The Global Fund
To Fight AIDS, Tuberculosis and Malaria

STANDARD CONCEPT NOTE

Investing for impact against HIV, tuberculosis or malaria

A concept note outlines the reasons for Global Fund investment. Each concept note should describe a strategy, supported by technical data that shows why this approach will be effective. Guided by a national health strategy and a national disease strategic plan, it prioritizes a country's needs within a broader context. Further, it describes how implementation of the resulting grants can maximize the impact of the investment, by reaching the greatest number of people and by achieving the greatest possible effect on their health.

A concept note is divided into the following sections:

Section 1: A description of the country's epidemiological situation, including health systems and barriers to access, as well as the national response.

Section 2: Information on the national funding landscape and sustainability.

Section 3: A funding request to the Global Fund, including a programmatic gap analysis, rationale and description, and modular template.

Section 4: Implementation arrangements and risk assessment.

IMPORTANT NOTE: **Applicants should refer to the Standard Concept Note Instructions to complete this template.**

SUMMARY INFORMATION			
Applicant Information			
Country	**Uzbekistan**	**Component**	**HIV**
Funding Request Start Date	**01.07.2016**	**Funding Request End Date**	**31.12.2017**
Principal Recipient(s)	The Republican AIDS Centre (RAC) of the Ministry of Health of the Republic of Uzbekistan		

Funding Request Summary Table

A funding request summary table will be automatically generated in the online grant management platform based on the information presented in the programmatic gap table and modular templates.

SECTION 1: COUNTRY CONTEXT

This section requests information on the country context, including the disease epidemiology, the health systems and community systems setting, and the human rights situation. This description is critical for justifying the choice of appropriate interventions.

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.

2-4 PAGES SUGGESTED

a. Epidemic situation and tendencies. Regional discrepancies

Estimated number of people living with HIV (PLHIV) in Uzbekistan is 37,295[1] out of which 30,315 are registered with HIV service. HIV prevalence among the general population is at the level of 0.1%.

HIV epidemic is on the rise in Uzbekistan. In 2014 new HIV cases made up 4,236 with men contributing 55.4%; majority in the age group 25-49 years. In 2014 new HIV infections constitute 13.8 per 100,000 persons[2] which is twice as high as in the countries of the European Union. It should be noted, however, that increased volumes of testing for HIV have been observed (from 1,223,525 tests in 2008 to 2,537,872 in 2013, substantially driven by the increase in testing among pregnant women and working migrants) in the last several years which contributed to the increased numbers of registration of new HIV cases[3].

[1] Spectrum estimates of PLHA in Uzbekistan for 2015.
[2] Global Report of the Republic of Uzbekistan on the Fulfillment of the Declaration of Commitment to Fighting AIDS, 2015 (in Russian).
[3] Analysis of triangulation data on HIV infection in Republic of Uzbekistan (in Russian).

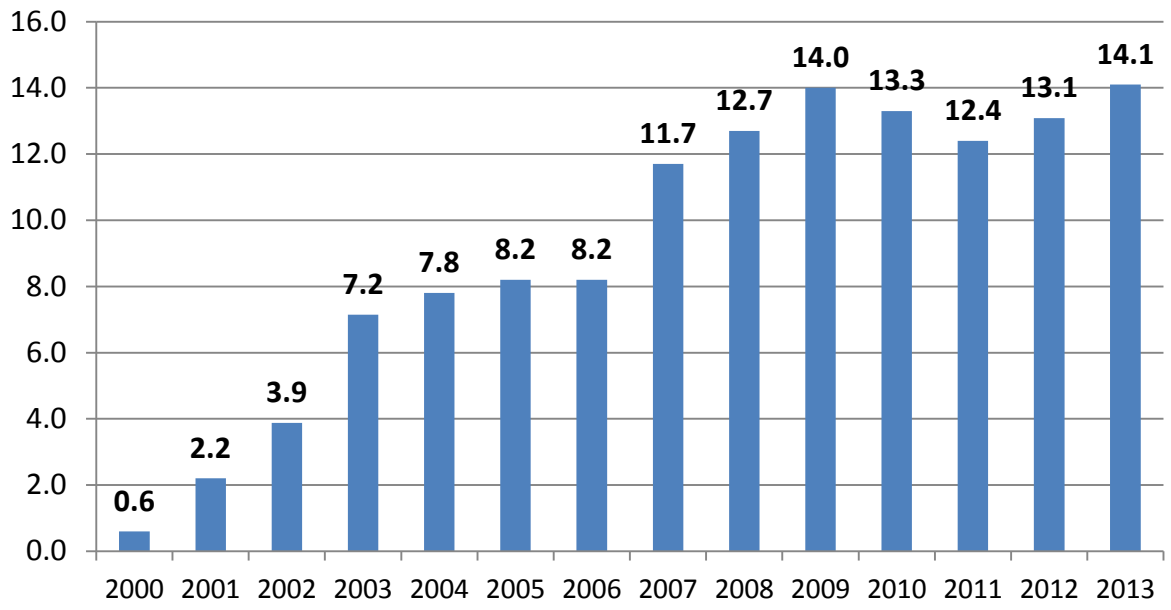

Diagram: Dynamics of HIV incidence per 100,000 population in Republic of Uzbekistan[4]

The HIV epidemic in Uzbekistan is in the concentrated stage. In 2014, parenteral transmission accounted for 24.4% of new cases of HIV, while heterosexual – 64.7%[5]. It is important though to analyze the transmission data inclusive of the changes in testing approaches. The growth in the testing of pregnant women at 30% lead to early diagnostics among women and timely PMTCT measures; at the same time it created the perception of shift to sexual transmission of HIV. Meanwhile the numbers of tests carried out among the key populations remains low. For example, among PWID that are referred for testing by the narcology service, in 2008 some 9,000 HIV tests have been conducted (at the then estimated 80,000 population size), or 11% of PWID group and in 2012 the number of tests among PWID reduced to 6,500 (at the then estimated 48,000 population size), or 13% of PWID group[6].

During 2014 some 700,000 pregnant women were tested for HIV and 382 received HIV-positive results. The overall number of HIV-positive pregnant women made up 706 (0.1%) in 2014. 97.4% of newborns received PMTCT. Vertical transmission made up 0.2%[7].

Registered HIV grows faster among women than men due to the fact that more women are tested for HIV than men every year: in 2013, about 1 Million men and 1.5 Million women were tested for HIV. Among men parenteral transmission prevails, while among women – sexual[8].

[4] Analysis of triangulation data on HIV infection in Republic of Uzbekistan (in Russian).
[5] Global Report of the Republic of Uzbekistan on the Fulfillment of the Declaration of Commitment to Fighting AIDS, 2015 (in Russian).
[6] Analysis of triangulation data on HIV infection in Republic of Uzbekistan (in Russian).
[7] Global Report of the Republic of Uzbekistan on the Fulfillment of the Declaration of Commitment to Fighting AIDS, 2015 (in Russian).

[8] Analysis of triangulation data on HIV infection in Republic of Uzbekistan (in Russian).

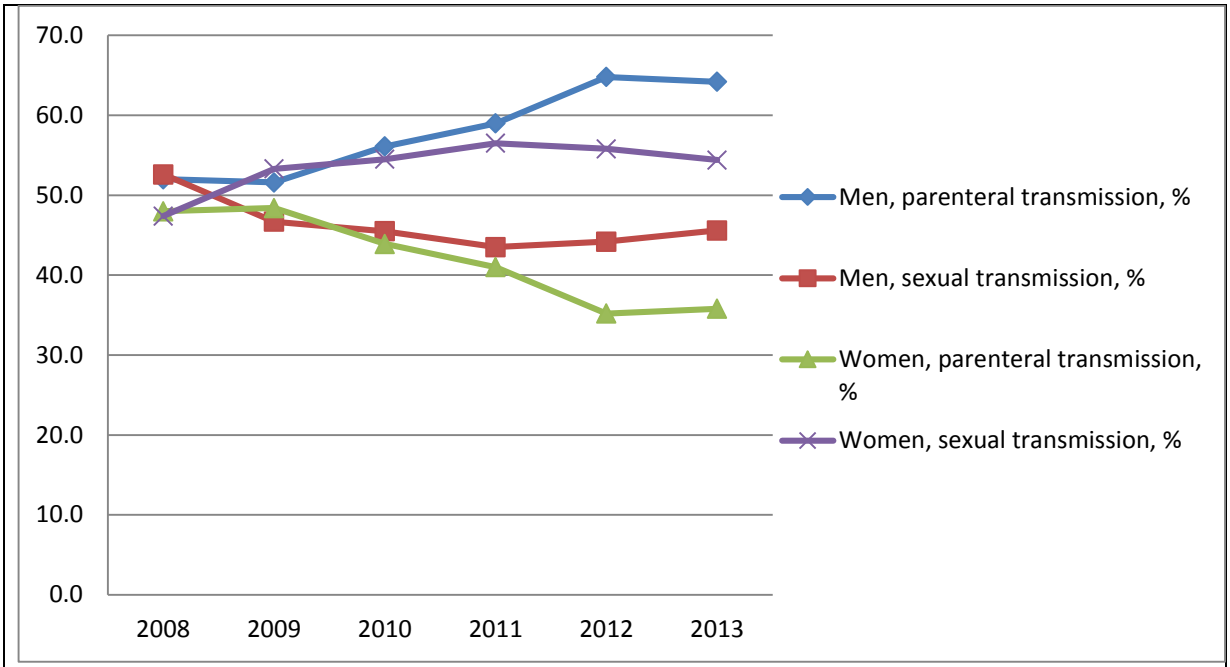

Diagram: HIV transmission modes by transmission route and sex[9]

Late diagnostics is a major problem in case finding in HIV: 38% of newly diagnosed in 2014 HIV cases were registered among those referred by the medical facilities due to clinical symptoms.

Regions of Uzbekistan are disproportionately affected by HIV. Five out of 14 regions are home to three quarters of the country's registered PLHIV: Tashkent city – 31%, Tashkent region – 15%, Andijan region – 15%, Fergana region – 7%, Samarkand – 8%[10]. HIV is growing in 11 regions. Triangulation report is dividing the regions of Uzbekistan into low incidence regions (0-100 new HIV cases per year): Jizzakh, Navoi, Syrdarye and Karakalpak regions, middle incidence regions (100-500 new HIV cases per year): Bukhara, Kashkadarye, Namangan, Samarkand, Surkhandarya, Fergana and Khorezm regions and high incidence regions (over 500 new HIV cases): Tashkent and Andijan regions and the city of Tashkent.

b. Risk groups

HIV epidemic in Uzbekistan remains concentrated among high risk groups with unsafe injecting practices and unprotected sex being the driving forces of HIV spread.

Although the overall share of PWID among officially registered PLHIV in Uzbekistan is 18.3% and in 2014 it made up 6.9%, the official registration data should be considered as underestimating the role of PWID and MSM in the epidemic process as they are likely to choose not to report this behavior while registering with HIV – fearing stigma and prosecution.

Estimated number of PWID in Uzbekistan is 48,000, SWs – 21,000. There is no estimated data on MSM in Uzbekistan and the size estimation research is currently underway[11]. The programmatic coverage of prevention interventions is 1,493 MSM. Even less information is available about transgender populations.

[9] Analysis of triangulation data on HIV infection in Republic of Uzbekistan (in Russian).
[10] Official data of Republican AIDS Center of Uzbekistan.
[11] The MSM estimation is conducted in all the 14 regions of Uzbekistan using Delphi method (approaching key service providers: STI doctors, narcologists, AIDS service) taken the scarcity of reach of this group in Uzbekistan.

Most of HIV-positive PWID and SWs are in the age group above 25 years only. Most of MSM based on 2013 IBBS in Tashkent, are younger than 25 years[12].

Based on the 2013 IBBS, conducted in Uzbekistan since 2005 every two years, HIV prevalence among people who inject drugs (PWID) made 7.3%, Sex Workers (SWs) – 2.1% and MSM – 3.3%[13].

	2007	2009	2011	2013
PWID	12,9% (n=3743)	11,0% (n=4098)	8,4% (n=5600)	7,3% (n=5600)
SW	4,7% (n=2493)	1,9% (n=2493)	2,2% (n=3379)	2,1% (n=3360)
MSM	10,8% (n=211)	6,8% (n=118)	0,7% (n=150)	3,3% (n=150)

Table: HIV prevalence among key populations according to IBBS 2007-2013[14]

Interpretation of decreasing HIV prevalence among PWID as per IBBS should be made with caution. This trend does not positively correlate with the behavioral changes using risky practices while injecting drugs. No changes have been observed in behaviors containing risks of HIV transmission among PWID between 2009 and 2013: sharing of injecting commodities increased from 28% in 2009 to 34% in 2013; use of blood while preparing drugs increased from 3.5% to 4.2%, use of pre-filled syringes – from 16% to 18%[15]. According to 2013 IBBS, some 28% PWID and 32% SW tested for HIV in previous year. Therefore, the official registration alone cannot explain the true nature of HIV epidemic process in Uzbekistan.

