

HIV/AIDS in Tajikistan

*Mid-term review of
The National AIDS
Programme 2011-15*

October 2013



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National AIDS Programme 2011-2015
October 2013**

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ABBREVIATIONS

ART	Antiretroviral therapy
BBP	Basic Benefit Programme
BCC	Behaviour Change Communication
CCM	Country Coordinating Mechanism
EECA	eastern Europe, central Asia Region
eMTCT	Ending Mother-to-child-transmission
EQA	External Quality Assurance
EWIs	Early Warning Indicators
FGD	Focus Group Discussion
HCF	Health Care Facility
HIVDR	HIV Drug Resistance
HSCC	Health Sector Coordination Committee
HTC	HIV Testing and Counseling
IBBS	Integrated Biological-Behavioral Surveillance
IDU	Injection Drug Users
IPT	Isoniazid Preventive Therapy
MARPs	Most at risk populations
MLEM	Model List of Essential Medications
MOH	Ministry of Health
MSM	Men who have sex with Men
NCC	National Coordinating Committee
NCCN	National Clinical Center of Narcology
NHS	National Health Strategy
NGO	Nongovernmental Organization
NLEM	National List of Essential Medications
NRL	National Laboratory
NSP	Needle Syringe Programmes
ONC	Oblast Narcology Center
OST	Opioid Substitution Therapy
PLWH	People living with HIV/AIDS
PMTCT	Prevention of Mother-to-child-transmission
PWID	People who inject drugs
QA	Quality Assurance
RACC	Republican AIDS Control Center
RCCN	Republican Clinical Center of Narcology
RH	Reproductive Health
RSBC	Republic Scientific Blood Center
SES	Sentinel Epidemiological Surveillance
SOP	Standard Operating Procedure
STI	Sexually transmitted infections
SW	Sex Workers
TGF	The Global Fund
TP	Trust Point
TWG	Technical Working Group
VCT	Voluntary counseling and testing
VL	Viral Load

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EXECUTIVE SUMMARY

Background

The Ministry of Health (MoH) of the Republic of Tajikistan had requested a mid-term review of the National AIDS Programme 2011-2015 which was conducted by WHO jointly with UNAIDS, UNDP, The Global Fund (TGF), UNICEF, in collaboration with the National AIDS Center.

The objectives of the review were to assess the implementation of the National HIV/AIDS Programme, whether it meets the targets defined by the National Programme, whether activities are in line with internationally recognized recommendations, and to identify gaps and give recommendations to achieve the set goals and targets of the National AIDS Programme as well as of the European Action Plan for HIV/AIDS 2012-2015. This evaluation should complement the findings of the TB & HIV/AIDS and Health System Strengthening mission at the end of 2010 by focusing on practical recommendations how to improve programme implementation despite the system's weaknesses noted in previous reports.

The WHO Country Office in Tajikistan led the preparation and coordination of the review process at country level. The evaluation was conducted during an in-country mission from 16th-25th September 2013. The team consisted of twelve members provided by WHO (Regional Office for Europe, WHO headquarters, country offices of Tajikistan and Ukraine, WHO Collaborating Centre for Harm Reduction, Vilnius), UNAIDS, UNICEF, the civil society forum (European Commission), and independent consultants. Team members reviewed a range of background documents and interviewed a range of stakeholders. Stakeholders included government officials from the Ministry of Health and its structures, other ministries, national AIDS centres, staff from international and donor organizations, physicians, representatives of NGOs and affected community. Visits were also made to a number of institutions and activities in and outside of Dushanbe, including a trip to Sogd and Khatlon Oblasts.

Key achievements

The National HIV/AIDS Programme has achieved good progress responding HIV epidemic despite complex political, economic and social challenges, including civil war, and resulting destroyed industry and agriculture, wide poverty and a weak health system. The major achievements are shortly listed below.

- There is a network of settings offering HTC services, and a variety of HTC models including mobile units implemented across the country; also an introduction of Rapid HIV tests that remains quite a sensitive issue in many countries of the eastern part of WHO European Region. Involvement of civil society settings in HTC, although limited, also reflects progress in this area. On-going efforts to revise HTC normative basis is also a positive development and should be encouraged.
- PMTCT was initiated in 2008 in 18 pilot districts of the country that account for approximately 70,000 deliveries per year. The PMTCT programme has been rapidly scaled up in a very short time frame and there is a continuous increase in coverage of services. There is integration of services within the MCH settings and collaboration with AIDS centres.
- Progress has been achieved by the National HIV Programme also in the area of treatment and care including access to ART being gradually scaled up; OST for injecting drug users has been initiated and serves as a promising base for their involvement in, adherence to and retention on ART; availability of ART in the prison system; development of a set of national clinical protocols based on WHO recommendations that are currently under revision to reflect latest WHO recommendations; clinicians have access to the international clinical expertise and leading world experts in treatment area; treatment laboratory monitoring is

available in 5 regions (CD4) and viral load at the national level. The National Reference Lab and labs in 4 regional AIDS centres are included in the external quality assurance programme.

- Elaboration and implementation of “friendly services” allowed achieving important progress in accessing treatment and care services. “Friendly services” being an important development in the country should be further promoted and optimized and become the blueprint for ART implementation and scale up.
- Initiation of an institute of social workers and professional education at universities and medical colleges is a very important development. There are not many countries in the eastern part of the region having such development. This initiative should become well known across the country, be further promoted and its opportunities well utilized as having a great potential in promoting access to treatment and treatment adherence.
- Inclusion of HIV/AIDS modules into the medical education and family medicine retraining programmes (Republican Family Medicine Center, postgraduate courses) provides a good basis for integration and capacity building. Promotion of linkages with AIDS centres will allow strengthening practical classes – an issue that is currently lacking.
- Availability of HIV prevention programmes in prisons including HIV testing, education, distribution of disinfectants and condoms.
- There is a well-established infrastructure for data flow with distribution of responsibilities covering the governmental based facilities. There are continuous efforts to make available strategic information for the decision-making.
- The Technical Working Group (TWG) on Harm Reduction is an example of a context where advocacy efforts received recognition. The members of this TWG are actively involved in the delivery of harm reduction services in different regions and belong to vulnerable groups. Over the past few years they have advocated for the improvement of harm reduction services and for the introduction of OST in the country, and succeeded in their efforts.
- Preparation of blood products and testing of donated blood for blood-borne diseases is performed in accordance with international standards.
- All laboratories within the blood services participate in External Quality Assurance (EQA), while reference laboratory in this case is the laboratory of the National AIDS Center. All laboratories also have intra-lab QA.
- Quality standards of donated blood components comply with the recommendation of the European Council of 2000. Some aspects to be updated.

Key findings and challenges

- Tajikistan has an IDU-driven concentrated epidemic; the true extent of HIV transmission among men who have sex with men is unknown; currently there is no evidence for significant contribution of migrants to the epidemic.
- Despite progress made, only one third of PLHIV are aware of their status
- Current implementation plan for the National Programme looks too broad and general, the indicators and targets require revision.
- The HIV Programme is heavily dependent on international funding – about 84% of budget needed is covered by different international donors and technical agencies.
- Insufficient coverage of NSP: only 15-25% IDUs are covered in some areas; roughly 1/3 has access to trust points as the majority lives in remote areas.
- OST covers approximately 1% of estimated IDU; restrictive national policies and practices including guidelines, narcological registry along with geographical remoteness of OST sites, and the absence of psychosocial assistance form major barriers preventing early access to treatment. The narcological services are not offered free of charge including detoxification from heroin thus creating additional barrier.

- Methadone has not been registered as medication and is not included in the essential drug list of MOH. Methadone is imported at higher costs than some neighbouring countries (e.g. Kyrgyzstan).
- There is no established OST capacity building system for medical staff. Most of the nurses have never been trained.

Treatment and care

- By the time of the review only 50% of the registered living PLWH were under medical follow-up (dispensarization) and out of them 88% have access to treatment and care which still indicates low ART coverage as 50% of PLWH is lost to follow up. Late presentation and ART initiation, low ART coverage in children (although due to national protocol criteria that requires urgent revision), low CD4 count laboratory monitoring coverage, limited access to regular viral load monitoring, non existence of prevention of HIV drug resistance (Early Warning Indicators), are among important challenge to be urgently addressed.
- Inadequate screening, diagnostic and access to treatment of HBV/HCV in PLWH
- There is suboptimal screening for and diagnostic of TB among HIV patients; MDR TB in HIV patients, including in prison settings.
- Insufficient pharmaco-vigilance system
- There is a need to strengthen efforts to improve ART adherence through NGO and PLHA community participation
- Persistent level of stigma and discrimination in medical settings is one of the main barriers to access for PLHIV and key populations to HIV services, including ART despite of improvements suggested as a result of the 2012 Assessment on S&D. The percentage of health workers saying that they would treat patients living with HIV in the same way as other patients has increased from 64.5% in 2010 to 74.3% in 2012. However, about 70% of PLWH mentioned that they had been stigmatized and discriminated in health care settings (their HIV status was disclosed without their consent, etc.)¹
- Physicians working at the AIDS centres are overloaded by variety of activities not related to the service provision.
- Collected data, including clinical indicators do not allow internal and external assessment of the treatment and care quality and outcomes.

PMTCT

- Funding gaps and funding insecurity in particular for testing commodities burden PMTCT.
- Early diagnosis of HIV exposed infants has only been initiated in 2013.
- Lack of evidence to support infant feeding policy. Newly adopted evidence based national infant feeding policy has not been implemented yet.
- Poor access to and utilization of family planning services for HIV positive women.
- Despite decreasing tendency mother to child transmission of HIV remains among the major challenges requiring urgent attention.

HTC

- Major challenges in the area of HIV testing and counselling include: mandatory HIV testing policy and practice; low proportion of key populations among those tested; large scale testing of low risk groups; re-testing of pregnant women, limited involvement of civil society in HIV testing. Long distance between NSP and HIV testing sites, fear of anonymity breach, stigma at testing sites, and long queues create potential additional barriers for IDUs to get tested. Access to confirmatory testing is limited and testing network needs further expansion. Interrupted supply of test systems and cost of testing services remains an issue of high concern as well as quality including that of test systems supplied. There is a

¹ National study on stigma and discrimination, 2012

confusion regarding confidential and anonymous testing in some settings providing HIV/AIDS related services.

