid techniques; cultures will be also performed for verification of diagnosis in smear-negative pulmonary patients and bacteriological monitoring of treatment progress in TB patients. As mentioned above, these technologies are functional in the country, however, the coverage of needs is not complete and Government has not yet been able to take over the costs of these technologies. Therefore, the CCM decided to seek additional support in the NFM application, to increase coverage and build sustainability until the Government allocates sufficient resources for this purpose with the aim to take over full costs beyond TGF support. The needs in MGIT culture and DST as well as LPA

[10] Automated real-time nucleic acid amplification technology for rapid and simultaneous detection of tuberculosis and rifampicin resistance: Xpert MTB/RIF system for the diagnosis of pulmonary and extrapulmonary TB in adults and children: policy update. WHO, October 2013

Hain tests were estimated in accordance with the NTP diagnostic algorithm. The calculations are based on epidemiological projections, planned increases in diagnostic coverage and expected DR-TB rates by patient category.

To ensure full functionality of the laboratory network, the Project includes appropriate support for maintenance and servicing of laboratory equipment (particularly MGIT and LPA equipment) and procurement of microscopes for peripheral microscopy centres according to the needs' assessment. Please, refer to the details in a separate sheet of the Work plan and Budget file. The Global Fund is requested to support transportation of sputum from peripheral microscopy laboratories to reference laboratory for further culturing and DST, within the routine drug resistance surveillance system. Under this intervention, supply of individual infection control protection measures (N95 / FFP-2 respirators) is included for the personnel working at the reference laboratory, as well as for staff at high risk of infection at inpatient treatment departments.

The 'Above allocation amount' under this component aim to increase access to TB diagnostic through further enhancing rapid diagnostic technics. In order to boost and institutionalize rapid TB diagnostics in Kyrgyzstan, the laboratory capacity will be further strengthened by BACTEC and Hain testing. To ensure full functionality of the laboratory network, the CCM included in the above allocation procurement of laboratory equipment according to the needs' assessment: one additional MGIT-960 system for the regional laboratory in Osh and two FluoroCyclers-96 for NRL and Osh RL. Also, the NFM Project will support necessary reagents and consumables estimated in accordance with the NTP diagnostic algorithm.

In addition, the above allocation funding is requested to scale-up Xpert MTB/RIF technology in Kyrgyzstan and procure three 4-modules and fourteen 2-modules Xpert instruments. Currently, there are 8 instruments in the country and 3 additional instruments will be procured in 2015. As the rapid diagnosis methods intend to be 'rapid', any additional referral layers will delay the diagnosis time as well as treatment initiation. Setting up MTB/RIF closer to patients makes sense given the administrative division of the country. The way health services are set-up, the hierarchy of services are village – district – oblast - national level. The patient referral pattern follows the same steps: rural patients are referred to district center, then oblasti center and lastly Bishkek. Given the socio-economic status of patients, if referred further, they are likely to not get to the health facility and time is lost in timely diagnostics, leaving them in their communities to further spread TB to contacts.

The placement of MTB/RIF closer to patients will address the critical barrier of time delays that arise with transportation and referrals and bring a critical value to getting same-day results and timely start correct treatment. Therefore the country has chosen the strategy where instruments are placed at the level where the diagnosis of TB is established and there is no specimen transportation for Xpert testing. As for indicative levels of use of machines, on average 4 with maximum 8 samples will be conducted per day per machine (processing time for 2 samples is 2 hours, 6 samples is 6 hours, this is in line with work schedule of a lab person, which gives sufficient time to get back same-day results). The project will support procurement of additional cartridges and relevant warranty (please refer to separate sheet on above allocation in the Work plan and Budget file).

Intervention 1.1.2. Treatment: MDR-TB. The Project seeks to uphold universal access to treatment of all forms of TB in Kyrgyzstan by supply of second-line and third-line anti-TB drugs for MDR-TB and XDR-TB patients in the civilian and penitentiary sectors. The estimates of the number of patients by category are presented in a separate sheet in the Workplan and Budget file. During two years 2016-2017, the NTP plans to enrol in treatment a total of 2,568 patients with MDR forms of the disease (1,284 per year) of them 480 will be covered by current TB grant and 172 by MSF. The estimated number of XDR patients to be

enrolled in treatment during NFM period is 280 (140 per year). The breakdown of drug procurement under TGF NFM Project is given below in Table 11.

Table 11. Number of M/X/PDR treatments to be supported with drug procurement by the NFM Global Fund grant, 2016-2017

	Year 1 (2016)	*Year 2 (2017)*	***Total***
Number of MDR treatments	718*	1198**	**1,916**
Number of XDR treatments	77*	127**	**204**
Number of PDR treatments	479*	479**	**958**
Total	**1,274**	**1,804**	**3,078**

* For 2016, the existing TGF funding will cover 480 MDR and 50 XDR treatments; MSF project will cover 86 MDR, 13 XDR and 20 PDR treatments per year in covered project regions. ** MSF project will cover 86 MDR, 13 XDR and 20 PDR treatments per year in covered project regions.

The treatment regimens have been designed according to the latest WHO guidance and take account of the expected pattern of resistance to second-line drugs (see details in a separate sheet of the Work plan and Budget file). The Government's co-financing covers other substantial costs of staff, and facility operations, as well as clinical investigations for treatment monitoring, drugs for management of adverse reactions of second-line drugs, etc. In accordance with TGF requirements, the project foresees centralized procurement of drugs through the Global Drug Facility (GDF). Besides proper cost of drugs and delivery costs, the project will cover relevant costs of storage and in-country distribution, as well as external quality assurance of drugs. In accordance with TGF requirements, this component also includes annual payments for the Green Light Committee (GLC) operations.

Intervention 1.1.3. Community TB care delivery. The activities under this intervention aim at promoting multisectoral and multidisciplinary response to TB epidemic, with special emphasis on involving non-state actors and communities for implementation of patient-centred TB care and achieving best patient outcomes. This will be achieved through continuing support to provision of adherence incentives; expanding and strengthening TB community involvement; implementation of the small grant program by NGOs addressing special needs of high risk groups; and conducting communication activities.

Ensuring compliance and adherence to lengthy and complex DR-TB treatment is a key challenge and the utmost important part of programmatic DR-TB management. The project will support the program for intensive patient support and follow up as a fundamental component for ensuring adherence. This program will provide daily adherence monetary incentives for MDR and XDR cases during outpatient phase of treatment, based on adherence criteria. The Global Fund is requested to cover the needs of patients receiving first-line treatment and to M/XDR patients based on the following covering schema: at least 50% of needs for susceptible TB patients and 85% for M/XDR-TB patients per year. Please, refer to detailed estimations in a separate sheet of the Work plan and Budget file.

The CCM and NTP recognize that the involvement of non-state actors, first and foremost that of civil society organizations, is of key importance to the success of TB control efforts. All planned TB control system reform interventions rely on reinforcement of patient-centred care, which becomes of special relevance for the management of drug-resistant TB and, on the other hand, for ensuring access to essential interventions for the disadvantaged and at-risk population segments. In this regard, the NTP pays an increasing attention to strengthening partnerships with the civil society establishments, especially in

the face of the high burden of DR-TB and limited capacity of TB services and general health care services to accompany the patients during their entire case management pathway. The needed emphasis on outpatient treatment requires an intensified effort for patient support. Intervention 1.1.3 aims at implementing patient-centred approaches through different models of the local TB Coalition involvement in TB care and support; it is deemed that the successful practices of the project will be expanded beyond TGF support and be further supported by the Government.

Besides activities receiving direct support from the Global Fund, the NTP has engaged in carrying out a number of measures, which will facilitate implementation of outpatient TB treatment model. A specific national working group to develop and implement a roadmap for outpatient care for Kyrgyzstan has been established. The Project will further support Working Group activities to improve treatment adherence and revise hospitalization policies and downsize inpatient TB care and complement PEPFAR initiative. The Working Group will attract ad-hoc local consultants representing TB sectors, primary health sectors, public health sectors, national health insurance systems, human policy makers and lawyers.