Comparison of patterns of official HIV registration in the regions of Uzbekistan and registration of new HIV cases among PWID regionally (according to IBBS) reveals similar regional trends leading to assumption of prominent role of parenteral transmission in the epidemic process.

Highest HIV prevalence rates among PWID, according to 2013 IBBS, are found in Samarkand – 10.5%, Surkhandarye – 16.4%, city of Tashkent – 24.5% and Tashkent – 13.4% regions[16].

Women who inject drugs make 10% of the overall PWID group[17]. Highest HIV-prevalence rates are observed among women who inject drugs. In this group some 14.7% HIV prevalence has been detected by official registration (in 2009 it was 10.3%)[18]. This is the result of highly risky practices: women inject drugs more frequently (according to 2013 IBBS, 9% of women inject more than once a day, compared to 5.6% in men); women have more sexual partners during last six months (7 against 2 in men); 53% of women compared to 49% men PWID did not use condom during last sexual intercourse.

At the same time this group is poorly covered by harm reduction services (in 2014, 3,029 women who inject drugs reached out of 24,552 PWID reached) and there is not targeted

[12] Analysis of triangulation data on HIV infection in Republic of Uzbekistan (in Russian).
[13] IBBS reports, 2013 (in Russian).
[14] Analysis of triangulation data on HIV infection in Republic of Uzbekistan (in Russian).
[15] Analysis of triangulation data on HIV infection in Republic of Uzbekistan (in Russian).
[16] Analysis of triangulation data on HIV infection in Republic of Uzbekistan (in Russian).
[17] PWID IBBS report, 2013 (in Russian).
[18] Analysis of triangulation data on HIV infection in Republic of Uzbekistan (in Russian).

intervention for this group. Substantial effort is needed to get in touch with the group and to better understand the risk behaviors and appropriate programming approaches[19].

Drug scene is dynamic in Uzbekistan. Earlier concentrated around heroin based consumption through trafficking routes from the neighboring Afghanistan (especially the case for Samarkand, Khorezm, Surkhandarya regions), more and more codeine containing desomorphine use is occurring, and some regions (like Tashkent, Navoi) are fully shifting to use of desomorphine[20].

Drug use is also prevalent among other risk groups – SWs and MSM. Proxy evidence for the overlap between the groups is the increasing Hepatitis C infection registered among all the groups according to IBBS, between 2011 and 2013: PWID – increase in HCV from 20.9% to 21.8%, SWs – from 3.8% to 4.8%, MSM – from 2.7% to 4%[21] .

PWID are reportedly under covered by HIV testing (28% according to 2013 IBBS). Especially low is the testing coverage among women who use drugs: reduction from 7.4% to 4.9% in the shares of women PWID tested for HIV in the general number of PWID tested has been observed.

In some regions numbers of PWID are growing. Growth in numbers of women who inject drugs is observed in Tashkent, Surkhandarya, Ferghana regions and the city of Tashkent.

During the last three rounds of sentinel surveillance HIV prevalence among sex workers remained above 2%. HIV prevalence among SWs varies from 0 to 5.7% with highest rates recorded in Bukhara (4.5%), Syrdarya (3%), Surkhandarya (3.5%), Jizzakh (2.2%) and Tashkent regions (5.7%) and the city of Tashkent (3%)**[22]**. Despite the relative high levels of knowledge of HIV transmission routes, risky practices remain high. About 45% of sex workers had symptoms of sexually transmitted infections.

Levels of HIV testing among sex workers are relatively low at 32% of respondents' sample. The reason for not testing is the fear of stigma in case of HIV-positive result.

Data about HIV prevalence among MSM is limited. According to Tashkent city based sentinel surveillance, HIV prevalence in this group has grown from 0.7% in 2011 to 3.3% in 2013. Coverage of prevention services in this group is low. 48% of MSM that were approached in 2013 IBBS have not received condoms in the last month, 85% have not received counseling, and 73% have not received information materials. 73% have not been tested for HIV.

Risky sexual practices prevail in this group. 63.3% of MSM did not use condom in the last anal sexual intercourse with a commercial partner[23].

Situation in prison populations is hard to estimate due to high barriers to access to the penitentiary system. Some 58 prison institutions contain about 46,000 prisoners with officially reported occupancy level of 80%[24]. According to official data reported by the Republican AIDS Center, as of January 1, 2014, in prison settings there were 820 PLHA (732 men, 88 women). Penitentiary system claims its own approaches and resources used in the prison to respond to HIV. ARV treatment is provided to some 226 PLHA[25].

[19] National review of the orientation of the HIV response measures towards the needs of men and women in Uzbekistan, 2014 (in Russian).
[20] There is no systematic assessment of drug scene carried out in Uzbekistan; anecdotal evidence is reported by the outreach workers and NGOs conducting harm reduction interventions.
[21] IBBS reports, 2013 (in Russian).
[22] Analysis of triangulation data on HIV infection in Republic of Uzbekistan, 2014 (in Russian).
[23] Analysis of triangulation data on HIV infection in Republic of Uzbekistan, 2014 (in Russian).
[24] World Prison Brief 2014 // International Centre for Prison Studies
[25] Data provided by Republican AIDS Center.

Information work is conducted in prisons: information booklets about HIV are disseminated to all the prisoners and they have to pass an exam about the key HIV transmission modes and prevention measures.

c. Human rights

2013 new law on AIDS had a number of positive developments:

- it allowed for entry to Uzbekistan of foreigners with HIV;
- foreigners found HIV-positive in Uzbekistan had no longer to be deported;
- the participation of the local self-government bodies and non-governmental organizations in HIV response measures has been defined[26].

At the same time the law requires mandatory HIV testing for pregnant women, blood donors, those planning to get married at the age below 50, medical workers who contact with blood, partners of PLHIV, PWID and their partners.

In the legislation there remains criminal prosecution of sexual relations between men. This increases stigma towards this group in society and drives its representatives underground, substantially limiting reach of prevention programs.

There exists an order of the Ministry of health of Uzbekistan regulating the activity of the Trust cabinets and their role in delivering HIV prevention services for risk groups. At the same time, taken that the decree is health sector oriented, there remains the need to further regulate the optimal provision models to key populations to strengthen their legal status and perceptions among general population[27].

d. General health context and community systems

State run health system consists of three layers: national, oblast and rayon levels. Ministry of Health regulates, plans, organizes, manages all the health activities will little role played by NGOs. The government strongly regulates and limits the services that can be provided by the private sector[28].

Uzbekistan is a low-income country. Overall expenditure on health in Uzbekistan is 5.9% of GDP in 2012, lower than in WHO European region with 8.3%, but higher than in in central Asian republics at 5.2%. Public sources raised through taxes account for over half of the expenditure[29].

The government provides primary care, emergency care and care for socially significant and dangerous conditions. The national government funds specialized medical centers, research institutes, emergency care centers and national-level hospitals. Regional and local governments are responsible for hospitals, primary care units, sanitary-epidemiological units and ambulance services[30].

The government prioritizes development of primary healthcare. In the last years Uzbekistan implemented health reforms including reforms in primary healthcare targeting reorientation

[26] Law of Republic of Uzbekistan 'On counteracting the spread of diseases caused by the human immunodeficiency virus (HIV-infection)', 2013 (in Russian).
[27] Order of the Ministry of Health of Uzbekistan # 123 'On further improvement of prevention measures and organization of medical assistance for HIV-infection', 2015 (in Russian).
[28] M. Ahmedov, R. Azimov, et al. Uzbekistan Health System Review // Health Systems in Transition, Vol.16, No 5, 2014.
[29] M. Ahmedov, R. Azimov, et al. Uzbekistan Health System Review // Health Systems in Transition, Vol.16, No 5, 2014.
[30] M. Ahmedov, R. Azimov, et al. Uzbekistan Health System Review // Health Systems in Transition, Vol.16, No 5, 2014.

towards family health. In the villages (50% of population lives in rural areas) village doctor points are established.

Uzbekistan has a network of 14 regional dedicated AIDS Centers vertical structure that ends at oblast level and is headed by Republican AIDS Center. Further down service are provided by the primary healthcare.

Uzbekistan guarantees free medial support to PLHIV provided by the government.

There is an infrastructure for implementing various key populations interventions in the country. There is a countywide network of 230 Trust cabinets located in primary healthcare, 30 Friendly Clinics for syndromic STI treatment based in STI clinics and several NGO initiatives on outreach in close cooperation with government service providers[31].

Lacking governmental funds are merged with the donor resources. In health there are projects supported by UNAIDS, UNODC, UNFPA, UNICEF, WHO, USAID, World Bank, Asian Bank of Development, Government of Japan, EU, Germany, South Korea, China, Russia etc.

The World Bank supported health reform in Uzbekistan. Two investment projects targeting reforms of primary medical aid were supported throughout 1998-2011. Third project started in 2012 targeting medical support on rayon level, non-infectious diseases, improved financing for health facilities.

USAID focuses on prevention of HIV/TB, while UNFPA and UNICEF prioritize traditional health programs for maternity and childhood. CDC is supporting sentinel surveillance on HIV/AIDS.

Several international NGOs operate in Uzbekistan – MSF, Project HOPE etc.

Starting 2004 HIV, TB and Malaria programs are supported by the Global Fund.

Community systems

Community systems are weak in Uzbekistan. There are only several NGOs working with key populations in Uzbekistan. The reasons for that have been described earlier.

The absence of community based organizations, which have good access to hidden or closed groups impede program reach and increase the gap between those who are HIV positive and those who are diagnosed with HIV. This can lead to hidden HIV outbreaks, which cannot be addressed by existing efforts on HIV response despite availability of HIV testing and ART.

Many of the NGOs that currently implement HIV prevention programs among key populations only have local registration which limits them in conducting national level activities and expanding to greater numbers of regions.

There is a strong need in development of community systems in Uzbekistan, to involve them in program development, implementation and evaluation; and also strengthening their leadership roles in regulating HIV strategies and shaping legal environment.

[31] Strengthening capacity for universal access to HIV prevention, diagnosis, treatment and care for most-at-risk populations in Uzbekistan // APMG, May, 2013.

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[32], 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.

4-5 PAGES SUGGESTED

a. Targets and aims of the program

Starting 2003 Uzbekistan has been implementing strategic programs to respond to HIV/AIDS epidemics: 2003-2006; 2007-2011. Implementation of strategic programs has been substantially supported by the government. Based on strategic programs, developed with participation of all stakeholders, National AIDS Program for 2014-2016 has been approved by the Cabinet of Ministers, detailing the sources of funding and those responsible for activities.

Uzbekistan strategic program on HIV/AIDS for 2013-2017 has been developed though multi-sectoral dialogue and consensus. It focuses on HIV prevention, treatment and care for key populations, based on internationally acknowledged methods, increases access to services including needle-syringe programs (NSP) and condom availability, as well as HIV testing, information materials, referral system, ART for key populations including PWID, SWs, MSM, monitoring and evaluation, including implementation of automated information system on client tracking in prevention and treatment programs.

Aim of the strategic program is ensuring the Republic's contribution to the achievement Millennium Development Goals on responding to HIV through improvementation of systems and mechanisms to allow universal access to HIV prevention, treatment, and care.

Objectives of the strategic program are:

1) reduction in the HIV growth and insuring universal access to comprehensive services on HIV prevention, treatment and care;
2) reduction in sexual transmission of HIV and in parenteral transmission of HIV, including among PWID as well as in cases of vertical transmission.

The following targets are put forth by the strategic program:

[32] 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.

- 100% access to ART for those in need of treatment by 2017;
- 90% adherence to ART during 12 months;
- legal framing of tolerant attitude to PLHIV;
- 70% of the national resourcing of HIV response, including gradual provision of ART by the government up to 50% by 2017.

The following priority directions are foreseen by the program:

- Improvement of legislation in order to achieve universal access;
- HIV prevention among high risk groups;
- Prevention of HIV transmission in medical settings;
- PMTCT;
- HIV and STI prevention among general population;
- Universal access to diagnostics and treatment of HIV and STI;
- Management of strategic program;
- Strengthening of national system of data collection and use[33].

