SUMMARY INFORMATION			
Applicant Information			
Country	**TAJIKISTAN**	**Component**	**HIV**
Funding Request Start Date	**October 1, 2015**	**Funding Request End Date**	**December 31, 2017**
Principal Recipient(s)		**UNDP Tajikistan**	

SECTION 1: COUNTRY CONTEXT

1.1 Country Disease, Health and Community Systems Context

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

a. The current and evolving epidemiology of the disease(s) and any significant geographic variations in disease risk or prevalence.

b. Key populations that may have disproportionately low access to prevention and treatment services (and for HIV and TB, the availability of care and support services), and the contributing factors to this inequality.

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

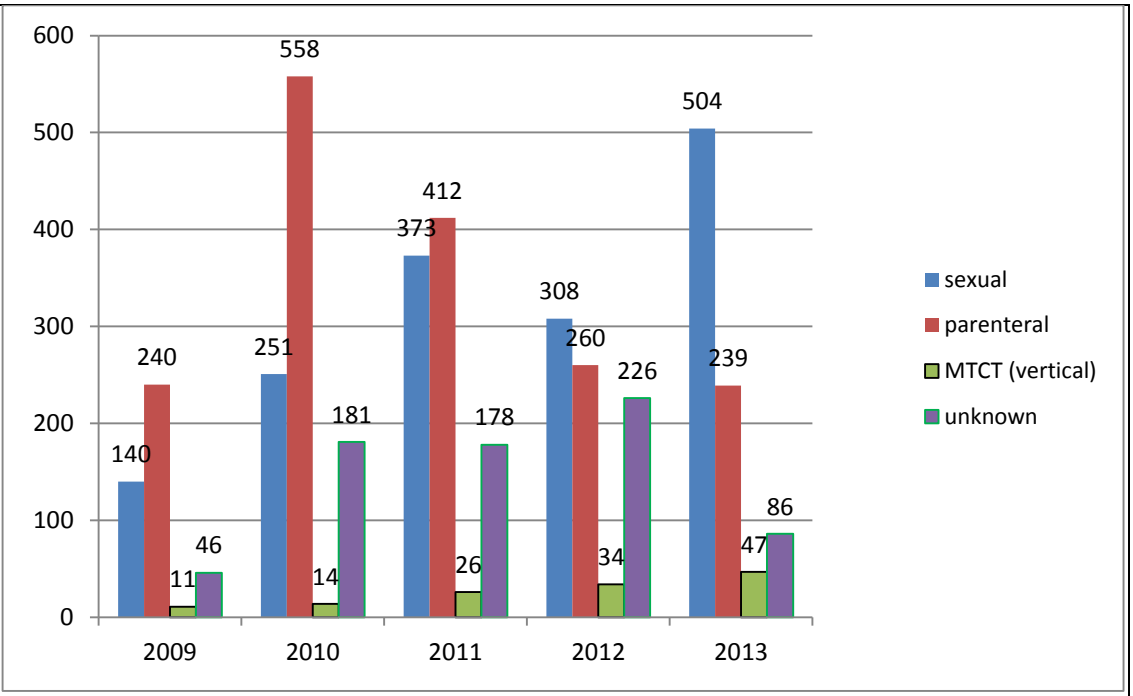
d. The health systems and community systems context in the country, including any constraints.

a. The current and evolving epidemiology of the disease(s) and any significant geographic variations in disease risk or prevalence.

The first HIV case in Tajikistan was registered in 1991. Tajikistan's HIV epidemic is a concentrated epidemic among key affected population. As of December 2013, a total of 5,550[1] HIV cases have been reported in the country. The vast majority of the reported HIV cases are of men (68%) of the age group 15-39. The estimated adult HIV prevalence reached 0.3% as reported by UNAIDS Global AIDS Epidemic Report 2013[2]. In 2013, the national AIDS Center estimated (spectrum) 14,000 people living with HIV in the country. In the last couple of years the HIV testing has been scaled up and more HIV cases has been detected among key populations including PWID, Sex workers, prisoners and MSM.

Figure 1: Newly registered HIV infections by transmission route 2009-2013

[1] Republican AIDS Centre, Ministry of Health of Tajikistan, January 2014
[2] UNAIDS Global Report on HIV Epidemics, 2013



The geographical pattern of the HIV transmission mode varies from region to region. In 2013, GBAO and Dushanbe City HIV cases were mainly due to intravenous mode of transmission - 46% and 35%, respectively. The sexual mode of transmission was high among the reported HIV cases in Sogd oblast and RRS (72%).

The highest share of intravenous transmission among newly registered HIV cases in 2013[3] is reported in GBAO (46%) and Dushanbe (35%), whereas in other regions it varies between 20% - 25%. The sexual transmission of new HIV cases in 2013 is more prominent in Sogd and RRS (72% in each region) followed by Khatlon (63%) and GBAO (51%). Vertical transmission rates are higher in Khatlon (7%) and Dushanbe (6%), whereas RRS and Sogd report only 3% of infections through vertical transmission.

Geographical distribution of all new HIV cases has quite varying tendency from the region to region. Dushanbe shows good trend of reduction of new HIV cases for the period of 2008-2013, while Sogd, GBAO and RRS have a propensity for increasing the incidence of HIV. Khatlon, on the other hand, by being a biggest region of the country, has unstable trend of occurring new infections.

Figure 2. New HIV infections by geographical locations for the period of 2008-2013

[3] RAC data, 2013

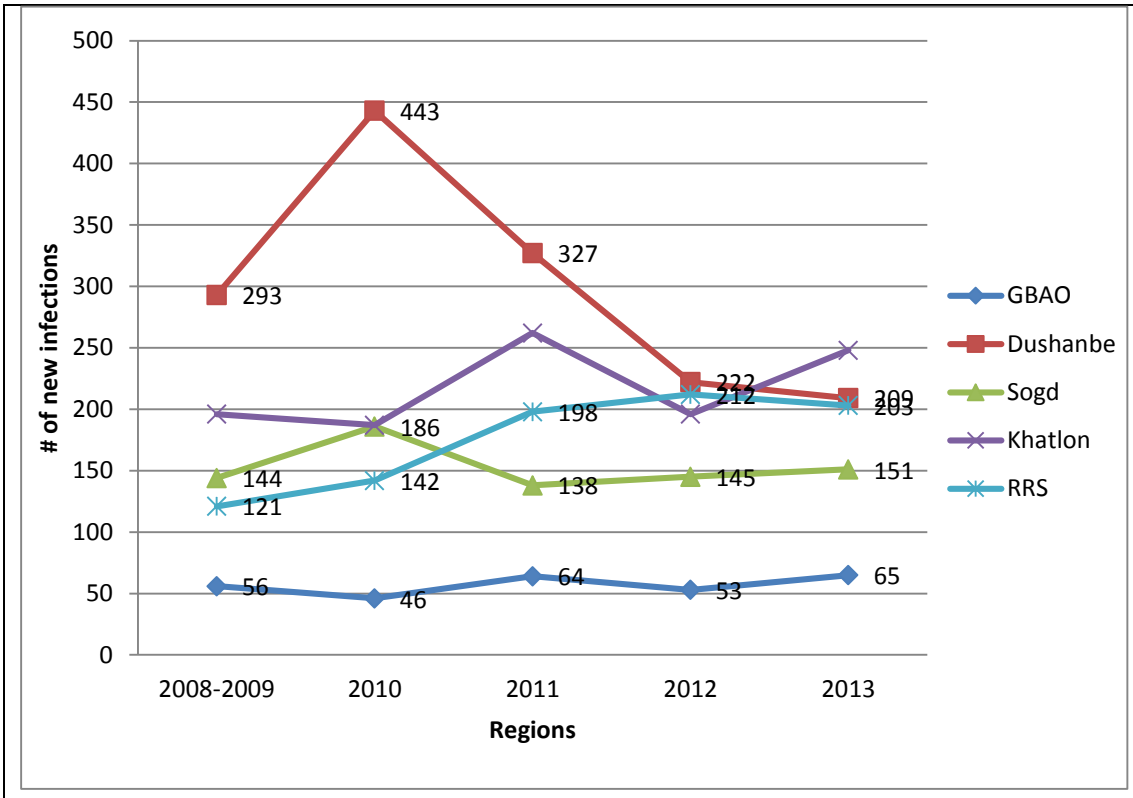
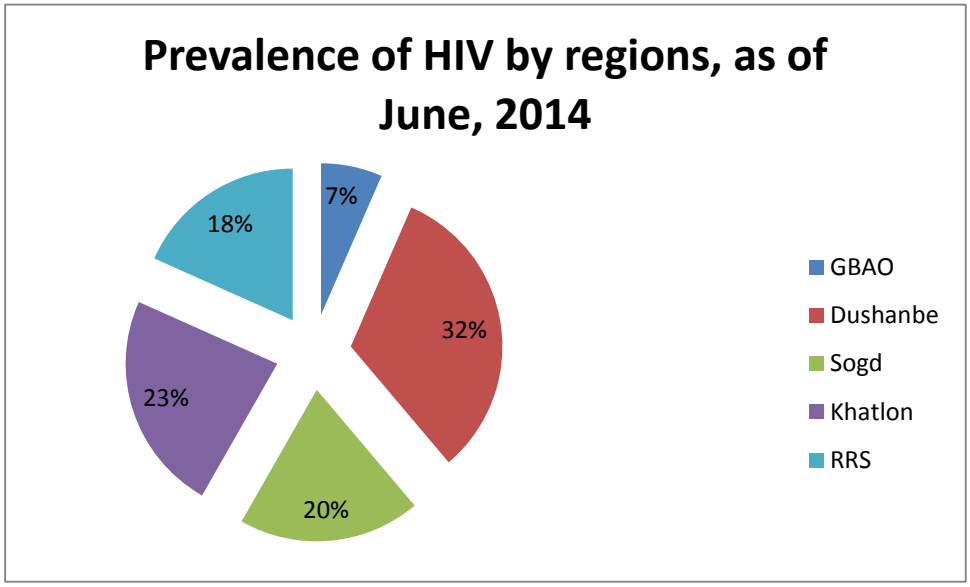


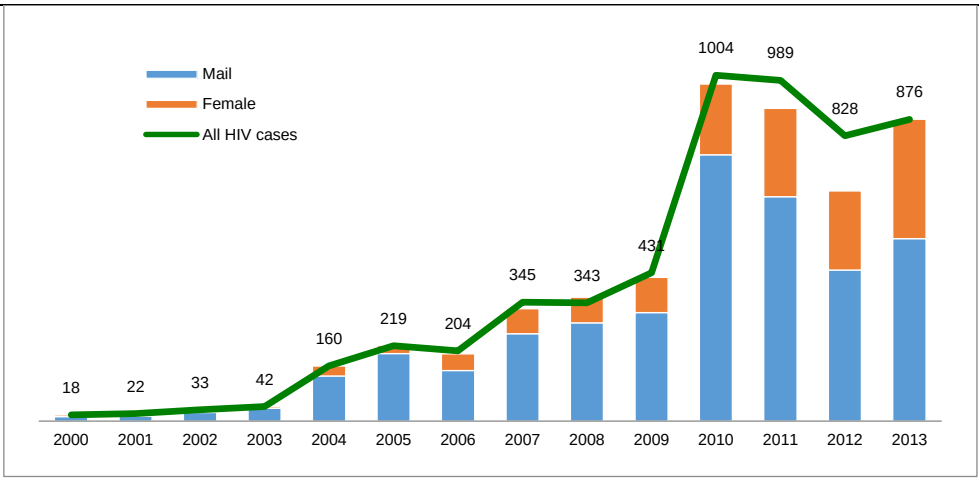
Figure 3. Prevalence of HIV by geographical locations, as of June, 2014



As it can be seen from the above two figures, the number of cases in Dushanbe prevails the other regions of the country. Accordingly, the prevalence of the infection is the highest in the capital city of Tajikistan.

In 2013, 876 new HIV cases were registered in Tajikistan. Despite the fact that most of the new infections registered were among men (530 men vs 346 women in 2013), there is a worrisome tendency of growing new HIV cases amongst women (346 in 2013 compared to 113 in 2009).

Figure 4. New HIV infections (National strategic plan 2015-2017)



Along with changes in the structure of the HIV transmission routes, variations are also observed in gender and age specific structure of the epidemic. During 2009-2013 infections were concentrated on the adult population (89%) and mostly affected the age group between 30 and 39. In 2013, the number of new HIV cases among female population increased by 5.9% in comparison to 2009. According to the official national statistics 42.4% of the new cases among female were in the age group 21-29 whereas 46.4% of all HIV cases among men were in the group of 30-39[4].

b. Key populations and vulnerable groups

Key populations in Tajikistan include: PWID, prisoners, sex workers, and MSM. Migrants, children and women in the reproductive age group are considered a vulnerable group by the national AIDS programe. Latest available prevalence estimates for key populations are presented in table 1. Trends for key populations obtained through integrated bio-behavioural surveillance (IBBS) are available but sampling methods and data collection localities in these IBBS have changed over time after 2011.

Table 1. HIV prevalence data for key populations (data from latest IBBS).

Key Population	HIV prevalence
PWID	12.8% (2014)
Prisoners	8.4% (2013)
Sex workers	3.5% (2014)
MSM	1.5% (2011)

Injecting Drug Use – As of January 1, 2014 there were 7176 people registered officially as people with addiction problems, of whom 4837 (67.2%) were PWID. The highest concentration of PWID was registered in Dushanbe (44%), followed by Sugd (19%) and GBAO (13%). The majority of officially registered PWID were aged 35-59 age group (69.9%). Most popular types of drugs among officially registered people with drug addiction problems in 2014

[4] UNGASS report, 2014

were heroin (5791 cases), opium (697), polydrug use (376) and hashish (311). The majority 6978 (97.2%) of all officially registered people with drug addiction problems are men, and women represent 198 (2.8%)[5]. These official statistics are likely to be an under-estimate of the real number of PWID in Tajikistan. The most recent PWID population size estimation was conducted in 2014 and suggests that there are 23,100 PWID in Tajikistan[6].

The HIV prevalence among PWID is 12.8% (IBBS 2014). If we extrapolate this prevalence from the estimated number of PWID, about 3000 infected PWID are likely to be currently living in Tajikistan. Acceleration of preventive activities in the past five years displays positive results. According to program data, there are 45 needle and syringe exchange (NSEP) trust points (TPs) operating across the country that provide free access to preventive services. The TPs ensured almost twofold increase (46%) of PWID coverage with HTC services in the period of 2009-2013 (HIV testing increased from 27.3% in 2007 to 46% in 2013 accounting to 9,872 PWID in the country).

The number of syringes distributed to each PWID per year increased two times from 76 in 2009 to 199 in 2013 and coverage with needles and syringes reached 43% of the estimated number of PWID in the country. There is 86% upsurge of PWID who reported using a condom during last sexual intercourse alongside with 49% increase of PWID reporting use of sterile injection equipment last time they injected. These improvements indicate effectiveness of preventive service corroborated by 23% decline of PWID who live with HIV (17.3% in 2009 and 12.8% in 2014). By end of 2013, 392 PWID received Opioid Substitution Therapy (OST services) through four OST sites[7] currently operating in the country.

According to sentinel surveillance conducted in 2011, 10.4% of PWID were women (2,402), of whom 39% (936) reported providing sexual services for money. There is a distinct overlap between drug use and formal and informal (transactional) sex work, especially in urban areas of the country. A proportion of sex workers who are also PWID, or partners of PWID, use revenues from sex work to finance their drug habits. This nexus is thought to compound the risk of HIV transmission.

Women drug users have poor access to harm reduction, HIV, sexual and reproductive health services in the region, posing a risk of rapid spread of HIV among their sexual partners, and their children[8].
The risks and needs of women who inject drugs often differ from those of men, and may vary depending on cultural and social context[9]. Female drug users experience double stigma, which reduces their ability or willingness to access health services[10]. It is a common practice that the woman is the last

[5] Narcology center report, 2013
[6] Estimated numbers of sex workers and people who inject drugs in the Republic of Tajikistan in 2014, Ministry of Health and Social Protection, RAC, 2014
[7] Dushanbe, Kyrgantube, Khorog and Khudjand
[8] OSI (2007) Pinkham, S. and Malinowska-Sempruch, K. Women, Harm Reduction, and HIV, International Harm Reduction Development Program of the Open Society Institute. New York. 2007
[9] UNODC (2004) Substance abuse treatment and care for women: Case studies and lessons learned. Vienna, 2004.
[10] UNODC (2004) Substance abuse treatment and care for women: Case studies and lessons learned. Vienna, 2004

one to inject if a couple or group is sharing one needle or syringe, which increases her vulnerability to HIV[11]. Violence and the threat of violence in relationships also add to vulnerability of many female PWID[12]. Counseling related to condom negotiation skills and other reproductive health issues and services are often neglected in harm reduction programs, and gender-specific harm reduction outreach and support groups for women are rare[13]. Most existing drug treatment services make no provision for childcare and therefore exclude women with small children. Hepatitis C (HCV) is widespread among drug users in Tajikistan and prevalence among PWID vary from 32.6% in Dushanbe (sample size=400) to 2.7% in Istravshan (sample size=110)[14].
According to data from Republican Forensic-Medical Center, 39 fatal drug overdose cases were registered in 2011, including 4 cases among women who inject drugs (Table 2).

Table 2. Number of overdose related deaths in 2009-2013

Type of drug/years	2009	2010	2011	2012	2013
Opium	4	0	0	0	0
Heroin	38	78	39	36	34
Total	42	78	39	36	34

Harm reduction, including access to clean needles and opioid substitution treatment (OST) was officially endorsed as a critical component of HIV prevention among vulnerable groups in 2009. By end of 2013, 392 PWID received Opioid Substitution Therapy (OST services) through four OST sites[15] currently operating in the country.

Sex Workers – The estimated number of sex workers (SWs) accounts in Tajikistan for 14,100 (2014)[16]. Sex workers are predominantly women with some men and transgender sex workers. All sex workers are at high risk of HIV infection and are vulnerable due to the high partner turnover and a limited capacity to negotiate safe sex during each sexual encounter, including with their permanent partners. The prevalence of HIV in SW increased from 2.8% in 2009 to 3.5% in 2014. In response, 24 friendly service points are operational. The coverage of SWs with HTC increased more than 3 times during 2009-2013. 52.4% of SWs received HIV tests; results and post-testing counseling (6552) and 64.7% were reached with prevention services (7591). Regardless of relatively high coverage of SWs by prevention services, effectiveness of these programs desires improvements. Even though using condom practice depends on partner, the percentage of SWs who used a

[11] OSI (2007) Pinkham, S. and Malinowska-Sempruch, K. Women, Harm Reduction, and HIV, International Harm Reduction Development Program of the Open Society Institute. New York. 2007
[12] Wolfe D. Paradoxes in antiretroviral treatment for injecting drug users: access, adherence and structural barriers in Asia and the former Soviet Union. Int J Drug Policy. 2007 Aug;18(4):246-54.
[13] Position paper on Women, Special groups, Eurasian Harm Reduction Network
[14] Analysis of sentinel surveillance among W, 2011
[15] Dushanbe, Kyrgantube, Khorog and Khudjand
[16] Population Size Estimate, RAC, 2014

condom with their most recent client decreased by 13% in the period of 2009-2012 as reported by the UNAIDS[17]. Female sex workers report partner refusal to use condom as the main reason for unsafe behaviour.