Objective 2. To implement evidence-based HIV preventive activities focused primarily on key affected populations and provide treatment, care and support to PLHIV

The design of current prevention program is largely consistent with the needs of the key affected populations, but requires scale up in coverage and quality improvements. Still, the HIV prevention services do not fully reach those most hidden and vulnerable populations and do not effectively address the high-risk behaviours of populations (as described in Sections 1.1. and 1.2. from above). The activities under this objective are focused on the needs of the key affected populations from civilian and penitentiary sectors. The Project uses outreach workers to target the most vulnerable PWID who cannot afford syringes and condoms, street sex workers who are the most vulnerable and MSM engaged in unsafe sex in cruising areas. The Project will provide a low-threshold range of harm reduction services, including community access to rapid voluntary counselling and testing for HIV, and will support prevention programs for prisoners.

Module 2.1. Prevention programs for people who inject drugs (PWID) and their partners

Sterile syringe use has not yet become consistent, and only a small portion of PWID in Kyrgyzstan has adopted safer sexual behaviours. At this stage, harm reduction services supported by the Global Fund offer a package of services for PWID close to the comprehensive package recommended by WHO for addressing HIV among PWID which include distribution of needles and syringes, information-education-communication (IEC) materials, condoms, water for injection, post-injection plaster, alcohol swabs and containers for used syringes. Free legal, medical and psychosocial counselling is also available as well as linkages to VCT services and the OST program and linkage to HIV care for positive PWID (See Annex 6. WHO 2014 Review of the HIV Programme in Kyrgyzstan).

To increase the coverage and make these measures more effective, the Project activities are centred on service provision of the comprehensive package (needle exchange, condom programming, IEC, VCT, Hepatitis, STI, ARV, OST) in areas with highest concentration and put additional emphasis on those at greatest HIV risk: female PWID/ SW in all geographical areas where PWID or female SW NGOs work, overdose prevention, peer-driven interventions, linkage to HIV treatment and care and integration of services for PWID. It is expected to reach 60% of PWID or 15,000 people by 2017. The coverage with the preventive services will constantly increase by 2020 to reach 75% or 18,750 people from 25,000 estimated.

Intervention 2.1.1. Needle and Syringe programs as part of programs for PWID and their partners.

Through specific grants to NGOs managed by the Principal Recipient, the Project will scale up the coverage, expand the range and support quality of harm reduction services

provided by NSP in 14 consolidated sites and ensure access for PWID to needle exchange, condom distribution, targeted behaviour change communication for PWID and their sexual partners, counselling and referral to VCT, STI prevention, linkage to care, ART, OST, legal advice and provision of on-site integrated services. The Global Fund is requested to support a total of 15 grants to NGOs per year.

To boost preventive activities the project will introduce a new approach in increasing coverage of key affected populations through peer-driven interventions in the project sites. It is estimated that the peer driven intervention (PDI) seeds will recruit additional 1,250 new beneficiaries by providing them peer-to-peer educational session and link them to NSP sites to access services.

To address the perpetuation of unsafe injection and unsafe sexual behaviours in PWID, the project will conduct communication for behaviour change activities to increase sterile syringes use and condom acceptability and promote safer injection and safe sex behaviours. Activities will include production of new informational materials to be used in motivational activities and will focus on developing new skills in service providers and outreach work in counselling for behaviour change in key affected populations. Community-based overdose prevention has proven to be effective in saving lives but also engaging PWID with harm reduction programs and outreach workers, thus the project provides that harm reduction organizations will add informational and educational activities regarding overdose prevention to their current range of activities, will procure Naloxone and promote its use. Also, the Programme will cover, as part of their comprehensive approach to behaviour change communication additional issues regarding the STIs, HCV, HBV and will build additional links to these services.

Additionally the project will encourage and provide HIV counselling and testing. The harm reduction sites will improve links with specialized TB and HIV health departments to improve crosscutting links and TB/HIV collaborative interventions. The detailed activities of this intervention are described further in the Modular Template attached to the Concept Note (Table 3 enclosed) as well as in the Work plan and Budget (Annex 7).

Intervention 2.1.2. Condoms as part of programs for PWID and their partners

The project will support procurement of condoms for the comprehensive package of preventive services for PWID and their partners. The condoms will be distributed through the network of harm reduction sites using outreach as well. The details and estimations are provided in the enclosed Work plan and Budget file.

Intervention 2.1.3. HIV testing and counselling as part of programs for PWID and their partners.

The testing for key populations has increased since the introduction of rapid testing, which has proven to be effective intervention in increasing the numbers of KAP reached with these services. While there have been improvements in reaching and testing key populations, these efforts will be further scaled-up to boost the coverage of PWID with HIV testing in Kyrgyzstan and reach 80% from those covered by preventive services by 2017 (about 12,000 people). The longer-term expectations are to reach 100% of PWID from those covered with preventive services by 2020.

During year one and year two of the Project, the Global Fund will support procurement of rapid tests to increase community-based rapid HIV testing and counselling in PWID through service delivery points and improve enrolment in care (pre-ART and ART) for PWID who test positive for HIV. The consolidated service provision units will continue to provide testing in sites with high concentrations of key populations. To support the targets mentioned above, behaviour change communication key messages will be enhanced so that all PWID are encouraged to test for HIV at least once per year. Also, about 20% of PWID will be tested using HIV ELISA methodology. The necessary testing

protocols have been developed with WHO support and pending MOH approval with inclusion of 4th generation tests and phasing out immuno-blotting confirmation.

Intervention 2.1.4. Diagnosis and treatment of viral hepatitis.

The project will support procurement of hepatitis tests for rapid testing as part of comprehensive package of preventive services for PWID and their partners. The tests will be promoted through the network of harm reduction sites using outreach as well. The details and estimations are provided in the enclosed Work plan and Budget file.

Intervention 2.1.5. Opioid substitution therapy and other drug dependence treatment as part of programs for PWID and their partners. OST strategy has been endorsed by the Government in 2006 by Resolution #498 from 6 July 2006 and has registered progress, especially in the penitentiary sector. Currently it is available in eight prisons, including prison Nr.2 for women. The project plans to further scale-up OST by geographic extension and cover additional two prisons (Prisons nr.10 and Nr.16). The project will provide operational support to existing 21 OST sites and will support methadone procurement, tests and disposable glasses to ensure quality OST maintenance. To improve on-side coordination, monitoring and evaluation of provided services, the project will support necessary technical assistance. The intervention will be implemented by the Republican Narcological Center in close collaboration with partners.

Under previous Global Fund support, Kyrgyzstan established a well functioning network with enrolling and maintaining PWID in OST, including penitentiary system. The activities under this intervention aim to ensure outreach to PWID and family members to improve enrolment for OST and adherence to treatment through self-support and psycho-social activities. The program will continue to provide support to community-based OST support sites to increase access to OST by facilitation enrolment and OST adherence. The community-based sites establish their services on 'one stop shopping' approach and provide additional services to improve cost-efficiency, quality of services and coverage, e.g. outreach work, HIV testing and counselling, harm reduction, linking with other services (including TB/HIV collaborative), peer-to-peer consultation, psychological and legal consultations, self support and social support. These services contribute to further prevention of HIV, tuberculosis, hepatitis and STIs, and improve the quality of life.

Taking into account performance and developments under previous Global Fund grants implementation, the Project is led by programmatic achievements of 40% coverage of registered PWID with prevention services by 2017 and will cover up to 2,254 PWID with prevention services. Under OST program, the project will enrol 55 new people per year and will contribute to further coverage increase to 80% by 2020. The activities under this module will be implemented by the Republican Narcological Centre as sub-recipient.

<u>Module 2.2. Prevention programs for sex workers and their clients</u>

Intervention 2.2.1. Behavioural change as part of programs for sex workers and their clients. The project will continue support of service provision to SWs through a consolidated 6 service provision sites. A comprehensive range of well-coordinated and flexible services will be provided to SWs, using peer and community outreach and based on lessons learnt in the previous period. HIV prevention in sex work settings will be directed to ensure: increased condom use and safer sex; reduced STI burden. A comprehensive approach to be able to adapt to changing needs and circumstances will be maintained. The following approaches will be used: easy access to condoms; easy access to information, communication, and education; risk behaviour change; peer education; referral system for health care, including HIV testing and counselling, as well as health services – VCT services provided within NGOs, management of sexually transmitted infections.

To increase the coverage of SWs with preventive services, the Project will introduce a new

approach in boosting access of key affected populations through peer-driven interventions (PDI). PDI seeds will recruit other new clients, by providing them peer-to-peer educational session and link them to sites to access preventive services. Around 355 new beneficiaries will be reached with prevention services per year, which will achieve coverage of 65% by 2017 on the way to the target established to be fulfilled (90%) in 2020. Targets include 4,260 SWs in Year 1 and 4,615 in Year 2.