The program foresees a number of activities, including 60% of access to services by key populations through the support of Trust cabinets and implementation of the quality control system, including distribution of information materials, effective referrals, HIV, TB and Hepatitis counseling and testing, training of staff of Trust cabinets and NGOs. Trust cabinets are established according to the Order of MoH in the primary healthcare settings and function in all regions of Uzbekistan. Their number depends on the sizes of key populations in the regions and HIV prevalence in the respective regions.

Strategic program regulates provision of the basic package of services, including information materials distribution, condoms provision, efficient referral system, HIV and STI testing and treatment among key populations.

PMTCT is included in strategic program with the target indicator at less than 2% of vertical transmission of HIV. 100% access of women to HIV testing in the first pregnancy semester is foreseen, in case of necessity – rapid testing at labor; in case of HIV-positive pregnancy - provision of PMTCT ART.

Management of strategic program is based on ‘three ones’ principles including the activity of the muti-sectoral coordinating body – interdepartmental expert council (IEC, or CCM), headed by the Deputy Prime-Minister. The council includes membership of governmental institutions, international organizations, civil society, including people affected by the epidemic. Similar coordinating bodies exist on regional levels.

A range of activities on strengthening monitoring system are envisaged: development of M&E plan and guidance, guidance on programmatic project monitoring, development of sectoral plans, training curriculums, development of national and international trainers database, support to the information web-portal. IBBS as well as mid-term and final evaluation of the strategic plan is included. Coordination and generalization of M&E data is the function of the Republican AIDS Center.

As part of strategic plan fulfillment, in 2013 a law on AIDS has been adopted, regulating human rights of key groups and PLHA.

Strategic program, outlining the aims and objectives of AIDS response, is a guidance that is

[33] Strategic Program on Counteracting HIV in Republic of Uzbekistan for 2013-2017 (in Russian).

reflected in other programs.

b. Results achieved by the national program

With the aim to reduce the number of parenteral and sexual transmissions of HIV among key populations, the strategic program for 2013-2017 continued implementation of existing prevention programs through outreach and the network of Trust cabinets and friendly cabinets with the following services: distribution of commodities and information materials, counseling, rapid testing for HIV, referrals. In 2014, 51% of estimated number of PWID, 56% - of sex workers and 1,491 MSM have been reached with services. The service delivery is organized so that key populations groups are first approached on outreach by outreach workers, are provided with the commodities and consultations, are further referred to Trust cabinets and HIV testing there. In Trust cabinets clients can also receive commodities, get consultations and testing for HIV[34]. During 2014, over 500,000 key population groups visits to Trust points have been registered, over 50 thousand information materials distributed, as well as over 2.4 Million commodities, 176 thousand persons have been referred to specialists (narcologist, psychologist, etc.) for further consultations[35]. The Triangulation report notices the effectiveness of Trust cabinets in HIV reduction: HIV and HCV prevalence among PWID who are visiting Trust cabinets is lower than among those who are not[36]. Friendly cabinets are the basis for STI diagnostics and treatment for key populations. Also the staged plan of OST introduction has been developed based on international best practice.

Despite the relatively high coverage of key populations by prevention measures, as above situation analysis shows, behavioral improvements are occurring slowly. This can be partly attributed to disruptions in service continuum over time. In 2008 over 3 Million syringes and 2 Million condoms have been distributed, while in 2009 – almost two times less. With the Round 3 project's ending in 2010 outreach work was stopped which had negative impact on the reach of key populations groups by the Trust cabinets. New Round of the Global Fund funding started in mid-2011 and the situation partially improved in 2012-2013[37].

Ministry of Heath approved of norms and standards of quality for service delivery for key populations based in Trust cabinets. Automatized service tracking system has been developed and used in the projects – management information system (MIS). Some 228 specialists have been trained to use MIS. A system of forecasting the needs in ART has been developed and in use. Program on automated case management is under development.

Most of these activities are funded by international donors.

Donor blood safety measures as well as prevention of hospital based HIV transmission are taking place: single use sterile commodities are provided to hospitals and blood centers funded by the national budget. The single database of blood donors has been created and functions. Starting 2014 post-exposure prophylaxis drugs are covered by the national

[34] According to APMG report (2013), the comparative analysis of coverage in the two models of Trust cabinet interventions showed that outreach work increased coverage from at least double to 20 times the coverage of Trust cabinets without outreach.
[35] Global Report of the Republic of Uzbekistan on the Fulfillment of the Declaration of Commitment to Fighting AIDS, 2015 (in Russian).
[36] Analysis of triangulation data on HIV infection in Republic of Uzbekistan, 2014 (in Russian).
[37] Analysis of triangulation data on HIV infection in Republic of Uzbekistan, 2014 (in Russian).

budget.

Pregnant women are positioned as one of the key groups for HIV finding and transmission prevention. In 2014 through primary healthcare institutions out of 688,855 pregnant women some 98.4% have been tested for HIV. In 2015 based on the new WHO recommendations the national protocol 'Using ART for treatment and prevention of HIV' has been revised, protocol 'Organizing care, medical and psychological and social support to HIV-positive children' adapted. Rapid tests are procured and provided to maternity hospitals. In 2014 ART prevention has been provided to 99.2% out of 396 HIV-positive pregnant women and 98.9% children born to HIV positive mothers. Thanks to the measures taken, vertical transmission of HIV reduced from 5.3% in 2011 to 0.2% in 2014.

Information activities for general population are conducted. NGO Women's committee of Uzbekistan conduct information work on community (makhalla) level using the cascade method, trainings for decision makers are conducted. Training for police is also taking place on the issues of HIV prevention and tolerant attitude towards PLHA.

Government funded equipment of laboratories of the Republican and regional AIDS Centers, including CD4 diagnostics, viral load, IFA equipment, hematological, biochemical and urine analyses and other equipment. Laboratories are provided with the necessary diagnosticums and reagents. Sequenator has been procured and provided to the Virusology Institute and will allow genotyping and ART resistance measuring. Existing GeneXpert in 3 laboratories allowed to conduct rapid diagnostics of TB in HIV-positive patients. All HIV diagnosed patients are tested for TB. In 2013 in 4,180 PLHA that were officially registered, in 1,098 (or 26.2%) TB has been detected. TB treatment has been provided to 1,097 PLHA, including in 762 patients together with ART. For 39.3% PLHA isoniazid TB prevention has been provided.

In order to initiate ART in all 15 AIDS Centers and penitentiary service, commissions on ART prescription have been established. As of April 1, 2015, ART is provided to 11,538 patients including 4,093 children. In 23% of patients ART is funded by the national budget. In 2015 it is anticipated that the share of patients funded by the national budget will increase to 30.6%. Share of adults, that stay on treatment after 12 months after initiating ART is 88.2%, children – 92.8%[38]. In 2015 national clinical ART protocol for adults and children has been updated based on WHO recommendations (2013). Standard operational procedures on ART provision and diagnosticums have been developed and approved of, in order to insure ART continuum. The same document regulates clinical-laboratory monitoring of PLHIV, and PLHIV patient management in the primary healthcare. Currently, some 39.2% HIV patients have been transferred to the management of primary healthcare[39]. Joint order of Ministry of Interior and Ministry of Health regulate ART continuum for citizens that are entering the penitentiary system or exiting prison institutions. Specialists from the health system, including those working in penitentiary service, are regularly trained in the institute of post-graduate qualification improvement, and middle medical personnel – in a specialized center.

Starting 2011 multidisciplinary teams (MDT) started to work in Uzbekistan, composed of employees of the AIDS Centers, NGO Anti-Cancer society and NGO Ishonch va hayot. In

[38] Data provided by Republican AIDS Center.
[39] Data provided by Republican AIDS Center.

every AIDS Center and in in-patient clinics with beds for HIV-positive patients there function MDT, consisting of a doctor, psychologist, middle medical worker and 2 or 3 volunteers/outreach workers.

The following cascade of HIV care can be developed based on the existing Spectrum estimates and data of national registration in Uzbekistan.

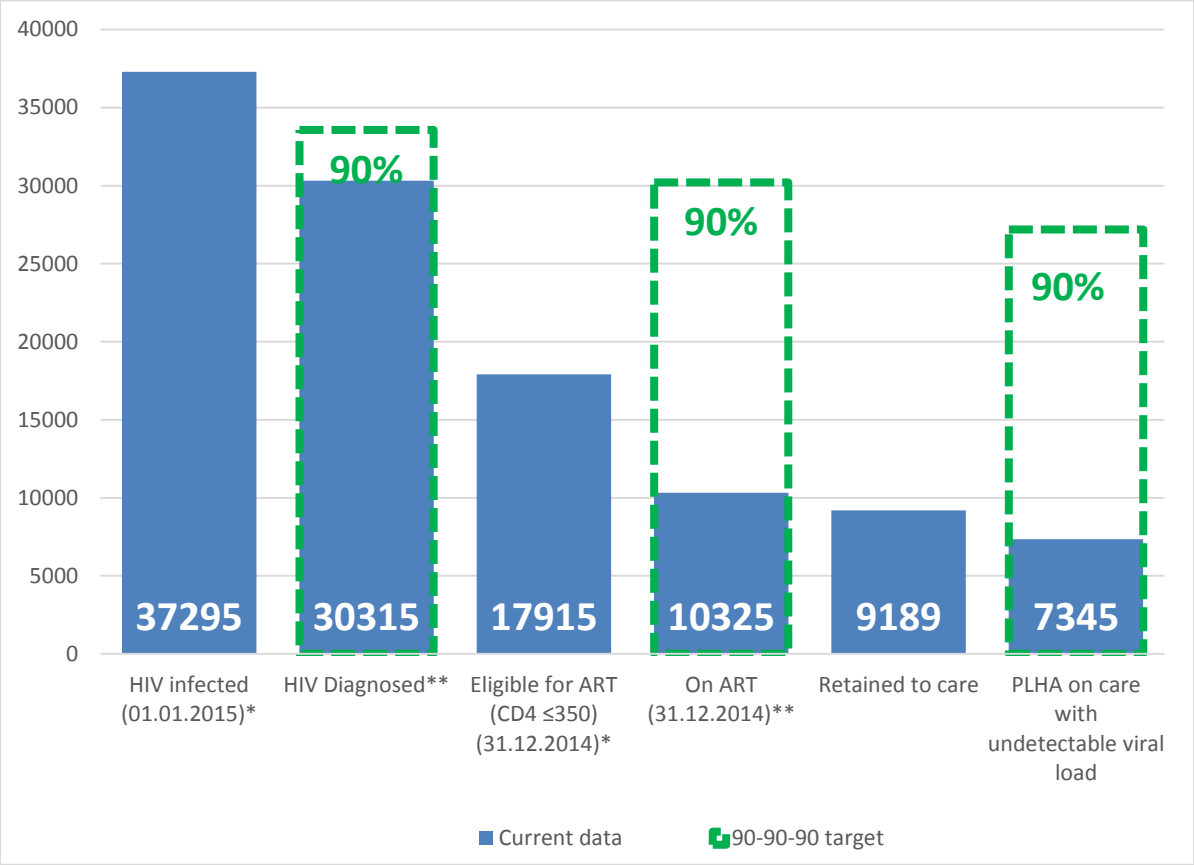

Diagram: Cascade of HIV care in Uzbekistan

**** Spectrum data***

***** Agregated ART report as of 31.12.2014 submited by Republican AIDS Center, Ministry of Health of Uzbekistan***

Cascade of HIV care above shows relatively high level of HIV case finding with 81% of those estimated to be living with HIV in Uzbekistan (Spectrum estimates) diagnosed by official registration system. Based on Spectrum estimates, some 17,915 PLHA have CD4 count at 350 and below and are in need of treatment. Out of them 10,948 (or 61%) are currently receiving treatment with some 89% retained to care after 12 months of treatment. According to the data of AIDS Center, viral suppression has been achieved with 7,342 PLHIV who are taking ART.

From the presented cascade, the biggest gap in achieving 90-90-90 targets appears at the level of treatment uptake with a little more than a half of those in need of ART actually receiving it (after application of new protocol this gap will become even bigger). This is addressed by the existing governmental plan to increase ART access which is partly included into this Concept Note and is one of its priority focuses.