Strengthening Community systems

- Lack of communication, synergy and trust between health governmental institutions and NGOs, on both sides.
- Scarce appreciation on the part of NGOs of their present representation in the CCM, and of members' election procedures.
- Lack of relevance and effectiveness of advocacy efforts.
- Despite of progress made in the recent years, integration of HIV programmes with other national programmes and services is insufficient. Integration should be further promoted, collaboration of different settings (including HIV/AIDS, TB, drug treatment, sexual, reproductive health, family planning, STI) should be improved, involvement of civil society settings expanded in order to better meet the needs of key populations and vulnerable groups including women and girls, achieve gender equality and reduce gender-based violence.
- Difficulties in ensuring quality and continuity of services due to insufficient financial resources, which should cover both the operational activities and reporting requirements and relations/networking with other NGOs, institutions, donors.
- Uninterrupted funding of projects not ensured. Services are discontinued and clients are left without essential prevention services.
- Sub recipients working only on HIV prevention and support need sustained capacity building. Staff quit because of funding interruptions; turnover is very high, causing loss of competences and poor quality in service delivery.
- Professional roles defined for social workers, outreach workers, counsellors etc. at central level are not properly communicated at peripheral level.
- Despite positive development of introducing social worker institute, this development remains unknown to relevant stakeholders.

Health System Strengthening

- Problem of treating the disease instead of the person, mainly caused by poor integration and continuity of services.
- Limited government expenditure for the health sector (6% in 2011) coupled with high donor dependence, especially in the HIV/AIDS programme (notably, reliance on the Global Fund), raises question of sustainability, equity and access issues (e.g., Basic Benefit Package, Decree 600).
- Verticalization of the HIV/AIDS programme (e.g. training, salaries, labs, treatment, testing, symptomatic disease).
- Stigmatization by primary health care providers.
- Limited linkages among the different work streams among development partners, government and civil society. Bilateral MOUs between government and development partners exist but there is no one agreement or mechanism between country governments and major development partners requiring reporting on externally funded expenditures and predictable commitments based on a format to be agreed (compact).
- Limited data by programme on service availability, and lacking complete picture on service readiness aspects by health facility, including mapping of different friendly cabinets, trust points, etc.
- Multiple sources of procurement of drugs and commodities based on programme (e.g., government, UNICEF, UNDP, UNFPA, donors)

Strategic information, monitoring and evaluation (M&E)

- Despite a well-established HIV M&E infrastructure for data flow with distribution of responsibilities covering the governmental based facilities, the NGO sector is not integrated within.
- Lack of trained human resources at all levels. The capacity building is mainly funded from external sources, without a sustainability scenario in place yet.
- The results framework for the NSP was not developed. This does not fully allow seeing the clear links, which indicator is measuring the achievements of which objective of the National Programme.
- HIV M&E framework is missing outcomes and impact indicators related to the prison population where HIV is concentrated.
- The existing M&E related documents do not provide with a full picture of the HIV M&E system functionality based on the 12 components approach for a functional HIV M&E system. However, at the time of the mission the M&E guideline was under the revision with consideration of 12 components.
- M&E data collection periodicity is not fully harmonized with the National Programme review schedule – this fact may compromise the effectiveness of the end-term review in 2015.
- The set of HSS HIV indicators is not harmonized with the HIV M&E framework of the National Programme under review.
- New IBBS protocols were approved in 2012, but operating procedures and size estimation component are missing.
- Electronic database for HIV cases follow up is in process of retrospective data entry. The built in reports do not allow assessing the quality of HIV care comprehensively.
- Many types of software use the unique identifier for different groups of population (donor driven). None is recognized as a national unique tool.
- Monitoring visits, conducted in partnership with the TGF grant cover the GO based facilities only.
- There are insufficient analytical skills and correct interpretation and use of existing data.
- Insufficient dissemination of the M&E and HIV surveillance information especially outside of the GO sector.

Blood safety

- Regulatory framework does not cover all aspects of the Blood Service, not all documents consider best global practices and strategies in regards of organizational and technological aspects of modern blood donations. There is no national guideline on clinical use of blood products.
- The Blood Service has no adequate stock of blood and blood products, nor of disposable materials, tests and reagents to study donated blood in case of emergency situations (armed conflicts, terror acts, massive outbreaks and etc.)
- Existing financing system is not capable to adequately meet needs of health care facilities (HCFs) in regards of blood and blood products (both quantitative and qualitative).
- Activities of the Blood Service are mainly supported by the international community (TGF, WHO), where the Blood Service receives financial, technical and methodological aid.
- At national level there is no effective system to motivate population for volunteer blood donations.
- Number of annual blood donations per 1000 population is 10 times less than minimum level recommended by WHO. 65% of donors are donors-relatives, which is considered the most dangerous category of donors due to high risk of transfusion of blood-borne diseases.
- There is no adequate supply system of blood products to HCFs.

Key recommendations

Health System Strengthening

It should be noted that a number of issues observed during this review were also highlighted during the Tajikistan *TB & HIV/AIDS and Health Systems Strengthening assessment* in 2010. It would therefore be important for the Government, partners and civil society to follow up and implement recommendations from that mission.

Short-term – should be addressed within a 6-12 months period

- Advocate with the Ministry of Finance (MoF) for increasing the total general government expenditure for health:
 - consider development of an action plan for phasing out donor support and ensuring financial sustainability
 - based on the needs, allocate funds within the overall health budget for HIV (e.g., testing, treatment, care, prevention activities)
- Consider undertaking a mapping of the procurement system (drugs, commodities – HIV, TB, STIs, reproductive health, etc.)
- Consider undertaking an assessment of health facilities for service availability and readiness to identify service delivery issues across programmes
- Improve integration of the HIV/AIDS module in the medical education curricula and improve health workers' (including family doctors, nurses and specialists) expertise in HIV/AIDS
 - Along with theoretical exercises incorporate practical classes into the training programme
 - Involve national AIDS centres into education/retraining programmes
- Develop a step-by-step plan for integration of HIV services into primary health care, including:
 - Increasing awareness of primary health care workers
 - Disclosure of status to care givers
 - Inclusion of family practitioners in general care of HIV positive people
 - Undertaking an assessment of health facilities for service availability and readiness to identify service delivery issues across programmes
 - Patient pathways (people-centred care)

Mid-term – maybe addressed within a 12 – 24 months period

- Promote person-centred care
- Prioritize and optimize services (e.g., labs, training)
- Start implementation of plan for integration of HIV services into primary health care by piloting some activities ²
- Further optimise work of AIDS centres including close link with PLHIV (including social support, involvement of peer support/civil society, mobile clinics) and further optimise integration of ART and OST services.

²One possible option could be to pilot integration of selected HIV/AIDS services into three primary health care centres in Dushanbe and in one rayon (for example, in Spitamen Rayon, Soghd Oblast). These trained family practitioners could undertake pre and post-testing counselling and testing. If a person has a positive status, person should be referred to the AIDS centre for follow up including treatment and care as appropriate. The person then receives treatment and care for general conditions from the trained family practitioner. In order to reduce spread of confidential information, the family practitioner should get appropriate training. Signing a confidentiality agreement could be considered as an option if needed; if this agreement is violated appropriate actions are taken against the family practitioner.

- Scale up efforts to achieve universal health coverage (e.g., Basic Benefit Package, vulnerable populations).
- Consider a “compact” among government, development partners and civil society to work together more effectively to deliver priorities in the overall national health sector strategy (also linked to Commission on Information and Accountability efforts).³
- Align various purchasing policy and logistics for drugs and commodities (e.g., existing state policies, UNDP) for treatment of other co-infections

Strategic information obtained through surveillance, monitoring and evaluation

Short term– to be addressed within a 6 – 12 months period

- Improve the quality of the next round of IBBS among PWID, SW, prisoners and MSM through adjustment of the newly developed protocols: adaptation of Kazakh version could be an option. Where the methodological assumptions are presented and field procedures are standardized¹; strengthening of the biological component (2); extension of the sampling frame for prisoners to get representative data for the entire penitentiary system (3); assurance of an external quality control during field data collection period (4); integration of the size estimation component in IBBS protocol and its regular implementation (5); improvement of the analysis and dissemination of IBBS process and results: a report should be produced after each IBBS round where each site results should be analysed and should contain chapters on methods and limitations (6).
- Conduct an advanced statistical analysis (trend analysis) of available IBBS in key populations databases to help understand the trends and to contribute to the end-term review of the National Programme.
- Review of the HIV M&E framework and development of HIV M&E related documents through: (1) review the set of indicators according to the mission recommendations and addition of prisoners’ indicators; (2) reshape the current table of HIV M&E plan into a results framework format; (3) reshape the Indicators Manual into a HIV M&E plan according to 12 components framework for a functional HIV M&E system and add country specific technical details to the indicators (data sources and data collection forms, data flow, data validation, other data for triangulation, etc.); (4) develop an HIV M&E work plan where the timeline of the data generating activities will be harmonized with the periodic reviews of the National Programme.
- Harmonization of HSS HIV indicators needs improvement.
- Speed up the implementation of the electronic system for HIV patients’ follow-up and review the reports built in to inform the quality assessment of clinical management of HIV patients.
- Conduct in 2014 a validation of data collected through routine statistics in preparation for the end-of-term review of National Programme.
- Develop a minimum set of recommendations to be used for correct interpretation of available HIV surveillance data.
- Ensure the broad dissemination of the M&E and HIV surveillance information and make them publicly available.

³Compacts can improve aid effectiveness; serve as a tool for mutual accountability, by introducing indicators for tracking progress against agreed commitments of government, development partners and civil society.

Mid-term – to be addressed within a 12 – 24 months period

- Develop a software for the system of the unique identifier and implement it for countrywide universal use by GO and NGO based service providers.
- Develop protocols for supportive supervision visits and data auditing. Comprehensive protocols for monitoring visits would help standardize the processes and ensure the methodological sustainability.
- Conduct additional studies to determine the extent of HIV epidemic among the MSM population.

Strengthening community systems

Immediate – requires immediate and priority attention within a 3-6 months period

- Review of CCM functions and procedures with regard to a more transparent election mechanism for NGO members and definition of TOR for NGO CCM members
- Grants (1) Definition of clear, balanced and transparent procedures for the application to grants. Wide promotion of funding opportunities (CCM website and other)
- Grants (2) For the Global Fund: uninterrupted provision of services within the TGF projects; proportionality of funding/resources and related indicators, with the possibility to discuss them and to introduce quality indicators; improvement of communications between civil society and Global Fund
- Grants (3) For principal recipients: transparency of procedures for the selection of recipients, procurement; optimization of grant management system (terms of agreements with sub recipients, buffer funding; capacity building for grant recipients)
- Support to new NGOs; continued investment in services provided by “old” NGOs with strong motivation to maintain HR services for their clients and need to ensure continuity

Short-term – Should be addressed within a 6-12 months period

- Promotion of a bottom-up approach to empower civil society and improve NGOs involvement in policy development, and their meaningful contribution to the HIV/AIDS Programme and M&E process.
- Reflection on actual good examples and best practices (good relations and cooperation within the CCM members in the Sogd oblast; good achievements of the TWG on harm-reduction) for their replication.
- Improvement of relations among NGOs at all levels; development of effective networking mechanisms; better representation of people from vulnerable groups; increase in sustained and joint advocacy campaigns and efforts.
- Funders and international agencies should improve mutual cooperation, ensure dissemination of data to both governmental institutions and NGOs and simplify/unify reporting requirements to avoid overload with data collection for NGOs.
- Address gender issues such as the restrictions placed by the family environment to perform tests and access treatment, care and support (in line with existing recommendations). Address implementation of findings and recommendation of a “Gender Assessment of HIV response in Tajikistan“, 2013⁴.
- Within the CCM structure, consider a technical working group for improving capacity building and advocacy for civil society.
- Identify effective interventions to reduce stigma and discrimination particularly in health settings and include them in the further plans as one of the priorities to improve access of key populations and vulnerable groups to HIV services.