Intervention 2.2.2. Condoms as part of programs for sex workers and their clients

The project will support procurement of condoms for the comprehensive package of preventive services for SWs and their clients. The condoms will be distributed through the network of NGOs active in the field using peer-to-peer approach as well. About 20% female condoms will be procured and used in cases when the use of male condoms is impossible. The utilization of female condoms will be promoted through educational sessions on service provision sites. The details and estimations are provided in the enclosed Work plan and Budget file.

Intervention 2.2.3. HIV testing and counselling as part of programs for sex workers and their clients. While there have been improvements in reaching and testing key populations, these efforts will be further scaled-up to boost the coverage of SWs and their clients with HIV rapid testing in Kyrgyzstan and reach about 80% from those covered by preventive services by 2017 (about 3,692 people). The longer-term expectations are to reach 100% of SWs from those covered with preventive services by 2020.

Over the Project life, the Global Fund will support procurement of rapid tests to increase community-based rapid HIV testing and counselling in SWs and their clients through service delivery points and improve enrolment in care (pre-ART and ART) for SWs who test positive for HIV. The consolidated service provision units will continue to provide testing in sites with high concentrations of key populations. About 20% of SWs will be tested using HIV ELISA methodology.

The activities under this module will be implemented by the civil society sector through small grant program managed by the Principal Recipient.

Module 2.3. Prevention programs for MSM and TG

Intervention 2.3.1. Behavioural change as part of programs for MSM and TG. The project will support continuation of service provision to MSM in 4 consolidated sites implemented by NGOs active in the field. Service provision includes outreach work in cruising areas, provision of IEC, condoms and lubricants, counselling services and peer support, STI management and linkage to VCT centres, medical and legal consultations. A complex approach to be able to respond to various needs (MSM who are sex workers) will be strengthened. To increase the coverage of MSM with preventive services, the Project will introduce a new approach in boosting access of key affected populations through peer-driven interventions. PDI seeds will recruit other new clients, by providing them peer-to-peer educational session and link them to sites to access preventive services. About 395 new beneficiaries will be reached with preventive services in 2016 and 1,090 in 2017 in view of reaching 20% coverage from estimated. The target is low as it is considered that there is an overestimation of the population size. However, by 2020 there is a commitment to increase the coverage to 60%. Similarly to PWID and SW, the increase in the number of MSM reached with HIV testing and counselling is due to PDI activities.

Intervention 2.3.2. Condoms as part of programs for MSM and TG

The Project will support procurement of condoms for the comprehensive package of preventive services for MSM. Condoms with increased resistance and lubricant will be procured and distributed by outreach workers. The details and estimations are provided

in the enclosed Work plan and Budget file.

Intervention 2.3.3. HIV testing and counselling as part of programs for MSM and TG. The Project will be further scaled-up to boost the coverage of MSM with HIV rapid testing in Kyrgyzstan and reach about 90% from those covered by preventive services by 2017 (about 3,924 people). The longer-term expectations are to reach 100% of MSM from those covered with preventive services by 2020.

Over the Project life, the Global Fund will support procurement of rapid tests to increase community-based rapid HIV testing and counselling in MSM and their clients through service delivery points and improve enrolment in care (pre-ART and ART) for MSM who test positive for HIV. About 20% of MSM will be tested using HIV ELISA methodology. As mentioned above, the testing protocols have been developed with WHO support.

The activities under this module will be implemented by the NGOs active in the field through a small grant program managed by the Principle Recipient.

Module 1.4. Prevention programs for prisoners

Intervention 1.4.1. Behavioural change as part of programs for prisoners.

Preventive and psychological services for prisoners expanded under the current grant and are provided in twelve prisons and correctional facilities. The Project will expand HIV preventive service by adding one correctional facility from Karakol and ensure access of prisoners to a standard package of services that include needle and syringe exchange, psychosocial support, safe behaviour promotion and IEC materials distribution, peer-to-peer education, etc. The preventive and psychological support activities are provided by Prison Medical Department and proved to be very effective in collaboration with the Republican AIDS Centre. The Project is led by programmatic achievements of 60% coverage of prisoners (estimated population 8,000) with prevention services by 2017 and will cover up to 4,800 prisoners. It is expected that by 2020, the National HIV/AIDS Programme will reach 90% or 7,200 prisoners.

Intervention 1.4.2. HIV testing and counselling as part of programs for prisoners. The project will increase HIV testing and counselling in prisoners and support HIV testing for patients in prison settings including TB patients. HIV testing in prisoners will be scaled up to reach 60% of prisoners with testing by 2017 and further increase to 90% in 2020. The established targets will be incorporated into the new cycle of the National HIV/AIDS Programme.

Due to legal constrains, the Prison Medical Department cannot manage directly external funding. The activities under this module will be implemented by the Principal Recipient through the Republican AIDS Centre as sub-recipient.

Module 2.5. Preventing mother-to-child transmission

Intervention 2.5.1. Preventing vertical HIV transmission. PMTCT within the National HIV/AIDS Programme is based on a comprehensive approach aimed at addressing a broad range of HIV – related prevention, care, treatment and support needs of pregnant women, mothers, their children and families. PMTCT remains one of the priorities of the national HIV response and is aligned to the new 2013 WHO recommendations. For 2016 – 2017, ARV drugs and HIV test kits for all patients will be covered through the Global Fund grant. The Government will gradually take over HIV testing of pregnant women during pregnancy and before delivery (55% in Year 1 and 80% in Year 2). As result, all HIV-positive pregnant women will receive ARV to reduce mother to child transmission and all infants born to HIV-positive women receive HIV tests. The activities under this module will be implemented by the Republican AIDS Centre as sub-recipient.

Module 2.6. Treatment, care and support

Intervention 2.6.1. Antiretroviral therapy (ART). The Project activities under this intervention aim to increase access to comprehensive HIV treatment. The proposed coverage with ART includes the following estimates: in 2016 – 2,904 and in 2017 – 3,478 PLHIV including from penitentiary system. Calculations have been made based on SPECTRUM and agreed with WHO and UNAIDS. An annual enrolment of 537 in 2016 and 574 in 2017 is in line with the National HIV/AIDS Programme and contributes to reaching 90% coverage with ART by 2020. A necessary technical assistance is required from the Global Fund to update related clinical protocols and ensure its implementation at the national scale.

Intervention 2.6.2. Treatment monitoring. The Project will cover the needs related to treatment monitoring: determining the viral load for patients, PCR and CD4 testing in patients for all those enrolled and also for HIV patients who are in pre-treatment phase, as following: in Year 1 - 3,594 patients, of which 2,904 - on ART and Year 2 – 4,240 patients, of which 3,478 - on ART. Funds provided by the Government cover additional substantial costs, such as staff remuneration, facility costs, opportunistic infections diagnosis and treatment, STI diagnosis and treatment.

Intervention 2.6.3. Treatment adherence. Under this intervention, the Project supports incentives and enablers for intensive HIV patient support and follow-up as a fundamental component for ensuring adherence to HIV treatment. This is a continuation activity from the previous Global Fund grant. To ensure access of PLHIV community and improve collaboration and provide low-threshold services to PLHIV and key populations, the work will involve joint actions of the Republican AIDS Centre with local NGOs who provide additional support and implement community outreach activities to ensure linking services, including counselling and psycho-social support (described below).

Intervention 2.6.4. Counselling and psychosocial support. As identified by the PLHIV needs assessment, one of the main deterrents of accessing and care retention is that PLHIV continue to experience stigma and discrimination when contacting public services. Peer support and community-based self-support programs have proven successful in providing enhanced wraparound services to PLHIV, while other project activities work on improving quality of public services and non-discriminatory attitudes. The project will continue to provide support to NGOs and community-based organizations to outreach to PLHIV and their families with a comprehensive support package, including psycho-social support, mentoring, case-management and linking them to other services. A total 5 grants per year will be awarded during project implementation.

Also, the Project will provide support to multidisciplinary teams created under the auspices of the Republican AIDS Centre. There are 5 multidisciplinary teams in total, one is active in the penitentiary system. Through these mobile teams, the Project will improve HIV case management and ensure quality of service provision. Also, it will ensure treatment and care follow-up for people releases from prisons. The activities under this module will be implemented by the Republican AIDS Centre as sub-recipient and Principal Recipient will manage the small grant programs for NGOs active in the field.