HIV is more common in sex workers who inject drugs, or who have partners who inject drugs. Sex workers are also at higher risk of other STIs, which also increases their risk of acquiring HIV. Furthermore, national legislation is not supportive of SWs. SWs are often vulnerable to police harassment and mistreatment. Decriminalization of SWs and the elimination of the unjust application of laws and regulations against SWs are required.

Men Who Have Sex With Men –The latest surveillance conducted among men having sex with men (MSM) is integrated biological and behavioral surveillance (IBBS) in 2011. According to the IBBS the MSM population size was not assessed. As a result, there are no data in the country indicating population estimate size for MSM[18]. Population size estimation assessment is to be conducted in the country in eary 2015 by Republican AIDS Center with financial and technical support of UNAIDS. Many MSM (57.3%) maintain heterosexual contacts. Even though outreach to MSM in Tajikistan is very challenging, Tajikistan managed to increase coverage of this group with HTC by more than 10 times, from 89 in 2010 to 942 in 2013[19].

The 2011 IBBS reports HIV prevalence of 1.5% among MSM. Conversely, the registration of HIV infection does not reflect the true level of HIV prevalence in this group. The National program seeks additional financial support from the donors to conduct IBBS among MSM in 2015. No single case of homosexual route of HIV transmission has ever been reported in Tajikistan. Due to very high level of stigmatization, MSM report heterosexual contact as likely mode of transmission during registration. Further, the prevalence of hepatitis C is 3.9% and syphilis is 5.1% amongst MSM studied in Dushanbe city (2011 IBBS).

In 2013, 2,645 MSM were reached with prevention services[20]. The coverage of MSM with preventive activities is higher in uninfected MSM (39.5%) than in HIV positive MSM (0.7%)[21]. According to IBBS 2011, the percentage of men reporting the use of a condom the last time they had anal sex with a male partner represents 67.8% in 2011, though no further data is available since 2011 to measure effectiveness of prevention activities in this population.

Because of the persisting social stigma and discrimination against MSM they are rarely willing to seek help from health providers. In conclusion, there are concerns that the true extent of HIV transmission among men who have sex with men is unknown. Further surveys are urgently needed to estimate the HIV epidemic in the MSM population.

Children - Approximately 2% of people living with HIV in Tajikistan are under the age of 15[22]. The number of new HIV cases reported among children has

[17] UNAIDS Global Report, 2013
[18] IBBS among MSM, 2011
[19] Grant Performance Report, 2014
[20] Grant Performance Report, August, 2014
[21] IBBS among MSM, 2014
[22] Grant Performance Report, August, 2014

increased significantly over the past years from 119 in 2009 to 480 in 2013, with majority (74%) of them being the children under five years of age[23].

Table 3. New HIV cases among children[24]

	2006	2007	2008	2009	2010	2011	2012	2013
Total new HIV infections, children	17	12	7	12	17	74	138	130
Reported cases of MTCT				11	14	26	34	47
Reported as 'unknown'				1	3	48	104	83

Eighty three out of 130 newly registered HIV positive children in 2013 did not have HIV positive mother and the transmission mode was reported as "unknown". As the number of vertical transmissions also increased over last 5 years (from 11 in 2009 to 47 in 2013), a study is required to investigate this major increase among children, and the real reasons for "unknown" transmission, to develop strategies to reduce the number of new HIV cases in children.

According to the national sentinel surveillance system, the estimated HIV prevalence among pregnant women is stable and ranges from 0.05 – 0.06%[25]. However, the number of new HIV positive cases among pregnant women increased almost 2.5 times in 2013 compared with 2009[26]. As of December 2013, there were a total (cumulative) of 306 pregnant women infected with HIV. About 70% had been identified during pregnancy and childbirth, and the remaining women previously had HIV. Such an increase can partially be attributed to intensification of HIV testing in this group of population demonstrated by the 1.4 fold increase of pregnant women tested on HIV reaching almost 100,000 pregnant women in 2013. However, testing of pregnant women during antenatal period requires to be further extended as in 46% of cases HIV infection has been diagnosed during delivery in 2013. The main reason for this is generally low attendance of antenatal clinics during pregnancy in rural areas (79% of women attend prenatal care, average in the country)[27]. By end of 2013, out of 306 pregnant women only 119 women (39%) received ART treatment. In order to improve identification of HIV positive pregnant women, who are expected to be more likely the women of Key population or the partners of KAPs, the National program will be implementing a strategy to work with the partners of KPs (see modules of Preventive programs for KAPs) and have a specific focus on women PWID.

According to RAC data (2013) only 30.7% of children born to HIV-infected women received viral HIV test within two months from the date of birth. PCR testing of children born to HIV infected mothers was first introduced in 2013. More than 190 newborns born from HIV-positive mothers in 2013 are still

[23] Grant Performance Report, August, 2014
[24] Republican AIDS center report, 2013
[25] UNGASS Report, 2014
[26] National HIV response Strategy of the republic of Tajikistan, 2013, Figure 8A, page 8
[27] World Bank database, http://databank.worldbank.org/data, accessed 13 October 2014

under epidemiologic observation, awaiting the final confirmation of their HIV status at the age of 18 months.

Given the recent change in epidemiological trend, it is of paramount importance to sustain and scale up the HTC and ART coverage in the context of PMTCT.

Prison Population -The HIV prevalence in prisoners increased from 6.2% in 2005 to 8.4% in 2013[28]. As of June 2014, 4353 prisoners out of estimated 10,000 inmates have been covered with prevention services. IBBS[29] data on prisons show mix trend on STI and HCV. For the period 2007-2013, prevalence rate of hepatitis C among inmates declined from 19% (2007) to 11% (2013) whereas STI prevalence demonstrates an increasing trend. Over the time, prevalence of Syphilis increased from 9% in 2007 to 13.1% in 2013[30]. The same study reports that drug injection and unsafe sexual practices continue to prevail in detention facilities[31]. 16.3% of prisoners share syringes and 9.9% had at least one symptom of STI.

Expansion of preventive activities in detention institutions is a priority of the government as at present only 48% of prison population is covered by prevention activities[32], mainly BCC. In 2009, first harm reduction needle syringe pilot project began within the Tajik prison system.

HIV/TB Co-Infection - Over the past five years the number of registered TB/HIV co-infection cases increased by almost 2.5 times representing 11.5% of the total number of registered persons with HIV infection[33]. This increase partially can be explained by integration of HTC in clinics providing TB related services. Among all TB patients tested for HIV, 1.4% of patients were diagnosed with HIV status. The TB/HIV co-infection death rate is ranging from 40 cases in 2009 to 42 cases in 2013.

Despite the fact that all, without exception, people living with HIV, TB, as well as people living with TB/HIV co-infection are eligible for antiretroviral therapy (regardless of the CD4 count). In the country the proportion of patients with HIV/TB co-infection covered by ARV in 2011 was - 57.4% and in 2012 - 67.2%. The main factors that influence the spread of dual infection with TB-HIV in the country are: the high prevalence of TB, including drug-resistant forms, poverty, economic hardship, high levels of migration, as well as lack of access to quick and quality medical services. The TB is not, however, the only co-infection that affects people living with HIV. The National program is targeting to increase coverage of ARV treatment among HIV/TB co-infected patients to the more than 90% level.

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

Tajikistan is a party to a number of international treaties/conventions that

[28] NAC data , 2014
[29] Report on IBBS in prisons, 2013, NAC (presentation)
[30] National HIV response Strategy of the republic of Tajikistan, 2013, Figure 9, page 9
[31] Report on IBBS in prisons, 2013, NAC (presentation)
[32] PUDR, 2013
[33] National HIV response Strategy of the republic of Tajikistan, 2013, Figure 12, page 11

recognize the right to health, including the International Covenant on Economic, Social and Cultural Rights. In accordance with Article 10 of the Constitution adopted in 1994, international legal instruments that are recognized by Tajikistan become a constituent part of its national legal system. The Constitution of Tajikistan contains a number of provisions relating to the right to health. Article 38 establishes the right to health care for all and to the protection of the environment for the promotion of health. Legislation relating to the realization of the right to health in Tajikistan includes among others the Reproductive Health Act (2002), the Act on the Fight against HIV/AIDS (2005), and the Act on Protection from Tuberculosis (2006).

The health system in Tajikistan has insufficient remedies and accountability for medical malpractice, which hampers the public's trust in the health system and the medical profession.

Stigma surrounding HIV and TB is a significant concern and that people living with HIV/TB co-infection had occasional limitations to treatment services for tuberculosis in certain facilities. Stigma and discrimination discourage people living with HIV and key populations from seeking testing, care and treatment, which in turn impede prevention, treatment and control efforts.

Women are vulnerable in Tajikistan regardless of the predominance of PWID in the course of HIV epidemic. Women account for most of the SWs and about 10% of the PWID are women. Moreover, there are several social economic and psychological factors influencing vulnerability of women to HIV in Tajikistan. Society in Tajikistan is characterized by a strictly patriarchal structure, where men have the right to manage the resources of the family and make decisions about any activities undertaken by women. Due to psychological and social taboos, norms and stereotypes, many women face difficulties in demanding safe sexual practice from their husbands or partners and limited opportunity to discuss reproductive and sexual issues with their partners. In addition, women's dependent status increases sexual exploitation, violence and unprotected sex.

People who use drugs and people in prisons are among the most marginalized and stigmatized groups of society. Given administrative and criminal penalties for drug use and possession of even very small amounts of drugs for personal use, people who use drugs are at high risk of ending up in prison.

The Administrative Code of Tajikistan qualifies "prostitution" as an administrative offence punishable by an official reprimand or a fine in the amount of ½ of one monthly minimal wage. Repeated offence committed within the same year leads to a higher fine of 2 minimal monthly wages[34]. The article 239 of the Criminal Law provides for criminal liability for organizing and maintenance of brothels or pimping, which is punishable by fine, or imprisonment for up to five years.

According to a 2012 study on stigma and discrimination, progress in decreasing stigma and discrimination in families and communities is somewhat discouraging. Attitude of family members after disclosure of HIV

[34] Administrative Code, Article 174.1.

status worsened during 2010-2012 from 14.8% to 7.7% respectively. Among the forms of discrimination in the family and community, the most negative is their isolation.

d. The health systems and community systems context in the country, including any constraints.

Many of the challenges that Tajikistan faces in developing its health system stem from the Semashko health system model inherited from the Soviet Union. The model relies on input-based financing and aims to provide a comprehensive set of health services. It traditionally focuses on infectious diseases and epidemic preparedness, which require large numbers of hospital beds and inpatient facilities staffed by specialized health workers. This results in the inefficient allocation of health funds to secondary and tertiary health care, and a health system that is unresponsive to the population's health needs. It also leads to rigid budgetary allocation among health facilities, as authorities may not be able to transfer funds among facilities without transferring physical resources, such as hospital beds and staff. Investment is thus, directed towards specialized hospital institutions, leading to the underdevelopment of the primary health-care sector, excess capacity at the secondary and tertiary care levels, and suboptimal allocation of health funds and resources.
The primary health-care sector in Tajikistan remains, however, underdeveloped and underfunded, in part because primary care facilities do not feature a large volume of health system inputs (such as for hospital beds, costly medical equipment and staff), which largely determine the amount of funds allocated to health facilities by the Government. Consequently, the primary health-care sector is often perceived as providing poor quality services and thus underutilized. For example, the Government estimated in 2005 that up to 80 per cent of people bypass primary health care and go directly to hospitals.

There is a shortage of trained primary health-care workers in Tajikistan. A variety of factors contribute to this deficit: the traditionally low status of primary health-care workers within the health sector; the fact that general practitioners receive less pay than specialists; and the absence of family medicine as a medical specialty in Tajikistan until only recently.

1.2 National Disease Strategic Plans

With clear references to the current **national disease strategic plan(s)** and supporting documentation (include the name of the document and specific page reference), briefly summarize:

a. The key goals, objectives and priority program areas.

b. Implementation to date, including the main outcomes and impact achieved.

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

constraints described in question 1.1 are being addressed.

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

e. For standard HIV or TB funding requests [35], describe existing TB/HIV collaborative activities, including linkages between the respective national TB and HIV programs in areas such as: diagnostics, service delivery, information systems and monitoring and evaluation, capacity building, policy development and coordination processes.

f. Country processes for reviewing and revising the national disease strategic plan(s) and results of these assessments. Explain the process and timeline for the development of a new plan (if current one is valid for 18 months or less from funding request start date), including how key populations will be meaningfully engaged.

a. The key goals, objectives and priority program areas.

The present National HIV Strategic Plan (NSP) covers the period from January 2011 to December 2015 (see Annex 1). In January 2014, Republic of Tajikistan (RT) initiated a process for reviewing and developing of a new NSP for the period of 2015-17. The new NSP was approved by NCC on July, 2014[36].

The review and the development process of the new NSP was participatory and interactive exercise, involving all sector of national response of HIV at all levels in Ministry of Health and Social Protection of Population (MoHSPP) and non-health ministries, UN Agencies, international and national NGOs, CSOs working with people living with and affected by HIV, key populations, academia, and private sector. The NCC has established a Technical Working Group for development of the NSP[37]. The technical working group oversaw the entire process, which had four inter-related phases: i) reviewing NSP (2011-2015); ii) documenting evidence for NSP 2015-2017; iii) drafting the new NSP 2015-17; iv) operationalizing and costing of the new NSP. WHO reviewed the draft NSP in second half of September and supported finalisation.

The NSP will contribute to the overall efforts of the Republic of Tajikistan to achieve the Sustainable Development Goals (SDG), hence improve the wellbeing of the population. Specifically, the NSP aims *at achieving universal access to HIV services through ensuring that all people regardless of gender, age or origin have access to prevention, treatment and support that enables them to live a fulfilling life*.

The overall goal of NSP is to effectively control the HIV prevalence rate to below 0.4% by the end of 2017 and reverse the epidemic among the key affected populations.

The NSP has five key priority areas which are the basic fact for the

[35] Countries with high co-infection rates of HIV and TB must submit a TB and HIV concept note. Countries with high burden of TB/HIV are considered to have a high estimated TB/HIV incidence (in numbers) as well as high HIV positivity rate among people infected with TB.

[36] NCC meeting minutes on NSP approval, July, 2014

[37] Decree of MoHSP on TWG establishment

development of the Concept Note. The Priority areas are:

Priority area 1: Prevention and testing

Prevention activities focused around main Key affected population, namely PWID, SWs, MSM and inmates through a) scaling up outreach to PWID, SWs, MSM and inmates with needles and syringes, other injecting equipment, condoms and naloxone as a key activity in encouraging KAP to HIV testing; b) introducing rapid testing of PWID, SWs and MSM at NGOs; c) provision of intensive training in communication with key populations to all doctors and nurses at HTC sites, primary health care centers, AIDS Centers and other health services in areas of highest concentrations of KAP; d) scaling up opioid substitution services, initially by increasing the number of patients at existing clinics to their full capacity; e) increasing availability of and access to friendly clinics for STI diagnosis and treatment and HIV testing; and f) analyzing the needs of female KAP and strengthen gender-sensitive harm reduction projects to provide comprehensive services to female KAP in areas of highest concentrations.

Priority area 2: Treatment and care

This priority area is focused on two main areas: 1. Provision of treatment and care to PLHIV and 2. PMTCT. The key activities include: a) Strengthen linkages between NGOs, friendly clinics and other agencies working with KAPs to ensure easy passage from positive test result to care ; b) ensure national ARV, HIV test kit, CD4 and VL test kits forecasting and PSM system is functional and networked to prevent stock-outs and ensure access to appropriate ART medications (including pediatric formulations) in quantities appropriate to increased numbers of PLHIV discovered through scaled-up testing of KAPs; c) forecasting the increased caseload of PLHIV on ART and in other HIV care, train sufficient health care workers to handle the caseload; d) ensure HIV care and ART in prison is equivalent to care and treatment and the community; e) increase engagement of CSOs and peer to peer approach to increase access of key population to treatment services and support adherence; e) establish 5 centers of excellence providing integrated PLHIV care (ART, OST, TB, OI); f) standardized medical record cards to allow easy analysis of patient-level data, especially CD4+ count and viral load; g) scale-up PMTCT coverage, train ANC staff in PMTCT; h) provide training to ANC staff in communicating with KAPs (concentrating on women PWID, SW, female partners of PWID and MSM).

Priority area 3: Blood safety and infection control

Priority area 3 is concentrated around two sub-areas: Blood safety and healthcare waste management. The implementation of this priority area is anticipated to be conducted through the following activities: a) carry out operational research to determine the source of infection among children (labelled “unknown”) as the basis for measures to stop this transmission; b) ensure implementation of international standards on the clinical use of blood; c) develop capacity in order to ensure safe injecting practices and infection control in all health facilities while adjusting the indication to use injections to international standards; d) advocacy for voluntary unpaid blood donation; e) encourage the reporting of systematic problems inside institutions to take action to improve services; f) develop a national healthcare waste

strategy & development plan and monitoring system; g) institutionalize waste management monitoring system.

Priority area 4: Strengthened health system

Priority area 4 has three objectives leading to implementation of the set up goals: a) Elaborate and fully roll out electronic HMIS for HIV treatment and care; b) elaborate and fully roll out unified electronic national HMIS for KP-targeted HIV prevention services; c) ensure that there are no stock outs in availability of HIV prevention commodities, medicines for HIV and OI, and laboratory

Priority area 5: Strengthened supportive environment to improve access to services to key populations

In order to achieve strategic goal 5, the NSP suggests to capacitate CSOs on programmatic and operational management, enhance coordination activities between CSOs and governmental institutions and engage CSOs in monitoring an decision making processes of the HIV programs.

In order to achieve its goal, the NSP emphasizes the importance of evidence-based interventions, provision of comprehensive prevention, treatment and care services and strengthen community systems and uphold human rights and gender aspect of the HIV response. The new NSP will focus on following primary strategies guiding interventions and this concept note is formed by six focus areas based on the facts of NSP.