⁴ Gender Assessment of HIV response in Tajikistan , 2013

Mid-term – maybe addressed within a 12 – 24 months period

- Involvement of NGOs in the delivery of services that are presently inadequate due to lack of staff in the health sector (e.g. counselling on treatment adherence) or insufficient (offer of rapid testing to vulnerable groups)

HIV Testing and Counselling

Immediate – requires immediate and priority attention within 3-6 month period

- Review and abolish mandatory HIV testing policy and practice. Elaborate evidence and human rights based national HIV testing policy that follows international norms and standards and ensure that national HIV testing policy is followed in practice.
- Lift existing restrictions on entry, stay and residence for people living with HIV supporting the right to equal freedom of movement regardless of HIV status and contributing to move towards a world with zero HIV-related stigma and discrimination.
- Abolish testing policy and practice of testing in low risk groups (including migrants, military, foreigners, medical staff and scale up HIV Testing and Counselling access and coverage for people who inject drugs and their sex partners, prisoners, men who have sex with men, and sex workers. Expand community based HIV testing and counselling, access to rapid testing primarily via civil society settings, including existing friendly services, NSP; ensuring access to free HIV testing; expand access to quality pre- and post HIV test counselling. Ensure HIV testing and counselling for patients having signs and symptoms suggestive of underlying HIV infection and for patients with diagnosed or suspected viral hepatitis.
- Universal re-testing for HIV negative pregnant women in the context of current epidemic in Tajikistan being at concentrated stage is not recommended.
- Re-testing should be recommended with each new pregnancy or if pregnant women are in high risk category, this includes: high risk partner with unknown status; HIV positive partner; sex worker or currently injects drugs.

Mid-term – maybe addressed within a 12 – 24 months period

- Expand access to truly confidential and anonymous HTC services. Confidentiality should not pose barriers for information sharing among care givers to PLWH. Nationally approved normative documents (including HIV testing policy, guidelines, treatment clinical protocols) should address confidentiality and anonymity issues, and should be well known in all settings involved in HIV/AIDS control, prevention, treatment and care. Relevant national capacities should be developed/strengthened and maintained.
- Optimize HTC network, testing algorithms, expand confirmatory testing starting from STI, reproductive health (RH), blood safety, TB, narcology settings. Ensure effective linkages, referrals to post-testing services.
- There is a need to further improve data on HIV testing access and coverage, post test referrals primarily for key populations and their sex partners, prisoners, men who have sex with men, and sex workers; better knowledge of barriers and facilitators and well defined plan to address them; realistic targets for HTC expansion and precise action plan to reach these targets.
- Uninterrupted supply of quality tests should be ensured; WHO list of prequalified tests should be consulted to get guidance required
- Professional education for HIV lab personnel should be improved. Capacity building of staff performing HIV testing, including that of civil society settings should be ensured and monitored

It is recommended to consult WHO Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach, World Health Organization 2013 (<http://www.who.int/hiv/pub/guidelines/arv2013/download/en/>), WHO HIV Testing and counselling documents (<http://www.who.int/hiv/topics/vct/en/> <http://www.euro.who.int/en/health-topics/communicable-diseases/hiv-aids/publications/2010/scaling-up-hiv-testing-and-counselling-in-the-who-european-region.-policy-framework>) that would guide national HIV testing and counselling scaling up efforts.

Prevention in people who inject drugs and prevention of sexual transmission

In order to control the HIV epidemic shift all efforts of the national programme activities towards people who inject drugs and their sex partners, prisoners, men who have sex with men, and sex workers and primarily to geographical areas with high incidence of HIV

Immediate – requires immediate and priority attention within 3-6 month period

To Ministry of Health:

- Implement rapid HIV testing of PWID at NSP sites (Trust Points, NGOs)
- Revise National OST Guidelines in accordance with WHO and other internationally agreed standards

Short-term – should be addressed within a 6-12 months period

To Ministry of Health:

- Establish positions of social workers and psychologists at existing OST sites to provide, comprehensive psychosocial assessment and support.
- Consider the reduction of the costs of methadone by importing methadone substance and preparing it in local pharmacies.
- Register methadone as a regular medication at MOH; include methadone in the Essential Drug List of MOH.
- Focus on PWID's sex partners, MSM and female injectors who work as sex workers in order to prevent sexual transmission of HIV.
- Extend STI services organized as “friendly services” to all STI service points in the country
- Abandon all name based national registers of STI.

Mid-term – may be addressed within a 12-24 months period

To Ministry of Health:

- Develop mechanisms of mixed (government/donor) funding of NSP/OST.
- Increase accessibility of NSP by expanding services to all areas with injecting drug use as well as increase the coverage through outreach.
- Replace “narcological dispensary registry” with national case-based statistical database (unique identifier code).
- With cooperation of donors, open new OST sites in narcological centres/cabinets; decentralize existing OST where possible to make OST geographically close to IDU. Promote integration of HIV/TB/OST services.
- Use existing narcological infrastructure and existing staff at primary and secondary level to provide more OST programmes.
- Consider introducing OST issues into curricula of narcologists, nurses and psychiatrists at medical schools, medical colleges and institutions of post-graduate training.

To Ministry of Justice:

- Expand existing NSP programme to all prisons
- Open OST in prisons (including remand prisons) so that OST patients could continue OST and inmates could initiate OST in prisons and continue in civil sector

To Ministry of Education:

- Increase number of trained professional social workers at universities and colleges to be employed for drug dependence and HIV infection treatment medical facilities, as well as in NSP in Trust Points and NGOs
- Include provision of OST in curricula of undergraduate and post-graduate training at medical universities and medical colleges for narcologists, psychiatrists and nurses

Prevention of Mother-to-child-transmission

- The trend of increasing coverage with PMTCT services will need to be continued and scaled up to achieve elimination of mother to child transmission.
- More attention needs to be paid to issues of adherence to ARVs for pregnant women and in general women of reproductive age including but not limited to: adherence support counselling, peer based interventions, use of mobile technologies etc. A number of innovative and effective approaches available across the world can be tested and adapted for use in Tajikistan.
- Additional efforts need to be undertaken to harmonize data collection and analysis system between antenatal services and maternities and AIDS centre, to ensure quality data collection and analysis and inform further programme development.
- Introduction of Early Infant Diagnosis system, using Dry Blood Spots is highly encouraged to ensure early diagnosis and early access to ARV treatment for HIV positive infants. The anticipated progress in laboratory diagnostic will also enable measuring of HIV transmission rates on annual basis, without reporting delays.
- To adopt such policies for HIV testing in pregnancy that ensure equitable universal access to HIV testing for all women, considering limited available resources. Reinforce MOH Decree #259 (6.05.2013);
- Conducting operational research and comprehensive data analysis to evaluate existing interventions and improve policy development is strongly encouraged.

Treatment and Care**Immediate – requires immediate and priority attention within a 3-6 months period**

- Access to ART for ALL children must be ensured. Remaining 114 HIV-infected children who do not receive treatment should be reached in a short perspective and examined for their eligibility to ART. If there is a lack of qualified national human resources possibility of external assistance should be explored.
- Country needs support in the development of the set of indicators to ensure a proper clinical monitoring of ART effectiveness and outcomes on a regular basis.
- E-database on all patients being under medical follow up should be completed at all levels and used as a tool to assess treatment outcomes and its dynamic.
- External evaluation of the viral load testing quality should be conducted.

Short-term – should be addressed within a 6-12 months period

- Early access to ART for children, adolescents and adults must be ensured based on WHO recent recommendations: <350 or < 500 CD4 cells/μl. All children < 5 y.o. should get ART regardless of CD4 count ⁵. One of the options might be to optimize treatment provision services by delegating part of it to the infectious diseases hospitals. It would require establishing outpatient management in infectious diseases hospitals (adults and children) as it is still lacking/non existing there.
- Strong linkages between out-patient and in-patient care management for PLHA should be elaborated to ensure continuity of care for children and adults. In this regard it is suggested that possibilities of establishing: a) out-patient unit at the Dushanbe City Infectious Diseases hospital for children and b) in-patient wards for children in Dushanbe City Infectious Diseases hospital for adults should be explored and resolved. An important pre-requisite is that the same staff provide out-patient and in-patient services to the patient in order to ensure continuity of care.
- Expanded access to ART for IDUs and prisoners should be provided. Scale-up of OST programme could make a significant contribution in provision of IDUs access to ART, strengthening their retention in care and adherence to treatment.
- Improve TB detection in PLHIV, scaling up ART in TB hospitals, expansion of OST and further integration of ART and OST services should be given serious consideration.
- ART retention rates indicators should be calculated and compared based on analyses of the monthly cohorts of patients instead of year cohorts.
- In order to ensure obtaining reliable, coherent and comparable data on ART effectiveness it is recommended to strengthen capacity of the out-patient department of the RAC in a way of tailoring at least 2 epidemiologists from the epidemiology unit to this department to assist clinicians in monitoring of indicator's trends over time.
- Results of the viral load detection have to be regularly checked and verified since it is a key indicator of the treatment effectiveness.
- Monitoring and analyses of ART side effects should become a part of a routine HIV treatment case management.