Objective 3. To create enabling environment and ensure programs sustainability

The design of current prevention program is largely consistent with the needs

Module 3.1. Community systems strengthening

Intervention 3.1.1. Institutional capacity building, planning, leadership and accountability. The activities under this intervention are oriented to further capacity building of key affected populations and communities, community organizations and networks to enable them to become meaningful participants in the dialogue with the government. These activities are

complementary to engagement of community-based organizations in the design, delivery, monitoring and evaluation of services, which is a part of the service component of the present programme. The Project will sustain a national network of organizations to coordinate community involvement on local and central level through small grant program. In this respect, a series of capacity building events are planned for civil society and PLHIV monitoring, advocacy, communication and social mobilization, organizational development, etc. The activities aim to empower and develop the activism of key affected populations through building mechanisms and platforms for dialogue, exchange of views, and meaningful engagement in the dialog with authorities at national and local levels. This intervention will be matched with the activities described in the Module 3.2 below.

Module 3.2. Removing legal barriers to access

Intervention 3.2.1. Legal aid services and legal literacy. Legal aid services will serve both to provide direct legal support and improve legal literacy of key affected populations, as well as will facilitate cooperation between KAP and public bodies. To further increase the effectiveness of legal support the project will develop key population communities by equipping members of key populations with practical skills in monitoring service quality and respect for human rights. A specific project "Street Lawyers" is seen instrumental to provide legal assistance using accessible legal resources involving outreach workers in mediation and other forms of legal issues resolution, and enabling key populations to use available legal tools to help accessing health care and/or social services. Additional training will be focused on developing practical skills and, with support of professional lawyers, outreach workers will take effective action to restore and protect the rights of key affected populations.

Specific activities will be oriented to enhance social accountability closely linked to provision of quality services and removing legal barriers to evidence-based and human rights oriented health services. This intervention will be matched with the activities described in the Module 3.1. above and will be implemented by NGOs through small grant program managed by the Principal Recipient.

Module 3.3. Health Information System and M&E

Intervention 3.3.1. Routine reporting. The activities under this intervention are oriented to support the costs for second-generation surveillance study in key population groups (PWID, SW and MSM). The most recent exercise has been conducted in 2013. The next round is proposed for 2016 based on the methodology used in previous rounds to ensure data comparability, consistency and progress/trends monitoring. In addition, routine monitoring and evaluation costs are budgeted for the National TB Centre, Republican AIDS Centre and for data verification and validation. The activities under this module will be implemented by the Principal Recipient in collaboration with the National TB Centre and Republican AIDS Centre as sub-recipients.

Module 3.4. TB/HIV

Intervention 3.4.1. TB/HIV collaborative interventions. As indicated in section 1.1 above, TB/HIV co-infection is a growing public health concern in Kyrgyzstan. While the programmatic and funding needs in this regard are mainly covered from domestic and external sources (such as provision of second line anti-TB drugs, antiretroviral (ARV) treatment, HIV testing in tuberculosis patients etc.) and some costs sharing from the Government (IPT, some infection control measures), it is recognized that specific aspects of TB/HIV collaboration need strengthening. The Project seeks targeted support to further strengthen national capacity for joint planning, implementation, and monitoring and evaluation of TB/HIV activities and improving collaboration between TB services and HIV services, in line with

the latest international guidance, e.g. WHO policy on collaborative TB/HIV activities: guidelines for national programmes and other stakeholders (WHO, 2012),[11] and in accordance to the findings and recommendations of the WHO NTP Review.

A national TB/HIV steering committee will be supported to strengthen practical aspects of TB/HIV collaboration by developing a roadmap for strengthening TB/HIV control, updating relevant regulations and monitoring of implementation/execution. The committee enrolled government stakeholders from outside health sector as well as relevant non-state actors. The national consultants will assist the committee in the above tasks and will strengthen, monitor and supervise activities, as well as empower M&E groups in TB and HIV programmes to prepare an annual joint report on TB/HIV indicators for screening, diagnosis, treatment and support across the two Programmes, including integration of the information systems. Targeted training activities such as training of TB and HIV service staff in modern approaches and practical aspects of management of HIV-associated TB, and other refresher training for service providers will be co-financed by other donors active in the country (ex. USAID, WHO, UNAIDS, MSF etc.)

At the same time, there are cross-cutting activities included under other components of the application that address TB/HIV activities, such as laboratory (TB and HIV tests, consumables for Xpert MTB/RIF, culture examination, rapid technics BACTEC and HAIN), anti-TB treatment and ART (provision of drugs included TB/HIV co-infection), NGOs projects etc. As result, the budget for TB/HIV measures exceeds a share of 15% from the total grant as calculated by the modular template.

Module 4.1. Programme management

Intervention 4.1.1. Policy, planning, coordination and management. The Project will gradually build up the capacity of the MOH to take over the PR-ship role by 2017 and strengthen coordination and leadership role. In this respect, CCM, UNDP and MOH assessed the governance bottlenecks, legal barriers, management needs and gaps, and the Programmes structure and responsibilities. As result, a transitional and capacity building plan to transfer PR-ship from UNDP to MOH has been developed, costed and agreed by CCM. The plan provides clear timeframes and outcomes (see enclosed Annex 8. Capacity development transitional plan). Necessary financial support will be provided to ensure proper operations of the central MOH unit responsible to take over the Project management (including office equipment, furniture, stationery etc.) The activities under this module will be implemented by the Principal Recipient.

Intervention 4.1.2. Grant management. The grant management component includes staffing, office management, communication and other relevant activities and costs of the Principal Recipient and three sub-recipients. The total grant management cost is about 13% of the total grant: overall planning and administration costs are below the regional benchmarks of the same range projects supported by the Global Fund in the region.

[11] http://www.who.int/tb/publications/2012/tb_hiv_policy_9789241503006/en/index.html

3.3 Modular Template

Complete the **modular template (Table 3)**. Note that the template allows access to modules that are specifically relevant to TB and HIV components, in addition to modules that are cross-cutting for both diseases.

To accompany the modular template, for both the allocation amount and the request above this amount, explain:

a. The rationale for the selection and prioritization of modules and interventions for TB and HIV, including those that are cross-cutting for both diseases.

b. The expected impact and outcomes of the interventions being proposed. Highlight the additional gains expected from the funding requested above the allocation amount.

This request for funding has been designed taking into account the epidemiological profiles (described in details in p.1.1. and p.1.2. above) and the most important targets to be addressed in the next period: ensure universal access to timely and quality diagnosis and treatment, especially MDR-TB and increase coverage and effectiveness of HIV prevention among key populations while providing treatment, care and support to PLHIV.

As drug-resistant TB is the major challenge for effective control of TB disease in the country, the great majority of TB interventions were included under 'MDR-TB' module. Funding-wise, they account for 43% of Indicative budget. At the same time, it should be noted that many interventions described above in Section 3.2, cut across different areas which could have been attributed to other 'standard' TGF modules (such as 'TB-HIV' – TB and MDR-TB detection among PLHIV by Xpert MTB/RIF, 'Monitoring and Evaluation' – M&E activities are integral part of the majority of interventions included; 'Community systems strengthening' – a number of interventions address the involvement of civil society and community actors to access appropriate diagnosis, treatment and support services, with special attention to vulnerable and high-risk population groups, under Objective 1).

An important focus of the proposal is the rollout of novel rapid diagnostic technology – Xpert MTB/RIF, which allows to simultaneously diagnose TB and resistance to Rifampicin (close proxy of MDR in Kyrgyzstan settings), which, therefore, may be attributed to both 'TB care and prevention' and 'MDR-TB' modules. However, in order to ensure consistency and emphasize the need of drug resistance prevention and management, the above interventions were included under 'MDR-TB' module.

To increase coverage of the key affected populations and increase effectiveness of prevention of sexual transmission from key populations to their sexual partners through consistent use of condoms, especially sex workers and MSM, the Project promotes new strategies: peer-driven interventions, strengthening behavioural change communication for each specific group, diversification of condoms and strengthening of counselling to reduce risk sexual behaviours etc.