There is no disaggregated by key populations data on ART coverage. Taken the very low HIV testing level among key populations groups, it can be assumed that their coverage by

ART is very low. Substantial effort is needed to increase HIV diagnostics and treatment initiation among key vulnerable to HIV groups.

c. Barriers

Despite the progress achieved by the strategic program, a number of barriers remain in implementing several of its strategies:

- New legislation on HIV requests mandatory testing for partners of PLHIV and people who inject drugs, which is likely to make the expansion of services to key populations difficult due to fears of public stigma. Criminalization of MSM complicates reach; at the same time it is worth noticing that not single person has been prosecuted in the court using this article (Article 120);

- New legislation on prevention of crimes may have a negative impact on prevention programs among key populations. Ministry of Health discussed the risks with the Ministry of Interior and sent out a formal request outlining the need for support to prevention programs among key populations when developing the detailing supportive legislation[40];

- Reaching out to key population groups especially such closed ones as MSM, remains a challenge. HIV cascade for some of the key populations groups such as PWID and MSM could be very different from the generic one. IBBS has shown that 71% PWID, 47% SWs and 86% MSM do not consider HIV testing as key prevention measure. The other two reasons for not testing are fear of prosecution (17.3%) and negative public attitude (24.2%);

- A challenge in provision ART to certain HIV-positive PWID is their adherence to treatment. A potential solution to this challenge is offered through piloting of OST for 50 HIV-positive PWID based in AIDS Center, as part of this program. Detailed plan has been developed for the pilot launch;

- Earlier, absence of quality standards for providing services to key populations partly limited prevention programs to reaching out to numbers of key populations without quality control. The newly developed standards will help to improve the quality and impact of prevention programs;

- There is a strong need to further integrate gender aspects into program design and delivery[41]. Triangulation report has reflected the growing role of women in development of HIV epidemic[42]. This requires additional action in redesigning the programs. This has been taken into account in the programmatic request;

- A certain challenge has been posed by the WHO new treatment guidelines recommending CD4 below 500 as treatment prescription margin. Based on this recommendation, the country has developed a clinical national protocol with gradual

[40] Letter from the Ministry of Health of Uzbekistan #12-8/234 as of 03.02.2015 (in Russian).
[41] National review of the orientation of the HIV response measures towards the needs of men and women in Uzbekistan, 2014.
[42] Analysis of triangulation data on HIV infection in Republic of Uzbekistan, 2014 (in Russian).

transition to covering with treatment all in need considering also their age, by 2017. WHO/EURO mission is expected in Uzbekistan in 2015 to probvide further assistance in the transition plan development. The gradual increase in the share of national funding is envisaged.

d. Integration with other programs

Prevention of and responding to HIV is integrated into other programs: 'Additional measures to achieve Millennium Development Goals in Uzbekistan for 2011-2015'; Decree of the President of Uzbekistan 1652 as of 28.11.2011 'On measures of further strengthening of reforming health system', President's Decree 2221 as of 01.08.2014 'On national program of further strengthening of reproductive health to the population, health protection of children, adolescents in Uzbekistan for 2014-2018', Decree of the Governmental commission on drugs control 11/11 as of 08.06.2011 'On the program against drug abuse and their illegal circulation for 2011-2015'. Various national programs complement each other, reflecting the unified complex approach in AIDS response in Uzbekistan.

Program against drug abuse for 2011-2015 among others regulates the measures to strengthen the existing and creating new services for PWID through functioning of Trust cabinets an opening of new ones, use of up-to-date international experience in drug use prevention and treatment.

Strategic program integrates with the National TB program in regards to HIV/TB co-infection. Joint activity of the phtysiatric service and AIDS service is aiming at timely detection of active TB forms among PLHA, as well as detection and treatment of HIV among patients with TB. Workers of both services conduct screening for TB and HIV, starting with the primary healthcare to insure early diagnostics, improve treatment access and prevent spread of TB. Involvement of non-medical workers, including outreach workers and NGO staff that work with key populations, for example PWID, to diagnostic process allows to substantially increase the coverage of people who don't usually visit medical facilities. Joint activity of HIV and TB services and corresponding reporting mechanisms are regulated by the Decree of the Ministry of Health. Izoniazid procurement for TB prevention among PLHA is conducted with the national budget funding.

There is an agreement with MSF that 100% of PLHIV registered within Tashkent city AIDS Center annually undergo TB screening using GeneXpert. The government allocated budget in the amount of 43 Million sum (20,000 USD) for procurement of isoniazid to prevent latent TB.

Diagnostics and treatment of Hepatitis is conducted in infectious diseases in-patient clinics. Within the Russia supported grant implemented by UNAIDS, multiplex rapid tests for HBV and HCV diagnostics have been supplied to the AIDS Center (for the overall amount of 50,700 USD). Similar procurement is planned up to the end of 2018. Also, MSF conduct rapid testing for HBV and HCV for PLHIV in Tashkent; 100 PLHIV are planned to be treated starting late 2015.

Within the Russian Federation supported grant implemented by UNAIDS rapid tests for syphilis and chlamydia have been procured and delivered to AIDS Center (for the overall amount of 131,000 USD), they will be also delivered to the Trust cabinets and AIDS

Centers for PLHIV. MSF conduct rapid testing for PLHIV in Tashkent for syphilis.

Government will continue providing syndromic treatment of STI, allowing to fully transfer this activity to the governmental funding (currently funded by the Global Fund grant). Funding in the amount of approximately 230,000 USD will be allocated for the procurement of STI drugs for the period of 2016-2017 (10,000 courses each year).

g. **Evaluation of the national program**

National M&E system functions in Uzbekistan in combatting HIV/AIDS, targeted at gathering and analyzing data, reflecting the level of fulfillment of tasks and activities of the strategic program, and reaching its targets. There is M&E guideline based on international best practice in HIV following the three ones principle, and also the national monitoring and evaluation plan of the strategic program. These documents define indicators of national statistics and fulfillment of the Political Declaration of Commitment to Fighting AIDS.

Once every two years IBBS is conducted among PWID, SWs and MSM in Uzbekistan which became part of the national system of epidemiologic oversight of HIV and is regulated by the respective orders of the MoH. It has complemented the routine surveillance having strengthened its analytical capacities. Starting 2007, sentinel surveillance is conducted in all administrative territories reaching out to the groups of PWID, SWs and MSM. Sentinel surveillance data was used for the triangulation exercise in 2014. Spectrum is used for or forecasting estimates of key population groups and PLHA.

Information about HIV program implementation starting 2012 is gathered and analyzed by department of Coordination of activities and HIV situation analysis within the RAC, funded by the national budget.

Starting 2003, Uzbekistan has fulfilled two strategic programs. On a regular basis the mid-term and final evaluations of the program have been conducted.

In 2011 evaluation of the results of the strategic program for 2007-2011 has been conducted by the international expert and the national experts[43]. The evaluation has shown that the epidemic remains in the concentrated stage. Further activities should be targeted at strengthening HIV counseling and testing among key populations, especially PWID.

Recommendations of the evaluation have been used during the development of the strategic program for 2013-2017. CCM formed the working groups of stakeholders and conducted activity planning. Workings of the working groups laid the foundations of the new strategic program for 2013-2017. The strategic program has been finalized with the participation of international consultant, reviewed by the working group and approved of by the Deputy Prime-Minister of Uzbekistan. Implementation of the plan started in 2013 and mid-term evaluation is planned for 2015.

In 2015 Uzbekistan is expecting to receive a WHO EURO mission for providing technical support on the following:

- assessing the existing system for providing ART services in the country, and
- supporting for development of transitioning plan from current CD4 <350 to CD4 <500.

[43] Evaluation of Strategic Program on HIV response in Uzbekistan in 2007-2010 (in Russian).

These measures will help further strengthen national HIV treatment program.

SECTION 2: FUNDING LANDSCAPE, ADDITIONALITY AND SUSTAINABILITY

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

2.1 Overall Funding Landscape for Upcoming Implementation Period

In order to understand the overall funding landscape of the 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.

1-2 PAGES SUGGESTED

During 2014 the government of Uzbekistan spent for HIV response measures 9 Million USD, funding from external sources made up 9 Million USD, including 7 Million sourced by the Global Fund. During 2013, 21 Million USD have been spent, including 8 Million USD from the governmental sources and 13 Million from external sources (including 12 Million sourced from the Global Fund). Therefore, about 50% of finance inputs into HIV response in Uzbekistan are from the governmental resources.

The government funds preventive, educational and treatment measures. Funding is distributed sectorally to allow fulfillment of the main activities of the strategic plan that are implemented by ministries and their sub-divisions. Thus the Ministry of Education and Ministry of Secondary Specialized and Higher Educational Establishments allocate funding for lessons on healthy lifestyles for pupils of secondary schools, lyceums and colleges and improving qualifications of teachers on HIV prevention. Ministry of Interior funds HIV prevention activities in penitentiary system and procurement of drugs to treat opportunistic infections. Ministry of Defense also with the funds from national budget conducts activities to increase awareness of the military contingent and their families about HIV and STI prevention, forming tolerant attitude towards PLHA. Ministry of Health as part of strategic plan implementation strengthens the facilities of the AIDS centers, laboratory base to include PCR equipment, citoflourimeters, hematological, biochemical analyzers, and for interdistrict laboratories – IFA complexes. Treatment for opportunistic infections in PLHA is conducted in all infectious in-patient clinics.

The Global Fund has provided to Uzbekistan substantial finance support in fighting HIV, starting with the first grant within Round 3 provided to the country in 2004. Programmatic activity within this grant was focused on increasing scales of HIV prevention among key populations. This activity was further supported within mechanism of continued funding. Round 10 program for health systems strengthening was also awarded to Uzbekistan. Starting from 2012 these 2 grants have been united into one funding stream with the overall budget of 22.7 Million USD.

The Global Fund has already provided substantial funding to increase the scale of prevention work among key populations, in particular PWID, having supported in 2015 139 Trust cabinets out of the total number of 230. These Trust cabinets were equipped not only with information materials, condoms, single use syringes and techniques on testing referral, treatment referral and care, but also became the coordinating points for outreach work.

The Global Fund and UNPD have increased the number of ART patients within the program. In 2013 and 2014 the government allocated 1 Million USD to increase ART coverage.

Alongside the success in response resourcing by the national budget, there remains a need to cover a number of critical interventions not covered by the government. Funding from international donors constituted substantial shares of funding for implementation of HIV strategic program in Uzbekistan (78.3% in 2007 and 54.14% in 2009). Additional resources are needed from donors to support ART in existing and new patients.

Taken the high numbers of key population groups in Uzbekistan (48,000 PWID and 21,000 SWs and unestimated population of MSM), resources are needed to fund prevention measures for them and national funding is lacking for implementation of such critical interventions as NSP, OST, condom distribution, low-threshold screening for HIV with rapid tests, TB screening and follow up.

The present funding request to the Global Fund is aiming at addressing gaps in the key national indicators in HIV treatment and prevention among key populations with allocation requested at 2.3 Million USD in 2016 (6 months) and 8 Million USD in 2017.

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	☒Yes ☐ No	

program		

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

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

2-3 PAGES SUGGESTED

Annually the government of Uzbekistan is allocating around 10 Million USD to finance the national HIV strategic program. An increase in national funding has been observed in the last years: from 8 Million USD in 2013 to 9 Million USD in 2014 and further increase is planned in the coming years.

The following diagram demonstrates the gradual increase in HIV funding through the governmental budgetand the relevant decrease in the needed co-funding from international resources. .