1. **Provision of cost effective prevention, treatment, care and support services, informed by an engendered rights –based approach to realize universal access** - Based on the lessons learned from NSP (2011-2015), this Strategic plan draws heavily on a cost-effectiveness analysis to determine appropriate package of services (geographical, epidemiological, socio-economic and gendered) to be provided in response to the diversity of the epidemic in Tajikistan. These services, aimed directly and immediately at reducing transmission and incidence on the one hand, and improving treatment and care outcomes on the other, will require dynamic and responsive sectoral systems. Service provision will also be guided by rights based approach, with a strong emphasis on ensuring respective appropriate rights holders' entitlements and duty bearers' responsibilities. Civil society will be strongly involved, not only to ensure that the "voice" of all stakeholders is heard, but also to support the social transformation for AIDS competent communities**.**
2. **HIV mainstreamed in key sectors through long-term programming addressing both the root causes and effects of the epidemic -** Considerable progress had been made in the previous strategic plan in sector mainstreaming, largely through engagement with Government in the Medium Term Expenditure Framework (MTEF) process. This NSP will be primarily geared towards: i) working with the ministries of Finance, as well as specific line ministries, to ensure sector specific HIV priorities receive adequate financial allocations in the MTEF budget process; ii) raising the profile of HIV in sectoral planning and budgeting to secure long term financing commitments to reserve negative socio-economic impacts; and iii) taking to scale proven, innovative, cost-effective sectoral programs,

including mainstreaming them in the private sector (formal and informal).

3. **Targeted, community-led programs supporting achievement of universal access and social transformation into AIDS competent society**. The situation analysis concludes that effective strategies require a combination of effective service delivery and enhanced risk perception and demand at the community as well as individual levels. Social mobilization is critical to realizing greater societal/individual acceptability, demand for quality services, and reduced marginalization (stigma and discrimination) of key populations and PLHIV. These micro-macro and macro-micro transitions are captured in the NSP, primarily through community-based intervention such as systematic mobilization of communities to undertake HIV related activities that respond to their needs.
4. **All stakeholders coordinated and operating within a nationally owned strategy and aligned results framework, grounded in mutual accountability, gender equity and human rights** - This strategy is based on the "Three-Ones" principles, as well as on international agreements for funding harmonization, such as the Paris 21 Declaration. The NSP aims to build upon and deepen achievements from the previous NSP in the coordination of stakeholders working on HIV in Tajikistan nationally, including development partners, government ministries, departments and agencies, as well as civil society organizations.

Concept Note Focus Areas:

Focus Area 1:	Increasing coverage, utilization of HIV prevention services and reducing risky behaviour among the general community, PLHIV, key populations and vulnerable populations.
Focus Area 2:	Increasing proportion of eligible PLHIV with access to continuum of care, treatment and impact mitigation services.
Focus Area 3:	Strengthening of Health systems to deliver a package of linked and integrated HIV services, which ensures continuity of care
Focus Area 4:	Mainstreaming of HIV in sector specific policies and strategies
Focus Area 5:	Supporting communities to respond to HIV within their local context.
Focus Area 6:	Effective operationalization of NSP

The greatest impact on HIV prevention and treatment will be achieved if the interventions are implemented as a package of combination prevention services addressing biomedical, structural and behavioral factors. The NSP includes comprehensive packages of services in each intervention area. In order to achieve these goals, the implementation of a comprehensive package for the prevention, treatment and care of key populations and people living with HIV is essential. The interventions will be delivered using a range of modalities, including community outreach, peer-to-peer work, and will be

implemented in the community, health facilities, prison settings and in other settings close to the targeted populations. The services will also be delivered with a human rights and public health approach, alongside supportive (or advocacy to develop supportive) legal and policy frameworks. One critical element of the comprehensive package is inclusion of sexual partners of those who are most at risk in intervention programs.

b. Implementation to date, including the main outcomes and impact achieved

National response to HIV at present is guided by National HIV strategic plan (2011-2015) that spelled out clear priorities for the implementation of key interventions. Prevention priorities in the NSP 2011-2015 include (i) Assuring safe blood supply; (ii) Preventing mother to child transmission; (iii) Preventing infection spread among key populations which included PWID, MSM, SWs, prisoners as well as migrant and uniformed services (military and law enforcement); (iv) TB/HIV collaborating activities; (v) Post-exposure prophylaxis.
The program strived to provide quality HIV interventions to key populations (PWID, SWs, prisoners and MSM) and vulnerable population (labor migrants and their family members, rural youth, uniformed staff, and others). The NSP also focused on health system strengthening interventions, particularly expansion and integration of voluntary and confidential counseling and testing services into the PHC and contributing to national health care reform through building and improving technical and managerial capacities of health professionals, promoting participation of civil society in response to the epidemic, and enhancing the cooperation of CBOs with the public health sector.

During NSP period for the first time the problem of women and girls, gender equality and related issues of HIV infection were included in the broad national agenda informed by the findings of the a study on access to social services for people living with HIV, with an emphasis on gender equality. The foundation for the integration of gender and HIV/AIDS activities into the ministries and department such as the Committee on Women and Family Affairs under the Government of the Republic of Tajikistan, Ministry of Health and Social Protection, and Ministry of Labour, the Ministry of Defense was established.

National efforts under NSP 2011-2015 have helped to establish enabling legal environment. The HIV/AIDS Law was amended and approved in March 2014, with the focus on anti-stigma and discrimination policies. With these changes, all HIV-related restrictions on entry, stay and residence are eliminated in Tajikistan. Furthermore, the definition of key affected population is clearly indicated in the revised HIV Law.

The HIV and AIDS routine surveillance systems along with BSS and sentinel surveillance are being implemented and rolled out nationwide.

Civil society participation in planning and budgeting of the national response and their role in delivering preventive, curative and supportive services has

significantly increased. NGOs are increasingly involved in advocacy efforts, research and community outreach activities to prevent the spread of epidemic.

c. Limitations to implementation and any lessons learned that will inform future implementation. In particular, highlight how the inequalities and key constraints described in question 1.1 are being addressed.

The analysis of implementation revealed that national response has not placed equal improtance on all listed interventions. Most efforts and resources were put towards priority areas/groups for prevention. Importance of key populations, prevention of mother to child transmission and assuring safe blood supply received highest priority. Because of the way national program has been prioritised, higher coverage of the prevention interventions among some key populations such as MSM and prisoners could not be achieved in the life cycle of the NSP (2011-2015).

Advocacy efforts have not fully rendered expected results. The presence of a legal framework is important, but is also important that laws and regulations are enforced. While non-discrimination of key populations is proclaimed, in practice stigma and discrimination against PLHIV and key populations are frequently encountered in Tajikistan, in particular in access to education, employment, health and social services.

Specifically, the facts of stigma and discrimination against PLHIV and key populations affected by HIV in education, employment, health, and social services are still present in Tajikistan.

Harm Reduction: In the last 5 years the needle and syringe exchange program (NSEP) has been scaled up. As of Dec 2013, there are 45 trust points are providing needle and syringe to 8378 PWID. The Decree of the MoH RT #485 (as of 07.06.2006), envisages that needle and syringe programs be a part of narcology assistance, but to date all commodities for the NSEP activities are covered from donor funds

At present there are six operational methadone substitution centres (OST) throughout the country. However, coverage with OST or detoxification services in the country is quite low and barely reaches 3% of PWID[38]. The OST program has proven its efficacy in the Republic of Tajikistan, and there is a high demand for it; however, there are only six pilot sites. Only 2.9% (677 as of December 2014) of the estimated population of PWID is covered. The main barriers for expansion of OST are a lack of specialists, high threshold for client enrolment and limited financing. The document regulating OST (Operational guideline “Substitution maintenance therapy by method, in case of syndrome of opioid addiction”, approved by MoH RT in 2009) covers only the pilot projects. There is a lack of mechanism of interaction among different agencies (prison, maternal houses, TB and other services), focused on

[38] Report of Narcology center, for Dec 2014

adherence to OST. OST programs are not complemented with psychosocial support and social integration. Mandatory registration of people who use drugs in a special registry in the narcological services (Narco-uchyot) is a main barrier that prevents early access to services for those diagnosed with opioid dependency. The situation is further complicated by the absence of methadone registration and inclusion in the essential list of medicines. Majority of services provided by the narcological centres, including detoxification therapy is charged services, except for the methadone maintenance treatment which is provided free of charge with the GF support. The training of OST staff is not institutionalized and most of nurses have not received any training. Furthermore, PWID interrupt OST treatment as they become seasonal migrants and further contact with HIV preventions services is largely unknown. In 2010, there were 78 deaths due to overdose. Naloxone is available only within harm reduction programs, and procured within the GF-funded project. Naloxone is not registered in the country. In many districts, there is no education for PWID and their surroundings on how to use naloxone. This concept note will advocate and support to scale up harm reduction program including OST, ensure quality of services to the PWID and prevention of deaths due to overdose.

MSM: The coverage rate of prevention interventions among MSM is based on programmatic routine reporting was 2,645 in 2013 and 5,086 in June 2014, which is over 100% achievement of the TFM target (4,500). However, as the population size estimate of MSM has never been conducted in Tajikistan, this performance cannot be an assurance for covering all MSM in the country. Further study to determine the population size estimate and revision of the target is scheduled during the NFM implementation period. The percent of MSM who have taken an HIV test in the last 12 months and know their results was 40.2% (IBBS in 2011), exceeding the coverage rate. The coverage rate of MSM with preventive activities based on IBBS is much higher in uninfected MSM (39.5%) than in HIV positive MSM (0.7%).

The level of the combined indicator on knowledge (prevention ways and reject major misconceptions) is higher than among PWID and SW and reached 45.3% in 2011 (IBBS data). Percent of MSM who said they used condoms using during last sex with a man was 67,8 %. The main source of condoms for MSM was friends (57%), outreach workers (46.1%) and NGOs (31.2%). Thirteen friendly cabinets for MSM (all run by NGOs) are providing services to MSM in Tajikistan. This concept note will continue to support and scale up the MSM interventions.

Anti-retroviral therapy: Tajikistan ARV program started in April 2007. Since beginning of the ART program a total of 2,541 PLHIV ever started ART. As of June 2014, there are 1,735 people receiving ART. ART is prescribed by infection disease specialists. Immunological criteria adopted by the WHO guidelines 2010, using a CD4 cell count cut-off of 350 cells/µl, were implemented since the start of the GF Round 4 HIV grant. New WHO 2013 criterion on ART initiation using 500-cells/µl cut-off means that a much greater proportion of PLHIV will be eligible for treatment and therefore, the number of people in need for ART will be considerably higher in the country in the nearest future. Some regions do not have AIDS centers, and patients have to

travel to other cities to access their ART. The ART project is facing several challenges. The retention rate of the ART patients needs to be improved through adherence support by health workers, CSOs and volunteers from the key populations. With the current ART provided only by the AIDS centers (vertical programme) significant increase in capacity (including trained infectious disease specialists) will be required to enable scaling up coverage with ART to meet the 500 CD4 threshold. The NFM grant activities will include building capacity of AIDS Centers to scale up ART coverage.

HIV testing: In the last 4 years the HIV testing has been scaled up from 280 thousand in 2010 to more the 500 thousand people in 2013. However, the proportion of the key population tested is less than 50% of the estimated key population (PWID, SWs, MSM and prisoners). For example in 2013, a total of 9710 (42%) members of key affected populations were tested. One of the challenges is the HIV testing policy (algorithm) of the country which requires 3 tests from different blood samples before a person is diagnosed as HIV positive. This approach often leads to longer waiting time for results and loss to follow up. Key populations also fear to access to health facility due to fear of stigma. This concept note will attempt to address the HIV testing policy update, support NGO managed HTC services and social accompanying, and scale up HTC services for the key population. Furthermore, the RAC will review the current testing algorithm in 2015-2016 to make it in line with WHO recommendations.

Table 4:Testing among Key population

	2010	2011	2012	2013	Total
PWID	4893	5362	7576	9872	27703
SW	1831	4333	4377	6552	17093
Prisoners	9185	1431	1659	2734	15009
TB patients	7279	12135	9259	8657	37330
MSM	89	790	613	942	2434
Annual number of persons tested for HIV in the country	280,281	438,532	453.8	517,376	1,236,643

TB/HIV co-infection: Collaboration and coordination at organizational and technical levels between the National Tuberculosis Program (NTP) and the National AIDS Program (NAP) has been strengthened during recent years through joint programming, capacity building, and data exchange and monitoring and evaluation activities. As a result, testing of TB patients for HIV has been scaled up (from 53% in 2010 to 97% in 2013). The coverage of TB/HIV patients with antiretroviral therapy (ART) reached 90% in 2013 (compared to 56% in 2011). Cotrimoxazole preventive therapy (CPT), not available until 2010, was provided to 80% of PLHIV in care in 2013. All diagnosed TB patients are offered HIV testing in a provider-initiated manner (provider-initiated HIV counseling and testing, PIHCT); however, rapid HIV tests are largely unavailable at TB institutions, therefore blood samples are sent to AIDS Centers, and the feedback on HIV status to TB care providers is

often delayed or absent. On the other hand, symptom-based and X-ray screening for TB suspects among PLHIV is performed mainly at TB specialized facilities, which is related to delays in seeking care due to stigma and other barriers present in PLHIV and increases the risk of TB infection to PLHIV.

The TB and HIV service in the Tajikistan need better integration, simplification of service provision procedures and scaling up TB screening among HIV patients. This concept note will address above-mentioned challenges. Further, the TB concept note will include funds for scaling up GenXpert diagnostic and transport of samples from the AIDS Centers.

STI treatment: Substantial progress is achieved in Sexually Transmitted Infections (STI) prevention and care where "friendly services" exist, either for migrants, youth or sex workers, in reproductive health clinics or at STI clinics. In public institutions, name-based STI register is counter-productive for the control of STI. These services are overly bureaucratic, not responsive to special needs of clients and not trusted. The analysis reveals that where NGOs are involved in services the utilization is higher, more involvement of NGOs and community members are therefore needed. This concept note will advocate for the revision of the STI treatment protocol and decentralizing STI services.

Prisoners: The HIV prevalence in prisoners varied from 6.2% in 2005 to 8.6% (about 860 prisoners) in 2013. Many prisoners are PWID, being confirmed by the routine surveillance data.

During 2001-2012, 514 HIV cases were reported among prison population. While HIV testing, condom and disinfectant distribution services have been introduced in penitentiary system, introduction of Needle and syringe program and OST services still remains to be addressed.

There is a high prevalence both of unsafe sexual and injecting practices within prison walls. Prisoners also serve as a bridging population. Once they are released back into the general community, they return to family and community, carrying any infections they have acquired while incarcerated. In response to these challenges, harm reduction needle exchange pilot efforts began within the Tajik prison system. This concept note will promote expansion of the harm reduction program in prisons in Tajikistan and provide comprehensive package of services.

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

Creating a healthier living environment and improving health of the population, particularly, its vulnerable groups is the National Health Strategy 2011-2020 (NHS) of Republic of Tajikistan overarching goal and, prospectively, the main result of its successful implementation. The NHS aims at Strengthened performance of the health care sector which will manifest itself in a reduced disease burden (socio-economic loss from premature death and disability) on the economy and the society of Tajikistan. Disease patterns will improve

primarily in areas where the burden of disease is substantial and can be reduced within the nation's economic means. Particular emphasis will be placed at TB and HIV centers. The NHS has for main objectives: i) Improving the Nation's Reproductive Potential: Women's, Maternal, and Newborn Health; ii) Healthy Childhood; iii) Prevention and Control of High-Impact Infections; and iv) a fulfilling life with non-infectious and Chronic Diseases.

The NHS also outlines the *key* areas of change, envisioned in the health care sector of Tajikistan in the next decade, such as (a) strengthening public governance in health; (b) improving quality and accessibility of health care; (c) development of health sector resources and financing. NHS will also attempt to revise and enforce health legislation and regulations, which ultimately will target the regulation of HIV service providers. Establishment of modern information infrastructure and analytic frameworks for operational and strategic research on the health care sector, as one of other directions of NHS, allows evidence based policy development; planning and management of HIV related activities.

The Government of Tajikistan, particularly the Ministry of Health and Social Protection of Population of RT and regional authorities will assume the leadership function in health through (a) elaboration of basic values, governing principles, and public policy for the health care sector; (b) establishment of modern information infrastructure and analytic frameworks for operational and strategic research on the health care sector; (c) modernization and improved enforcement of health legislation and regulations; (d) strengthened alignment with advanced international experience; coordination of international aid and technical assistance; (e) improved current management and controls.

The HIV NSP 2015-2017 echoes NHS main goal and covers measures intended to ensure that the entire population has universal access to HIV/AIDS prevention, treatment, care and support. The objectives and priority directions outlined in the NHS will enable and enforce National HIV strategy implementation. Implementation of measures directed towards enhancement of health system governance at national and local levels will contribute towards enhancement of HIV services provision and strengthening of NSP governance and implementation management. This objective will also contribute towards optimization of health provider network and assurance of equal access to health services for the population. Next important direction of NHS is improvement of quality and access to health services. The latter will enforce introduction of new, evidence based HIV and TB prevention and treatment technologies as well as expansion of HIV service provision and improvement of geographical access to HIV prevention and treatment. Refinement of health sector financing and budgeting objective of the NHS plans to leverage increased public funding for health sector in general and the HIV response in particular as well as set conditions for motivation of HIV service providers and consequently, improvement of HIV service quality, minimize stigma and discrimination through capacity building of the health workforce.

e. Existing HIV and TB collaborative activities[39]

Although Tajikistan is not in the list of high TB/HIV co-infection countries, this section describes the current efforts of the TB/HIV co-infection management and coordination. The MoHSPP plays a key role in coordination of TB and HIV program implementation with all relevant national stakeholders and international partners active in the field. Collaboration and coordination at organizational and technical levels between the NTP and NAP has been strengthened during recent years through joint programming, capacity building, and data exchange and monitoring and evaluation activities. As a result, testing of TB patients for HIV has been scaled up (from 53% in 2010 to 97% in 2013). The coverage of TB/HIV cases with antiretroviral therapy (ART) reached 90% in 2013 (compared to 57.4% in 2011). Cotrimoxazole preventive therapy (CPT), not available until 2010, was provided to 80% of patients in 2013.

This concept note will continue to support current efforts and further strengthen TB/HIV co-infection management, integration of services and coordination of the TB and HIV services and the overall health service delivery of TB and HIV infections.

f. Country processes for reviewing and revising the national disease strategic plan(s) and results of these assessments.