A particular focus emphasizes the role of NGOs in community-based outreach with rapid HIV testing, timely clinical follow-up and start of ART and adherence and psychosocial support to PLHIV including home based care. It also takes into account the need for further work on increasing medical workers and public awareness towards stigma reduction and strengthening M&E system as part of the process of service institutionalization and sustainability.

To address the need to improve TB/HIV collaborative activities, the Project will provide support to harm reduction sites that will improve links with specialized TB and HIV health departments to improve crosscutting links and TB/HIV collaborative interventions. The community-based sites establish their services on 'one stop shopping' approach and provide additional services to improve cost-efficiency, quality of services and coverage, e.g. outreach work, HIV testing and counselling, harm reduction, linking with other services (including TB/HIV collaborative), peer-to-

peer consultation, psychological consultations, self support and social support. The collaborative activities of that aim for health system changes and collaboration of public medical institutions are being addressed in the TB/HIV module.

Taking all this into consideration, the following modules have been prioritized:

- Multidrug-resistant tuberculosis (MDR-TB)
- Prevention programs for people who inject drugs (PWID) and their partners
- Prevention programs for sex workers and their clients
- Prevention programs for MSM and TG
- Prevention programs for prisoners
- Preventing mother-to-child transmission
- Treatment, care and support
- Community system strengthening
- Removing legal barriers to access
- Health information system and M&E
- TB/HIV activities
- Program management

The Modular Template has been completed and attached to the application in Table 3 enclosed. The performance indicators and budget figures, presented in the Modular Template, are based on detailed estimates of programmatic and financial needs.

3.4 Focus on Key Populations and/or Highest Impact Interventions

This question is <u>not</u> applicable for Low Income Countries.

For TB and HIV, describe whether the focus of the funding request meets the Global Fund's Eligibility and Counterpart Financing Policy requirements as listed below:

a. If the applicant is a lower-middle income country, describe how the funding request focuses at least 50% of the budget on underserved and most-at-risk populations and/or highest-impact interventions.

b. If the applicant is an upper-middle income country, describe how the funding request focuses 100% of the budget on underserved and most-at-risk populations and/or highest-impact interventions.

In this application, the majority of activities aim at supporting special groups and key affected populations with specific interventions. DR-TB patients, out which the majority present with M/XDR-TB forms, are especially prone to service barriers and are likely, if not provided with an appropriate support to receive the needed package of care, to incur catastrophic financial expenditures and indirect losses (e.g. being away from the family, economic gain activity and, generally, normal way of life for the long period of time required for DR-TB treatment). It is therefore considered that all, or almost all, DR-TB patients fall under TGF categorization of 'underserved population segments' likely to be deferred access to modern diagnosis, quality treatment and adherence support, and being, therefore, at high risk of DR-TB amplification and default from treatment, with the resulting treatment failure and death.

At the same time, the proposal includes high-impact interventions, such as rolling out modern molecular diagnostic technologies (Xpert MTB/RIF) to the lowest service delivery level with the scope of rapid diagnosis of TB and rifampicin resistance, and promotion of outpatient treatment of DR-TB cases instead of hospital treatment, with appropriate adherence support and involvement of civil society and community establishments. These key interventions of the project are expected to produce an important and quick impact on the service performance, which, in turn, will

contribute to the alleviation of the overall burden of TB DR-TB.

The Project is oriented to the needs of the key affected populations: PWID, SW, MSM and prisoners. Although PWID, SW and MSM are the main drivers of the HIV epidemic, they are those who most often experience barriers to prevention measures, treatment and care. These populations are perceived as lower social classes, are especially vulnerable economically and often hesitate to seek treatment for fear of discrimination and potential legal ramifications. The focus will be made on increasing their access to health care services, promoting harm reduction, condom use and other safe behaviours to prevent the spread of HIV as well as to improve health care services and making them user-friendlier to KAP.

The Project aims at increasing coverage and targeting enhanced access to essential comprehensive packages of services for the most vulnerable marginalized and discriminated sub-populations of KAP. Outreach workers will target the most vulnerable PWID who cannot afford syringes and condoms, SW projects will target mostly street SW, which are the most vulnerable socially and simultaneously at highest risk of HIV transmission, as will MSM outreach work target MSM engaging in unsafe sex in cruising areas. The project will provide low-threshold range of harm reduction services, including community access to rapid HIV testing and counselling. The project will provide preventive services to prisoners in all penitentiary institution, including, follow up at release and linkage to civil sector services, and also promote HR service for prisoners.

Additionally, the project proposal includes specific interventions, which aim at increasing access and improving quality of TB, DR-TB and TB/HIV care among PLHIV, SW, MSM, prisoners and ex-prisoners. These groups are considered as having limited access to care, and the Project is expected to have an important impact on service delivery in this regard and uptake of successful practices by the national / local authorities, e.g. through sustainable involvement of civil society organizations and ensuring appropriate patient support.

The program M&E and capacity building activities are seen as fully eligible in the above context. The CCM therefore considers that the TGF requirements regarding the focus on key populations and high-impact interventions have been fully met in this application. Budget-wise, the interventions for diagnosis, treatment and adherence support and those targeting risk groups, contribute to over 85% of the total project budget, far exceeding the minimum share required by the Global Fund in this regard.

SECTION 4: IMPLEMENTATION ARRANGEMENTS AND RISK ASSESSMENT

This section requests information regarding the proposed implementation arrangements for this funding request. Defining the implementation arrangements for the program including the nominated Principle Recipients (PRs) and other key implementers is essential to ensure the success of the programs and service delivery. For the concept note for TB and HIV, the Country Coordinating Mechanism (CCM) can nominate one or more PRs, as appropriate given the country context**.**

4.1 Overview of Implementation Arrangements

For TB and HIV (including HSS if relevant), provide an overview of the proposed implementation arrangements for the funding request. In the response, describe:

a. If applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector PRs).

b. If more than one PR is nominated, how co-ordination will occur between PR(s) for

the same disease and across the two diseases and cross-cutting HSS as relevant.

c. The type of sub-recipient management arrangements likely to be put into place and whether sub-recipient(s) have been identified.

d. How coordination will occur between each nominated PR and its respective sub-recipient(s).

e. How representatives of women's organizations, people living with the two diseases and other key populations will actively participate in the implementation of this funding request.

The Country Coordination Mechanism oversees the overall implementation of the project and ensures proper coordination between different sectors as well as different programs implemented by other external partners. The CCM will monitor the project progress to ensure that the activities are carried out according to the work plan and indicators of programmatic and financial performance are accomplished. It will make the key financial and programmatic decisions and will have the responsibility to address the main problems and challenges related to the project.

The CCM meetings will be convened quarterly or more frequently, as necessary. Technical working groups for TB and HIV will work with the stakeholders between the CCM meetings and prepare the documentation to be endorsed by the CCM. The CCM and the Ministry of Health will carry out the role of coordination with other programs and development initiatives. The CCM will ensure practical coordination and collaboration with all local partners involved.

On an annual basis (or more frequently as requested by the CCM), the Principal Recipient will prepare the project progress reports for review by the CCM. These reports will present the current state of the epidemic, project implementation progress, financial expenditures and implementation challenges and problems. The CCM will use this information to approve the changes in the program setup and resource allocation when necessary. The CCM will negotiate the recommended changes with the Global Fund through the country's Fund Portfolio Manager and the Country Team.

The Principal Recipient will execute its functions and apply procedures in accordance to the Global Fund requirements and in compliance with the national legislation. The PR will be responsible for all practical issues related to the project implementation including oversight of the Sub-recipients (SRs). The PR will undertake the functions of procurement (of health and non-health products, equipment and services), financial management, project-related monitoring and evaluation and reporting to the Global Fund.

The PR will develop work plans for project implementation and will present project performance reports to the CCM. Financial and activity progress reports will be forwarded to the CCM members for review. On an annual basis, the CCM will review the project performance and proposed work plans for the upcoming year. The following SRs have been identified for this Project:

- National TB Centre – to implement TB control activities related to case detection, diagnosis and treatment, including prison settings: necessary laboratory investigations, routine drug resistance surveys, rolling-out Xpert MTB/RIF methodology, TB treatment and care, infection control measures etc.
- Republican AIDS Centre – to implement prevention programs for PWID and their partners, SW and their clients, MSM, prisoners, HIV testing and counselling for key affected populations, counselling and psycho-social support to PLHIV and KAP, capacity building for medical and non-medical service providers, M&E system strengthening and stigma reduction activities.
- National Narcological Centre – to implement OST programs for PWID, including prisoners and link services with other Project activities.