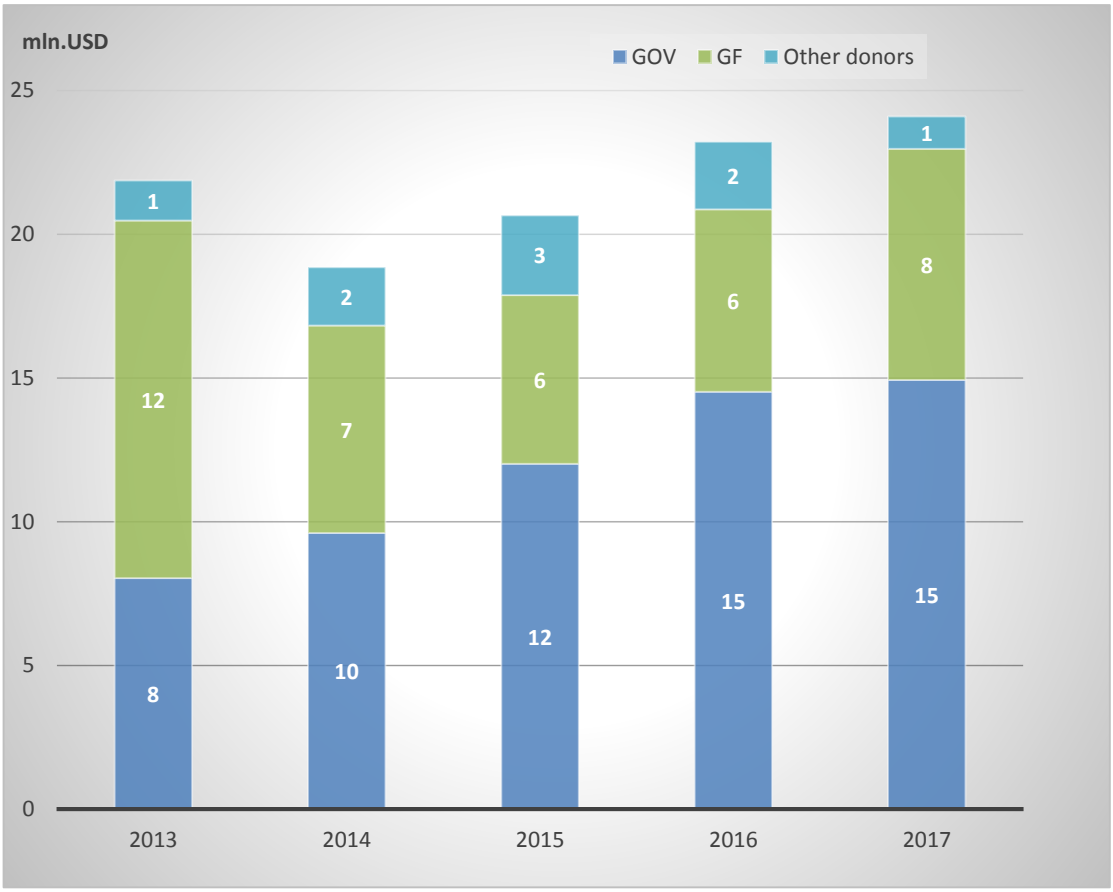

Diagram: Funding sources for HIV strategic program in Uzbekistan, 2013-2017

The following HIV budget lines will be fully financed by the national budget in the period 2016-2017, providing counterpart financing to this Global Fund request:

- operational cost (premises, utilities) of all Trust cabinets will be covered from state funds. Also country will cover 50% salary of Trust cabinets' assistant and nurse salary;

- STI testing and treatment;
- isoniazid preventive therapy for PLHA;
- procurement of HIV tests for 90% of pregnant women and full coverage of costs for service provision (medical staff salary, health facilities overheads etc.);
- ART service delivery (staff costs, premises etc.) is fully financed from the state sources;
- pharmaceuticals (ART drugs) for 5,430 patients in 2016 and for 7,500 in 2017.

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.

1-2 PAGES SUGGESTED – *only for modules that are difficult to quantify*

Quantifiable analysis has been done for key interventions in priority modules which have the strongest impact on the program outcomes. The following interventions were selected for analysis: Treatment, care and support and Prevention programs for PWID, SWs and MSM and their partners (coverage with services package and HIV testing).

Treatment, care and support

2014 coverage of ART is 30% of the estimated PLHA in Uzbekistan. National ART targets are at the level of full coverage of all patients with CD4 count at and below 350, at 18,175 (51%) and 18,510 (54%) of estimated PLHA in 2016 and 2017 (Spectrum estimates). National budget and MSF are planning to cover some 5,515 (14.7% of the estimated PLHA) in 2016 and 7,500 (20%) in 2017. The funding requested from the Global Fund is for additional 10,500 patients in 2016 and 11,500 patients in 2017. Therefore, the overall ART coverage at the end of 2016 from all sources will constitute 15,930 patients (or 46.3% of estimated PLHA) and 19,000 patients (57%) at the end of 2017, which is slightly below the national treatment targets for 2017.

Prevention programs for PWID, SWs and MSM

There is a 100% gap in funding for prevention programs for key populations. This program requests resources to partially fill this national gap. No other donors fund prevention programs for key populations in Uzbekistan.

For PWID, national targets in Strategic Program are at the level of 60% and above. In

2014 The Global Fund supported program reached 51% of the estimated group number. In the current program it is planned to reach with prevention services some 21,000 (44%) PWID in July-December 2016 (annual target 30,000 (63%)) and 32,000 (67%) PWID in 2017.

For SWs national targets are at the level of 80%. In 2014 The Global Fund supported program reached to some 56.4% of the estimated SWs. Under the current request 9,975 (48%) of SWs in July-December 2016 (annual target is 14,250 (or 68%)) and 15,750 (or 75%) are planned to be reached with The Global Fund funding and nationally.

At the absence of national estimates for MSM, there is no target or percentage available for programmatic analysis. The current request is for the coverage of 1,260 and 2,000 MSM in July-December 2016 and 2017 respectively.

Levels of HIV testing among key populations in Uzbekistan are low according to 2013 IBBS: 28% for PWID and 32% for SWs. This program works to substantially improve the situation with testing utilizing broadly the rapid testing methodology. With the national targets at 40% for PWID it is suggested to cover 12,600 (26.3%) of PWID in July-December 2016 (annual target in 2016 is 18,000 (38%)) and 19,200 (or 40%) in 2017. Similarly with SWs with the national target of 50% reached with testing, 7,350 (or 35%) are planned to be tested in July-December 2016 (annual target in 2016 is 10,500 (50%)) and 10,500 (or 50%) in 2017. 60% of the annually reached MSM group will be tested – 1,080 in July-December 2016 (annual target in 2016 is 1.080) and 1,200 - in 2017.

It is planned to test 60% of the reached MSM population at the levels of 756 in July-December 2016 and 1,200 in 2017.

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.

4-5 PAGES SUGGESTED

The HIV epidemic in Uzbekistan is growing and remains concentrated among the key populations. The level of their role based on official registration is probably underestimated due to administrative and criminal prosecution and stigma associated with risk groups as well as lack of structural access to these groups.

National strategic program of Uzbekistan prioritizes interventions among key populations and sets goals of reducing the incidence of HIV in Uzbekistan and provision of universal access to comprehensive services on HIV prevention, treatment, care and support. This Concept Note aims to support the national strategic program for 2013-2017.

Programmatic and financial gaps have shown the need for a focus on further ART expansion and care as well as for increased preventive effort among key population groups providing low threshold services like NSP, condom distribution and OST – both through primary healthcare and Trust cabinets as well as through outreach.

Thus, the aim of this program is the reduction of HIV-related morbidity and mortality in Uzbekistan.

The total request to the NFM for 2016-2017 is USD 10.3 Million in the allocation funding.

Based on the epidemic situation, the targets in the national strategic program,

programmatic and financial gaps and using the experience from earlier programs implemented in Uzbekistan a number of key strategic directions have been guiding the development of this Concept Note.

The following 4 strategies have been utilized to shape the programmatic approach.

1. Focusing on risk groups: needs based and integrated services at scale

HIV epidemic in Uzbekistan is driven by key populations: PWID, SWs, and MSM. Acknowledging their role, this program is focused on service delivery to those affected by and at greatest risk of infection. This proposal uses the WHO 2014 key populations guidelines and envisages the most effective and evidence based interventions for key populations, including ART, condom distribution, NSP, OST, HIV testing and care.

It is planned to increase coverage of key populations groups up to the levels of 67% PWID and 75% SWs, increase MSM reach up to 2,000 MSM in 2017, including through increased geographic reach. In particular, for sex workers programs with service delivery sustaining in 10 existing oblasts, 4 new oblast/sites (Fergana, Navoi, Samarkand, Tashkent oblast) will be added which will allow coverage increase to 9,975 in July-December 2016 and 15,750 in 2017. Similarly, for MSM several new oblasts will be added based on the results of sentinel surveillance and size estimation studies conducted in 2015.

Acknowledging the lack of epidemic data for better understanding of epidemic trends among key populations, and positioning HIV prevention among key populations as a priority task for the national response, research agenda has been formulated for this program with special focus on key populations.

Special attention is dedicated to women injecting drugs who appear at the highest risk of HIV infection. As this group is poorly covered with interventions and little information exists about it, the initial effort within this Concept Note is directed towards increased finding of women PWID utilizing Peer Driven Intervention. This intervention will be linked with research to receive better understanding of the practices and needs of this group and develop and test the most appropriate interventions to be rolled out in all regions in the future, taking into account the recommended in 2014 WHO guidelines for key populations interventions for women who inject drugs.

Special attention is paid to increasing access to HIV testing among key populations groups. The program envisages the following activities:

- Improving knowledge about reasons for refusing HIV testing by key populations through targeted research activities;
- Providing low threshold testing options and motivation for testing for key populations, including through the use of rapid tests and motivational packages for key populations showing up for testing;
- Increasing regional coverage of key populations and thereby increasing access to testing in the regions not covered before;
- Conducting activities to strengthen community systems.

The current program works to link vertical HIV and Tuberculosis systems to the benefit of key population groups providing early diagnostics of Tuberculosis among key populations and linking them to treatment. Outreach screening is proposed as a strategy covering all the key groups reached at least 2 times a year with screening and necessary follow up.

2. Regional prioritization of service delivery with the focus on key populations

Disproportionate levels of HIV in various oblasts of Uzbekistan are reflected in the levels of response effort proposed under this program. In particular, the concentration of the Trust cabinets in oblasts – the main service delivery and outreach coordination entity –

varies according to the numbers of PLHA registered in each oblast. This is presented in the diagram below.

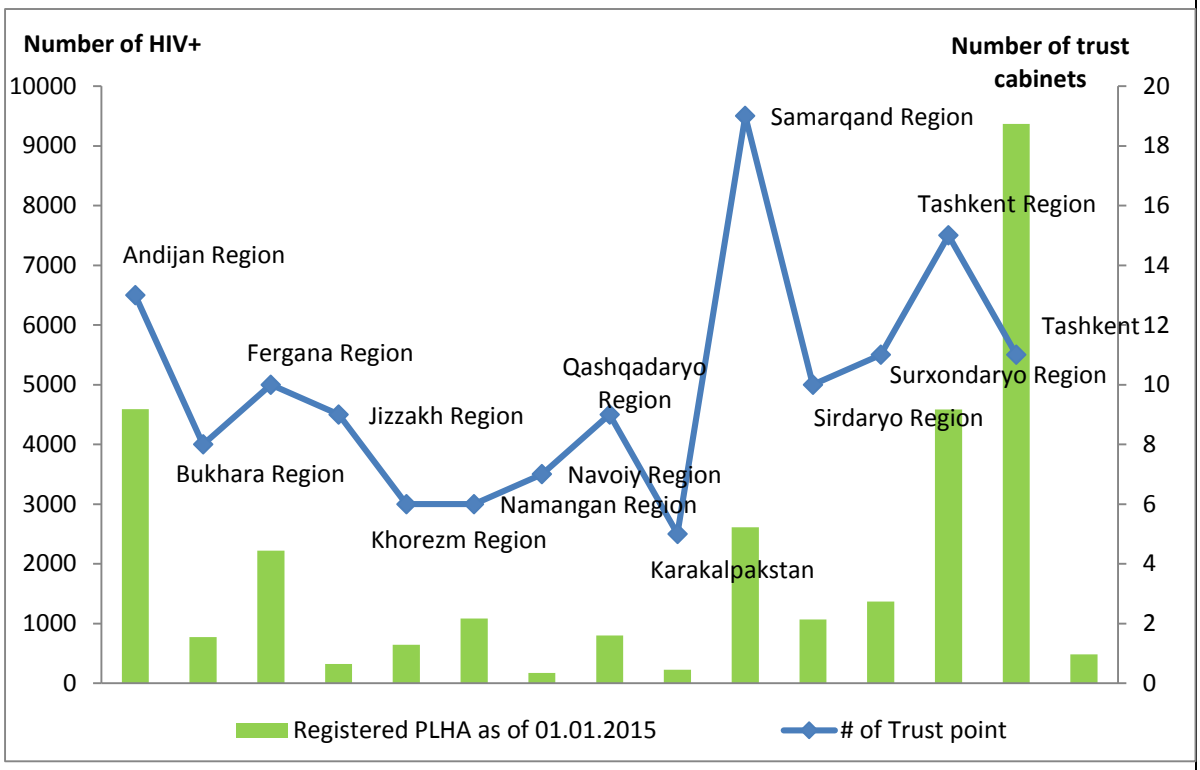

Diagram: Correlation between numbers of registered PLHA and Trust cabinets in regions of Uzbekistan

The outstanding high number of Trust cabinets in Samarkand is explained by the presence of drug transiting spots and high levels of local drug availability and use. In Tashkent city the number of Trust cabinets is low because city allows easier connection and service availability, therefore higher concentration is achieved with smaller number of Trust cabinets serving at higher capacities.