The current National strategic plan covers the duration of 2011-2015. This NSP has been regularly reviewed during the implementation period. For instance, WHO has conducted a National AIDS Program Review in 2013. The Principal Recipient, UNDP has also conducted an Outcome evaluation in 2013. Furthermore, during the implementation period, strong monitoring and evaluation at national and regional levels has been implemented. The results of monitoring and evaluation including on-site data verification (OSDV) have been regularly reviewed with partners under the leadership of Republican AIDS Center (RAC).

As the current NSP is ending in 2015, the NCC has established a national Technical Working Group to review the implementation of the current NSP, identify successes and challenges and develop a new NSP with its costs estimation and plan of operationalizaiton to cover the period of 2015-2017. In the current NSP, the key population (PWID, SW, MSM, prisoners) are targeted as the main intervention area with meaningful engagement of the civil society to enhance the HIV control program, which is on the concentrated stage in Tajikistan. During the NFM implementation period and based on the surveillances, program reports, regular M&E, the NSP will be regularly reviewed in order to ensure the achievement of its goal and objectives.

The main areas recommended for focus in the next period were scale up of harm reduction (NSEP and OST) programmes for PWID; scale up of prevention programmes for MSM and SW.

[39] Countries with high co-infection rates of HIV and TB must submit a TB and HIV concept note. Countries with high burden of TB/HIV are considered to have a high estimated TB/HIV incidence (in numbers) as well as high HIV positivity rate among people infected with TB.

2.1 Overall Funding Landscape for Upcoming Implementation Period

In order to understand the overall funding landscape of the national program and how this funding request fits within this, 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 total budget of the NSP (2015-17) is US$ 48,580,063.79 with annual requirements around US$ 16.5 million per year. A significant portion of the total cost estimate (85%) is allocated for prevention activities. In Prevention activities the NSP envision to scale up the needle syringe exchange program to at least 60% coverage, expand OST sites as well as scaling up of HIV counseling and testing among key populations. Around 4.6% will be spent on PLHIV treatment and care. The NSP targets to retain 80% of ART patients enrolled while expanding the ART coverage to 44.8% of estimated need. Around 8% of the total budget will be allocated for the health system strengthening and 0.5% for mainstreaming the HIV in sector specific policies and strategies. The NSP will also focus on the development and capacity building of CSOs. 1.3% of total budget will be dedicated for organizational and managerial capacity building of the CSOs, while CSO activity implementation will largely be financed under the Focus Area 1 “Prevention”.

According to the NSP the CSOs will be actively engaged in activities such as community based rapid testing, systematic follow up on those who were identified as HIV infected, but not enrolled in care, social accompanying for key populations, shorten the time between taking the blood sample and delivering test results, to locate LTFU patients after diagnosis and to treatment support self-help groups.

Uncertainty in availability of external donor resources other than the GF is a major concern. Further external support to NSP is largely linked to the new programmatic cycle of international partners and their ability to leverage sufficient funding. As per the most conservative scenario, a gap of US$ 16 million representing 32% of total NSP financial needs.

The existence of GF in the region for almost more than 10 years had unintended consequence of gradual withdrawal of other major donors that were active in supporting the three diseases. Most of bilateral and multilateral donors are contributors to the GF so they are referring the entire requests to their GF contribution. Nevertheless, if in the past the GF investments served as a good tool to leverage other resources, for the new NSP the situation looks rather pessimistic. Accurately assessing the gap over time span of the NSP requires consideration of potential variation in revenue sources over time. Uncertainty in availability of external donor resources other than the GF is a major concern.

Thus no definite donor commitment has been yet made available to the Republic of Tajikistan for the period covered by the NSP (2015-2017). The only preliminary forecasts subject to approval of respective donor authorities are available from USAID and UNAIDS. USAID's indicatively plans to make available USD 3.5 million USD per year in 2016 and 2017 earmarked for preventive activities and USD 700,000 per year for Health System Strengthening component. UNAIDS estimates to get around USD 250,000 for the year 2016, albeit allocation priorities yet have to be defined.

Availability of the GF indicative funding in an amount of US$ 17 million and public funding which will ensure an increase in 2015 by 9.6%; in 2016 by 19.4% and in 2017 by 14.7% (local currency investment) totaling to US$ 24,713,426 does not warranty full coverage of all NSP focus areas. Even those activities included in the NFM funding proposal cannot ensure full attainment of NSP coverage targets if additional external funding is not mobilized by the government.

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. 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	
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	

iii. Increasing government contribution to disease program	☒ Yes ☐ No	

b. Compared to previous years, what additional government investments are committed to the national programs (TB and HIV) 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.

In general, the health care system is severely underfunded. On average 95% of public funds cover payroll expenses and remaining 5% is left to cover communal costs, procurement of medicines and supplies as well as capital investments. Recent health reform initiated in the country aims at improving efficiency, access and quality of care. The country progressed in reforming financing of the primary health care by introduction of per capita funding of the primary health care. While the government demonstrates willingness to improve health financing by increase of health budget, yet the resources made available to fund the health care system are very limited. There is a decentralized system of financing health care in Republic of Tajikistan. The Oblast and MoHSP decisions on allocation of available public resources to different services including HIV/AIDS is based on the yearly budget plan composed based on request, magnitude of the problem and on available funding. There are no specially earmarked budget line items for HIV/AIDS related services. In support to NSP 2015-2017 and proposed funding request, the Government of Tajikistan plans to increase spending in 2015 by 9.6%; in 2016 by 19.4% and in 2017 by 14.7% (local currency investment). Annual funding requirements for the full national disease program are based on forecast of the financial expenses for the implementation of the NSP 2015-2017. The 2013 government share of funding is based on the results of two recent NASA reports and MoHSPP confirmation. The data on estimated external donor financing of HIV related activities are based on the information provided by the partners. However, key limitation of this information is partners do not have confirmed budgets and spending priorities yet defined.

SECTION 3: FUNDING REQUEST TO THE GLOBAL FUND

This section details the request for funding and how the investment is strategically targeted to achieve greater impact on the disease and health systems**.** It requests an analysis of the key programmatic gaps, which forms the basis upon which the request is prioritized. The modular template (Table 3) organizes the request to clearly link the selected modules of interventions to the goals and objectives of the program, and associates these with indicators, targets, and costs.

3.1 Programmatic Gap Analysis

A programmatic gap analysis needs to be conducted for the three to six priority modules within the applicant's funding request.

Complete a programmatic gap table (Table 2) detailing 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.

A Programmatic gap analysis was conducted for the following five main priority modules and included in Programmatic Gap Analysis table. The modules are quantified, explained and commented in Programmatic Gap Analysis table. The modules included:

1. Prevention programs for people who inject drugs (PWID) and their partners
2. Prevention programs for MSM
3. Prevention programs for SWs and their clients
4. Treatment, care and support
5. TB/HIV

The 4th priority module "Treatment, care and support" selected coverage indicator of "Percentage of adults and children currently receiving anti-retroviral therapy among all adults and children living with HIV". Due to this reason the data provided in Programmatic Gap Analysis table are for both adults and children. The treatment, care and support data of the National AIDS centers are also consolidated.

3.2 Applicant Funding Request

Provide a strategic overview of the applicant's funding request to the Global Fund, including both the proposed investment of the allocation amount and the request above this amount. Describe how it addresses the gaps and constraints described in questions 1, 2 and 3.1. If the Global Fund is supporting existing programs, explain how they will be adapted to maximize impact.

The Global Fund allocation for Tajikistan HIV component USD 24.6 million of which USD 17 million is additional (new) funding for 2015-2017 period. The national coordination committee (CCM) considers that the allocation is taking into account of the disease burden and level of income of the country. Additionally, it recognizes the progress of the national HIV/AIDS response and the Government's commitment to follow the international recommendations and apply evidence-based interventions for effective fight against the disease.

The CCM and national partners conducted series of country dialogues and formed a technical working group to discuss on the allocation amount and disease split. Malaria component did not receive additional funding/allocations from the GF. The CCM and MoHSPP have explored the possibility to allocate some of the HIV allocation to Malaria. Unfortunately, it was difficult to reallocate some of the HIV allocation to Malaria. This is mainly due to limited allocations to the HIV and increasing demand to scale up the HIV prevention, treatment and care interventions. The CCM meeting on 23 September 2014 decided to keep the same allocation amount for the HIV/AIDS Component (See Annex 2). The details of the disease split dialogue and documentations are uploaded in the Grant Management Platform.

The ***Goal*** of the NFM project is ***to achieve universal access to HIV services; prevention, care, treatment and support that enables people living with HIV to live a fulfilling life*****.**

The project is built on lessons learned during the implementation of the National HIV/AIDS strategic plan and the existing capacities to address programmatic and financial gaps. The project is an integral element of the national HIV/AIDS control program and involves relevant governmental stakeholders and non-governmental organizations (NGOs).

The application is aligned to the recently developed *National HIV/AIDS Strategic Plan in the Republic of Tajikistan 2015-2017* and its principles and priorities are consistent with the national and international policies, initiative and best practice.

This concept note will have five main objectives:

Objectives:

1. Ensure high quality and coverage of prevention services for key populations (PWID, SW, MSM, prisoners - including their partners)
2. Ensure quality care and treatment and support the people living with HIV/AIDS
3. Health system strengthening.
4. Strengthened supportive environment to improve access to services for Key

populations.

5. Program Management

Based on a detailed programmatic and financial gap analysis of the National HIV/AIDS program, the CCM decided to set the timeframe this concept note from 01 October 2015 – 31 December 2017. Under framework of this concept note, the CCM requests to maintain and expand the interventions that have been previously supported by the Global Fund, as well as to support new activities. The current TFM HIV grant will expire in September 2015; therefore, there is no duplication or overlap of the activities. The project activities have been planned in view of the increasing contribution of the Government in taking over key financial needs of the program, as stipulated by the NSP.

The United Nations Development Program (UNDP) was nominated by the CCM as the Principal Recipients of the grant funds.

Objective 1: Ensure high quality and coverage of prevention services for key populations (PWID, SW, MSM, prisoners), including their partners

The current TFM program supports essential prevention services for the key populations (PWID, SWs, MSM, Prisoners) and their partners) such as: harm reduction program via community outreach and peer to peer education, distribution of prevention health commodities and dissemination of information and communication materials, promotion of support services (e.g. voluntary and provider initiated counseling, testing, referrals to specialized services, testing and management of STIs and other opportunistic diseases).

Furthermore, the PR under the oversight function of the CCM will strengthen the strategies to improve better partnership among partners working with Key Populations. Such strategies include but not limited to:

- The CCM to regularly review the status of the partnership working on Key Populations to ensure coordination, synergy and efficiency.
- National level outcome evaluations, surveillances and monitoring will be coordinated by Republican AIDS center supported by the PR.
- The PR will continue coordinating efforts sharing results and plans to promote cost effectiveness and sustainability.
- As indicated in the Concept Note, the PR will also enter into a Memorandum of Understanding with partners who are working on Key Populations to supply with commodities required for service package of key Populations. The MoU will clearly indicate the roles and responsibilities in project management, reporting and result measurements.

As of June 2014, with the support of the GF and UNDP the national HIV/AIDS program covered the following key population with prevention (Table 5):

Table 5: Coverage of Key Populations as of June 2014

Key Population	Target	Result achieved as of June 2014	Population estimation
PWID	12000	12261 (53%)	23100

Sex workers	6480	7702 (55%)	14100
MSM	4500	5086	N/A
Prisoners	4500	4353 (43%)	10000[40]

The current prevention effort of the program is reaching around 50% of the key populations such as; PWID, SWs and Prisoners. In respect to the MSM, there is no reliable population size estimation. UNAIDS country office in Tajikistan is planning to conduct PSE among MSM in Tajikistan. The result of the study will published in mid-2015. This objective aims to scale up the coverage of the prevention interventions and provide comprehensive package of services to the key population.

Table 6: NFM Targets for Key populations

KAP	2015	2016	2017	PSE
PWID	12,705 (55%)	13,860 (60%)	14,553 (63%)	23,100
Sex workers	7,755 (55%)	8,460 (60%)	9,165 (65%)	14,100
MSM	6,000	6,600	7,200	N/A
Prisoners	5,500 (55%)	6,700 (67%)	7,800 (78%)	10000

The targets are calculated based on the UNAIDS and WHO recommendations of coverage of key populations of at least 60%. In some cases, for instance a population estimate size was not available for MSM. As described in the above paragraph this Concept Note describes the plan for new population size estimate. A gradual scale up of the coverage with prevention programmes is anticipated. The basic package of services includes: distribution of BCC educational materials; provision of Harm reduction consumables (condoms; sterile injecting materials), counseling/peer counseling, intensified HTC through a different approach such as facility based HIV testing, NGOs/Community based testing, Mobile outreach testing and referral services as required. In addition, despite of the fact that the algorithm of testing was updated in 2014, the National program with support of WHO will start the process of revision and amending the National HIV testing algorithm before the start up of NFM.

At the moment 11 mobile units provide testing 4-5 times per month. Furthermore, RAC has 21 TPs for PWID funded through the GF and other seven TPs funded under CDC. By the end of 2017 all RAC TPs will be performing HTC. Additional services to be provided to PWID can include referral other medical services, including STI diagnosis and treatment, legal and psychosocial support, referral to OST program. The services will be offered through trust points and outreach both by governmental services and CSO. The CSOs will play a central role by providing Harm reduction services, including referral and social accompanying to ensure linkage to medical, social and treatment services. (Please refer to Objective 4

[40] The size of prison population fluctuates and in previous periods it was between 6,000 and 14,000. The estimate of 10,000 is used for planning purpose, while the results will be reported against denominator based on current data in the reporting period.

under CSOs capacity development and support intervention 8.1 and 8.2).
Targets: PWID with their regular sexual partners – Y1 55%; Y2 60% and Y3 63%. In addition the HTC will be expanded to the regular sexual partners of PWID.

MODULE 1: Prevention programs for people who inject drugs (PWID) and their partners

The target population is people who inject drugs and their partners, including female PWID. People who inject drugs are exposed to HIV/AIDS transmission, hepatitis and other social burden like stigma and discrimination. According to IBBS 2014, the PWID have more prevalence of hepatitis than HIV/AIDS and in comparison to the other key population groups, which is shown in Table 7 below. At the moment, few organizations support hepatitis program among PWID.
The funding request to the GF will continue focusing on reducing Harm Reduction among PWID, focusing on control of HIV transmission. The program will be implemented countrywide. Overall, the program will be implemented in 45 Trust points (28 under National AIDS center) and 17 established under CSOs. Out of 28 RAC TPs, seven will receive financial support for administrative cost from CDC and commodities from the GF grant. The implementation approach will ensure provision of Harm reduction interventions; providing comprehensive package of services, which include conducting peer-to-peer or regular counseling, distribution of IEC materials and providing the sterile injecting materials (syringe, alcohol swabs, water for injection) as well as HIV counseling and testing. Additional services will be overdose management, STI treatment, legal counseling, and psychosocial support. Furthermore, under the frame work of this concept note it is envisaged to continue and expand OST activities in Tajikistan.

Table 7. Trend of HIV and Hepatitis C prevalence among key affected populations

	Prevalence of HIV among KAP			Prevalence of Hepatitis C among KAP		
Years	**2010**	**2011**	**2014**	**2010**	**2011**	**2014**
PWID	16.3%	13.5%	12.8%	27,8%	24.9%	22.7%
SWs	4.4%	3.7%	3.5%	5,7%	2.5%	4.2%
MSM	-	-	1.5%	-	-	3.9%
	2009	**2010**	**2013**	**2009**	**2010**	**2013**
Prisoners	8.6%	8.5%	8.4%	20.6%	18.1%	11%

According to the 2014 IBBS among PWID, the prevalence of HIV among PWID is 12.8%. The prevalence among male PWID is 12.2%; among female is 17.6%. But this gender breakdown of the prevalence is not mentioned in the report. To calculate that the row/tabulated data from the IBBS database was taken.

1.1. Behavioral change as part of programs for PWID and their partners

Behavioral change communication is one of the critical interventions and it is an integral part of the service package for PWID including prison inmates and their partners. According to the sentinel surveillance report 2014, the proportion of the

PWID who reported using condom in their last sexual intercourse have reached 86% and those who report using clean needles and syringes 90.3%. This demonstrates great programme achievements of previous years. At the present time there are not specific intervention targeting the partners of the PWID. The NFM programme will work to maintain the gains of the previous investment and expand the programme to female PWID and to sexual partners of PWID.

The proposed project will develop, distribute BCC materials and provide education and counseling to PWID and their partners in Tajikistan. The Activities under this intervention will be implemented through government run trust points, community based organizations, health service delivery points and outreach/peer to peer. Four types of BCC material will be designed for (i) harm reduction and HIV prevention, (ii) legal assistance and rights, (iii) OST services and (iv) drug overdose management. A technical working group will be established to ensure design, the content and relevance of the information to the target and the society.

TGF support under this Intervention is aligned with the assistance that will be provided by other partners (USAID, WHO, UNAIDS, OSI). The CDC program will support seven TPs with educational sessions and other services for PWID; and the GF NFM project will supply the TPs with commodities.

Activities

1.1.1. Development of standardized communication material on HIV prevention, legal protection and human rights for PWID and their partners by a working group

1.1.2. Provision of 82,236 BCC materials to PWID and their partners during the life-time of this project.

1.1.3. Training of peer educators and social workers on harm reduction case management

1.1.4. Conduct educational sessions for the PWID and their partners four times a year in each service delivery point (45 trust points)

1.2. Condoms as part of programs for PWID and their partners

In the last three years the HIV epidemic in Tajikistan started to spread mainly through sexual transmission mode. In 2013, the sexual mode of HIV transmission accounted for 58% of the reported HIV cases *(see Figure 1: Newly registered HIV infections by transmission route 2009-2013)*. It is critical to step up efforts for condom promotion and condom use among key populations. Condom distribution is part of the harm reduction package and it will be distributed through the existing service delivery points (trust points) as well as outreach activity.

Activities

1.2.1. Provision of sufficient quantities of condoms to PWID and their partners.

1.3. Diagnosis and treatment of STIs as part of programs for PWID and their partners

Although there is an improved level of prevention and behavioral change among PWID, certain number of the PWID are practicing unsafe sex. According to sentinel surveillance conducted in 2011, suggested that 10.4% of PWID were women (2,402), of whom 39% (936) reported providing sexual services for money. The TFM supported STI activity implemented by RCVD, for which 29 districts were served through Friendly cabinets. During NFM, out of 29 FCs: all will serve PWID, 10 out of them MSM and 18 out of them SWs.