- The civil society organizations active in the field of TB and HIV/AIDS control will be contracted directly by the Principle Recipient based on small grants program.

Before signing the SR agreements, the PR will carry out assessments of prospective SRs in terms of their correspondence to the Global Fund requirements vis-a-vis capacities for financial management, procurement, M&E and other aspects. The activities of SRs will be continuously monitored on the basis of verification of programmatic and financial indicators towards project implementation progress, including visits to SRs project sites. The CCM Secretariat and the PR will communicate with the Global Fund on the project progress. Progress Updates and Disbursement Requests will be forwarded to TGF FPM on a semi-annual basis or as otherwise agreed; other documentation will be provided as requested by TGF.

The sub-recipients are also seen as the main technical partners of the Project. The CCM and MOH will ensure practical coordination and collaboration with all involved stakeholders. The Local Fund Agent (currently United Nations Office for Project Services, Kyrgyzstan) will act within the Terms of Reference agreed upon with the Global Fund, including on-site verifications of project performance. External audits evaluating the project performance and financial management are an integral part of the proposed management arrangements.

4.2 Ensuring Implementation Efficiencies

Complete this question only if the CCM is overseeing other Global Fund grants.

From a program management perspective, describe how the funding requested links to any existing Global Fund grants, or other funding requests being submitted by the CCM at a different time. In particular, explain how this request complements (and does not duplicate) any human resources, training, monitoring and evaluation, and supervision activities.

Currently there are two Global Fund grants under implementation (TB and HIV), valid until the end of 2015. The NFM Project has been built to uphold the goal, scope and key directions of the on-going TGF-financed programmes through supporting the key priorities of the National TB and HIV control programmes. The implementation of the National Diseases Programms, as well as development of external funding applications in support the Programmes implementation are coordinated by the Country Coordination Mechanism, an interministerial and intersectorial decision-making body that has under its auspices functional working groups enhancing coordination and capitalizing upon the value added of joint efforts of all key stakeholders from different sectors. Any type of new or additional intervention in TB and HIV are discussed through the CCM structures to avoid overlapping.

Interventions proposed under current Concept Note have been designed following a thorough analysis of programmes needs for 2016-2017 and their coverage under planned funding from both governmental and external sources and are integer part of the National Diseases Programmes. The process has been carried in a transparent, cooperative and participatory manner, through a country dialogue involving relevant governmental entities, international agencies, and civil society, with the aim to avoid any overlapping of activities, as well as to ensure that all priority interventions are covered, from either local, or external resources.

4.3 Minimum Standards for Principal Recipient (PR) and Program Delivery

For both TB and HIV complete the table below for each nominated PR. For more information on Minimum Standards refer to the Concept Note Instructions.

PR 1 Name	United Nations Development Programme in Kyrgyzstan	Sector	IO
Does this PR currently manage a Global Fund grant(s) for this disease component or a stand-alone cross-cutting HSS grant(s)?		☒Yes ☐No	
Minimum Standards		**CCM assessment**	
1. The Principal Recipient demonstrates effective management structures and planning	The Global Fund partnership is of important strategic value to UNDP, with a total portfolio of US$1.92 billion in signed active grants, representing approximately 10% of Global Fund grant resources. UNDP currently serves as interim Principal Recipient for 51 grants in 26 countries and 1 regional programme covering 7 countries (South Asia Regional programme). The partnership between UNDP and the Global Fund focuses on three closely linked areas of work: implementation support, capacity development, and policy engagement. Implementation support: UNDP serves as an interim Principal Recipient in a variety of settings including countries that face capacity constraints, complex emergencies, poor governance environments, political upheaval, or donor sanctions. It does so upon request by the Global Fund and/or the Country Coordinating Mechanism (CCM) and when no national entity is able to assume the role at the time. Therefore, UNDP's role as Principal Recipient is a temporary arrangement until circumstances permit or national entities are prepared to take over. Tens of millions of people benefit from prevention and treatment services for HIV/AIDS, TB and malaria thus making a significant contribution to achieving MDG 6 and all MDGs more broadly. Capacity development: The partnership aims to strengthen a country's capacity to manage large-scale public health and development programmes. Therefore, UNDP's role as Principal Recipient is a temporary arrangement until circumstances permit or national entities are prepared to take over. UNDP also strengthens the capacity of national entities to manage and implement Global Fund-financed programmes in eight countries where it is not the interim Principal Recipient. Improved procurement systems and supply chain management has made service delivery quicker, more consistent and reduced drug stock outs. Monitoring and evaluation systems are implemented and strengthened to ensure frequent assessments of services provided and oversight for different management levels. Another major area of capacity development is financial management; by working with national entities to better manage grants, UNDP aims to reduce corruption and fraud. Lastly, countries employ better strategies for programme management. UNDP not only ensures that clear leadership and accountability are present but that there is sufficient infrastructure and technical expertise to carry out programmes. As a result, UNDP has handed over the role of Principal Recipient in 14 countries and is in the process of doing so in another eight countries. Policy engagement: As a Co-sponsor of UNAIDS, a member of the UNAIDS delegation to the Global Fund Board, a Board member of		

	both the Stop TB and Roll Back Malaria Partnerships, UNDP also engages with the Global Fund on important substantive policy and programmatic issues. UNDP, in line with its core mandates, promotes the incorporation of good governance, human rights and gender initiatives into Global Fund grants. UNDP also helps to align grants with national development plans and poverty reduction strategies, promotes appropriate public sector reform and anti-corruption initiatives, and promotes principles of national ownership, aid effectiveness and sustainability. UNDP also ensures that financing reaches key populations such as men who have sex with men and contributes to the further enhancement of the country-level governance of Global Fund. In November 2011, the Global Fund Board approved its new Strategy Framework (2012-2016) with the promotion and protection of human rights as one of its key objectives. UNDP is supporting the development of an implementation plan that will greatly enhance the Fund's ability, as a global public health organization (or enter term of choice here) to advocate with countries to place human rights at the forefront of delivering tangible health and development results. UNDP Country Offices are supported by its Partnership team office in the Headquarters and Procurement Support offices as well as global long-term agreements. At a Country office level, UNDP has a senior management with all it structure to support the fully functional and experienced PIU team managing the GF grant implementations.
2. The Principal Recipient has the capacity and systems for effective management and oversight of Sub-Recipients (and relevant Sub-Sub-Recipients)	The UNDP SR management toolkit is recognized by the Global Fund and used systematically in all countries. Well defined contracting procedures with Government entities, UN agencies, International organizations and Local NGOs as well as clear systems of SR management principles in the area of Procurement, finance and program management. In 2014, the SR Management Guidelines were revised based on practical experience, GF recommendations and risk management principle. UNDP Kyrgyzstan has demonstrated effective SR management since 1 January 2011 through standardised system of controls, SR management letters, spot checking, rigorous monitoring and evaluation and electronic risk follow up system through Atlas.
3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud	In relation to each existing and every new grant, UNDP requires a detailed mapping and analysis of the organization's responsibilities and the corresponding capacities of each Country Office to effectively manage the associated accountabilities and risks effectively. More information on risk and fraud management related to the programmes implemented with funding from the Global Fund in UNDP's role as interim PR can be provided as required. UNDP also operates with Enterprise Resource Planning/People Soft System, which is comprehensive, to monitor and manage finance, human resources, project management as well as risk monitoring. Furthermore, UNDP is well aware of the changes being made under the New Funding Model and Global Fund's new programme modules