Based on the data obtained through interventions for women who inject drugs, and the size estimation research for MSM in 2015, regional re-prioritization will be conducted to fine tune the program geographic approach, in 2016 and to ensure the necessary geographical expansion of service coverage.

3. Sustainable development, ART decentralization, prioritizing key populations in ART access

The Principal Recipient of this program is the national institution under the Ministry of Health responsible for HIV/AIDS – Republican AIDS Center. It will replace UNPD in this role. This will further develop the national capacities to plan, implement and control national AIDS response in order to gradually uptake full responsibility for program implementation.

The government of Uzbekistan is playing a growing role in sourcing provision of ART to PLHA. In particular, in 2015 it will be funding ART for 30% patients and by 2016 this share will increase to 37%. This creates the necessary capacity and insures sustainability of service delivery. In the current proposal this is taken into account and the levels of funding for ART from the Global Fund is decreasing.

The government of Uzbekistan has been prioritizing strengthening of primary health care

in the health reform over the last decade.

The growing number of ART patients is reflected in the monthly plans prepared by the AIDS Center by region[44]. This dynamics increases load on AIDS system and further decentralization is happening to effectively work with the growing number of HIV patients in Uzbekistan. Stronger involvement of the general health network is envisaged as one of the program strategies. Primary health network received the major role in patient follow up and support upon ART prescription by AIDS Centers.

Strengthening the capacity of medical professionals of primary healthcare in delivering ART for PLHIV and especially among the key populations groups is planned every year. Republican AIDS Center is taking the lead role in planning, organizing and following up on the training and coaching for the doctors of general network.

Increasing key populations access to ART is a priority focus for this program. A number of strategies are envisaged to increase ART coverage among key populations and most importantly – increased coverage with HIV testing among key populations and increased HIV case finding through supporting research.

•

4. Overcoming legal barriers and creating enabling environment for sustained response

Criminalization of key populations, criminal responsibility for same sex practices, popular positioning of drug using and sex working behaviors as contradicting to traditional values, drive the representatives of key populations underground and hinder the delivery of HIV prevention and treatment services.

This proposal addresses these challenges from multiple angles. Firstly, it works towards coordinated effort of civil society organizations to jointly play a stronger role in establishing and developing governmental AIDS policies. It is anticipated that a coordinating group of HIV service organizations will become a lobbyist for critical legislation change and sustained civil society response, including addressing the legislation limiting rights of PLHIV – mandatory testing for HIV.

Secondly, the program suggests further advocative effort to increase the national funding for HIV response programs among key populations implemented by civil society organizations. Social contacting regulations will be reviewed and recommendations made and promoted on including stronger key populations focus and increasing allocations for this work.

The program will also address the popular negative attitudes towards key populations through a national campaign with posters, media coverage, and participation of celebrities. Focus of the campaign and its details will be developed in early 2016 with involvement of a consultant and the CSO working group.

Rights of the key populations groups will be protected through provision of legal support in the cases when human rights are violated. All CSOs involved will develop and approved of the system of recording of the rights violations and will collaborate with the College of Attorneys to bring the cases further.

Based on these strategic priorities, three strategic objectives have been identified for this program:
1. To deliver comprehensive, evidence-based, integrated and regionally prioritized HIV prevention and treatment services to key populations groups at risk of HIV and living with HIV.

2. To support the development of national health infrastructure for sustained, relevant and

[44] Monthly growth of PLHIV on ART by Republican AIDS Center, by end of 2016 (in Russian).

optimal HIV response.

3. To strengthen community systems and support civil society to ensure needs-based, human rights and public health driven and sustainable HIV response with particular focus on key affected populations.

The objectives are reflected in 9 modules. Rationale for module selection and outline of activities under each module are presented in the following section.

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.

3-4 PAGES SUGGESTED

Gap analysis has identified the greatest programmatic and financial gaps in interventions for key populations and HIV treatment. In particular, 100% gap has been identified for HIV prevention services for 2016 for PWID, SWs and MSM, and 84% gap in ART for 2016.

The government will gradually increase its funding share for ART reaching the share of ART coverage of 39% of patients on ART in 2017.

Five service modules have been selected and interventions developed to partially address this gap: modules on PWID, MSM, SWs, PMTCT, Treatment and care. The modules prioritize scaling up of ART and prevention interventions with focus on key populations.

Based on the situation analysis, program implementation environment is challenging for key population and civil society in Uzbekistan. A number of legal barriers to access for key populations exist in Uzbekistan. New Principal Recipient from the government will address some of the policy barriers, but will require capacity building in certain areas, and particularly sub-award management and PSM. The existing monitoring system does not provide reliable information on the disease and the dynamics in key populations. This context led to the selection of three enabling environment modules: HSS M&E, CSS, Management and governance.

The following funding distribution occurs between the modules.

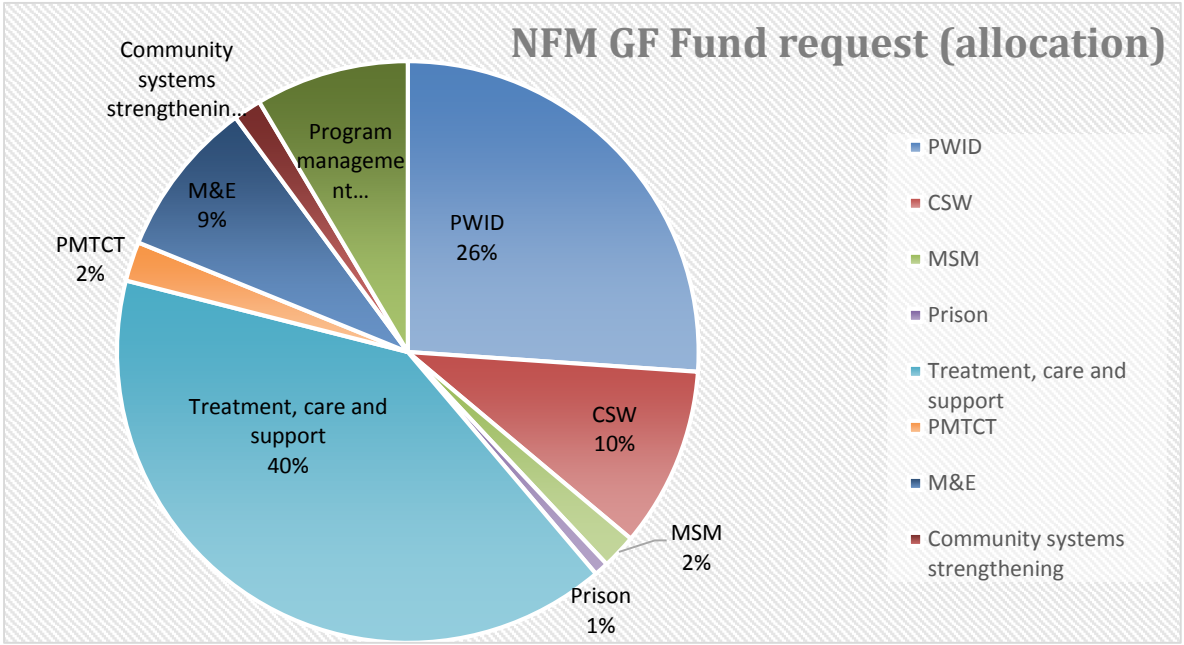

Diagram: The Global Fund request budget split between program components

Service delivery modules account for 81% of the total allocation.

Treatment, care and support

ART is currently provided in designated ART Centers in all 14 regions of Uzbekistan and is gradually decentralized into primary healthcare facilities at the treatment management stage in all regions. Current guidelines prescribe ART to those with CD4 count below 350. The new guidelines approved in 2015 foresee introduction of 500 cells as a margin and a plan is in place for gradual transition to the new guideline. As of January 1st, 2015, some 10,948 persons received ART in Uzbekistan, out of whom the Global Fund funded 8,325. 13 ART schemes are currently used for all patients; 11 schemes are prescribed to the new patients. Treatment cost is relatively low: average patient/year cost is 191 USD.

It is envisaged that 15,930 PLHA will receive ART by the end of 2016, out of which 10,500 funded by the Global Fund. ART will be prescribed to all those with CD4 count below 350 cells, and those with CD4 below 500 and age below 32 years.

In 2017 some 19,000 PLHIV are planned to be receiving ART out of whom 11,500 with the Global Fund funding. Treatment will be prescribed to all patients with CD4 below 500.

This program will facilitate access of key populations groups to HIV treatment through increased HIV testing among PWID, SWs and MSM using rapid tests based in Trust cabinets and using motivation schemes described in the following sections.

For ART monitoring in the national budget for 2016 and 2017 procurement of CD4 reagents for 30,000 detections is planned. Besides, in the current year within the governmental budget procurement of CD4 reagents for 15,000 detections is taking place with the delivery planned in early 2016.

More educational focus is planned to support treatment management with the primary healthcare. Prescription is done in AIDS Centers and further management is gradually transmitted to the primary healthcare. Training is planned to support new doctors in ART management and refresh the knowledge of experienced doctors.

Currently 16 multidisciplinary teams are providing support to PLHA and the same will continue under the current program. Psychosocial support will be delivered to 10,000 PLHA in 2016 and in 2017 by CSOs. Condoms at the amount of 60 per PLHA per year have been planned. 25% of those reached to receive product packages designated for those in constrained economic conditions and with TB co-infection, single mothers or women in constrained life circumstances.

The expected in Uzbekistan in 2015 WHO EURO mission for providing technical support on the existing system for providing ART services and supporting for development of transitioning plan from current CD4 <350 to CD4 <500 will help further strengthen national HIV treatment program.

According to the Ministry of Health regulations in Uzbekistan, all the patients receiving TB treatment in TB hospitals are tested for HIV. In case HIV is detected, joint HIV and TB treatment is provided. Patients with HIV registered with HIV service, are annually examined and consulted by the phtysiatrician. In case of necessity more regular consultations of phtysiatricial can be provided. Therefore, all the patients with TB or HIV in case of co-infection detected, have access to complex treatment of HIV/TB.

TB proposal to The Global Fund does not include any activities for patients with HIV/TB co-infection, same as HIV proposal. This is due to the fact that starting from 2014 medical prevention of TB among HIV-positive patients with isoniazid is funded from the national budget. According to the decree of the Ministry of Health # 402 from 2013, provision of funding for the procurement of isoniazid is the role of the oblast health departments. The annual need for isoniazid for TB prevention among PLHIV in Uzbekistan is 42 Million Uzbek sums (around 20,000 USD). It is covered by the Government of Uzbekistan.

Starting 2014, three institutions of the AIDS service have GeneXpert, that allows

conducting early diagnostics of TB. Within the current program the procurement of two more GeneXperts and cartridges for them is planned.**PMTCT**

For 10% of pregnant women HIV tests will be procured by the Global Fund, the rest is funded by the national budget.

250 and 500 women will receive PMTCT under this project in July-December 2016 and 2017 respectively. 325 and 700 children born to HIV-positive mothers will receive treatment.

People Who Inject Drugs

Projects to prevent HIV transmission among PWID have been implemented by a national NGO Intilish linked with Trust cabinets under AIDS Center during 2012-2014, and since June 2014 based on the decision of the Cabinet of Ministers organized commission have been transferred to the implementation by the Republican AIDS Center. Currently the program is implemented through the network of Trust cabinets based in primary healthcare settings with substantial outreach component implemented through direct contracting of outreach workers by RAC. During 2014, 24, 552 PWID have been reached by the program in all oblasts of Uzbekistan through 139 Trust cabinets and outreach.

It is planned that in the proposed program service delivery will continue to be provided in Trust cabinets and through outreach in all 140 Trust cabinets in the locations with highest prevalent rates of key populations groups and HIV run by 300 outreach workers. The following package of services will be provided:

- Syringes and spirit wipes (400 syringes per PWID per year and 800 spirit wipes per PWID per year) on outreach and in Trust cabinets;
- Condoms (100 per PWID per year) on outreach and in Trust cabinets;
- Counseling by outreach workers and medical professionals of the Trust cabinets;
- Rapid testing for HIV in Trust cabinets (60% of PWID reached);
- Information materials (1 per PWID per year, focusing more on new clients) on outreach and in Trust cabinets;
- TB screening 2 times per year for 100% PWID reached, with 100% positive referred for diagnostics and treatment to TB service;
- Overdose prevention with Naloxone (50% PWID receiving 1 vial per year) on outreach and in Trust cabinets;
- Delivery of gender sensitive services for women who inject drugs.