Activities

1.3.1. Provision of client friendly STI services (screening, syndromic treatment) to PWID and their partners through 17 trust points (CSOs)

1.4. HIV testing and counseling as part of programs for PWID and their partners

In 2013, there were more than 9800 PWID tested, which represents 42% of the estimated PWID in the country. The WHO has recommended scaling up HIV test and ensuring treatment and caring pathways among key populations. Under this intervention the project is planning to provide HIV counseling and testing to at least 80% of reached PWID. This concept will continue to support 7 mobile HTC service and will strengthen the referral system of the PWID and their client to the HIV testing centers. It is planned to support CSOs to carry out the HIV testing at TPs. Furthermore, UNAIDS Tajikistan office plans to introduce two mobile HTC services for migrants and hard to reach population. The National Strategic plan is robust in scaling up HIV testing through exploring different resources.

Activities

1.4.1. Provide HIV testing and counseling to PWID and their partners through trust points and mobile HTC teams

1.4.2. Train health workers on client centered HIV counseling and testing (HTC), with focus on providing friendly services to key populations.

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

Under this intervention the proposed program is aiming at higher coverage and provision of comprehensive package. As of June 2014, the project reached 53% of the estimated PWID. At the end of the proposed project the project will reach more than 60% (14550) of the estimated (23100) number of PWID in Tajikistan.

Activities

1.5.1. Ensure coverage of 63% PWID by end of the program with safe injecting equipment through governmental and CSO run trust points, mobile medical units

1.5.2. Train CSOs outreach workers of the harm reduction on client management, referral and counseling

1.6. OST and other drug dependence treatment (PWID and their partners)

At the present time there are 5 OST sites in Tajikistan. Under the TFM grant it is planned to open 2 more OST sites. The CDC of USA is planning to open two additional sites. Under this intervention the proposed project will expand OST services by adding three new OST sites for provision of drug dependency and drug substitution treatment within the NFM which will make the total number of OST sites in the country to 12. There is a clear plan developed and endorsed by MOHSPP to address obstacles on way of OST expansion in Tajikistan. Currently this plan is under implementation and already has positive results: i) the revision of the OST guideline and development of the OST treatment protocol towards alignment with WHO recommendations are in process; ii) Inclusion of the Methadone into the list of essential drugs (the order is on stage of revision and endorsement by MOHSPP). Also, within the framework of this plan two new OST sites are opened and operational. As of 1st January 2015 overall 677 (3% of PWID) patients received OST. services. (Annex 3).

Activities

1.6.1. Provision of methadone therapy, referral to other services and psychosocial support to 1,000 PWID during the lifetime of this project through 10 sites

1.6.2. Establish and equip 3 new OST sites and provide additional equipment for existing sites. Provide regular monitoring of service quality and training of health workers.

1.6.3. Supply sufficient quantities of diagnostic kits for monitoring OST and medicines detox for PWID on OST.

1.7. Other interventions for PWID- Overdose prevention as a part of programs for PWID

The proposed activities under this intervention are aimed to reduce overdose related deaths. Naloxone will be available at Accident and Emergency (A&E) rooms of the major urban setting, harm reduction CSOs, and police stations.

Activities

1.7.1. Prevention of overdose through provision of sufficient quantity of naloxone for CSOs, A&E and police stations.

1.7.2. Train social workers (40) working in harm reduction programs; police personnel (120) and health workers (100) at Accident and Emergency departments on naloxone administration.

MODULE 2: Prevention Programmes for Sex Workers and Their Clients

The interventions of this module will be implemented within the allocation amount. The target population is sex workers and their clients. The program will be

implemented country-wide. Overall, the program will be implemented through 22 Friendly cabinets (11 under Republican Aids center) and 11 established under CSOs (depending on which and how many CSOs will be selected during the tender process). Out of 11 RAC friendly cabinets, the administration of one will be supported by US CDC, and commodities will be provided by the GF. The implementation approach will embrace providing minimum package of services, which include conducting peer or regular counselling, distribution of IEC materials and providing prevention materials (condoms, lubricants). Additional activities may include: social support, referral to medical and social services, referral to HTC and other medical services, including STI treatment, providing ART. These activities will be supplemented with monitoring and documenting human rights violations as well as legal aid services.

Starting from 2012, PR has been using an umbrella approach, in which one leading NGO works with several NGOs in the region. This approach ensures higher coverage of the target group, covering more geographical locations (districts) of the regions, which improves the access of the KAPs to the HIV services; the approach proved itself to be more cost-effective and finally, sharing knowledge, skills and supporting each other's activities by NGOs under the umbrella.

The NCC in collaboration with Republican AIDS center, the PR and other stakeholders will further improve the strategy to sustain gender-responsive programmes in area of harm reduction based on needs of different groups of PWID community. In particular, considerable attention will be paid to improved access to specific HIV services for PWID / SWs-PWID as a more excluded group of community. Based on reported data of NGOs working PWID, there are female-PWID only in Dushanbe and Sogd oblast; few female-PWID in Khatlon and no female-PWID in GBAO. Accordingly, to provide specific services to female-PWID, the PR will coordinate with partners to identify/estimate number of SWs who are PWID. In conclusion, the CCM proposed plan and strategy for improved access to services of SWs who are PWID within CN includes: (i) intensive outreach work to reach SWs-PWID and estimate number of them through NGOs working with PWID; (ii) distribution of HIV prevention commodities: female condoms, single-used gynaecological kits; (iii) possibility of provision of low-threshold services for SWs-PWID in drop-in centres.

2.1. Behavioral change as part of programs for sex workers and their clients

Activities

2.1.1. Ensure coverage of 65% SW and their clients by end of the project with comprehensive package of services through governmental and CSO run trust points, mobile medical units

2.1.2. Development of standardized communication material on HIV prevention, legal protection and human rights for SW and their partners by a working

group

2.1.3. Provision of BCC materials for SWs and their clients

2.1.4. Training of peer educators and social workers for SWs on HIV prevention, and case management including on referral to harm reduction services to SWs who use drugs.

2.1.5. Conduct educational sessions for the SWs and their clients four times a year in each service delivery point (friendly clinics)

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

In the last three years the HIV epidemic in Tajikistan started to spread mainly through sexual transmission mode. In 2013, the sexual mode of HIV transmission accounted for 58% of the reported HIV cases *(see Figure 1: Newly registered HIV infections by transmission route 2009-2013)*. According to the sentinel surveillance report in 2014, 79.5% of SWs reported using condoms in the recent sexual intercourse. Furthermore, 33.5% of the SWs stated that the reason for not using condom is due to client refusal to use it. It is critical to step up efforts for condom promotion and condom use among SWs and with special focus on their client. Condom distribution is part of the harm reduction package and it will be distributed through the existing service delivery points (trust points) as well as outreach activity.

Activities

2.2.1. Provision of sufficient quantities of condoms for SWs and their clients through governmental and CSO run trust points, mobile medical units.

2.3. HIV testing and counseling as part of programs for sex workers and their clients

The HTC will be based on medical centers (RAC, ARV clinics) and will also have community based testing approach. The latter will be done through Friendly Cabinets of RAC as well as mobile units, established within the AIDS centers.

Activities

2.3.1. Provide HIV testing and counseling to SW and their partners through friendly cabinets and mobile HTC teams

2.3.2. Train CSOs outreach workers of the SWs program on client management, referral and counseling

2.3.3. Train health workers on client centered HIV counseling and testing (HTC), with focus on providing friendly services to key populations.

2.4. Diagnosis and treatment of STIs (sex workers and their clients)

According to the 2014 sentinel surveilance report, SWs that reported having at least one STI symptoms were from 9.8% in Dushanbe to 98% in Kulyab town. In addition, one in five (22%) stated that they could not access access to STI services, where 15% of the participants did not know availability of services. Activities under this intervention are aimed to make STI service accessible, affordable, and available to SWs and their clients.

2.4.1. Provision of client friendly STI services (screening, syndromic treatment) to SWs and their clients through friendly cabinets

MODULE 3: Prevention programs for MSM

The interventions of this module will be implemented within the allocation amount. The target population is Men having sex with men. The implementation approach will embrace providing comprehensive package of services, which include conducting peer-to-peer or regular counseling, distribution of IEC materials and providing prevention materials (condoms, lubricants), referral to HIV counseling and testing, STI syndromic treatment. Additional activities may include: social support, referral to medical and social services, referral to HTC and other medical services, including STI treatment, providing ART. These activities will be supplemented with monitoring and documenting human rights violations as well as legal aid services.
Overall, the program will be implemented in 10 Friendly cabinets, established under CSOs, however, the number of FCs will depend on which and how many CSOs will be selected during the tender process.

3.1. Behavioral change as part of programs for MSM

Activities

3.1.1. Support CSOs to provide comprehensive package of services through 10 Friendly cabinets for MSM within Tajikistan (CSO grants)

3.1.2. Development of standardized communication material on HIV prevention, legal protection and human rights for MSM by a working group

3.1.3. Provision of BCC materials to MSM during the life-time of this project.

3.1.4. Conduct series of training for peer educators and social workers on MSM case management

3.2. Condoms as part of programs for MSM

Activities

3.2.1. Provide condoms and lubricants to MSM

3.3. HIV testing and counseling as part of programs for MSM

Activities

3.3.1. Provide HIV testing and counseling to MSM through AIDS centers and Mobile units

3.3.2. Train health workers and social workers on client centered HIV counseling and testing (HTC), with focus on providing friendly services to key populations.

3.4. Diagnosis and treatment of STIs as part of programs for MSM

Activities

3.4.1. Provision of client friendly STI services (screening, syndromic treatment) to MSM

MODULE 4: Prevention program for other vulnerable populations- prisoners

The target population is prisoners. The program will be implemented in 13 prisons in Tajikistan. In Tajikistan the prison population is estimated around 10,000, although it fluctuates between 6,000 and 14,000. The implementation approach will embrace providing comprehensive package of services, which include conducting peer-to-peer or regular counseling, distribution of IEC materials and providing prevention materials (condoms, lubricants), HIV counseling, testing, STI treatment, needle and syringes and OST. Currently, TFM project provides a package of services (IEC materials, education sessions and condoms) to 4,353 prisoners in 13 colonies of the country as well as provision of HTC. NSEP is provided in one of the colonies. Furthermore, under the USAID React project, AIDS Foundation East-West (AFEW) provides IBCC and prevention services to six colonies of the country with coverage of 4,200 inmates. The NFM project will build up on the existing results to achieve the goals of the NSP.

4.1. Behavioral change as part of HIV prevention programs for prisoners

Activities

4.1.1. Provision of IEC materials on HIV prevention, including STI and harm reduction to 55%, 67% and 78% prison inmates in each year respectively.

4.1.2. Conduct TOT for 260 peer educators in prison on HIV prevention

4.1.3. Conducting mini education session among 55%, 67% and 78% inmates each year respectively on HIV prevention and STI

4.1.4. Conduct series of training for 75 prison health personnel on prisoners case management

4.2. Condoms as part of HIV prevention programs for prisoners

Activities

4.2.1. Provision of condoms to 55%, 67% and 78% inmates each year respectively

4.3. HIV testing and counseling as part of HIV prevention programs for prisoners

Activities

4.3.1. Ensure coverage of 55%, 67% and 78% prisoners each year respectively with HIV testing and counseling through 13 prison health cabinets.

4.3.2. Train 15 health workers in the prison on client centered HTC with emphasis on communication with key populations

4.4. Diagnosis and treatment of STIs as part of HIV prevention programs for prisoners

Activities

4.4.1. Provision of STI services (screening, syndromic treatment) for 1000 prison inmates annually by end of the project

4.4.2. Conduct training of prison health personnel on STI case management in prison.

4.5. Needle and Syringe programs as part of programs for PWID in prison setting

In 2009, the first NSP pilot harm reduction in prison was started. The HIV prevalence in prisoners varied from 6.2% in 2005 to 8.4% in 2013[41]. Only 48% prisoners out of estimated 10,000 prisoners have been covered with prevention services.
Under this intervention the proposed program is aiming at scaling up of harm reduction services in prisons in Tajikistan.

Activities

4.5.1. Provide clean injecting equipment PWID in prison through 2 existing trust points and 2 newly established sites

4.5.2. Training on awareness of NSEP benefits for staff in penitentiary institutions and for prisoners in six colonies (two in Dushanbe and others in the regions).

4.6. OST and other drug dependence treatment prisoners

At the present time there is no OST program in prisons in Tajikistan. Under this objective the proposed project will support initiatives for establishing pilot OST project in prison. Under this intervention the project will conduct needs assessment for OST services in prison and develop pilot OST project in prison.

Activities

[41] RAC data , 2014

4.6.1. External technical assistance to conduct harm reduction needs assessment in prison and develop OST pilot project.

4.6.2. Train prison health workers on OST management

4.6.3. Provide equipment and improve infrastructure for 2 OST sites

4.6.4. Provide methadone maintenance therapy to 50 PWID in prison

4.6.5. Procurement of diagnostic kits for regular examination of patients on OST

4.6.6. Provide psychosocial support to OST clients (counseling, referral to clinical services by peer educators).

Objective 2: Ensure quality treatment and care for the people living with HIV/AIDS

Under this object the project will support (i) scaling up of ART and treatment of opportunistic diseases for PLHIV, including HIV infected TB patients, pregnant women and children born to HIV positive mothers (ii) Increase the proportion of eligible PLHIV who have access to psychological, nutritional, social and economic Support and (iii) Strengthening TB/HIV collaboration.

The program aims to increase the coverage of PLHIV including the people with TB/HIV co-infection, adults and children from 16.1% by 178% of estimated population of PLHIV eligible to ART by end of 2017. The intervention under this objective will address long term adherence to treatment through social protection and psychosocial support. This activity will be implemented by RAC and CSOs working with PLHIV. The proposed project will improve the follow up on those who were identified as HIV infected but not enrolled in care, social accompanying for key populations, formalize and scale up use of peers/ social workers to locate LTFU patients after diagnosis as well as improving early initiation of ART with clinical symptoms has been identified (codes 113 and 117).

As of June 2014, there were a total of 6152[42] registered PLHIV cumulatively. This represents 42% of the estimated number of PLHIV (14000). Up to 20% of those started ARV have died, which indicates delayed ART therapy. In addition 12% of the ART patients have stopped the treatment. The main cause of the stopping treatment is migration or lost follow up (see table 5. HIV care and treatment). At the present time ARV therapy program is managed by the national AIDS center. RAC provides HIV and care treatment to PLHIV. PLHIV are relatively satisfied to get such services from the RAC. However, this approach has some systemic weaknesses. Firstly, the RAC is not part of the curative services of the MOHSPP structures and cannot provide inpatient services to patients. Secondly, although the RAC is willing to continue to provide services to PLHIV, its current capacity is limited and would need more trained health and social workers. This project will strengthen the capacity of the 43 AIDS centers and five infectious disease clinics that provide ARV treatment services. In addition, during the duration of this project OST, ART and TB services will be integrated in certain number of service provision points.

Interventions under this objective will be implemented nation-wide. The project is

[42] RAC report, June 2014

prioritizing to reach key population and PLHIV who are in need of care and treatment.

Table 7: PLHIV care and treatment as of December 2013

Total Number of PLHIV registered	5550
Under care	2717 (49%)
Number of ART patients prescribed ART therapy	2143 (39%)
Number of patients stopped treatment (lost follow up, poor adherence and side effects)	297 (14%)
Number of patients who died	445 (21%)
Alive under treatment as of June 2014	1403 (65%)

MODULE 5: Anti-retroviral therapy (ART)

Activities under this intervention are aimed to scale up ARV treatment, patient enrollment and retention. While scaling up the treatment and care, the project will address the capacity of the health service delivery, promote patient centered care and treatment; improve referral of PLHIV and Key population to access lifesaving ARV therapy. The activities under this module will also include improving the pre-ART care such as regular CD4 follow up, adherence and linkages, as consultations to PLHIV who do not receive ART. Furthermore, the new National ART guideline is updated in correspondence with 2013 WHO guideline in 2014 and MoHSPP has endorsed it. In addition, with regards to 2013 WHO guideline the following changes were included into the National guideline:

- ✓ Patients in clinical stages 1-2 with CD4= 500 level and below that are ready/agreed to start ART;
- ✓ Patients in clinical stages 1-2 with CD4 350 level and below;
- ✓ Patients in clinical stages 3-4 regardless of CD4 level;
- ✓ Patients with co-infection of HIV/TB regardless of CD4 level;
- ✓ Patients with co-infection HIV/hepatitis, who have destructive changes in kidney regardless CD4 level;
- ✓ Discordant pairs regardless of CD4 level;
- ✓ Pregnant women of reproductive age regardless of CD4 level (option B+);

The gradual movement from previous regimens of treatment to FDCs and reducing the consumption of suspension forms of ART drugs in favor to tablets have been already started in 2014 and is currently going on. RAC will control this process throughout the project.

5.1. Anti-retroviral therapy (ART)

Table 8: Projection of ARV therapy expansion

	2015	2016	2017

Estimated number of HIV positive people	14972	15581	16208
Under care	9800	10500	11200
ART Eligible	9803	10287	10800
Adult eligible	2720	3425	3994
Children eligible	749	796	844
Targets in CN	3469	4221	4838

The target in the CN is calculated based on spectrum and WHO recommendation with ambitious plan of the Republican AIDS Center to accelerate ART therapy. Based on the current capacity issues, the urgent need to strengthen the capacity of the health system and available financial resource for the national HIV response, the MOHSPP made informed decision on the pace of the planned scaling up of the care and treatment. Furthermore, due to limited resources the request to Global Fund focuses on targeted HIV testing among KAP. The country is also in the process of preparation for endorsing the new WHO recommendation CD4 limit of 500 to initiate ARV treatments.

Activities

5.1.1. Increase coverage by ART by reaching 4,838 of ART Eligible PLHIV by 2017, which is 178% increase from the current performance

5.1.2. Integrate ARV services to TB and reproductive health centers. A new USAID Regional Grant is also planning to cover integration of services

5.1.3. Train 120 pulmonologists and infection disease specialists, and 50 nurses on ART patient management. The infectious disease specialists will have the overall patient responsibility with task delegation to Nurses and social workers.

5.1.4. Provide psychological support to PLHIV (counseling)

5.1.5. Systematic follow up on lost to follow up patients through peer educators and social workers

5.1.6. Provide social protection to PLHIV and their families (The Government will support this activity and provide 50USD per month for families with HIV positive children).