	and risk management tools like the Grant Risk Assessment and Action Planning Tool v2.012, which will also be utilized as necessary.
4. The financial management system of the Principal Recipient is effective and accurate	The GF has accepted UNDP's financial management and asset management policies and procedures and procurement systems and audit arrangements when acting as interim PR. UNDP has robust systems and processes including: ▪ Financial Management and Systems - Recording all transactions and balances, including those supported by the Global Fund; preparation of regular reliable financial statements; safeguarding PR and SR assets; and systems to disburse funds to Sub-recipients and suppliers in a timely, transparent and accountable manner. The Atlas system used by UNDP provides various reports to monitor and track the use of resources. Globally, official financial statements (Certified Financial Reports) are issued annually to each donor. In addition, each grant and project receives specific financial reporting as specified in the respective grant agreements. An oversight mechanism at implementation level (UNDP PIU) is in place, which requires the production of certain reports on a monthly basis for review and approval by management. The reports and procedures have been further enhanced by the adoption of International Public Sector Accounting Standards by UNDP in January 2012. Atlas is a web-based system, which works on real time basis. The Atlas reporting system is very flexible and can generate different types of reports, which have been endorsed by the Global Fund. The Atlas system is designed to control the expenditure against the project budged on the total amount, however we have monthly project budget review to ensure the expenditure remains with the given budget limit. Disbursements from the Global Fund and/or PR are deposited into a bank account. Cash not maintained in the bank account should only be for the petty cash float. UNDP as PR, uses the existing UNDP Contributions Accounts (USD and Euro). In addition, UNDP requires that its SRs open separate bank accounts to receive funding from the Global Fund. Signatories to UNDP bank accounts are appointed in accordance to UNDP rules and regulations. For SRs, the bank account should be operated by a double signatory and details of those signatories should be shared with UNDP. UNDP staff cannot be co-signatories to SR bank accounts. UNDP advances funds to non-International Organization SRs in local currency for the implementation period not exceeding 3 months budget. The funds should be used in accordance with the approved work plan and budget. The SR designated official is responsible for safeguarding the funds. 5 SRs were audited for the financial year ended 31 December 2014. They all received an unqualified audit opinion.
5. Central warehousing and regional warehouse have capacity, and are aligned with good	UNDP has organized (rented) a non-refrigerated Central Warehouse with the storage space of 750 m2 for goods procured under Global Fund grants. The decision to arrange a central warehouse was taken

[12] Global Fund (April 2012) Grant Risk Assessment and Management (GRAM) Tool

storage practices to ensure adequate condition, integrity and security of health products	considering shortage of storage space at SRs and that storage conditions needed to comply with WHO Good Storage Practices. The warehouse is equipped with air conditioners, heaters, fire extinguishers, shelves and thermometer/hygrometers to meet the standards of WHO Good Storage Practice as per recommendations of International Consultant. The Central Warehouse also equipped with security alarm system in order to ensure safety of goods. FEFO and FIFO methods are used for distribution of goods. For goods that require temperature regiment restrictions UNDP rents a cold chain Warehouse with storage space 36 m2. Cold chain warehouse is dedicated for goods with temperature regiment (+2 +8 C). It is also equipped by security control, thermometer/hygrometers. UNDP GF GIU also contracted Insurance company (LTA) for Central warehouses. These facilities were reviewed by UNDP Procurement and Supply Management Support Team and assessed as meeting GF requirements. Furthermore, the Capacity Development/ Transition Plan includes: • A rapid scoping of the future procurement and supply chain management options taking into account the roles and responsibilities will help to optimise the existing facilities, and provide an opportunity to consider greater integration between supply chains. • Develop and implement a road map to put in place the arrangements for the selected option for Procurement and Supply Chain Management. To consider the storage options including taking over the rental of the current equipped warehouse or renovating and equipping the existing storage facilities in the Department of Drug Supply Department.
6. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment / program disruptions	All medical, health products, lab equipment and etc. are received to UNDP Central warehouse and further distributed according to distribution plan to final SRs. In order to enhance and facilitate warehouse management, starting from 2013 1C programme was developed with Logistics module. All arriving goods are entered into system (shelf live, prices, quantities, batch numbers and pack sizes are reflected for each item) and distributed to SR, data is reflected for every period as well as per SR. A programme is under development to connect SR warehouses and central warehouse, and to enable real time viewing of all available stocks of each SR. This will facilitate efficient and effective re-distribution of goods, avoid overstocks, stock outs and disposals of goods with short shelf lives. Due to the limited storage capacity at oblast level, UNDP distributes directly to both oblast levels and rayon levels. This system minimises the stocks held at each level. Goods delivered and transferred by an Act of acceptance issued and signed by UNDP and head organizations like NCP, RAC, NGOs. Currently UNDP has contracted 2 LTA companies to provide transporting services, including cold chain transportation, to assure monthly distribution of goods to the SRs in 7 oblasts of Kyrgyz Republic. We have 2 type of trucks: refrigerator track with

	temperature regime +2 +8C (with capacities: 35-50 cub meters, 15-25 cub meters) and truck without temperature regime (35-50 cub meters, 15-25 cub meters). All goods sent to the regions are fully insured by insurance company. Furthermore, the Capacity Development/ Transition Plan includes a review of the transport and distribution systems of the Regional Coordinator for drugs supply management and develop a distribution plan approved by the MOH that meets national and Global Fund requirements.
7. Data-collection capacity and tools are in place to monitor program performance	UNDP has extensive experience and capacity in obtaining reliable data and information for monitoring programme performance, which is part of routine processes in its programming practice as well as in its technical and capacity development support to government and CSO partners. Ideally, monitoring data originates or is collected from national sources. However, this depends on the availability and quality of data from those sources. In an increasing number of countries, analytical data does come from national development information systems, which are also the repositories of important monitoring data and information. Specific attention is given to establishing baselines, identifying trends and data gaps, and highlighting constraints in country statistical and monitoring systems. In Kyrgyzstan, UNDP strengthened data and M and E management through different mechanisms, such as: - A joint monitoring template with Government partners is in place - UNDP and NTP are conducting joint monitoring and taking proper actions - In particular in 2012, in close cooperation with the Ministry of Health, regulations on M&E Technical Committee (TC) has been developed; discussions on membership in the TC conducted (the members are approved by the MOH decree # 524); several working meetings as well as a basic training for TC new members took place - In order to ensure collection of quality data on the State HIV Programme and to evaluate the programme UNDP, UNAIDS, ICAP/CDC and CSOs provided technical assistance NAC and MoH to develop and approve Guidelines for monitoring and evaluation of public programme on HIV/AIDS for 2012-2016. The guidelines were published in 2012 with the financial support of UNDP - In 2013, MOH with the financial support of UNDP established a Working Group on the revision of existing recording and reporting forms on HIV. WG according to the State HIV Programme M&E plan revised recording and reporting forms, which were approved by MOH. A training for AIDS service and the Republican Medical and Information Centre specialists on the use of new forms was conducted with the support of UNDP; - SRs have been supported with equipment such as computers, incentive payments to key M&E officers - Data quality is checked at different levels including on site data verification after SR reporting with onsite feedback and on job

	trainings/support. Apart from the overall support to establish functional and solid M&E system, UNDP utilises an MIS database to ensure data can be collected and accurately reported to TGF.
8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	UNDP Monitoring and Evaluation arrangements which include, collection and recording programmatic data with appropriate quality control measures; supporting the preparation of regular reliable programmatic reports; and making data available for the purpose of evaluations and other studies. UNDP has strong and well established routine reporting system and procedures since both M&E and reporting are mandatory corporate processes. The key reporting instrument for UNDP is the Results Oriented Annual Report (ROAR). The information in the report should be based on a process of collective reflection and analysis by the Unit of the programme and project monitoring data entered in the Results Based Management (RBM) Platform. In addition UNDP prepared specific reports as per partnership agreements on an agreed upon scheduled basis. For Global Fund projects the management unit prepares and submits to the Global Fund Progress Update/Disbursement Requests per timelines detailed in the Grant Agreement between UNDP and the Global Fund. UNDP also reports to the CCM on a regular basis on the overall progress of the programmes, including performance and finance. Financial reporting to the Global Fund is done in compliance with terms set in the Grant Agreement between UNDP and the Global Fund. As mentioned under criterion 7, for UNDP, all results (outcome and output level) must be monitored regularly, even in cases where UNDP is not solely accountable for achieving the result. Similarly, all outcomes to which UNDP is contributing through its activities and planned outputs must be monitored regardless of budget and duration. Indicator data are gathered and collated with due regularity to inform programming decisions. Monitoring is based on and integrated with national systems whenever possible. Information on the status of indicators, particularly outcome indicators, must also be based on independent and verifiable sources wherever possible. Status updates on outcome and output indicators and indicator targets are also entered in ATLAS (UNDP's Enterprise Resource Planning Software) and the Results Based Management Platform (IWP monitoring tool) whenever new data is available (the latter are standardized monitoring and reporting platforms used by UNDP).
9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain	UNDP has established policies and procedures on procurement. These procedures clearly define the principles of procurement of UNDP, methods or procurement, types of competition, solicitation processes, supplier sourcing and appraisal. Review Committees have been established at the Country Office, Regional and Headquarters levels to review and approve procurement cases exceeding certain thresholds. Existing procedures require a high degree of transparency in the conducting of procurement activities.