It is planned that the coverage of programs will increase to 21,000 in July-December 2016 and 32,000 in 2017.

Special attention will be dedicated to women who inject drugs. In 2014, only some 3,029 women drug users were reached with services out of 24,552 PWID reached. In order to increase the coverage of women, Peer-Driven-Intervention (PDI)[45] will be piloted in 2 sites in Uzbekistan selected against the following criteria: PWID coverage is low against the estimated number of PWID and share of women covered is disproportionately low. Technical support will be provided to enable the intervention quality implementation. It is expected that through PDI additional 2,000 women who inject drugs will be reached with the program services. PDI will be accompanied with research component that will allow to better understand the needs of women who inject drugs and modify accordingly the

[45] PDI is an outreach model involving people who use drugs to increase access to harm reduction services and reach greater numbers of PWID, especially those who have not been reached before.

mainstream prevention programs for the group.

OST has been in the pipeline for the last several years. After the pilot project on OST did not reach its goals in 2008 and was closed, several attempts have been made to renew the program within the Global Fund grant. Situation assessment conducted by Emilis Subata in 2012 concluded that it made sense to initiate the renewal of the OST. Study tour to Geneva on OST has been conducted in 2013. UNDP subcontracted WHO at end of 2014 to implement OST. Plan of roll out of OST with buprenorphine has been developed and approved of. But activity has not yet started, primarily due to the opposition of the national narcology specialists.

As part of the current program pilot project based on Republican AIDS Center is planned for 50 HIV-positive PWID in Tashkent using tableted buprenorphine. It is positioned as adherence measure for HIV-positive PWID initiating ART.

In order to initiate the program the following activities are suggested:

- Establishment of the working group to oversee pharmacotherapy for the patients with opioid dependence with the membership of experts in HIV, drug use, hepatitis, Tuberculosis, service of quality control for medical drugs;
- Familiarization of the working group with all the aspects of OST among patients with opioid dependence through studying of clinical and scientific experience in Uzbekistan and abroad, conduct of round table with involvement of international experts (WHO, UNODC, UNAIDS), study visit to an operational OST program and finalization of the decision on OST program perspective in Uzbekistan;
- Identification of the criteria of patient enrollment to the program (clinical criteria and the patient group size);
- Request for approval of OST approach by the Ministry of Health of Uzbekistan to the State Commission;
- Ensuring the necessary starting conditions for pharmacotherapy of opioid dependent patients:
    - Preparation and passing of the decision on the conduct of the pilot project on OST either by the Committee on Drugs Control or the Cabinet of Ministers, to be coordinated with the Ministry of Health, Ministry of Interior and Prosecutor General offices;
    - Preparation and approval of the Decree of the Ministry of Health on conduct of the pilot project on OST, including the procedure of OST provision;
    - Conduct renovation of the cabinet of OST to develop the base and receiving of the license for the right to store and use the narcotic drugs;
    - Selecting the group of drugs for pharmacotherapy of opioid dependent patients;
    - Selecting the medical institution to host the OST site;
- Conduct of the procurement of OST dugs: finalization the volume of OST drug procurement, develop the specification, announce the tender, evaluate the proposals and award contract; receive the import quota for Uzbekistan and export quota for the country-manufacturer; ensure production and delivery of the OST drug; conduct certification and customs clearance;
- Start of OST among patients with opioid dependence among PLHA on ART, including concilium with participation of narcologists and infectious disease doctors,

regular monitoring of ART adherence and efficiency of combination with pharmacotherapy for opioid dependence;

- Analysis of effectiveness of ways of improving adherence to ART by means of pharmacotherapy of opioid dependence.

Preparatory activities are planned for 2016: renewal of cabinet, procurement of drugs, study tour, preparatory measures to develop the necessary legislation. The drugs will be procured for one year and OST will start in July of 2017. AIDS Centre will be fully responsible for the roll out of this activity.**Sex Workers**

Implementation structure under the leadership of NGO will remain in 2016-17. Service delivery in 10 oblasts (6 reached by NGO and 4 through RAC) was based in Trust cabinets/ NGO offices and outreach, reaching annually to 11,842 SWs.

In the project it is planned to significantly scale up service delivery to SWs and increase coverage with HIV testing. It is suggested to use motivating packages containing hygienic pads to distribute as bonus for testing and for bringing a friend from among SWs to do the same. Service delivery will sustain in 10 existing and will be launched in 4 new oblast/sites (Fergana, Navoi, Samarkand, Tashkent oblast) which will allow coverage increase to 9,975 in July-December 2016 and 15,750 in 2017 all over the country utilizing the overall resource of 140 outreach workers.

The service package will be the following:

- Condoms (350 per SW per year) on outreach and in Trust cabinets;
- Female condoms (4 per SW per year) on outreach and in Trust cabinets;
- Counseling by outreach workers and medical professionals of the Trust cabinets;
- Rapid testing for HIV in Trust cabinets (50% of SWs), motivation packages for HIV-testing for new SWs (3,780 packages in 2016 and 7,560 in 2017);
- Information materials (1 per SW per year) on outreach and in Trust cabinets;
- TB screening 2 times per year for 100% SWs reached with 100% positive referred for diagnostics and treatment to TB service.

Men having Sex with Men

Prevention services for MSM will be sustained in the locations they were initially launched: Jizzakh, Syrdarye and Tashkent city, in 2014 reaching to 1,491 MSM. Implementation sites will be revisited based on the results of sentinel surveillance and size estimation studies conducted in 2015 and additional 5 outreach workers will be hired (totaling 40 outreach workers in Uzbekistan). Selected via competitive process NGO will oversee the service delivery in the Trust cabinets/NGO offices and through outreach.

Service package will consist of:

- Condoms (100 per MSM per year) on outreach and in Trust cabinets;
- Lubricants (50 per MSM per year) on outreach and in Trust cabinets;
- Counseling by outreach workers and medical professionals of the Trust cabinets;
- Rapid testing for HIV in Trust cabinets (60% of MSM reached);
- Information materials (1 per MSM per year) on outreach and in Trust cabinets;
- TB screening 2 times per year for 100% MSM reached with 100% positive referred for diagnostics and treatment to TB service.

It is anticipated that the project will cover 1.260 MSM in July-December 2016 and 2,000 MSM in 2017.

Prisoners

Some 58 prison institutions in Uzbekistan contain about 46,000 prisoners with officially reported occupancy level of 80%.

When new prisoners are admitted to prison institutions IFA testing for HIV is conducted. Confirmatory immunoblotting is conducted in AIDS Service institutions. Thus, reporting on HIV cases in prison settings is included in the overall reporting of the health system. As of January 1, 2014, in prison settings there were 820 PLHA (732 men, 88 women).

Information work is conducted in prisons: information booklets about HIV are disseminated to all the prisoners and they have to pass an exam about the key HIV transmission modes and prevention measures. In prison settings there are condoms available in the meeting rooms for spouses.

Medical and non-medical personnel undergo training on HIV-infection, doctors take the course on 'Problems of HIV-infection' in the Institute of qualification improvement of the Ministry of Health of Uzbekistan.

Provision of medical assistance to PLHA in prison settings is regulated by the joint Decree of the Ministries of Interior and Health as of 2007. Based on this document, ART initiation happens by prescription of a commission with the participation of the specialists of AIDS service. ART in prisons started in 2008; as of January 1, 2015, 182 PLHA received ART in prison settings. CD4 count is regularly monitored for these patients. PLHA on ART after being admitted to prison, continue receiving ART in prison. When PLHA are being released from prisons, prison institution sends to the territorial AIDS Centre where the prisoner is to be released the notification to continue treatment and receiving ART drugs without interruption.

Information about prison-based HIV infection and risk practices is not available.

According to the letter from the Penitentiary service, there is a need for improved diagnostics of HIV and opportunistic infections and therefore the request includes the procurement of Immunosorbent Assay analyzer and Flow citofluorimeters for CD4 counting, rapid tests for HCV and HDV for all incoming prisoners (1500 each per annum), and 8 computers for data processing.

Enabling environment modules attract budget share of 19%. The following modules have been selected: Community Systems Strengthening, Health information systems and M&E, Program management.

Community systems strengthening

Consultation with involvement of international expert is planned to detail the capacity building plan for Uzbekistan CSOs and to develop the advocacy agenda for 2016-2017.

A selected national NGO will lead in the civil society strengthening and community support. It will form a group of HIV NGOs that would advise and make decisions on the work plan and priorities for the component. The membership of the group will include representatives of the civil society organizations that implement HIV programs for key populations: Istykbali avlod, Intilish, PLHA organization Ishonch va hayot, Anti-cancer society and other organizations. Group composition will be finalized after the selection of the lead advocacy NGO is conducted based on open call for proposals. Its role will be to:

1) coordinate the activities of civil society on HIV;

2) lobby for legislation changes to improve key populations' access to services;
3) stigma reduction for key populations and PLHA through national campaign;
4) protection of human rights of key populations and PLHA, including through collaboration with national College of Attorneys;
5) lobbying for relevant volumes of governmental funding allocation for HIV prevention programs among ley populations.

Republican AIDS Center in the capacity of the PR of the program will provide the necessary support for the registration of the implementing NGOs at the national level, as most of them currently possess local registration which limits their nation-wide activities.

Monitoring and research

The monitoring and research function is coordinated by the RAC. The following research agenda is planned as part of the project:

- IBBS with size estimation for PWID, SWs and MSM groups in 2017;
- Operational research for the 4 groups (including PLHA) in 2016 with additional focus on vulnerabilities of female PWID and changing drug scene for the PWID group;
- Size estimation research for PWID, SWs and migrants groups in 2016;
- Operational research on Stigma Index to develop evidence and justification for further prevention interventions in 2016;
- Qualitative research to explore reasons of low levels of HIV testing among key populations in 2016;
- Efficiency of the prevention activities in key populations, in 2017.

Strengthening M&E capacity of SRs for national M&E system development is planned via refresher trainings on using MIS to be conducted annually to improve reporting and management data quality. For the same purpose bi-annual workshops to discuss targets for the national program are planned (one for CSO and one for governmental representatives).

Expected outcomes, impact and targets

As a result of the implementation of the activities within the modules the following coverage of key populations groups will be achieved with The Global Fund funding:

Estimated size, 2015	Target group		2016	2017
48,000	PWID	Target reach of PWID	21,000	32,000
		% of estimated PWID	43,8%	67%
N/A	MSM	Target reach of MSM	1,260	2,000
		% of estimated MSM	N/A	N/A
21,000	SW	Target reach of SW	9,975	15,750
		% of estimated SW	47.5%	75%
37,295	ART	Target reach ART	10,500	11,500
		% of estimated PLHA	28%	31%

As a result of this increased HIV prevention and treatment coverage, it is expected that HIV prevalence rates among key populations groups and AIDS mortality rates in Uzbekistan will stabilize.

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.

½ PAGE SUGGESTED

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.

1-2 PAGES SUGGESTED

The funding request is in line with the national Strategic Program on AIDS for 2013-2017.

The Principal Recipient for the program is the Republican AIDS Centre (RAC) of the Ministry of Health of the Republic of Uzbekistan.

The Principal Recipient has been selected through the competitive process following the call for applications for PR organized by the CCM of Uzbekistan and following the recommendation made by the especially established by the Ministry of Heath working group with the membership of governmental, non-governmental and international organizations (established as of May 2, 2014). Two organizations have applied to become the PRs on the HIV grant – UNDP (current implementer of HIV grant) and RAC. During its meeting on April 15, 2015, as reflected in The Minutes of the CCM meeting #07/10-11119, 20.04.2015, the group advised the CCM to approve of the RAC as the PR of the HIV grant because they have greater experience in HIV prevention, diagnostics and treatment, have a strong staff capacity, the necessary premises and facilities, network of the regional AIDS Centers, laboratories and warehouses, and experience of implementing The Global Fund

grant in 2004-2009. The CCM unanimously supported the nomination of the RAC as the PR for HIV grant ('for; - 24 out of 25 members of RAC, 'against' – 0; not voted – '1', RAC did not vote due to the conflict of interest).

None of the national NGOs applied to become the PR. This is unofficially explained by the high standards for the NGOs needed to become the PR, weakness of civil society in Uzbekistan and challenging environment for the functioning of NGOs in Uzbekistan with strong governmental centralization.

For the Tuberculosis grant the Republican DOTS Center has been approved of as the PR. For Malaria – the Republican Sanitary Epidemiological Centre.