5.2. Treatment monitoring

Activities under this intervention area are aimed at improving the health status of the PLHIV who are receiving ART. Currently, around 20% of cumulatively enrolled ARV patients died. In order to achieve long term adherence and delayed potential

treatment failure require routine clinical and community level treatment monitoring. So far, the country has one PCR machine, which was not covering 100% of ART patients countrywide due to technical and resource related challenges as well as geographical locations of AIDS centers. However, in NFM, RAC will continue providing the same VL testing in the same capacity. However, once the second PCR machine is procured, RAC be obliged to cover all ART patients with VL testing twice a year. CD4 testing will be done for all patients coming to pre-ART care twice a year.

The country has been implementing an enhanced electronic surveillance system for HIV cases. Once the system starts working cohesively in all districts and regions of the country, and the information on each patient is entered into the system timely and accurately (clinical examination, CD4, treatment regimen, substitution treatment, side effects, etc.), the necessary information about KAPs will be available and will be monitored adequately.

Activities

5.2.1. Ensure coverage with required testing in pre-ART (CD4 twice per year) and during ART (VL and CD4 testing twice per year per ARV patient)

5.2.2. Procure a PCR machine for VL testing for Sogd and Khatlon oblast

5.2.3. Support HIV laboratory quality assurance

5.3. Treatment adherence

The proposed project is planning to improve the long term adherence of the ART patients through self-support groups, ART clinic adherence sessions and monitoring.

Activities

5.3.1. Conduct weekly clinic based ART adherence sessions for PLHIV on ART from key populations

5.3.2. Establish and support self-support groups at each ART health facilities (monthly sessions at CSO/ health facility)

5.3.3. Develop tools for adherence monitoring

5.3.4. Provide adherence support equipment (pill boxes, timers, reminders etc.)

5.3.5. Print ART education material for PLHIV

5.3.6. Print medical recording and reporting material

5.4. Prevention, diagnosis and treatment of OIs

Majority of the HIV infected people in Tajikistan are PWID. This group has high HCV prevalence. This project will not provide HCV treatment in line with GF decision. The proposed project will support prevention diagnosis and treatment of OIs (PCP, GI infections, skin infections and TB).

Activities

5.4.1. Train 60 health workers on OIs management

5.4.2. Procure essential medicine of OIs management

5.4.3. Develop monitoring tools for OIs management

5.5. Counseling and psychosocial support

Psychosocial interventions are integral part of the treatment and care services. Most PLHIV are PWID or members of other key populations and vulnerable groups and require psychosocial support to facilitate adherence to lifelong treatment. The proposed project will support counseling on treatment adherence, legal support and referral to the other social services. Recently approved government social protection scheme will provide a monthly cash transfer of 50USD to children living with HIV.

Activities

5.5.1. Support CSOs to provide counseling services on social issues to the key populations and PLHIV

5.5.2. Develop user service guide, which includes information about patients' rights relating to access to medical and social protection service and contact information of existing services.

5.5.3. Develop checklist/job-aid for service providers to assess the specific needs of the client

5.5.4. Train 60 social worker on client management and social accompanying

5.6. Out-patient care

The current OP care is fragmented and does not provide comprehensive continuum of care to PLHIV. The PLHIV face difficulties in receiving treatment services in general public health care system. The proposed project will support integrated care and treatment service by establishing 5 integrated ART treatment and care centers (centers of excellence), and improve referral system. Activities under this intervention will be implemented as part of the HSS service delivery

block.

Please note that majority of the activities below are also available in most of the current ART sites at different level of integration per the context of the site. The center of excellence will serve as a model of effective integration of comprehensive HIV care which also serves as a reference to other ART sites.

Activities

5.6.1. Train 20 health workers working in the 5 centers of excellence on integrated health service

5.6.2. Recruit external technical assistance to develop clinic protocol and checklist of the integrated service.

5.6.3. Provide consumables and hygiene kits to the 5 centers of excellence

5.6.4. Establish appointment system for ART patients. The patient support group budgeted under CSO grant will be trained and supported with referral formats for follow up.

5.6.5. Support CSOs to support adherence and tracing lost follow up.

5.6.6. Train CSOs on treatment adherence support of the PLHIV

5.6.7. Strengthen patient reporting system of the referral system of the PLHIV pre-ART and those receiving ART and other service OST, NSEP TB, and OIs treatment at AIDS centers.

5.6.8. Strengthening continuation of HIV treatment and care started in ANC/ID hospitals/TB hospitals/ prison health, etc. in particular for key populations (incl. social accompanying for key populations by peers/ social workers; operational follow up by AIDS centre, actively using community-based organizations to facilitate the linkage)

5.7. In-patient care including palliative care

At the present time, PLHIV in Tajikistan have limited access to in-patient service. In-patient services are either expensive or stigmatized. In addition, palliative care of chronically ill patients and people with disability who live with HIV is not available. Palliative care in HIV is vital to address the high burden of pain, medicine side effects, immune reconstitution inflammatory syndrome and co-infection of hepatitis C and TB. Activities under this intervention are attempting to identify and support hospitals and health facility that provide quality in-patient service for PLHIV.

Activities

5.7.1. Train 15 health workers and 15 social workers on palliative care of chronically-ill patients

5.7.2. Support in-patient care of PLHIV and provide treatment to manage pain

5.7.3. Support in-patient care of PLHIV and provide food support

5.7.4. Provide counseling to PLHIV including those who live with disability

5.7.5. Support patient health education and self-care skills for managing symptoms and medicine side effects in the home and recognition of danger signs.

MODULE 6: PMTCT

PMTCT is one of the priority module selected by NCC and national stakeholders. Prioritization of PMTCT is also accompanied with clear strategies and vision of the National AIDS centre as described below. In order to ensure Tajikistan will achieve the global e-MTCT goal, the country has accepted and signed introduction of early testing of infants born to HIV+ mothers with dry blood sampling collection. The introduction is also supported with the MoHSPP decree, # 14, from 14.01.2014. With the support of Russian grant and UNICEF, it is planned to train the staff on doing testing with dry blood sampling. This will ensure all new born infants in the country will be tested within the 48 hours and 4-6 weeks after the birth. Due to this national strategic vision, the country has set high targets for 2015, 2016, 2017 as indicated in the modular template. The intervention strategy will be implemented countrywide mainly: (1) To include provision of consultations to mothers with HIV and their children, providing ART treatment; if they are hospitalized, provision of food parcels; providing legal and social support if required, such as consultations to receive financial support to children with HIV from the social support services, etc. (2) Support will be provided based on the 38 AIDS centers located in various country regions and districts, as well as 5 ARV clinics. In conclusion, a steady increase of HIV incidence in pregnant women and children born to HIV positive mothers along with recent change in epidemiological trend call for sustainment and scale up of HTC and ART coverage in the context of PMTCT. Proposed funding request plans to maintain present coverage (71.4%) of pregnant women with HTC but intensify performance of HTC in antenatal care facilities, as at present about 40%[43] of HIV cases are detected during delivery. The indicative funding will also support procurement of protective kits for maternity homes and infant early diagnostic kits. Furthermore, it will attempt to ensure at least 80% coverage of newborns with ART born to HIV positive mothers *(see target in table 8).*

6.1. Treatment, care and support to mothers living with HIV, their children

Activities

[43] RAC data, 2013

6.1.1. Provide ARV treatment to all eligible children by the end of this project.

6.1.2. Support scale up of pediatric ART by training 50 pediatricians on pediatrics ARV management

6.1.3. Procure early infant diagnostic kit

6.1.4. Provision of ART for pregnant women during the life time of the project

MODULE 7: TB/HIV

Since 2011, Tajikistan made a significant progress for TB/HIV services. In 2013, almost all TB patients were provided HIV testing. In addition the referral system for TB screening for PLHIV has also increased. The activities will further strengthen the referral system and service integration. Under the TB CN, it is planned to procure 35 GenXpert machines of which five will be provided to main AIDS centers. The NTP will provide TB testing to PLHIV by using GenXpert. The RAC and NTP will develop procedures for sample transport. The program will invest in refinement of the TB/HIV integration by development and implementation of phased plan, enforcement of HIV/TB treatment protocols adherence, provision of HTC to TB patients and timely diagnostics of TB amongst PLHIV.

In order to facilitate timely detection and, further, ensure quality treatment of HIV-associated TB, rapid HIV testing assays will be procured for all TB institutions and will be used in diagnostic counseling and testing of TB patients for HIV. For treatment antiretroviral medicines will be provided by the National HIV/AIDS Program, while TB drugs (including isoniazid for IPT) and GenXpert MTB/RIF technology for testing PLHIV for TB will be provided through the NTP. It is foreseen to perform GenXpert MTB/RIF testing at five sites in the HIV/AIDS service: at four regional AIDS Centers in Khujand, Kurghonteppa, Khorogand Kulyab, and at the Republican AIDS Center in Dushanbe. In GBAO, given the substantial distances to reach the region's capital, Xpert testing in TB suspects among PLHIV will be carried out by the NTP facilities at the district level where Xpert instruments will be placed; the same applies to the RRS. Appropriate training on practical issues related to Xpert rollout will be provided for medical staff involved in Xpert testing at four AIDS Centers.

According to National protocol, all HIV positive people should be screened for TB infection in each visit to the doctor. Up to date, HIV positive patients are referred to TB settings for collecting sputum, i.e. for passive method of screening. Once sputum is collected it is tested for TB infection. If the result is positive, the sputum additionally tested for MDR TB (by GenXpert machine, GenXpert-rif method). In prison settings, all HIV positive inmates go through active method of screening, i.e. fluorography. If inmates present symptoms of coughing, they also go to passive method of screening, i.e. sputum checking as well. Within the proposed Concept Note, the country will strive to improve the situation of screening by procuring and installing GenXpert machines for five biggest AIDS centers of the country. The patients will have access to TB screening in the HIV settings. As for the remaining AIDS centers of the districts, the previous scheme of referral and/or transportation

of sputum collected from the patients on sites will be organized to the AIDS regional centers, where GenXpert machines will be established.

7.1. TB/HIV collaborative interventions

The funding from NFM will be made available for the following main activities:

Activities

7.1.1. Support TB/HIV coordination's at all level: national, regional and district level

7.1.2. Procure HIV test for 7000 TB patients per year

7.1.3. Train health workers on HTC and TB/HIV co-infection management

7.1.4. Train CSOs on HTC and TB/HIV co-infection adherence support.

7.1.5. Support to sample transportation for TB testing (to be supported through TB CN)

7.1.6. Integrate TB diagnosis and treatment at selected AIDS centers.

Objective 3: Health System Strengthening

Health system strengthening component will mostly finance M&E activities, gathering of strategic information including needs analysis and documentation of impact and good practices of programmes and policies. More specifically it will support implementation of BSS, population estimation surveys, operational research on the quality and package of impact of services, NASA and ensure presentation and dissemination of results to the wide range of stakeholders.

Since collapse of the soviet union Tajikistan faces chronic shortage of qualified human resources at public health service providers. Continuous medical education programs on HIV prevention and control doesn't exist. The motivation of human resources is further aggravated by law wages resulting in brain drain and challenges with staff retention. In response, this concept note will address human resource capacity building through provision of trainings planned under objective 1 and 2 of this concept note.

The overall purpose of the HSS is to optimize health service delivery and infection control through service integration and optimization of human resources. In regards with improving the service delivery, the main considerations include integration of services such as TB/HIV, OST, community engagement, and others. The main activities under HSS includes: 1) establishing 5 centers (2 in 2016 and 3 in 2017) of excellence to provide integrated care and treatment service to PLHIV and key populations (ART, OST, TB and OIs management) in and out-patients services. The five centers will established in the locations with the highest prevalence of HIV infection in the country: Dushanbe city and 4 main regional centers: Khujand, Kurgantube, Kulyab and Khorog; 2) Support accreditation of the 5 centers of excellence; 3) Support CSOs provide counseling services on social issues to the Key populations and PLHIV; 4) Strengthen TB/HIV referral system

through development of job aid, checklists and referral forms and guidelines; 5) Strengthen HIV testing of Key population through referral and joint HTC by CSOs and AIDS centers; 6) Step by step actions to dispense ART on site in all OST centres and dispense OST medicines in AIDS centres if no other options of OST dispensing exist in a district.

In regards to optimizing the human resources, it is planned to provide technical assistance to optimize health service delivery approaches and organization to through strengthen management capacity through delegating prescription of ART to trained infectious disease specialists at infectious disease hospitals as well as delegating non clinical works from ART clinicians to administrative staff.

The main activities to improve optimization of human resources include: 1) Provide technical assistance to develop ARV clinic triage and delegation of work flow procedures; 2) Introduce patient appointment system; 3) Recruit external TA to review ART clinic processes and reporting system and simplify the ART clinic procedure.

The above activities are budgeted under the relevant modules in the CN. However, some of the activities such as, operational researches, population size estimation assessments, IBBS, NASA, and others are to be financed by other donors and the resources of the government.

Objective 4: Strengthened supportive environment to improve access to services for Key Population

This module will support management of the CSO organisations (including umbrella organizations) to ensure effective outreach activities for Key populations. A need for further enhancement of CSO capacity has been identified during the situation analysis. Intervention under this object will focus on CSO capacity development, human rights and HIV and strengthening legal environment.

MODULE 8: Community systems strengthening

8.1. Institutional capacity building planning and leadership development

The NCC and national stakeholders has selected community system strengthening as one of the priority module for the Concept Note submission. The main target populations are all stakeholders and beneficiaries of the HIV program; have impact on all geographical areas of the country. This module is focused on the approach to enhance the capacity of Community based organizations, i.e. Civil society organizations to conduct Country level activities, strategies and grant implementation. However, the role of the civil societies in the implementation of the grant has been taken as a main priority of the NCC and the specific roles of the civil societies in scaling up community based HIV testing, outreach services, community linkage and adherence support etc are explained in detail per each module and interventions in the Concept Note. In order to ensure the institutional capacity of the civil societies and NGOs is adequate to support the implementation of the grant, the following strategies in strengthening their capacities will be undertaken: a) Support to CSOs advocacy and policy engagement to strengthen enabling environment for HIV response through provision of small grants to CSOs; b) Support CSOs to advocate for increased domestic funding for HIV/AIDS

response through provision of small grants to CSOs; c) Support quarterly review meeting and planning for CSOs and Government at service delivery points; d) Support CSOs participation in national and international dialogue and conferences; e) Creation of web portal to enhance coordination and mobilization activities; f) Support capacity development of CSOs on program management, PSM, finance and monitoring and evaluation, including provision of training; g) Develop electronic software on financial management system for 15 CSOs. Hence,the proposed intervention will support capacity development of CSOs in HIV/AIDS prevention and Key populations related issues. In 2013 the MoHSPP has endorsed and widely disseminated a national Capacity Development and Transition Plan. During 2014 some part of the plan was implemented through financial support of UNDP and other partners. During the NFM period, the CCM will continue mobilizing resources to finalize the implementation, revise the plan as required.

Activities

8.1.1. Support capacity development of CSOs on program management, PSM, finance and monitoring and evaluation, including provision of training.
8.1.2. Develop electronic software on financial management system for 15 CSOs

8.2. Social mobilization and building community linkages, collaboration and coordination

Activities under this intervention will make available grants to communities for the development of PLHIV community initiatives. The CSOs will be an active player amongst other partners in implementation of activities during World AIDS and AIDS Memorial days and will also advocate for addressing key issues affecting the communities they represent. CSOs will get funding for organization of regular regional CSO meeting/workshops as well as for organization of national CSO conference in 2016.

Activities

8.2.1. Support to CSOs advocacy and policy engagement to strengthen enabling environment for HIV response through provision of small grants to CSOs
8.2.2. Support CSOs to advocate for increased domestic funding for HIV/AIDS response through provision of small grants to CSOs
8.2.3. Support quarterly review meeting and planning for CSOs and Government at service delivery points
8.2.4. Support CSOs participation in national and international dialogue and conferences
8.2.5. Creation of web portal to enhance coordination and mobilization activities.

MODULE 9: Removing legal barriers to access

Only few studies were conducted to identify the Gender based violence (GBV) rate in Tajikistan. In 2005, a study conducted by WHO showed 42% of women reported

sexual violence in their lifetime[44]. According to the data, of the state women committee of 2012, about 19,000 victims of violence, half of them women, were registered and received assistance from crisis centers existed in the country. The 2012 study showed that 94.8% of women living with HIV face stigma and discrimination, while among men it was 85.7%. Activities under this intervention area will support anti-stigma and discrimination toward PLHIV, uphold human rights and health care for all and capacity development on human rights and gender equity aspect of HIV in Tajikistan.

9.1. Training on rights for officials, health workers and police

Activities:

9.1.1. Develop guidelines, job aid and checklist for law enforcement staff to prevent violence against women and vulnerable groups, including PWID, SWs, MSM, links between violence and HIV and support for victims of violence
9.1.2. Organize quarterly round table dialogue with representatives of law enforcement agencies to achieve high-level support for the development of programs to prevent violence by law enforcement staff.
9.1.3. Conduct a series of trainings on HIV, prevention of violence against women and key population for law enforcement officials
9.1.4. Train staff of the crisis centers on the issues related to HIV prevention, care and treatment to provide referral to HIV services.
9.1.5. Conduct a series of training for medical personnel, staff of friendly clinics and CSOs and other service providers on case management of the victims of violence (medical, legal, and referral to the existing social protection and services.
9.1.6. Develop and disseminate information about the existing services (crisis centers, legal support, and psychosocial support)
9.1.7. Conduct training for judges on human rights and HIV
9.1.8. Organize workshop for national and subnational Ombudsman offices and branches on human rights and HIV.

9.2. Legal and policy environment assessment and law reform

Activities under this intervention will review the existing legislation, including secondary legislation, as well as and policies and promote legislative reform creating enabling environment and improving access to services for key populations. UNAIDS and UNFPA has been conducting a legal environment assessment (LEA) in HIV prevention, care and treatment among key populations following the incidents happened to SWs in June 2014. In June 2014, a number of key Population organizations and human right activists reported the legal barrier for SWs and LGBT which in long run would affect the program implementation.