	In Kyrgyzstan like any other country, UNDP gives a serious attention to quality assurance. The UNDP Procurement team in Kyrgyzstan is trained at international and national level on international quality standards. Procurements for Pharmaceuticals and Health Products are conducted with manufacturers who only meet the WHO quality standards, GF Quality Assurance Policy and/or ISO standards. Furthermore, a number of Standard operating Procedures for Quality Assurance are already in place and functional. A Quality Assurance Plan is in place and regularly implemented by UNDP and the Government partners with a close support of Quality Assurance team in UNDP/GF Partnership team in Geneva. To ensure effective medicine is used by the patients, specimens of health products and medicine are sent out of the country for Quality Assurance.

4.4 Current or Anticipated Risks to Program Delivery and PR(s) Performance

a. With reference to the portfolio analysis, describe any major risks in the country and implementation environment that might negatively affect the performance of the proposed interventions including external risks, PR(s) and key implementers' capacity, past and current performance issues.

b. Describe the proposed risk mitigation measures (including technical assistance) included in the funding request.

No major external risks are anticipated that may negatively affect the implementation of the proposed interventions. Still, there are some issues that have to be raised as factors to contribute to risk appearance as following:

External funding and sustainability: currently, external financial support provides the majority of the funding for HIV interventions (about 75% in 2013), and Global Fund provides more than 50% of all international funding for the HIV programme. Any significant reduction of this support would negatively affect the sustainability of activities under this grant. GF has historically funding the vast majority of sensitive TB and MDR TB drugs. The Government has committed to ensuring funds are available for first line TB drugs, some HIV diagnostics, diagnostics of opportunistic infections and treatment and STI diagnosis. As the national programme becomes increasingly reliant on national financing there is a risk that some programme activities may be delayed. To mitigate this risk, the CCM will continue to monitor the Governments contribution and ensure there is adequate funding from National sources to complement this funding request and ensure a sustainable national response.

Governance, Leadership And Coordination: strong leadership across government, combined with effective coordination and demand for performance accountability from all stakeholders by CCM, is vital to the achievement of the programme results. Therefore, any significant changes in the current political environment, such as weak governance, lack of evidence based decisions at National or CCM level could seriously undermine the implementation of this programme and the planned results. In addition, any changes in the legislative environment, such as a law to prohibit non-traditional sexual relations may make it difficult to implement affect programmes with sex workers and MSM. Further any changes restricting the use of methadone, would seriously affect the ability of the programme to enrol and retain clients in the MMT programme.

Further, any laws which restrict the ability of NGOs and other entities to receive funding from international sources may delay or limit the number of organisations who can deliver services, This may be a particular challenge for NGOs providing services to key populations. The CCM with the support of other key Government entities, civil society and development partners, will undertake

continuous advocacy to ensure wide political commitment towards the fight against HIV and TB, mitigating these risks as well as promoting the effective engagement of civil society in leadership and decision-making.

Financial Flow And Management: the ability of Government and development partners to effectively and efficiently disburse, manage and/or account for funds may negatively affect implementation of this programme. Measures to mitigate these risks include strengthening public sector financial management systems for expenditure tracking and accountability, scaling up capacity for pooled funding at decentralized levels, and capacity building for financial management and reporting at all levels. CCM will regularly monitor movement of funds to timely identify bottlenecks and address accordingly, reduce loss of the funds and risk of such loss or fraud, as well as streamline accountability structures. An IDA grant agreement to strengthen the institutional capacity of the Accounting Chamber of Kyrgyzstan was signed earlier this year, and this expected to improve audit effectiveness and audit compliance of all State Entities.

Procurement and Supply Management: the ability of programme to timely procure quality assured health products in adequate quantities; achieve cost efficiencies throughout all stages of the procurement and supply chain; ensure the reliability and security of the distribution chain and encourage appropriate use of health products, are key to its success. To mitigate this risk, the CCM will closely monitor all aspects of the supply chain. Further, within the health SWAp, KfW are currently in the process of launching a tender for consultancy services to improve procurement practices with Ministry of Health and other health facilities. This is expected to result in increased institutional capacities in this important area.

Stigma and discrimination towards PLHIV, TB patients and key populations: the programme provides treatment care and support in State and NGO entities. Stigma and discrimination remains a major barrier to accessing services. This may be a perceived or real discrimination from medical professionals and/or society. As a result of stigma and discrimination, or fear of it, members of vulnerable groups may be reluctant to disclose their status, and follow up on the results of testing/survey/medical examinations, even if they have access to services. The CCM is aware of the need to create and sustain an enabling environment, advocacy and protection of human rights. This includes peer support, street lawyers and key populations and a genuine desire to increase programme coverage. The CCM membership ensures that all populations are represented and any reported human rights violations will be thoroughly investigated by the CCM oversight committee.

Transition to Ministry of Health as PR: although there has been an extensive, participatory capacity development (CD) and transition planning process to ensure effective implementation during the transition from UNDP to MOH, there is a risk that this process does not proceed as quickly as hoped. To ensure the sustainability of essential services and an orderly transition, a detailed plan was prepared focusing on functional capacities identified by the Global Fund minimum PR requirements namely; i) program management and implementation (including SR management); ii) financial management; iii) monitoring and evaluation; and iv) procurement and supply chain management.

To further mitigate the risk to programme activities, the progress towards transition of the PR role will be jointly monitored using transition milestones for each of the main functions. Measurable transition milestones have been developed for each of the PR implementation functional areas. The CCM is in the process of establishing systems to monitor implementation of the milestones. As the national systems are strengthened, there will be a transition of the PR functions based on reaching the measurable transition milestones. Regular joint monitoring of the progress of the CD and Transition Plan will enable any delays to be identified and collective action taken. In preparation for taking on the role of PR the Global Fund will arrange for a CAT assessment of the MOH to be conducted before the end of 2016 to check the readiness of MOH and identify measures to enhance the efficiency and effectiveness of the grant.

We highlight that the Ministry of Health is working with Ministry of Finance to obtain tax exemption for all goods and services procured using grant funds. It is expected that the VAT exemption will be confirmed by 31 March 2016. In addition the Framework Agreement to be signed between Global Fund and the Government of the Kyrgyz Republic has already been reviewed by several Government Ministries and preliminary feedback has been provided to the Global Fund. Ministry of Health hopes that the agreement will be signed by 30 June 2016. CCM members are well aware of the need for tax exemption and framework agreement, and have agreed to support the Ministry of Health in meeting the proposed timelines. These timelines are also included as critical activities for transition and will be very closely monitored by the CCM oversight committee.

Delays in grant signing: the activities funded under this concept note are due to commence on 1 January 2016. This includes contracting of SRs, procurement of medicines and health products and overall programme management. There is a risk that the grant negotiations take longer than expected and a grant agreement is not in place to allow a competitive process for the selection of SRs and contracting of SRs to be completed before the end of December 2015. There is also a risk of service interruption of prevention activities as well as treatment care and support. To mitigate these risks UNDP has shared with GF the timelines for key activities to be competed. At the 31 December 2015 UNDP will ensure that as far as possible, except for HIV test kits for pregnant women, buffer and pipeline stock of key pharmaceuticals should equate to approx. 6 months supply. This is expected to ensure that provided medicines and health products are procured in the first quarter of 2016, most targets should be reached. To further mitigate this risk the CCM will monitor the situation closely and advise Global Fund of the impact of any delays in grant signing.

CORE TABLES, CCM ELIGIBILITY AND ENDORSEMENT OF THE CONCEPT NOTE

Before submitting the concept note, ensure that all the core tables, CCM eligibility and endorsement of the concept note shown below have been filled in using the online grant management platform or, in exceptional cases, attached to the application using the offline templates provided. These documents can only be submitted by email if the applicant receives Secretariat permission to do so.

☑	Table 1: Financial Gap Analysis and Counterpart Financing Table
☑	Table 2: Programmatic Gap Table(s)
☑	Table 3: Modular Template
☑	Table 4: List of Abbreviations and Attachments
☑	CCM Eligibility Requirements
☑	CCM Endorsement of Concept Note