The coordination between the PRs occurs through the governmental system (all three PRs are governmental organizations within the Ministry of Health of Uzbekistan) and the CCM. Based on the approved Regulation on the Inter-departmental council on coordination with international and foreign organizations to respond to HIV, Tuberculosis and Malaria and raising donor resources on conducting activities (CCM in Uzbekistan), the functions of the CCM include: coordination of the activities to respond to HIV, Tuberculosis and Malaria, implemented jointly with the international and foreign organizations). Representatives of all the three PRs for The Global Fund supported programs – Republican DOTS Center and Sanitary Station as well as the AIDS Center – are members of the CCM.

The Global Fund program in Uzbekistan has been actively collaborating with the governmental and civil society organizations that have been implementing certain programmatic areas against high programmatic standards. For instance:

Istykbali avlod – has been implementing programs for PLHIV, MSM, CSW in some regions;

Anticancer society – has been implementing programs for PLHIV in 13 regions;

Ishohcn va hayot - has been implementing programs for PLHIV in Tashkent;

Intilish - has been implementing programs for PWID.

Sub-recipients selection will happen through competitive process by means of open call for proposals organized by the Principal Recipient. NGOs with implementation experience of key populations programs are positioned as preferred sub-recipients.

Standard grant agreement will be developed for sub-recipients, basing on the existing formats used by the UNDP. Technical support on sub-recipient management will be provided to the new PR.

Civil society has been involved into the development of the Concept Note. CCM membership includes representatives of the civil society organizations: Mahalla foundation, youth union ' Kamolot', National Association of the non-governmental and non-commercial organizations of Uzbekistan, Intilish NGO, PLHA organization Ishonch va hayot as well as representative of PLHA community. The key NGOs working with key populations and PLHIV have been approached during the development of this Concept Note and their feedback received and incorporated. The NGOs will take an active role in the implementation of the program for key populations groups. Also it is expected that the NGOs will implement the advocacy component and the development of enabling environment for NGOs in Uzbekistan.

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.
1 PAGE SUGGESTED The Global Fund is currently funding together with the HIV, TB and Malaria grants implemented by UNDP (HIV), Republican DOTS Center and the Republican Sanitary Epidemiological Centre. CCM is overseeing the HIV grant currently implemented by UNDP and in future – AIDS Centre, the Tuberculosis grant implemented by the Republican DOTS Center and for Malaria – the Republican Sanitary Epidemiological Centre. The grants will be implemented by different Principal Recipients within different vertical systems of the health system of Uzbekistan. Secretariat of Country Coordinating Mechanism is coordinating the proposals, according to its scope of work approved of by the CCM. Also, as all the three PRs are part of the Ministry of Health structures, and regularly meet in the MoH coordinating meetings. In particular, weekly meetings with the participation of the Minister and Deputy Minister and the heads of the three services along with heads of other departments take place; during these meetings progress on projects is raised and discussed among other business. The Tuberculosis grant is focused on early detection and treatment of TB and MDR TB cases in PLHIV. In TB project HIV-TB module is planned with focus on procurement of cartridges for rapid diagnosis of TB and an early diagnosis of RR/MDR TB in PLHIV, using the existing Xpert machine network. The Malaria grant is focused on reduction of local transmission of imported new cases of Malaria, prevention of Malaria renewal in Malaria-free zones, certification of Malaria elimination in the Republic[46]. There is no duplication of the activities between the three proposals. Programmatic integration of the activities of TB and HIV grants happens at the level of early diagnostics of TB in key populations vulnerable to HIV and followed referrals to diagnostics and treatment for HIV prevention and treatment program clients as part of the HIV program. No duplication in the human resources, training, monitoring and evaluation or oversight of the three programs occurs.

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	The Republican AIDS Centre (RAC) of the Ministry of Health of the Republic of Uzbekistan	**Sector**	**Gov**
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	

[46] Uzbekistan Concept Note to The Global Fund on Malaria, 2015 (in Russian).

Minimum Standards	CCM assessment
1. The Principal Recipient demonstrates effective management structures and planning	The Republican AIDS Center (RAC) is a governmental institution within the Ministry of Health of Uzbekistan. It was established in 1990. Decision making in RAC is regulated by the Statute. Number of staff is 207 in the Republican center and 956 in 14 regional centers (one in every oblast). In the structure of the AIDS Centre there are administration, finance, prevention departments, planning analysis and coordination department, dispensary department, laboratory. RAC has been the PR for HIV/AIDS in The Global Fund Round 3 (2004-2010) under the financial, procurement and administrative stewardship of UNDP. About 30 subrecipients were programmatically managed by RAC. Office of Inspector General (OIG) evaluated the mechanism of collaboration of RAC and UNPD in Round 3 as ineffective and PRship for the subsequent program has been transferred to UNDP. Currently RAC is the sub-recipient with UNDP as PR, responsible for PWID prevention (directly contracting outreach workers in all oblasts) and ART, as well as M&E including sentinel surveillance. RAC has experience of managing other international projects, for example World Bank Central Asian project where AIDS Centre was a sub-recipient.
2. The Principal Recipient has the capacity and systems for effective management and oversight of sub-recipients (and relevant sub-sub-recipients)	RAC is controlling the activities of the regional AIDS Centers. Though, sub-contracts are not concluded as RAC hires oblast AIDS Centers staff to implement the Global Fund program. RAC is legally allowed to subcontract NGOs. There is a specialized finance reporting system for budget state enterprises UzASBO that has been in use since May 2015. It is not used for the Global Fund program as it does not correspond to its reporting needs. So far RAC has no accounting software (several unsuccessful attempts to procure a relevantly developed version of 1C), and Excel is used for finance records. As the principal sub-recipient in the existing Global Fund grant, it has a separate Program

	Implementation Unit (PIU) which will be extended with the uptaking of the PR role in 2016. AIDS Centre has the experience of procuring project laboratory equipment for clinics, test systems for HIV, drugs, vaccines (through UNICEF), as well as maintaining office procurement. There is committee that is ongoingly operational for every procurement based on the Decree of RAC. It is composed of the office staff such as bookkeeper, laboratory head, and deputy head doctor. Capacity building is needed to further develop the capacities to financially manage sub-recipients from governmental and non-governmental sectors.
3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud	In RAC there exists the system of internal finance control at the level of book keeping. For the purpose of procurement, monitoring of supply, movement and use of commodities, there exists an ongoingly operational commission. Once every two years RAC is contracting external audit; once every two years RAC undergoes audits by the Ministry of Finance, Prosecutor's General office and the Ministry of Health.
4. The financial management system of the Principal Recipient is effective and accurate	Overall RAC budget in 2015 is forecasted at 1,524,455 USD and the Global Fund project is additionally 1,072,760 USD. Funding for the governmental programs in the AIDS service is controlled by the treasury. RAC has accounts that are verified by treasury every time payment is made. RAC uses financial management and accounting IT System for all state organizations UzASBO - for its treasury account. RAC has a separate account for the Global Fund grant. With international projects, after the grant commission gives approval for the funds transfer to the separate grant account, further the targeted use of the grant resources is controlled by the book keepers of RAC and bank through the grants commission . There is no client-bank system used for the Global Fund program.

5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products	In the AIDS service there is one warehouse of the republican level and warehouses of the regional AIDS Centers that correspond to the requirements of drugs storage outlined in the normative documents (Sanitary Norms #0152-04). The republican warehouse may not be able to contain all the procurement within the grant when RAC attains the PR role. The Center is planning to rent 2 more warehouses for medical drugs and commodities. The republican and the regional AIDS Centre storages are equipped with climate control and temperature control. Most have electric generators in case of power cuts. Regular checks of correspondence of the regional warehouses to the standards are conducted by RAC.
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	Distribution of the medical goods is regularly conducted by RAC under the current Global Fund grant based on the planned patient/client coverage and monitoring of the use and remaining supplies in order to void stock outs or treatment interruptions. Distribution is handled by RAC - for ART with bus Gazel (currently not equipped with climate control) with use of refrigerators, only one vehicle is available for the existing program. There is a need to procure another vehicle with climate control option. Regional AIDS Centers also conduct distribution of commodities to their respective Trust cabinets, under the current HIV grant.
7. Data-collection capacity and tools are in place to monitor program performance	There are existing approved reporting forms and regularity of reporting on the following components: prevention, treatment, project monitoring. Program monitoring is conduced both on the level of the project, as well as at the levels of the Ministry of Health, Cabinet of Ministers, and CCM. There are electronic records in place for registering of HIV-infection cases and ART, currently in Excel. Automated ART monitoring database according to national standards is being developed in 2015 using the governmental funding in order for it to be able to be integrated into governmental accounts. It will also enable co-infections control and TB prevention. Management Information System (MIS) is used for tracking clients reached with prevention services, since 2011 and

	redeveloped in 2013. Outreach worker receives commodities, records them in his dairy linking to clients' Unique Identifier Code (UIC) and in the register. Data from the register is entered into MIS. Once a week database is transferred to the central server and aggregated. The database produces a number of automated reports, on client reach, materials distribution, indicates risks of stock outs. Weekly it gets automatically updated when sending the report to UNDP and oblast AIDS Centers. MoH report template has been downloaded into the MIS and the report is automatically generated. Dedicated staff is working with the database of the RAC. Sentinel surveillance is conducted by RAC using the network of regional centers. Other research is contracted through open tenders by AIDS Centre using competitive processes. Monitoring visits form part of the reporting system to oblasts including Trust cabinets, ART, commodities, storage etc. They are conducted once every quarter using the existing reporting format.
8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	There is a system of regular reporting in place on the program performance. The information is provided to the donor, Ministry of Health, Ministry of Finance and CCM.
9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain	In RAC and its regional centers there are provisors responsible for receiving and storing the medical goods. These specialists have undergone training in the Global Fund project on forecasting the needs in health products, their distribution and storage.

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.
1-2 PAGES SUGGESTED A number of risks exist to program implementation. Weakness of civil society and a lack of NGOs to implement the prevention program

constitute the risk of reaching out to targeted numbers of representatives of risk groups. The fact that the new PR comes from the government to replace UNDP and absence of dual track funding misbalances program implementation to the government side. The existing practices of direct contracting outreach workers and linking them with Trust cabinets in primary healthcare, despite generating cost-effective and government controlled solutions, hinders the development of civil society organizations and the leadership of the third sector.

Legislation on mandatory testing for PWID, those getting married and criminalization of MSM pose risks to extension of HIV testing service and to delivering prevention and treatment services to PWID and MSM communities.

To deliver the program in a transparent, human rights based and civil society driven manner a call for proposals for the key interventions will be organized by the PR with multiple stakeholders with close involvement of the Global Fund. NGOs should be prioritized as implementers of sub-components on HIV prevention for key populations and palliative care for PLHA. The component of community systems strengthening that has been developed as part of this program is among the key measures to respond to this risk.

Although the stepping in of the governmental PR is a strong development that would insure sustainability of the national HIV program, in order for the program to be implemented against the high programmatic standards, a range of capacities have to be developed with the new PR. Such resource-heavy functions as subrecipient management and procurement are among the key gaps in capacity of the new PR.

To mitigate risks in health procurement, procurement through UNICEF has been planned in this program. Also additional quality control measures have been foreseen, such as: rent of additional warehouse, procurement of vehicle for health products distribution, deliveries of commodities and drugs in smaller volumes. Capacity building plan has been developed for the RAC and will already start to be implemented in 2015 within the current UNDP grant. A range of capacity building measures specifically focusing on subrecipient management and health procurement have been included into the current program.

Substitution therapy pilot may get delayed, which is happening in the existing HIV grant, despite the condition precedent. It remains one of the risk areas and may fail to get implemented taken the opposition to the approach of the narcology in Uzbekistan.

To mitigate the risk the OST introduction failure, implementation leadership in this component is transferred to the AIDS Service where PR has the largest responsibility and influence. Substantial preparatory work has been envisaged in the proposal for 2016 to lead to smooth transition to implementation in 2017.

Information about prison based HIV infection and risky practices is not available. It is not known what HIV prevention measures and at what efficiencies are conducted in the prison system. There is a risk that HIV may be further spreading among prison population and that new infections may be occurring in the prison settings.

In order to mitigate the risk, RAC will work in close contact with the penitentiary medical service to make sure HIV prevention measures are provided and that continuum of prevention services is ensured in prison settings.

Financial instability in the region and substantial devaluation of Uzbek som pose risks to the ability of the government to provide counterpart financing. The current plans of ART increase as well as other components are at risk in the current circumstances.

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