Mid-term – maybe addressed within a 12 – 24 months period

- EWIs system should be set up following by HIVDR transmission survey
- Consider decentralization involving family medicine rather than “KIZ” (Kabinet for Infectious Diseases) as a long-term perspective
- Operational research on HIV/TB case management is needed
- Develop system of uninterrupted support for PLHA to foster high adherence with NGO and PLHA community active participation
- Improve mechanism of integration HIV treatment and care with TB, HCV and HBV diagnostic and treatment

Blood Safety

- Ensure stable financial support from the state budget, including activities envisaged by different programmes to be covered by central and local budget, with involvement of donors' funding.
- Ensure enhancement and improvement of regulatory and legal frameworks in regards of improvement of the Blood Service:

⁵ WHO Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach, World Health Organization 2013 (<http://www.who.int/hiv/pub/guidelines/arv2013/download/en/>)

- Revise legal and regulatory frameworks of the blood service, with further consideration of structural changes
- Update standards related to all technological phases of preparation of blood products, laboratory testing, storage, stocking, transportation and transfusion, in accordance with modern international standards and technologies
- Develop national guidelines on clinical use of donated blood and its components
- Develop unified set of requirements for equipment and disposables in accordance with WHO recommendations
- All transfusion units to be equipped with the specialized equipment for storage, transportation and preparation for transfusion of blood products.
- Ensure compliance and follow-up of cold chain at all stage of preparation and transportation of blood products.
- Based on assessment of need in transfusion media, ensure existence of optimal stock of blood products within HCFs; establish a system of registry and storage.
- All blood examinations for blood-borne diseases and immune-haematological aspects shall be conducted in accordance with WHO recommendations.
- Conduct a social survey/study in order to reveal motivational tools leading to volunteer non-paid donations among different groups of population, with further elaboration and based on results of the survey and relying on participation of the government, further introduce a comprehensive PR-strategy to develop volunteer blood donations.
- Ensure quality conformity of all blood products: to develop provisions on accreditation of all blood centres and their subunits. Perform accreditation of the whole blood service.
- Establish and ensure control on rational and effective clinical use of blood and blood products, where this control system shall rely on evidence-based medicine with further introduction of modern technologies on saving blood of the patients.
- It is important to develop a quality management system for blood banks at HCF level.

Way forward

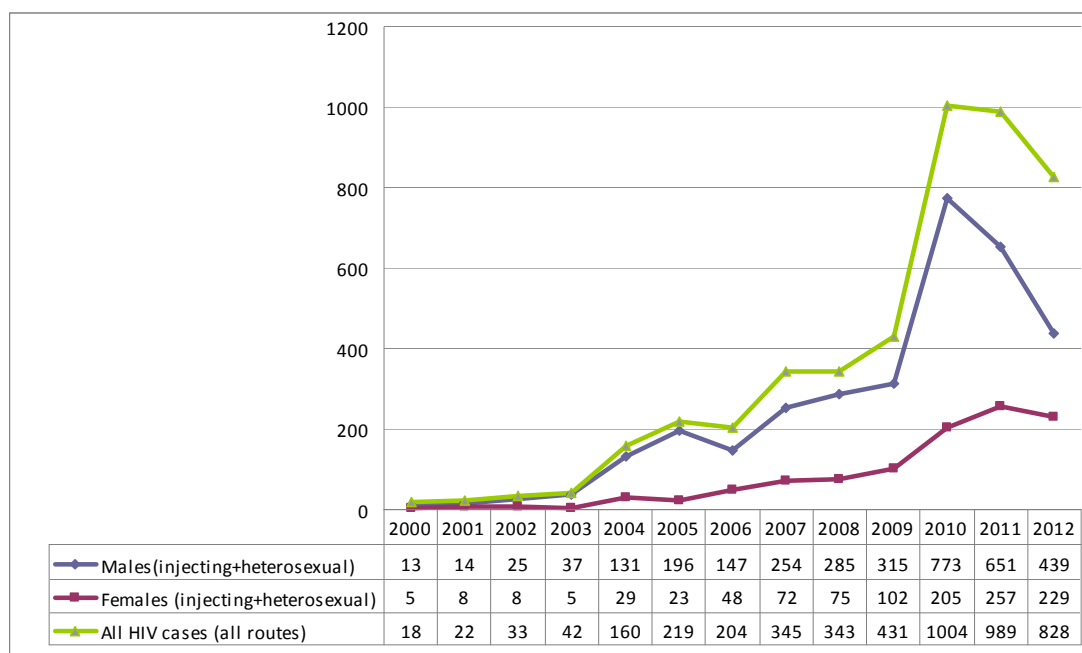
It is hoped that the recommendations from this mission will help to further strengthen the national HIV control, prevention, treatment and care programme in the Republic of Tajikistan. They could serve as the basis to adjust activities in the remaining two years of the programme and in the formulation of the new programme beginning in 2015 – a process that should start immediately with a national discussion of these findings with all stakeholders.

Political commitment, MOH leadership, technical competence, dedication of leading staff of National HIV/AIDS Programme, national technical and public health experts, awareness of existing challenges, willingness to address issues in a comprehensive way and following evidence and human rights' based policies, practices, norms and standards form a foundation for future success of National HIV/AIDS Programme.

CURRENT STATUS OF THE HIV EPIDEMIC IN TAJIKISTAN

The first HIV case in Tajikistan was registered in 1991. By July 2013 5,144 HIV cases have been registered (3,744 adult males, 1,370 adult females and 311 children under 18 years old). The number of newly registered people with HIV peaked in 2010 (see Fig. 1). However, it is unclear if this figure represents accurately the number of new infections or is affected by HIV testing policy⁶. There are also concerns that some people with HIV are being diagnosed late.

Fig. 1: Number of newly registered HIV cases per year, 2000 – 2012



Injecting drug use among men has largely driven the HIV epidemic in Tajikistan. In such an epidemic, it would be expected that heterosexual transmission of HIV would occur among the sexual partners of injecting drug users. Over time, it would be expected that the number of HIV positive women would rise and the number of men and women infected would become roughly equal.

This is the situation in Tajikistan (see Figs. 2 and 3). The number of women infected heterosexually has risen. Since 2005, more women have been infected heterosexually than through injecting drug use. However, the number of infected women is about half of those of men. This does not mean the epidemic is generalizing. Rather, it is the natural course of an HIV epidemic among male IDUs. HIV transmission can be reduced most cost-effectively in Tajikistan by focusing prevention efforts among IDUs. These efforts should ensure that transmission through both injecting drug use and sex between injecting drug users and their partners is prevented. Regular surveys to monitor the prevalence of HIV and hepatitis B and C among IDUs (especially in prisons) should be undertaken to better document the effectiveness of interventions in Tajikistan.

⁶See number of tests in prisons which led to the detection of cases in 2010
Mid-term review of the National AIDS Programme 2011-2015 of Tajikistan

Fig. 2: Newly registered HIV infections among men by reported route of transmission (sexual and injecting): 2000-2012

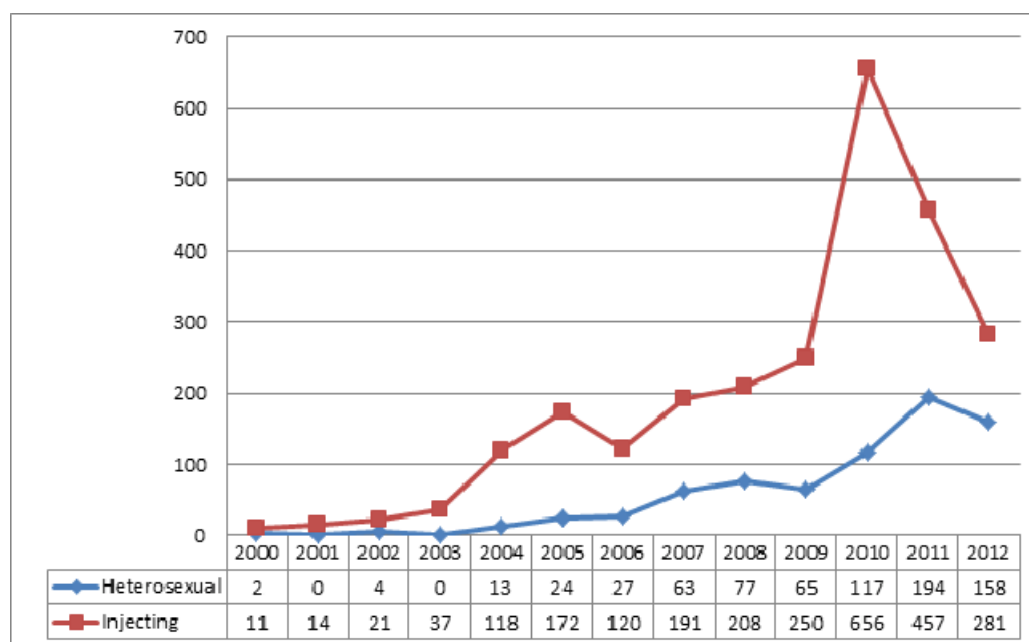
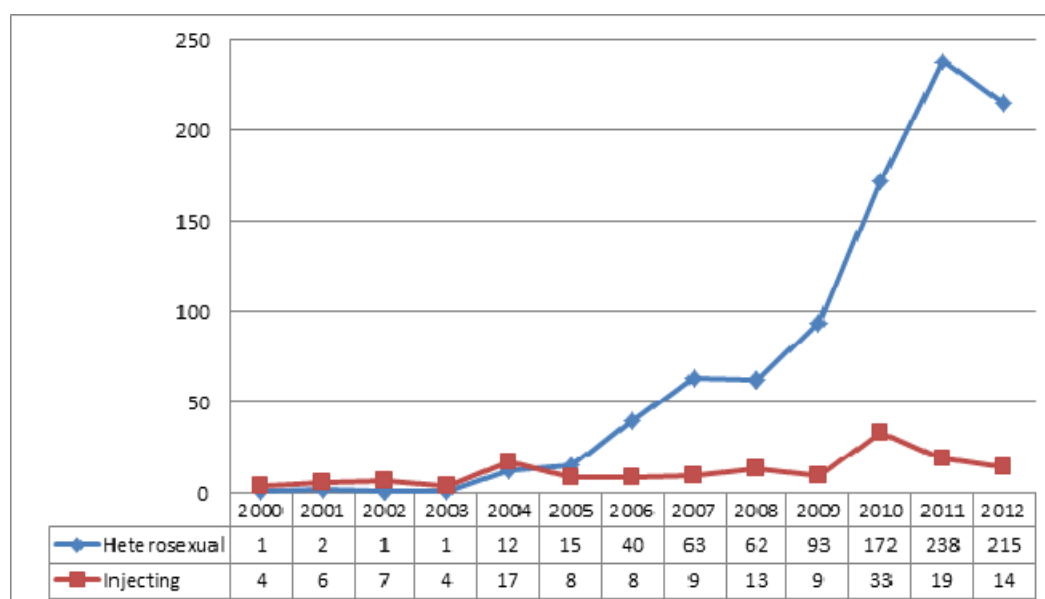


Fig. 3: Newly registered HIV infections among women by reported route of transmission (heterosexual and injecting): 2000-2012



In 2010 the coverage with HIV testing in prisoners increased significantly (9,185 tested in 2010 compared to 844 – 1,985 tested per year in other years). This led to the increase of numbers of newly registered HIV cases in injecting prisoners (292 HIV cases in 2010). In the same time the number of male injectors in settings outside of prison is increasing as well.