[44] Violence Against Women In Marriage: A General population Study In Khatlon Oblast, Tajikistan, 2005

However, Tajikistan CCM, UN agencies and other partners took an immediate action which improved the situation. Such interventions included the following:

- UN agencies through the Office of the Resident Coordinator presented the issue to high level government officials which were positively accepted by the Government.
- Following the voice of the Key Populations, the Civil societies, activist group and UN recommendations, the CCM invited the Deputy Minister of Ministry of Interior Affairs to the CCM meeting to reaffirm the position of the government that the human rights are respected and the HIV project implementations will also be supported per the National laws.
- By the end of 2014, UN JAP (a joint program of several UN agencies, such as UNDP, UNFPA, UNAIDS, UNICEF, WHO) with financial support from the UNDP Regional Centre for Europe and CIS conducted series of educational activities directed to raise awareness of the national partners on legal issues associated with HIV/AIDS and harm reduction programme among vulnerable groups of population (including SWs). The special round table and educational sessions have been conducted with participation of law enforcement representatives, representatives of local authorities, national service providers in order to minimize the potential risk towards legal aspects of high-risk groups of population".
- As mass media plays an important role in addressing legal issues in regards of KAPs. Thus, UNJAP organised special workshop for Mass-media representatives in order to overcome stigma and discrimination of KAPs associated with HIV/AIDS.
- UN agencies provided their commitment to support HIV legal environment towards KAPs as a one of the priority area for upcoming UNJAP activities framework for 2015.
- A joint task force established on the case has already conducted a LEA (Legal Environmental Assessment) which will be implemented during the NFM period. The field work of LEA has completed and it is on the stage of data analysis and report development.

Furthermore, the PR in collaboration with RAC will further conduct analysis and design how to better reach the hidden key populations to increase service utilization.

Activities

9.2.1. Conduct legal environment assessment (LEA) in HIV prevention, care and treatment among key populations
9.2.2. Conduct national round table dialogue for LEA
9.2.3. Develop human rights guidelines on HIV for judges and law enforcement institutions
9.2.4. Develop monitoring tools and reporting forms for HIV related

human rights violation

9.3. Legal aid services and legal literacy

9.3.1. Support quality free legal aid services for key populations (PWID, SWs, MSM)

Objective 5: Program Management

The indicative funding of this concept note will support program management including support capacity development and management cost of the national AIDS center as the main SR of this concept note, and PR administration and operational cost.

MODULE 10: Program Management

10.1. Capacity development

Since 2005, UNDP Tajikistan has supported capacity development. In 2012, based on capacity assessment result UNDP assisted the government of Tajikistan and MoHSPP to develop a national capacity development intervention. The plan consisted of three interlinked implementation phases. In 2013 and 2014 the phase I of the capacity development plan was implemented, which include the following key interventions were implemented

a) Review of organizational structure including implementation modality, roles and responsibility of the National AIDS center personnel.
b) Development of SOPs on HR oversight, PSM, M&E and finance
c) Established electronic financial software (C1) in 15 National centers
d) Human resource policy including recruitment procedures
e) Conducted financial sustainability study for national HIV/AIDS program
f) Reviewed legal framework on the impact of WTO accession for the procurement
g) Developed electronic HMIS for the national HIV/AIDS

The implementation of the phase II & III of the CD plan requires funding. The indicative funding of this concept note will support the following activities.

Activities

10.1.1. Implement the National capacity development and transition plan (CDTP) for RAC, CSOs and local NGOs. The activities include capacity assessment to evaluate the impact

10.1.2. Conduct series of training for the RAC and CSOs on the developed procedures and SOPs during phase I

10.1.3. Continue resource mobilization to finalize the implementation of CDTP which includes adopting SOPs for CSO on HR management, monitoring and evaluation and financial management.

10.2. Supporting procurement and supply management

One of the main components of the National health system strategy is improving Supply chain management system, promoting quality of medicines (PQM), improving regulatory experience and pharmaceutical quality assurance as well as positioning the country to the accession of the World Trade Organization's membership to ensure access to affordable and quality medicine. Furthermore, the main element of the GF resources is directly invested on procurement, supply and chain management.
The main activity under this intervention is:

10.2.1. Capacity building of national partners on procurement and supply chain management to promote quality of medicine and sustainability

10.3. Grant management

Activities under this intervention is to support grant management costs of PR (UNDP) and RAC (main-sub-recipient of the project) *(please see detailed budget and work plan)*

3.3 Modular Template

Complete the modular template (Table 3). To accompany the modular template, for both the allocation amount and the request above this amount, briefly:

a. Explain the rationale for the selection and prioritization of modules and interventions.

b. Describe the expected impact and outcomes, referring to evidence of effectiveness of the interventions being proposed. Highlight the additional gains expected from the funding requested above the allocation amount.

Rationale for the selection and prioritization of modules and interventions

The epidemiological situation, effectiveness of prevention activities implemented during national response and availability of funding largely informed prioritization of key interventions, location and/or intensity of interventions as well as key target populations for the indicative funding. The NCC has established a technical working group that oversees the development of this concept note. The NCC organized a prioritization meeting (Annex 4).

Based on the goal of the concept note to achieve universal access to HIV services; prevention, care, treatment and support, 10 modules were selected and prioritized accordingly. The prioritization was also informed by the current epidemic response of the country as well as recent WHO regional office review conducted for National HIV program. The 10 modules described in the Modular Template are as follows:

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

2. Prevention programs for sex workers and their clients

3. Prevention programs for MSM
4. Prevention programs for other vulnerable populations (prisoners)
5. Treatment, care and support
6. PMTCT
7. TB/HIV
8. Community systems strengthening
9. Removing legal barriers to access
10. Program Management

The prioritization and selection of the modules is described as follows:

A) **Key Affected Population Groups:** the NCC has identified four priority modules namely prevention among PWID, SWs, MSM and prisoners in this group. At the present time the HIV epidemic still remains to be largely driven by drug injecting male population, albeit 44% increase in the heterosexual transmission and 54% increase of vertical transmission are reported, whereas number of cases with injection transmission decreased. All sex workers are at high risk of HIV and STI infection. HIV is more common among sex workers who inject drugs, or who have intravenous drug user partners. Although HIV prevalence among MSM is low, due to the highly stigmatized context, most MSM are living bisexual and every six MSM in ten report having sexual contacts with both male and female partners thus raising risk of HIV case increase in their female partners. There is a high prevalence both for unsafe sexual and injecting practices within prison walls. Prisoners also serve as a bridging population. Once they are released back into the general community, they return to family and community, carrying any infections they have acquired while incarcerated. While past experience revealed steady increase in percent of PWID who report use of sterile injection equipment and condoms during last intercourse, the share of SWs reporting the use of a condom with their most recent client has declined. 67.8% of MSM surveyed reported using a condom during their last anal intercourse. The stigma and discrimination along with legislative barriers makes MSM and SWs hard to reach population to be targeted with BCC activities. In this context MSM sex workers as well as their sexual partners need special attention. Such programs can only work effectively if implemented by community groups themselves. Furthermore, acceleration of preventive activities during the last five years displays positive results corroborated by decline of PWID who live with HIV from 17.3% 2009 to 12,8% in 2014 and decrease of HIV cases in SWs by 1.19 times in 2013 compared to 2012. However increase of share of sexual transmission in new cases indicates a need for acceleration of preventive activities for PWID, SW and MSM. Targeting strategy for preventive activities will be mainly guided by geographical distribution of HIV cases and key populations. In case of PWID preventive activities will be intensified mainly in GBAO, Dushanbe and Khatlon, while for SWs and MSM priority will be

given to Sogd, Khatlon and regions of republican subordination, including Dushanbe.

Over 80% of the NSP budget is directly linked with HIV prevention interventions among key affected populations.

Furthermore, the National investment case model (Annex 5) indicates strategic investment on prevention of HIV through increasing access to HIV testing and services among key affected population is cost efficient investment both to save lives of PLHIV as well as promote the development of the country.

In this CN as the scenario 3 is impossible due to lack of allocation, the interventions are targeted to second scenario in optimizing the current investment allocations by mainly focusing on the epidemic drivers, key affected populations (PWID, SWs, MSM and prisoners).

B) Increased access to care, support and treatment including ART, TB/HIV and PMTCT

Despite the low coverage of PLHIV with ART treatment and adherence, AIDS mortality rates in Tajikistan are declining. In order to support the given trend, further increase in retention and ART coverage will be supported under the indicative funding. In this regard the NCC has prioritized three modules focusing on increased access to treatment (ART, TB/HIV and PMTCT).

PMTCT: According to the UNGASS report 2012, the percentage of HIV-infected pregnant women, who received ART to reduce the risk of HIV transmission from mother to child ranged from 82% (national statistics) to 56.1% (spectrum analysis). The limited capacity among local specialists involved in ANC in this area and periodic shortages of rapid tests are some of the biggest factors impeding PMCTCT scale-up in the country.

PMTCT is now fully integrated into the routine work of antenatal care and maternity services which requires training primary health care staff to conduct HIV counseling and testing in pregnancy, and ensure access of women living with HIV to adequate services. Operational research is needed to understand implementation weaknesses, prevent vertical transmission and save the lives of the children.

ART: National policy provides equal access to ART for adults and children, men and women free of charge.

ART is provided in 38 AIDS centers and five infectious disease clinics. As of June 2014, a total of 1,735 patients receive ART across the country, including 1040 men and 695 female. The latest estimates generated in 2013 indicate ART coverage of 15.7% out of 8,900 individuals who are in need of ART. CCM Tajikistan has made an informed decision in order to scale up the treatment coverage by 178% to reach 4,838 patients on treatment as compared from 1,735 patients who are currently on treatment.

In recent WHO Euro Regional mission to Tajikistan it was recommended to scale up treatment and reach 6,000 patients by 2017, while the NCC has selected the module as one of the top priority, however, due to the following reasons it would be unrealistic for Tajikistan to achieve 6,000 patients on treatment by 2017.

- Timing of New Funding Model: The New Funding is for 27 months and the ART scale up requires a significant interventions and time to make necessary changes such as amendment of Policy, Guidelines, training of health workers,

establishing and upgrading ART sites, strong psycho social program to reduce stigma and discrimination, etc.

- According to UNAIDS Global Report for the year 2012[45], twelve month retention on ART of children and adults represents 74%. These cumulative numbers do not allow assessment of the actual situation with patients' flow and their retention on ART, and this approach needs to be changed. During the New Funding Model the RAC will mainly focus in improving retention and adherence as well as highly accelerated scale up of treatment services by 178% from June 2014.
- New WHO 2013 criteria on ART initiation using 500-cells/µl cut-off mean that a much greater proportion of PLHIV will meet the eligibility criteria and Tajiksitan has not yet adopted this guideline due to fact based reasons.

Despite the reasons mentioned above the NCC and RAC has still decided to plan a very ambitious target for ART.

C) Strengthen the Health System and legal environment

This category identified three modules namely Community Systems Strengthening, Removing Legal barriers to access and Program Management.

The NCC selected these modules as priorities due the existing challenges of the health system and the legal environment to achieve the set targets and goal. The main challenges considerations include the following:

Legal barriers limit PWID, SWs and MSM to access a required HIV prevention and treatment services. The national legislation is not supportive of PWID, SWs and MSM mainly Article 125 of the Penal Code. These groups are often vulnerable to police harassment and mistreatment. Decriminalization, improving the administrative norms and the elimination of the unjust application of laws and regulations against these key population groups are required for expansion of coverage with prevention and treatment services. Therefore, removal of legal barriers has been prioritized for indicative funding to ensure effective coverage of key populations.

Community system strengthening: The role of CSOs has been significant in reaching key populations through peers and volunteers. Building CSO capacity will ensure further enhancement of their work, formalization and scale up use of peers/ social workers to locate LTFU patients after diagnosis will be given a priority. There is also limited information on the availability of services that are being provided by the NGOs, the private sector and the mapping of the different friendly cabinets and trust points across the country. The CSOs in close collaboration with PLHIV associations and support groups play a key role in improving appointment system to improve retention and quality of treatment. Furthermore, a complete picture on service readiness aspects by health facility and community system is required.

Program Management: This module included Continuation of the CDTP, grant management support as well as supporting procurement and supply management. National response analysis identified weaknesses of the health system impeding

[45] UNAIDS Global Report, 2013, page A78

effectiveness of HIV related activities. Although the need for HSS enhancement is much wider, the indicative funding will be used to support implementation and evaluation of the CDTP. Inadequate health service provider capacity will also be addressed with focus on compliance with guidelines as well as diminishing stigma and discrimination.

- Human resource barriers are most obvious in relation to the numbers, distribution, and mix of health staff at the most peripheral level of the health system as well as knowledge, practice and attitude; high staff turn-over, especially in HIV and AIDS related issues.
- Domestic and international financial support remains largely insufficient to respond comprehensively to the HIV epidemic even in the most accessible parts of the country. While the Government of Tajikistan provides support for the national response by way of manpower, staff salaries, buildings and operational costs, government spending on health is amongst the lowest. Sub-optimal national procurement and supply management practices sometimes results in shortages and/or stock outs of vitally important medical products and consumables.

Above allocation: The HIV National Strategic Plan for 2015 – 2017 is ambitious with high set targets to control the HIV epidemics in Tajikistan. However, the NSP implementation requires USD $48,580,063.79 while the New Funding Model allocation for HIV control in Tajikistan is only for 17 million USD. The funding gap is indicated as funding required for NSP less available resource from NFM allocation, Government contribution and other stakeholders' contributions. As the NSP is ambitious the funding gap between NSP and CN allocation is requested as above allocation amount. The funding for above allocation is mainly to expand the services within the NSP to achieve the goals and set targets. For instance, blood safety, surveillance studies among KAPs, trainings directly linked to scale up prevention and treatment services, programs for migrants and vulnerable youth and others are not yet covered. Financial support to such important interventions through above allocation will help Tajikistan to control the HIV epidemics.

As described above, the above allocation is calculated as follows:

a. NSP Budget
b. Government contribution
c. Other partners' contribution
d. Global Fund allocation

Funding Gap is calculated as A-(B+C+D), which equals to $10,009,616.25. Therefore, CCM Tajikistan kindly requests the consideration of the GF for the above allocation request to support the commitment of the Government in fighting HIV/AIDS in Tajikistan.

Please note that the above allocation amount is not indicated in the platform due to the activity breakdown and the structure of detailed interventions presented in a different manner as compared with the CN template. In case a detailed analysis per each activity of the NSP is required, the CCM will be able to provide the information as requested.

Furthermore, the National investment case model (Annex 5) indicates strategic investment on prevention of HIV through increasing access to HIV testing and services among key affected population is cost efficient investment both to save

lives of PLHIV as well as promote the development of the country.
The investment approach of Tajikistan has three scenarios.

a) Scenario one: “Maintaining the 2013 investment allocations and budget level”. This scenario is to continue with current investment allocation and current budget ceiling. Compared to the counter-factual scenario of no HIV/AIDS program at all “maintaining the current investment allocation and budget ceiling” would avert around 2,850 new HIV infections and 600 DALYs by 2020.
b) Scenario two: “Optimising the investment allocations at the 2013 budget level” This scenario is to continue with optimized investment allocations and current budget ceiling. Compared to the counter-factual scenario of no HIV/AIDS program at all “optimizing the current investment allocation and budget ceiling” would avert around 3,100 new HIV infections and 1,800 DALYs by 2020.
c) Scenario three: “S**caling up to universal coverage by 2020”**. This scenario is to continue by scaling up to universal coverage of essential HIV prevention and treatment services. As a return on this investment, around 30,000 new HIV infections would be averted between 2014-2030. Under Scenario 3 with “test and treat” approach (around 27,500 using 2013 WHO ART guideline, 27,000 using current WHO ART guideline).

   The facts under the three scenario presented as follows. Scenario 1, maintaining the current investment allocations and budget level should be the absolute minimum target in order not to fall back behind the moderate impact the national HIV response has achieved so far..

   Only improving efficiencies without addressing the overall budget constraints (scenario 2) will not be sufficient in Tajikistan for ‘Getting-to-Zero’, achieving MDG6 targets, ending the HIV/AIDS epidemic by 2030 and fulfilling the basic rights for access to essential HIV services for those in need.

   To achieve these goals and targets, and particularly to fulfill the basic right for access to essential HIV services (scenario 3) the overall investment until 2020 would need to be increased by some 30%.

   . For detailed information, please refer to Annex 5, Modeling an optimized investment approach for Tajikistan.

In this CN as the scenario 3 is impossible due to lack of allocation, the interventions are targeted to second scenario in optimizing the current investment allocations by mainly focusing on the epidemic drivers, key affected populations (PWID, SWs, MSM and prisoners). Therefore, if Tajikistan would have an opportunity to access the above allocation to fulfill the funding gap, the country will embark into universal coverage to control the epidemics. In mean time, the CCM in collaboration with MoHSPP will continue advocating for further increased state budgeting and resource mobilization in order to move to Scenario 3 as early as possible. The interventions, priorities and approaches for above allocation are described in the NSP and Modeling an Optimized investment approach for Tajikistan. The above allocation request will ensure the implementation of the

Investment model and finance the funding gap between the allocation and NSP budget.

3.4 Focus on Key Populations and/or Highest-impact Interventions
This question is <u>not</u> applicable for low-income countries.
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 percent of the budget on underserved and key populations and/or highest-impact interventions. b. If the applicant is an upper-middle-income country, describe how the funding request focuses 100 percent of the budget on underserved and key populations and/or highest-impact interventions.
Not Applicable

SECTION 4: IMPLEMENTATION ARRANGEMENTS AND RISK ASSESSMENT

4.1 Overview of Implementation Arrangements

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 Principal Recipient(s).

b. If more than one Principal Recipient is nominated, how coordination will occur between Principal Recipients.

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

d. How coordination will occur between each nominated Principal Recipient and its respective sub-recipients.

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

The NCC has advertised for nomination of PR through transparent and competitive process. The NCC established an independent team evaluating the nominees expressed their interest for the PR role. On 23 September 2014, the NCC held NCC meeting which selected UNDP Tajikistan as a PR for the HIV Grant implementation (Annex 2). The mission of UNDP is to support countries in the development and implementation of national policy oriented towards sustainable human development, with a focus on: Poverty Reduction; Democratic Governance; Crisis Prevention & Recovery; Energy & Environment; HIV, Health & Development; Women's Empowerment and Capacity Development.

UNDP supports countries to achieve their development goals as well as internationally set goals, including the Sustainable Development Goals (SDGs). UNDP has well-established legal and administrative agreements with host Governments, especially in countries facing weak regulatory frameworks. This includes critical aspects such as project implementation and oversight arrangements, importation and tax exemption agreements, fund transfer and banking arrangements, privileges and immunities, protocols for audit and investigations, visas for international staff, and so on.

In addition, UNDP is a founding cosponsor of the Joint UN Programme on HIV/AIDS (UNAIDS), a partner of The Global Fund to Fight AIDS, Tuberculosis and Malaria and a co-sponsor of several other international health partnerships. UNDP's work on HIV, health (TB, malaria, non-communicable diseases) and development leverages the organization's core strengths and mandates in human development, governance and capacity development to complement the efforts of specialist health-focused UN agencies (e.g., UNFPA, UNICEF, WHO). UNDP delivers three types of support to countries in HIV, health and development, which are 1) capacity

development of government structures and CSOs; 2) policy engagement and 3) acting as a Principal Recipient in special circumstances.