The last available estimated number of PWID living in Tajikistan is 25,000 (in 2009). The last HIV prevalence registered in 2011 IBBS is 13.6%. Extrapolating this prevalence to the estimated number, about 3,400 infected PWID are currently living in Tajikistan.

The HIV prevalence in prisoners varied from 6.2% in 2005 to 8.4% in 2013. Most of prisoners are injectors, being confirmed by the routine surveillance data (Fig. 2). The HCV prevalence rate in prisoners has a decreasing trend from 24% in 2005 to 11% in 2013. The HCV rate has unusual low values in PWID too; this may be due to HCV testing policies.

Since 2005 when HIV prevalence was first measured in sex workers (SW), the rate has never reached 5% (0.7% in 2005 up to 4.4% in 2010). It may be assumed that HIV in SW is mainly in an injecting subpopulation.

The high numbers of men sexually infected (194 in 2011) indicate a potential acute epidemic in homosexual men. These infections are probably mislabelled as 'heterosexual'. No single case of homosexual route of HIV transmission has ever been reported in Tajikistan. Because of the highly stigmatized context most MSM are living as bisexuals which will increase HIV cases in females too.

In 2011 an IBBS in MSM was conducted for the first time in the capital city. HIV prevalence was 1.5%. The method was a convenience sampling (snow-ball); results may therefore not be considered representative for the MSM population for the country.

In 2008 – 2012 the HIV prevalence in pregnant women based on the ANC varied between 0.04-0.06 percent while testing coverage during the same period increased from 20% to 80%.

In conclusion, the HIV epidemic in Tajikistan is concentrated in PWID. There are concerns that the true extent of HIV transmission among men who have sex with men and sex partners of IDUs in Tajikistan is unknown. Further surveys are urgently needed to estimate the HIV epidemic in the MSM population.

Migrants

There is currently no evidence that migration of seasonal workers significantly contributes to the HIV epidemic in Tajikistan, although migrants are always listed in reports as those at highest risk. The last IBBS conducted in 2008 in this population (inclusion criteria – being abroad during last 10 years) found a low HIV prevalence rate (0.5%) and was associated with presence of HCV virus antibodies. This indicates a risk through injecting drugs.

In one rayon about half of 81 registered PWID were currently in the Russian Federation. According to information obtained during the mission there are several reasons for PWID to move abroad: PWID believe that the quality of heroine in the Russian Federation is of higher purity, they can much easier earn money to buy drugs and parents would urge their injecting children to move abroad to get a relief from them.

Taking into account that migration is more or less homogeneously distributed across the country, it may be assumed that the same situation might contribute across the country. One of the NGOs working with PWID reported that PWID are frequently migrating to the Russian Federation, and are therefore lost from follow-up.

In conclusion, the evidence provided does not support the existence of a parallel HIV epidemic in migrants. The registered HIV cases among migrants mostly represent infections among PWID and persons practicing unsafe sex as in the general population. Additional investigations on the role of labour migration in HIV epidemics in the EECA region might be justified in order to eliminate the misconception that migration significantly contributes to HIV transmission, but this should have a regional/multicountry perspective and be conducted in a standardized manner for many relevant countries (definition and sampling methods). It is not recommended that Tajikistan initiates such research on an individual basis.

OBJECTIVE, SCOPE AND METHODOLOGY

The objective of the evaluation was to assess the progress and direction of the National AIDS Programme 2011-2015 at mid-term by focusing on key areas in order to:

- give practical recommendations for improving performance in these areas;
- identify whether activities are in line with international recommendations;
- find gaps and necessary changes;
- give guidance for donor and overall health sector coordination to improve the quality and cost-effectiveness of HIV service delivery, consistent with objectives and benchmarks outlined in the National HIV Programme for 2011-2015;
- identify shortcomings and areas where increased international support would be most beneficial.

The **scope** of the evaluation was focussed on key areas (listed in the terms of reference for this evaluation, provided in Annex 1) and by reviewing inputs, process, outputs, and outcomes of these areas. Additionally the evaluation should contribute considerations of what changes need to be done in the direction of the National AIDS programme after 2015.

The evaluation focused on considering the structures and systems in place related to the national response to HIV and the coverage and quality of services available for people living with HIV. There was also a particular focus on structures and services related to injecting drug users. The evaluation was conducted during an in-country mission from 16-25 September 2013. The team consisted of twelve members provided by the WHO (including the Regional Office for Europe, WHO headquarters, country offices for Tajikistan and Ukraine, and Vilnius based WHO Collaborating Centre), UNAIDS, UNICEF, the Civil Society Forum (European Commission) and consultants. Team members reviewed a range of background documents (see Annex 2) and interviewed a range of stakeholders. Stakeholders included government officials, technical and public health experts and staff from the Ministry of Health and its structures, other ministries, national, Oblast and district AIDS centres, and related organizations and settings, staff from international and donor organizations, physicians, nurses and representatives of NGOs and affected communities. Visits were also made to a number of institutions and activities outside of Dushanbe, including trips to Sogd and Khatlon Oblasts and to Tursun-Zade District. Full details of the mission schedule are provided in Annex 3.

As with all reviews of this nature, there were a number of limitations. Time available to the team was very restricted. As a result, it was not possible to visit all activities or organizations.

Health System Strengthening

Governance

In 2010, HIV/AIDS accounted for 1.11% of all deaths in the country (in comparison, coronary heart disease and hypertension accounted for 29% of all deaths)⁷. Despite of this, HIV/AIDS is a priority area for Tajikistan and it is reflected in both the country's national development and health strategies.

The *National Development Strategy for the Republic of Tajikistan for the Period to 2015* recognizes the growing burden of infectious diseases and identifies slowing the spread of HIV/AIDS as a key priority. Similarly, the *Poverty Reduction Strategy of the Republic of Tajikistan 2010-2012* highlights the importance of cross-sectoral collaboration in combating HIV/AIDS, malaria, tuberculosis and other infectious diseases and ensuring universal access to HIV/AIDS prevention and treatment as well as reducing stigma and discrimination and promoting positive public opinion on prevention programmes.

The *National Health Strategy of the Republic of Tajikistan 2010-2020* (NHS) covers measures intended to ensure that the entire population has universal access to HIV/AIDS prevention, treatment, care and support. The NHS explicitly states that ARV therapy of HIV positive patients will be free of charge within the entire country; however, the financing mechanisms for this treatment are not elaborated. The NHS, starting in 2018, aims at incorporating the treatment of HIV/AIDS patients into family medicine. Furthermore, the needs of pregnant women, children, youth and most at risk populations such as injecting drug users are also highlighted, but concrete measures to cover these populations are lacking. Key HIV/AIDS indicators are included in the accompanying *Indicators Package Monitoring and Evaluation Matrix within the framework of the National Health Strategy*. Although during this mid-term review slight discrepancies in indicators have been revealed between those in the *Indicators Package* and the *HIV programme* (such as formulation of indicators and their estimations), these issues will be addressed by the National AIDS Centre and the MOH.

Communicable diseases, including prevention and control of HIV/AIDS, continue to be a priority of the Government, as evidenced in the recent Joint Annual Review (JAR) report of 2011-12⁸. However, much of the focus was on testing of pregnant women. Other challenges noted were lack of funding for the HIV/AIDS programme, duplication of measures by development partners and inadequate coverage of prevention programmes for most at risk groups. The JAR also identified two recommendations for the HIV/AIDS programme: raising awareness among young people about HIV/AIDS and implementing the PMTCT strategy while also achieving 100% ART coverage among newborns.

Specifically to the HIV programme strategy, one of the main strategic areas in the *Programme on the response to the epidemic of HIV in the Republic of Tajikistan for the period 2010-2015* is to, "Create a legal environment that facilitates universal access to prevention, treatment, care and support." However, neither the *Programme* nor *Implementation plan of the HIV/AIDS Counteraction Programme for 2011-2015 in Tajikistan* clearly articulate how this strategic area would be achieved, i.e. what actions/measures should be undertaken to facilitate universal access to the HIV/AIDS services. Furthermore, while reviewing the *Implementation plan* it was revealed that some sections are not covered in the *Programme*, for example, section 1.6 – *Review and revision of the regulatory*

⁷WHO (2010).Global Health Observatory.

⁸Ministry of Health of the Republic of Tajikistan (2012).*Report of the Joint Annual Review on The National Health Strategy Of the Republic of Tajikistan for 2010-2020 Period of 2011-2012*.

framework of policy and practice implementation to promote HIV/AIDS prevention – is not a part of the Programme.

Following the finalization of the *National Programme on HIV/AIDS*, the Ministry of Health has developed and approved eight regulations:

- Introduction of electronic surveillance for HIV infection cases, and a referral system for HIV-testing
- Medical examination of health workers
- Prevention of HIV transmission from mother to child
- Setting-up mobile units to strengthen prevention of HIV transmission in target groups in the Republic of Tajikistan
- Measures for provision of HIV/AIDS related services
- Improvement of HIV/AIDS services
- Measures for HIV/AIDS prevention among high-risk groups in the Republic of Tajikistan
- Strengthening HIV/AIDS monitoring and evaluation in the Republic of Tajikistan

In accordance with the *Programme on the response to the epidemic of HIV in the Republic of Tajikistan for the period 2010-2015*, the National Coordinating Committee (NCC) to combat HIV/AIDS, tuberculosis and malaria is responsible for the programme coordination, management and supervision. The NCC has an established Secretariat, which is currently funded entirely by the Global Fund. The NCC also has four technical working groups (TWGs) that are organized around key issues, monitoring and evaluation; national policy and legislation; harm reduction; treatment, support and care. The NCC is chaired by the deputy prime minister and meets on a quarterly basis. It is composed of ten government structures, three international organization and nine public organizations. In addition, each region has regional coordinating committees that mirror the roles and functions of the NCC.

Tajikistan also has a Health Sector Coordinating Committee (HSCC) that oversees issues related to the overall health sector, but linkages between the NCC and the HSCC remain unclear.

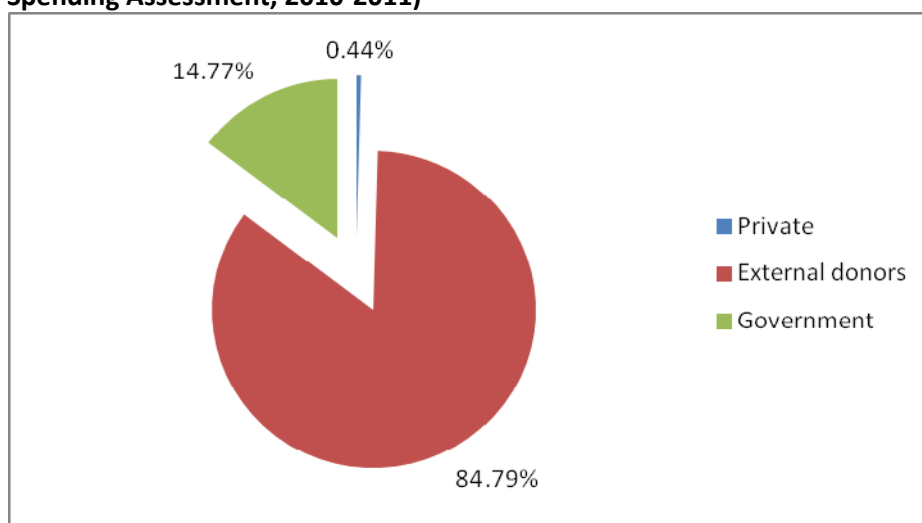
Financing

The government expenditure for health in 2011 was USD 108 million (515 million Somoni) of which the Programme on HIV/AIDS received USD 2.3 million⁹. The overall total funding of the Programme on HIV/AIDS in Tajikistan has been steadily increasing – from USD 6.2 million in 2008 to USD 15.4 million in 2011, with about 85% coming from external sources (primarily the Global Fund),¹⁰ which raises a question of sustainability; particularly in light of the latest round of cuts from the Global Fund in this region (Fig.7). Although Global Fund will continue its funding in the coming years, the country would need to consider developing a strategy for programme support post-Global Fund. It should be noted that the next round of National AIDS Spending Assessment would take place in 2014 where the latest data on funding for the HIV/AIDS Programme will be presented. The *Programme on the response to the epidemic of HIV in the Republic of Tajikistan for the period 2010-2015* states that financing will be through various sources such as allocation in the State budget, including support for NGOs, external donors, additional resource mobilization and advocacy and scaling up of targeted resources from the private sector, but provides no specific mechanisms. Additionally, the implementation plan does not include concrete activities/measures.

⁹Ministry of Health of the Republic of Tajikistan (2012). *Report of the Joint Annual Review on The National Health Strategy Of the Republic of Tajikistan for 2010-2020 Period of 2011-2012*.

¹⁰National AIDS Spending Assessment, 2010-2011

Fig. 7: Sources of funding of the national response to HIV, Tajikistan, 2011 (Source: Nat. AIDS Spending Assessment, 2010-2011)



A further breakdown of funding for 2011 show that the largest share are the costs of preventive measures (36%); costs of treatment and care (9%), as well as the programme management costs (27%). In addition, significant funds are allocated to cash incentives, and training of medical personnel working in the field of HIV (26%). External donors (primarily the Global Fund) provide funding for blood safety, counselling and testing to determine HIV status, antiretroviral therapy (drugs), laboratory monitoring of HIV infection, while the government contribution covers maintenance of buildings and facilities, as well as salaries of specialists of medical institutions (State funds per year make up about 15% of the total financing of the national response).

Since 2008, the *Midterm Expenditure Framework* (MTEF) has been piloted by the MOH. MTEF is budgeting based on the priority programmes. The MOH has identified four key priorities for 2014-2016, among which is timely diagnostics and treatment of HIV/AIDS patients. However, the MTEF in the health care system is only partially used as a tool for strategic planning – more work needs to be actively done in this area, including capacity-building and better assistance from the MOF to the MOH.

It is important to note that the overall government expenditure for the health sector is very low – in 2011 it was 1.7% of GDP whereas the out-of-pocket payments was 3.7% of GDP. Furthermore, health financing reforms that are currently being rolled out by the government will have an impact on the ability of people to access important services, including HIV-related interventions.

Since 2005, the Government of Tajikistan has been piloting the Basic Benefit Programme (BBP) – eight districts are currently covered under this scheme. BBP regulates the provision of the health care for population, in particular for vulnerable groups of population i.e., it is directed for improving the quality of health care and providing adequate access to health care services. Within BBP, HIV/AIDS infected people are one of the beneficiary groups that are entitled to receive health care services for free. Due to the current limited coverage of districts under this scheme, only a small segment of the population is covered.

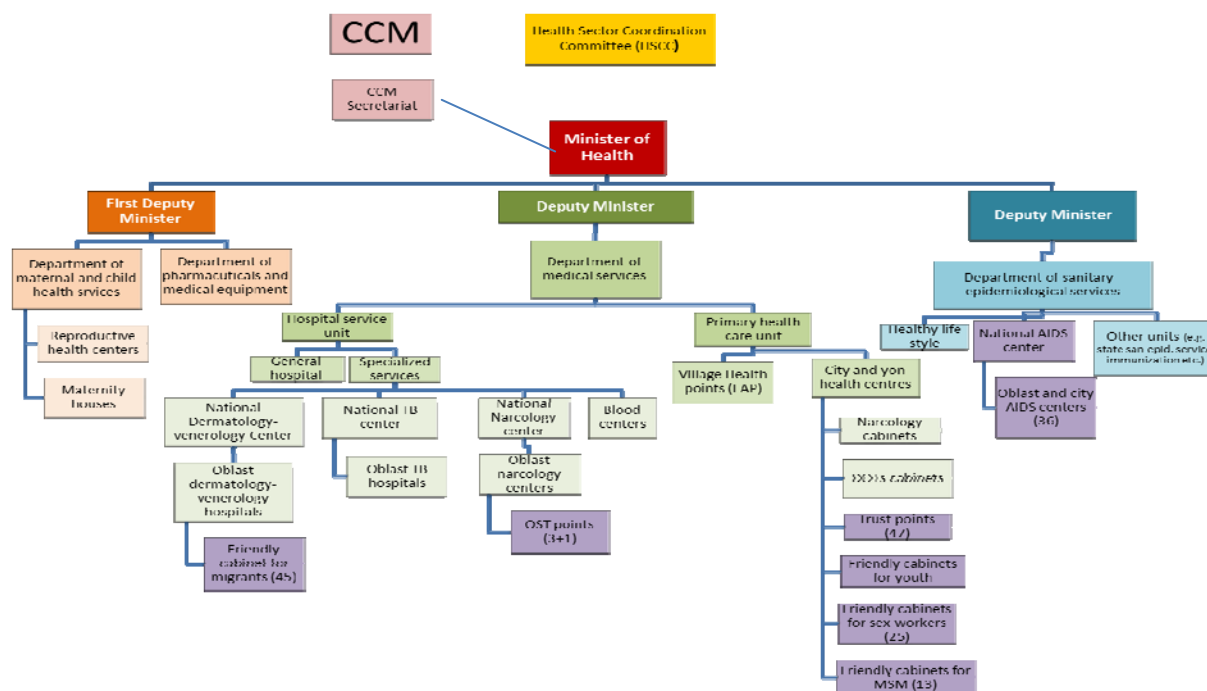
Similarly, another mechanism was introduced by the country in 2008, Government Decree No.600, which regulates the health service provision in the public health facilities and determines the types of health care services provided free of charge and those for which a fee will be charged. Decree No.600 has been rolled out through the entire country, but to a limited extent – it is currently applied to laboratory, diagnostics, support, dental and high-technology services, and recently, some hospitals have started to apply it for other services as well. This review found that a MOH order has just been issued (1 September 2013) that Decree No.600 should be applied for HIV testing, i.e. a Mid-term review of the National AIDS Programme 2011-2015 of Tajikistan

person getting a HIV test (rapid and UFA) would be required to pay (23-26 Somoni) Confirmatory testing for samples found positive in initial testing will cost 96 Somoni. Although HIV infected clients and MARPs should be exempt from this payment, certain populations, such as migrants are still required to pay for HIV testing and other services. Furthermore, Decree No.600's fee-for-service could raise important issues around equity and access, particularly, if co-infections such as STI and TB are not covered by this mechanism.

Organization and delivery of services

The HIV/AIDS programme falls under the purview of the Department of Sanitary-Epidemiological Services. The organigramme below highlights the main components of the programme, which includes a national AIDS centre as well as 36 oblast and city AIDS centres. (During this review, the National AIDS Center noted that more city and rayon AIDS centres will be opened – i.e. one each rayon and city across the country. However, as represented below, there are various other programmes that interact with the HIV/AIDS programme, and the inter-linkages between these different structures are not always clear. The lines of accountability and associated financing streams are also lacking.

Fig. 8: Organigramme of main components of the HIV/AIDS programme



Note:

Trust points for IDUs and friendly cabinets for SWs are coordinated by AIDS Centres but physically they are situated at PHC facilities therefore they are reflected under PHC level but coloured as AIDS center. 21 TPs managed by National AIDS Center and 22 NGO based

Ten Friendly cabinets for migrants are coordinated by AIDS Centres but physically they situated under dermatology-venereology service. 15 FCs for migrants are managed by NGOs. Therefore, they are reflected under relevant facilities but coloured as AIDS center.

Friendly cabinets for MSM are coordinated NGOs. In the organigramme they are situated under the PHC unit because providing primary services.

From a service delivery perspective, this disconnected structure results in the same client being sent to different centres for testing, counselling and treatment depending on the type of illness, e.g., HIV,

TB, STIs, narcology, since services are organized in silos – the problem therefore arises of treating the disease instead of the person.

There is also a clear case of verticalization of the HIV/AIDS programme, which is evident in several areas highlighted in other sections including:

- Salaries: health workers in AIDS centres receive 100% incentives (compared to 60% for those working in TB centres). It should be noted that salaries of health workers in the country are generally very low.
- Laboratories: there are laboratories that have been established to specifically test only for HIV, despite having the equipment and human resources to test for other diseases.
- Treatment and care: the ambulatory treatment and care for persons living with HIV is in AIDS centres primarily; but for hospitalization PLWH are referred to the infectious diseases clinics. The current referral mechanism does not allow for the AIDS centre to share the status of the client with the referring institutions/site including family medicine doctor. The responsibility is on the patient to reveal that information, thereby causing potential disruptions in the continuum of care. Levels of service delivery:
 - Primary – mainly services provided in relation to the non-HIV/AIDS related illnesses, such as reproductive and mental health counselling, STI diagnostic and treatment, HCV treatment (in some hospitals), etc. PMTCT is provided in ANC.
 - Secondary – at this level oblast (4), city (8), district and inter-district (25) AIDS centres provide HIV screening, counselling and testing for HIV, CD4 count (in 4 centres), medical follow-up of HIV patients, preparation to ART, prescription of ARVs and treatment monitoring, reproductive and mental health counselling.
 - Tertiary level is presented by the Republican AIDS Center with responsibility to provide HIV testing and counselling, perform confirmation tests, CD4 and VL counting, ART prescription and monitoring, opportunistic infections (OI) diagnostic and treatment, national ARV procurement plan elaboration and coordination with TGF PR, technical support to other AIDS centres, specialists' training, mentoring, and reports preparation.