UNDP Tajikistan Country office has been Principal Recipient of 7 the GF grants for all HIV, TB and Malaria diseases since 2003. For efficient implementation UNDP has established partnership with more than 40 national and international partners, including society based organizations. In particular UNDP strategic priorities in health areas are focused on strengthening the programmatic implementation capacities of government, local implementing partners serving as the GF sub-recipients, and country coordination mechanisms in their national responses. Through increased partnership with NGOs, UNDP facilitates community involvement in health care; promotion of the role of CSO/NGOs in health governance and service delivery, creating a supportive environment for disease-affected people. Since 2003 UNDP has been providing technical and financial support for the Country coordination mechanism for mobilizing additional resources through the GF and improvement of coordination with other donors and partners. Through its Country program, UNDP is also aimed to facilitate alignment of health priorities with new poverty reduction strategy, advancement of human rights and gender equality agenda in health programming and promotion of appropriate public sector reform and anti-corruption initiatives in health care sector.

Performance of UNDP Tajikistan with regards to the GF grants is maintained at the efficient level of A for all TB, HIV and Malaria programs. Internal audit of UNDP Tajikistan conducted in 2010 confirmed overall satisfactory management. The audit of sub-recipients is conducted on annual basis, showing fully satisfactory status in 2012 and 2013. By establishment of rigid mechanism for follow up of audit findings, in the last 3 years UNDP has considerably strengthened its operational risk management system and internal control with regards to the GF funds. In 2014, UNDP Tajikistan also piloted a new initiative named CSA (Controlled Self-Assessment) which was facilitated by the Office of Audit and Investigation. The CSA is a risk management tool which helps the PR and SRs to identify, diagnose and manage risk within the grant implementation.

Since 2006, UNDP Tajikistan is allocating annually its core funds to reinforce the capacities of the GF implementing partners and provide technical assistance and trainings for sub-recipients for appropriate management of grants. In the past one decade UNDP Tajikistan has invested its internal resources amounting to 2.5 million USD which was mainly invested in capacity development. In 2013, for the first time, UNDP Tajikistan has facilitated and financed the development of National Capacity Development and Transition Plan with five key milestones. Through the implementation of the transition plan as of today the achievement includes establishment of electronic financial management system in 15 Government SR offices, human resources and SR contracting policy, PSM Policies and procedures and M and E tools. UNDP/the GF Partnership Team established at UNDP Bureau of Development Partnership and UNDP Procurement Support Office in Copenhagen are providing legal, technical and advisory support to UNDP PR country offices with regards to policies, procedures, regulations and

quality assurance for the GF-funded programs in full compliance with the GF requirements.

4.2 Ensuring Implementation Efficiencies

Complete this question only if the Country Coordinating Mechanism (CCM) is overseeing other Global Fund grants.

Describe how the funding requested links to existing Global Fund grants or other funding requests being submitted by the CCM.

In particular, from a program management perspective, explain how this request complements (and does not duplicate) any human resources, training, monitoring and evaluation, and supervision activities.

The current funding request is a logical continuation of the TFM (Round 8) grant, which ends on September 30, 2015. Although the burden of TB/HIV co-infection is relatively low in Tajikistan, management of HIV-associated tuberculosis will be given proper attention by the National TB (NTP) and the national HIV/AIDS programs through both CNs. The NCC has established different technical working groups for TB and HIV CNs' development. However, the two TWGs has been closely working to avoid funding duplication, ensure efficient HIV/TB collaboration as well as improve the integration of the two diseases programs.

The National Coordination Committee (NCC) for HIV/AIDS, TB and Malaria in Tajikistan facilitates horizontal links and participatory governance of disease control programs. NCC includes representatives from different ministries, governmental agencies and committees, external development assistance agencies, people living with diseases as well as the civil society. The NCC will closely oversee implementation of the support from the Global Fund to Fight AIDS, Tuberculosis and Malaria and ensure close coordination between NTP and RAC. Furthermore, CCM Tajikistan has already established grant overseeing committee who regularly travels to the grant implementation sites and advises the CCM Secretariat on the successes and challenges of the PRs and other implementers.

All planned TB/HIV interventions will be implemented jointly by the National TB Program and National HIV/AIDS Program. During the next program period, their cooperation will be further strengthened. This involves clear division of responsibilities, including the supply of medical commodities. Key areas, identified for enhanced coordination and close monitoring in both programs are:

Enforcement of protocols on management of TB/HIV cases – External *technical assistance in TB/HIV collaboration* will be provided to the NTP and National HIV/AIDS Program in overseeing implementation of the updated national TB/HIV strategy and action plan, case management protocols and other relevant policies, in line with the international standards and available evidence. This activity will be financed through the TB program.

National working group on TB/HIV, representing both TB and HIV/AIDS control services, will be engaged in facilitating the application of the guidelines and regulations for practices at service delivery level, improving collaboration between the two programs, conducting training of staff, ensuring proper information exchange and integration of TB/HIV data in the national TB information system, and supervision of implementation at sites.

Human resource capacity building – Capacity-building activities will be focused

on the implementation of revised policy and protocol as well as revision of the current CDTP following capacity assessment to be conducted during the NFM period. In order to avoid duplication of funding, the PR(s) together with National working group under the guidance of CCM will closely coordinate all training activities, monitoring and evaluation, supervision activities, incentive funding and ensure that tasks are correctly and accurately distributed between these two programs. More specifically, combined implementation annual plans will be developed with funding source identified accordingly.

Monitoring & Evaluation and strategic research - The NCC and PR will also ensure that there is a clear division of responsibilities for monitoring, evaluation and operation research among key implementing agencies for both programs. The NCC, with the assistance from M&E TWG will institutionalize combined annual M&E planning practices and closely coordinate activities planned by each program. The annual M&E plans will spell out purpose of the monitoring visit, geographical location, service providers to be monitored as well as exact dates and responsible entities/organizations. Furthermore the annual plan will also include researches and surveys planned, their purpose and funding source(s). The M&E plan will be updated on a quarterly basis by M&E TWG and progress reported to NCC. *Joint program supervision* will be promoted for the NTP and National AIDS Program officers with the aim to improve TB/HIV collaboration as well as increase the efficiency of resource use allocating to both HIV and TB grants.

4.3 Minimum Standards for Principal Recipients and Program Delivery			
Complete this table for each nominated Principal Recipient. For more information on minimum standards, please refer to the concept note instructions.			
PR 1 Name	UNDP	**Sector**	**UN**
Does this Principal Recipient currently manage a Global Fund grant(s) for this disease component or a cross-cutting health system strengthening 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$1.74 billion in signed active grants, representing approximately 10 percent of Global Fund grant resources. UNDP currently serves as interim Principal Recipient for 53 grants in 25 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 Cosponsor 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 head quarter and Procurement Support offices as well as global LTAs. 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 Guideline is revised based on practical experience, GF recommendations and risk management principle. UNDP Tajikistan has demonstrated effective SR management since 2003 through establishment of a self controlled assessment, SR management letter, spot

	checking, rigorous M and E 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. In Tajikistan the UNDP CO has piloted Controlled Self Assessment which is a tool to identify and manage existing and possible risk. UNDP also operates with ERP/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 v2.046, 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

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

	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 (IPSAS) by UNDP in January 2012. Atlas is a web based system which works on real time base. 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. Central warehousing and regional warehouse have capacity, and are aligned	The Republican Medical Procurement Centre (RMPC) is a public non-for-profit enterprise accountable to its governing board, which

with good storage practices to ensure adequate condition, integrity and security of health products	consists of the MoHSPP and international aid organizations such as UNDP, UNFPA, WHO and EU. RMPC provides storage and distribution services to the existing the GF grants in Tajikistan. It has sufficient space and adequate storage capacity to meet the requirements of this grant. It has been identified to undertake all supply management functions related to pharmaceuticals and other health commodities and supplies to be procured in the course of the project. The RMPC receives a direct supervisory and assistance from the UNDP to ensure the coordination of supply chain. The RAC especially at the regional and district levels will also take large part of the supply chain through distribution, storage and rational use of medicine. In November 2011 PIU recruited a Consultant to conduct an assessment to strengthen supply chain management starting from the central level till end- users. Therefore, as per recommendations of Consultant PIU has developed an Action Plan with Standard Operating Procedures (SOP) for further implementation. SOPs developed has been endorsed by MoHSPP and distributed across the country and is in use. Furthermore, under the Capacity Development Plan UNDP supported the development of PSM policies and Procedures at SR level to ensure effectives PSCM brief description. The Capacity Development and Transition Plan contain file milestone areas one of which is Procurement and Supply Chain Management. This milestone is composed of several activities including Procurement Policies and Procedures, Intellectual Property Rights, Procurement Planning, Quality Assurance Systems, Product Selection, Management Information Systems, Forecasting, Receipt and Storage, Distribution, Rational drug use, Management

	& Human Resources. The SOPs developed serves as a tool to implement the above activities. The plan is mainly developed for the three main centers. During NFM period the focus will be to SRs including local NGOs, Civil societies and other governmental institutions. These activities include but not limited to: - Adapting the Capacity Development Plan to include specific milestones targeted to all SRs mainly local NGOs and civil societies - Strengthening Public Private Partnership - Regular on job technical assistance for implementation of the SOPs Support the national TWG on Capacity Development to improve Coordination and review meetings to regularly asses the progress in capacity development
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	The UNDP, up on reception of distribution plan from the end users, will conduct the distribution through RMPC. The RMPC has an extensive experience in conducting distribution with the proper cold chain and transport standards. The RMPC has already established the system of distributions for different categories of products and supplies. The RAC and RMPC at oblast and Rayon level are also responsible for distribution of products and supplies to the level of end users. The RAC structures have proved a solid and practical approaches and experiences of distribution in the past many years with Round 1, Round 4, Round 6 and 8 and TFM the GF grants. Considering recommendations of 2014 OSDV and GF mission reports, the PR/UNDP strictly controls over proper drug distribution; particularly, needless treatment regimens were identified and deleted from ART database. Based on new treatment protocol,

	regimen was optimized by shifting from single formulation to fixed drug combination (FDC). Within the optimization initiative, the treatment regimen has been minimized to the accepted minimum. AIDS centres will consider necessity of introducing multi-regimen treatment of the patients to minimize number of regimens. Even though there were couple of cases of small amounts or no buffer stock of ARV drugs in Sogd (in May – June 2014 and in Oct-Nov 2014), there were no cases of interruption of treatment of ARV patients. The main reasons of the situation were a) high staff turnover of local staff; b) low capacity of health workers at facility level; c) inadequate reporting and recording system; and d) high number of treatment regiments which resulted in changing the regiments of treatment. As soon as it was revealed during M&E visits, in order to avoid treatment interruption, the PR/UNDP has raised 2 more urgent procurement cases of ARV. In order to avoid such situations in the future, PR has recruited two national consultants: the first to coordinate ART-related issues, including coaching the medical staff on overall supply management of drugs and second is PSM consultant who will further capacitate the SRs on proper supply chain management of all commodities. Furthermore, based on 2014 OSDV recommendations, the existing monitoring checklist was modified and section on PSM, including ARV drugs stock (availability of waybills, balance of commodities, etc.) is added.
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 Tajikistan, 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 the three disease centers are conducting joint monitoring and taking proper actions - In the past years UNDP supported the development of different electronic data management system for instance Open MRS for TB program, electronic HIV data base and other electronic databases - The SR has been supported with equipment such as computers, incentive payments to M and E officers and continuous on job and centralized training on M and E - The UNDP regional sub offices in Tajikistan has been working closely with the district health officials to strengthen regular data management - Data quality is checked at different level including on site data verification after SR reporting with onsite feedback and on job trainings. Apart from the overall support to establish functional and solid M and E system, during NfM specific measure for systematic quality control of data flow includes the following: - UNDP recently developed an online reporting software to be used by all SRs which will ensure the collection of data in good quality and timely as well as ensure utilization of data by the

	SRs who collected the data. The software is already developed and tested by UNDP. UNDP also initiated a procurement of server for installation of the software, which is on the stage of transfer to RAC as a future PR for collecting and consolidating all data related to HIV program. Following the installation of the server and software, UNDP consultants will conduct training on the use of the platform and by time NfM starts the platform is expected to be fully in use. - UNDP in collaboration with NAC will also developed a comprehensive monitoring checklist which includes all components (Programmatic performance, Monitoring and Evaluation function of the SR, procurement and supply chain, financial management as well as operational management. At the moment the existing PR, UNDP, developed one joint M and E checklist for program, M and E as well as PSM and another combined checklist for Finance and operation management. Developing one universal monitoring checklist will enhance cost effectiveness, learning by doing and ensure sustainability of the data quality. The project standard dataflow is as follows: (i) primary level data are recorded in logbooks at service delivery points (SDP) that is consolidated on monthly reporting form; (ii) the monthly reported data are sent to coordinating SR that compiles quarterly/semi-annual data or in the case of RAC, date are verified and consolidated in the regional/oblast levels; (iii) the regional centers further send the data to the Republican or national level, where final verification and compilation of the data and

	report is completed; (iv) the PR receives and aggregates the quarterly/semiannual data of the SR.
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 Tajikistan like any other country, UNDP gives a serious attention to quality assurance. The UNDP Procurement team in Tajikistan 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, number of Standard operating Procedures to Quality Assurance are already in place and functional. Over the past years a regular 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. As part of capacity building UNDP has been supporting the Tajikistan Drug Authority to meet the ISO standard for Quality Assurance testing. Number of Government staff has been trained on, Quality Assurance and Supply Chain Management.

4.4 Current or Anticipated Risks to Program Delivery and Principal Recipient(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, Principal Recipient and key implementers' capacity, and past and current performance issues.

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

In developing this concept, a number of risks have been identified, and discussed here.

External funding and sustainability - Currently, development partners provide bulk of the funding for HIV interventions in Tajikistan. Any significant reduction of this support would negatively affect the implementation of this Strategic Plan. NCC will focus on securing increased funding from the Government, in additional to applying resources from UNAIDS Investment Framework, Total Market Approach (TMA) for commodities, NFM of the GF existing devolved funds operating at the constituency level, among others in an effort to mitigate this risk. Furthermore, an active fund rising strategy will be developed and implemented to mobilize additional resources through obtaining technical assistance. The NCC will be responsible for implementation of the fundraising strategy. Allocation of mobilized financial resources will be guided by cost-effectiveness of interventions.

Governance, Leadership And Coordination - Strong leadership across government, combined with effective coordination and demand for performance accountability from all stakeholders by NCC, is vital to the achievement of the NSP impact results. Therefore, any significant changes in the current political environment, such as weak governance and decisions not based on evidence, at National and NCC level could seriously undermine the implementation of this Strategic Plan and achievement of results it sets out to deliver. NCC, with the support of key Government, civil society and development partners, will undertake continuous advocacy to ensure wide political commitment towards the fight against HIV mitigating this risk as well as effective engagement of civil society in leadership and decision-making.

Partnership commitment and capacity- Successful NSP implementation will require a multi-sectoral response involving partners from public and private sectors and civil society. Any significant lack of commitment or

capacity will seriously affect the achievement of NSP results. NCC will implement a comprehensive partnership framework along with CSO capacity building plan. Efforts are made to further enhance capabilities and capacity of NCC through deployment of the USAID funded Grant Management Solution (GMS) support. The technical support plan will be developed to address the capacity needs of public and private sector to deliver on the outcome. There will be continued monitoring and updating of the technical support plan. The Portfolio Analysis indicated risks related deficiency of LMIS and patient registration which in turn affects proper forecasting to result in stock out situations. The NCC and the MoHSPP will be paying due consideration in strengthening the Procurement and Supply chain management through implementing the ongoing capacity building plan and appropriate training as required.

Financial Flow And Management - The failure of Government and development partners to effectively and efficiently disburse, manage and/or account for funds will negatively affect implementation of this Strategic Plan. 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. NCC 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 by relying more on the local office structures.

Results based management - Lack of proper reporting structure, weak analytical capabilities alongside with quality assurance of reported data, will negatively affect the evidence based planning and implementation of the NSP. To mitigate these risks the new M&E framework has been developed to support the implementation of NSP and to coordinate monitoring by stakeholders. It clearly outlines reporting structures and hierarchies; provides indicators on results-based management and outlines responsibility of each partner.

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 Annexes
- ☐ CCM Eligibility Requirements
- ☐ CCM Endorsement of Concept Note

Abbreviations:

A&E – Accident and Emergency room
AFEW- AIDS Foundation East-West
AIDS- Acquired Immunodeficiency Syndrome
ART – Anti-retroviral therapy
BCC – Behaviour change communication
CCM – Country Coordination Mechanism
CDC – Center for disease control of USA
CDTP – Capacity Development and Transition plan
CN – Concept note
CSO – Community Systems organization
FC – Friendly Cabinet
GBAO – Gorno-Badakhshan Autonomic Oblast (region)
GBV – Gender based violence
GF – Global Fund
GMS – Grant Management Solution
HCV – Hepatitis C virus
HIV- Human Immunodeficiency virus
HMIS – Health Management Information System
HSS – Health Systems Strengthening
HTC – HIV Testing and Counseling
IBBS - Integrated Bio-Behavioural Surveillance
IEC – Information, education and communication materials
KAP – Key affected population
LEA - Legal Environment Assessment

LTFU – Lost to follow up
M&E – Monitoring and evaluation
MoHSPP – Ministry of Health and Social Protection of Population
MSM – Men having sex with men
MTEF - Medium Term Expenditure Framework
NAP – National AIDS Program
NASA – National AIDS Spending Assessment
NCC – National Coordination Committee
NFM – New Funding Model
NGO – Non- governmental organization
NHS – National Health Strategy
NSEP – Needle and syringe exchange point
NSP – National Strategic Plan
NTP – National TB program
OI – Opportunistic infection
PCR - Polymerase Chain Reaction
OSI – Open Society Institute
OST – Opioid Substitution Therapy
PLHIV – People living with HIV
PMTCT – Prevention of mother to child transmission program
PSE – Population size estimation study
PQM - Promote quality of medicine
PWID – People who inject drugs
RRS – Rayons of Republican Subordination
RT – Republic of Tajikistan
SDG – Sustainable Development Goals
SR – Sub-recipient
STI – Sexually transmitted illnesses
SW – Sex worker
TB - Tuberculosis
TFM – Transitional Funding Mechanism
TP – Trust point
TWG – Technical working group
UNAIDS – United Nations AIDS Program
UNGASS - United Nations General Assembly Special Session On HIV
USAID – United States Agency for International Development
VL - Viral load
WHO – World Health Organization