The lack of integration is also apparent in training – HIV/AIDS modules are included in the medical education curricula and family medicine retraining programmes (republican family medicine centre, postgraduate courses), but this is not sufficient. There are weak linkages with AIDS centres and while the theoretical aspects of HIV/AIDS are covered, practical classes are missing. During this review, some family doctors interviewed in Khatlon and Soghd did not appear to have received sufficient training on HIV/AIDS issues during their re-training programme. When questioned whether they would be willing to treat a HIV/AIDS patient for general conditions (e.g., influenza, hypertension, stomatitis, etc.) most of the respondents replied positively. In fact, some noted that they might currently be treating people living with HIV, but were not aware of their status. There is some confusion around confidentiality. The existing law does not clearly state that the patient's status cannot be revealed to medical staff; it suggests that it could be done by a person who provides pre- and post-counselling. Further details and a better understanding are required of this law.

These interviews also revealed the issue of stigmatization from primary health care providers. This could be partly attributed to a lack of knowledge about HIV/AIDS issues and limited access to HIV patients. Further trainings of family practitioners and practical classes could help reduce stigmatization.

Some efforts are currently underway to integrate the HIV/AIDS programme into general health services, particularly into PHC family medicine. For example, integration has started with reproductive health centres and some TB services. However, a clear plan of action is needed for complete integration.

There is also limited information from the HIV/AIDS programme on the availability of services, including services that are being provided by the NGOs, the private sector and the mapping of the different friendly cabinets and trust points across the country. Furthermore, a complete picture on service readiness aspects by health facility is lacking.

Coordination with other development partners and civil society

Overall, there are limited linkages among the different work streams among development partners, government and civil society and although bilateral MoUs between government and development partners exist, this mechanism needs to be strengthened. The JAR report 2011-12 highlighted this issue as an, "...imperfect mechanism for planning of investment projects, which in turn, diminishes the efficiency of funds, coordination of external aid management, implemented through the civil community (NGOs, charitable funds, community centres, etc.)".

As previously stated, Global Fund is a major donor of the HIV/AIDS programme. UNDP is the principal recipient for Global Fund grants (HIV, TB and malaria) and manages the sub-recipients and sub-sub-recipients, many of whom are NGOs. In such a structure, the funding reaches the NGOs directly and the government is bypassed. Reporting is done by the NGOs to UNDP and in turn, UNDP submits an annual report to the government. Therefore, a platform for joint programme planning and implementation is limited. Furthermore, the sustainability of the NGOs, including retention of their staff (who sometimes receive higher salary incentives than health workers in the public sector) and hence the services they provide once the Global Fund grants ends need to be considered. The role of UNDP as the principal recipient over the past ten years also raises the question of sustainability and capacity building at the government level.

Similarly, several projects funded by different donors and development partners cover different target populations and provide a variety of interventions. For example, USAID is funding a project in three localities that is aimed at integrating various programmes at the service delivery level. Through the establishment of local coordinating committees (LCCs), they have improved interactions between NGOs and health workers, thereby attempting to strengthen services such as counselling. However, such efforts are still in a project mode and scale up remains a challenge.

Finally, there are multiple sources of procurement of drugs and commodities based on programme – such as the government, UNICEF, UNDP, UNFPA and other donors, but no overall mapping of the systems exists. Adding to the complexity of the system, the role of the private sector is unclear – they provide some programme-specific services, such as HIV testing, but the full extent of their interventions remains unknown.

Recommendations

It should be noted that most issues observed during this review were also highlighted during the Tajikistan *TB & HIV/AIDS and Health Systems Strengthening assessment* in 2010. It would therefore be important for the Government, partners and civil society to follow up and implement recommendations from that mission.

Short-term – should be addressed within a 6-12 months period

- Advocate with the MoF for increasing the total general government expenditure for health
 - consider development of an action plan for phasing out donor support and ensuring financial sustainability
 - based on the needs, allocate funds within the overall health budget for HIV (e.g., testing, treatment, care, prevention activities)

- Consider undertaking a mapping of the procurement system (drugs, commodities – HIV, TB, STIs, reproductive health, etc.)
- Consider undertaking an assessment of health facilities for service availability and readiness to identify service delivery issues across programmes
- Improve integration of the HIV/AIDS module in the medical education curricula and improve health workers' (including family doctors, nurses and specialists) expertise in HIV/AIDS
 - along with theoretical exercises incorporate practical classes into the training programme
 - involve National AIDS centres into education/retraining programmes
- Develop a step-by-step plan for integration of HIV services into primary health care, including:
 - increasing awareness of primary health care workers
 - disclosure of status to care givers
 - inclusion of family practitioners in general care of HIV positive people
 - undertaking an assessment of health facilities for service availability and readiness to identify service delivery issues across programmes
 - patient pathways (people-centred care)

Mid-term – ,maybe addressed within a 12 – 24 months period

- Promote person-centred care
- Prioritize and optimize services (e.g., labs, training)
- Start implementation of plan for integration of HIV services into primary health care by piloting some activities ¹¹
- Further optimise work of AIDS Centres including close link with PLHIV (including social support, involvement of peer support/civil society, mobile clinics) and further optimise integration of ART and OST services
- Scale up efforts to achieve universal health coverage (e.g., Basic Benefit Package, vulnerable populations)
- Consider a “compact” among government, development partners and civil society to work together more effectively to deliver priorities in the overall national health sector strategy (also linked to Commission on Information and Accountability efforts). ¹²
- Align various purchasing policy and logistics for drugs and commodities (e.g., existing state policies, UNDP) for treatment of other co-infections

¹¹One possible option could be to pilot integration of selected HIV/AIDS services into three primary health care centres in Dushanbe and in one rayon (for example, in Spitamen Rayon, Soghd Oblast). These trained family practitioners could undertake pre and post-testing counselling and testing. If a person has a positive status, person should be referred to the AIDS centre for follow up including treatment and care as appropriate. The person then receives treatment and care for general conditions from the trained family practitioner. In order to reduce spread of confidential information, the family practitioner should get appropriate training. Signing a confidentiality agreement could be considered as an option if needed; if this agreement is violated appropriate actions are taken against the family practitioner.

¹²Compacts can improve aid effectiveness; serve as a tool for mutual accountability, by introducing indicators for tracking progress against agreed commitments of government, development partners and civil society.

Strategic information obtained through surveillance, monitoring and evaluation

Organizational structures and their capacities

The M&E department within the Republican AIDS Center was established in 2008. Currently it has 7 full time positions, all of them are filled. In all 4 oblast level AIDS Centres the M&E units were established in 2010. According to the last changes applied in 2012 to the Sanitary System regulations the district and city level AIDS Centres (38) responsibility for M&E is given to the head of centres. Thus, there is a vertical system of collection, gathering and reporting HIV related data. Currently, in those rayon level AIDS centres where the monitoring and evaluation (M&E) units were not established yet, the M&E responsibilities are distributed among exiting staff, and the director is overall responsible for on time quality data reporting. The M&E positions at national and oblasts levels are funded by the state funds and supported by the TGF grant.

The M&E units at national and oblast levels are equipped with IT assets (at least 1 set). The installed software is MS Office (Word, Excel and Power Point) and in some AIDS centres – Epi Info and RDSAT, which are free of charge. The software for electronic follow up of HIV patients was installed in 10 AIDS Centres. The procurement of the IT equipment for rayon level AIDS centres are currently on-going within the framework of the Regional Cooperation Programme (RCP) funded by the Russian Federation, implemented by UNAIDS in cooperation with the Republican AIDS Center. 30 local level specialists were trained in using the software for electronic follow-up of HIV patients.

The AIDS centre staff at oblast and rayonal levels went through many M&E and HIV surveillance capacity building exercises in a format of formal trainings or mentoring, all of them funded from external sources. This approach has a short-term effect and the capacity is lost when trained people leave their position. There is no formal education system in place for M&E and/or HIV surveillance. This gap was taken into account and is reflected in the implementation plan of the Regional Cooperation Programme (RCP) funded by Russian Federation, implemented by UNAIDS in cooperation with the Republican AIDS Center. Within this framework it is planned to introduce HIV epidemiological surveillance into the curriculum of the post diploma education. This will potentially have a long term effect in capacity building.

Horizontally, the AIDS centres at all levels are interacting with penitentiary departments, TB services, narcologic and dermato-venerology services, in case additional data is needed which is not already available from the national health information system. The interactions take the form of formal requests and are justified by the multisectorial provisions in the National Programme.

At NGO level, the M&E component is designed by donors without much involvement of the governmental side.

National HIV M&E plan and implementation plan

The national HIV M&E plan represents a table of indicators (including definitions, baselines and targets, data sources, periodicity of reporting, dissemination format) developed and approved in 2009 as part of the National Programme for 2010-2015. The indicators are located by the type of phenomena/interventions they are measuring: coverage of HIV testing, coverage of HIV prevention, knowledge, prevalence of bio-markers, ARV treatment, PMTCT, etc. This does not fully allow seeing the extent of which indicator is measuring the achievements of which objective of the National Programme. It may be seen in the implementation plan, where the indicators as targets are presented for each objective of the National Programme. The mid-term review is a good opportunity to develop a result-based framework in its globally recommended format. The implementation plan

with its targets per each objective and the HIV M&E framework would serve as a basis for development of such framework. This will allow tracking the progresses per each of the objectives stated in the National Programme.

A sample of results framework might be found at http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_172588.pdf.

The package of indicators covers all standard relevant globally recommended indicators for a concentrated epidemic (at the time of their development). Meantime some of them were removed from the globally recommended set (knowledge indicators in key groups at higher risk), but it is worth to keep them in the national HIV M&E framework, once there are activities which results they are measuring and if it is part of the reporting commitment with TGF. The comments per each indicator are presented in a separate annex.

In relation to the priorities of the National Programme/implementation plan two key indicators on prisoners are missing. The existing indicators (HIV prevention coverage and HIV knowledge) do not allow measuring the outcomes and impact of interventions among this population, where the injecting practices and HIV are still concentrated. The following indicators are subject to addition:

- HIV prevalence in prisoners (%)
- % of prisoners who have been tested for HIV and know the result of the last test.

Because of their irrelevance for the current type of the HIV epidemic, cancellation of some data collection events, no other data points than the baseline, no other interventions planned, and lack of specificity several indicators are subject to exclusion, to increase the usefulness of data at country level several indicators are subject to adjustments (see Annex 5).

There is a well-developed Indicators Manual in place where each of the indicators from HIV M&E framework is technically described according to global recommendations, where existing. However, the technical description of indicators at country level should contain also country specific details – concrete sources of administrative data, data collection forms, data flow, responsibilities, data validation, etc. An important issue is the description of country level data useful for triangulation to confirm the trends of indicators (example: increasing coverage with HIV prevention from IBBS should be confirmed by the increasing number of clients of HIV prevention programme).

All indicators collected within administrative statistics have to go through a data validation process in 2014.

When synthesizing the information stated in the HIV M&E framework, implementation plan and Indicators Manual, it is not possible to get a full understanding of the arrangements of functionality of 12 components in the country. It is recommended in short term to reshape the Indicators Manual within an HIV M&E plan following the 12 components approach approved by global M&E community back in 2008 (available in English and Russian at http://www.unaids.org/en/media/unaids/contentassets/documents/document/2010/20080430_JC1769_Organizing_Framework_Functional_v2_ru.pdf). The development of such document would be the first and most important step in further strengthening of the Tajik HIV M&E system. This document is under preparation and is planned to be discussed/adopted by the CCM by the end 2013.

A highly important issue to be mentioned is that data collection periodicity is not harmonized with the National Programme review schedule. In consequence, data for later time points than 2011 are available only for prisoners (2013 data) and data collected through programme monitoring (Annex 5). *As explained by the NAC, the main reason for this is lack of fund.* Therefore it is not possible to track progresses towards targets for many indicators, especially measuring the outcomes in populations where HIV is concentrated. Thus, the mid-term review of the National Programme is

based mainly on the administrative statistics data, including those that are not part of the HIV M&E framework, and qualitative data from the field visits. In the future, this fact may compromise the effectiveness of the end-term review in 2015.

There is no annual HIV M&E work plan in place to get data according to the review schedule and intervention activities needed. If no additional data points are available by the end of the National Programme implementation, the evidence based end-term review will be questionable. The activities that are needed to strengthen the HIV M&E system should be planned and budgets assigned from governmental and nongovernmental sources. The development of such document has to be part of a process of revision of the HIV M&E Framework, development of the results framework and Indicators Manual.

HIV surveillance and surveys

The HIV surveillance is designed to collect biological and behavioural data through (1) case reporting, (2) programme surveillance data collection, (3) periodic bio-behavioural surveys in selected groups of populations and (4) size estimation of selected group of population. From this perspective the HIV surveillance system in Tajikistan has three functional components, but with different performance levels.

The presentation of the HIV surveillance system in Tajikistan is dispersed across the national regulating documents. It is recommended to create one document, gathering all existing pieces of information about the HIV surveillance, including data to be collected and their interpretation on the status of the HIV epidemic in the country.

Case reporting is supposed to register the new HIV cases found by the health care system. There is a national data base (excel format) of registered HIV cases, which allows their disaggregation by age at registration time, gender, probable route of transmission, administrative units.

Once a new HIV case is confirmed (2 positive ELISA followed by a WB confirmation), according to the regulations, an epidemiological investigation of each case should be carried out. As a result, the probable route of transmission should be identified and the potential contacts traced.

From individual discussions with field epidemiologists, there might be an underreporting of injecting route (especially for those injectors that are not officially registered) and homosexual behaviour (0 case ever reported). The heterosexual route is the most registered route because it does not imply any additional societal stigma associated with risk behaviour. The heterosexual route of transmission with casual partners is the most convenient scenario because the possibility to trace those partners is reduced. Assuming that every HIV infected man infects at least one woman in his HIV positive status career, only one third of female sexual partners infected by males were registered by the health system.

Taking into account the decreasing credibility of the reported route of transmission an HCV screening at the HIV case registration time would allow estimating the rate of injecting route among newly registered HIV cases, and an HBV screening the rate of homosexual route among newly registered male HIV cases. These estimations should be adjusted by the prevalence of viruses in the general population.

According to the regulation, testing of CD4 count is conducted at the time when the newly registered HIV case enters the medical follow-up for HIV. This may take considerable time after the registration point. During the mission it was difficult to get valid data about CD4 levels. CD4 testing for all new HIV cases at registration should be implemented by AIDS centres as an indicator of the stage of HIV infection when entering the health care system. Prior to the mission other incidence studies were not conducted to estimate recent infections.

When the HIV patients' electronic tracking software becomes fully functional in generating reports, it should offer additional information on the length between the time points of registration and entrance of new HIV cases into the medical follow-up, and CD4 levels at registration/initiation of the follow-up.

In meetings with international partners, we were informed that among those new HIV cases with unknown route of transmission are about 100 children with HIV negative mothers. Other countries in central Asia (Kazakhstan, Kyrgyzstan and Uzbekistan) faced nosocomial outbreaks in childrens' hospitals. The cases in Tajikistan should be investigated for a possible nosocomial infection and further actions taken in prevention of the nosocomial infection.

Programme surveillance collects the number of HIV tests performed/people tested in each of the population groups and the number of new HIV cases per each group. Data have been provided since 2009 and the quality is checked on a monthly basis.

Integrated bio-behavioural surveillance

The integrated bio-behavioural surveillance in key populations at higher risk started in 2005. The collected specimens of blood dry spots are tested to antibodies to HIV, HCV and Treponema Pallidum and respondents are provided with the tests results. The periodicity and target groups are shown in the Table below.

Target groups	2005	2006	2007	2008	2009	2010	2011	2012	2013
PWID	X	X	X	X	X	X	X		
SW	X	X	X	X	X	X	X		
MSM							X		
Prisoners	X	X	X	X	X	X			X
Pregnant women	X	X	X	X					X
Migrants				X					
Patients with STIs	X	X	X	X	X	X	X		

Prior to 2012, no formal protocols were in place. In 2012 protocols were developed. According to them the IBBS will be conducted on a biannual basis. Taking into account the status of the HIV epidemic it is recommended to remove the following groups from IBBS:

- pregnant women – because of the universal HIV testing (PMTCT) and irrelevance for the type of epidemic
- migrants – irrelevance for the type of epidemic
- patients with STIs – because of the universal HIV testing and irrelevance for the type of epidemic.

Taking into account the inconsistent trend of data collected through IBBS due to methodological changes, it is recommended to conduct an in depth statistical analysis (trend analysis). This may help understand the trends and will contribute to the end-of-term review of the National Programme.

PWID

With the aim to improve the representativeness of data for the PWID population, the sampling methodology and number of data collection localities have changed over time. The number of sites increased from 2 in 2005 to 10 in 2011. Prior to 2009, the "Snow Balls" was applied. In 2009 the first attempt was made to implement Respondent Driven Sampling (RDS). Based on the national experts' opinion the 2010 round is considered to be the best one, where not only the sampling followed the RDS method, but also the data were analysed in RDSAT (weighted with the social network size). The national indicators were generated by weighting the local values with the number of the general population (15-65 years old).

The changes in the sampling methodology affected the comparability of data over time (see Annex 4). This is seen by the decreasing trend of the HIV prevalence. If there is not a very high mortality rate and not a very high migration rate the HIV prevalence should increase, even if incidence was decreasing.

Compared to other countries from the central Asian region, PWID in Tajikistan have an unusually low rate of HCV prevalence. This might be a laboratory or testing problem. In the next round of IBBS the biological component should get special attention ensuring well functioning QA and use of quality rapid tests.

The newly developed protocols (2012) are not containing field standard operating procedures, thus lacking the internal quality control mechanism for field staff. It is strongly recommended in the short term to adjust the approved protocol (adapting the Kazakh version could be an option), where the methodological assumptions are presented and field procedures are standardized.

A report should be produced after each IBBS round and should contain chapters on methods and limitations (currently missing from those we have seen). The findings should be disseminated broadly and made publicly available (placed on web sites).

Prisoners

Since 2005 the IBBS has been conducted in 2 sites by applying a systematic sampling in prisoners detained in 4 penitentiary institutions only (out of 19). Data are considered comparable over time (see separate annex).

When visiting the medical department of Penitentiary Department we were told that 225 PLWH were detained in 2013. Of these, 127 PLWH were detained in 4 institutions where the IBBS was conducted in 2013. This shows that about 40% of detained PLWH are not based in those 4 selected institutions. The sampling frame should be extended to make the data representative for the entire penitentiary system.

In addition to other benefits of using representative data for all prisoners, the HIV prevalence rate may help to estimate the number of PLWH in detention. If applying the 2013 HIV prevalence rate of 8% to the number of prisoners in those 4 institutions used for sampling frame, the estimated number of PLWH is about 350 (2.5 times higher than officially registered number). This suggests that there are still prisoners who are not aware of their HIV status (every third as in the general population). A testing campaign meeting the needs and expectations of prisoners should be planned.

Men having sex with men (MSM)

The first time an IBBS in MSM was conducted was in 2011 in 1 site (Dushanbe). According to the study report the respondent sampling established by respondents was applied and reached 350 respondents. The registered HIV prevalence rate is low – 1.5% (see separate annex). For the next round of IBBS in MSM the applicability of RDS method should be investigated.

Sex Workers (SW)

Since 2005 the cluster sampling was applied. The number of sites increased from 2 in 2005 to 10 in 2011 (see separate annex). The national indicators were generated from the merged data bases. It is recommended to apply the same approach as for PWID – calculate the values locally and then

weight by the estimated number of SW per each site individually. This approach takes into account the individual contribution of each site to the national epidemic.

Size estimation

The last exercise of estimating the size of PWID (25,000) and SW (12,500) was conducted in 2009. No size estimation of the MSM population has ever been conducted. The size estimation is not integrated into the IBBS that are conducted regularly. The IBBS is a source of proportions for estimating the size by making use of multiplier method, the most pragmatic one and the single one that really works, especially in PWID, in the context of central Asia. It is strongly recommended for the next round of IBBS to adjust the approved protocol (adapting the Kazakh version could be an option), where the size estimation methods are integrated. The next IBBS round should contribute to the size estimation of PWID and SW.

Periodic nationally representative survey providing sufficiently precise and accurate estimates

Surveys in youth and general population

Because of the concentrated type of the HIV epidemic, surveys in the general population are conducted to get an overview of HIV knowledge, HIV testing and some risky behaviour.

Nationally representative surveys in general population are conducted on a biannual basis among 15-49 years old. Through surveys data were collected for the indicators part of the HIV M&E framework that are mainly used for global reporting purpose. In addition the results were used to validate the HIV testing indicators. The data appear consistent and the same methodology was used. For the next round of a general population survey it is recommended to adjust the data collection tool to the data needs of the modes of transmission.

Programme monitoring data and data bases

At the Republican AIDS Center there is a list of service providers working in the field of HIV. The list is updated on a semiannual basis. The staff assess the list as being almost complete. The sources to identify the service providers are the MoH, private sector and donor community. However, the Republican AIDS Center would opt for an improvement of exchange of such information with all sources. There are no databases offering a roster of professionals working in the field of HIV.

The NASA exercise was completed in 2012 and planned to be repeated in 2014 funded from the Regional Cooperation Programme funded by the Russian Federation. The health resource tracking is conducted by the MoH and mainly for public expenditures. There are achievements in gathering information on external contributions, but they are not yet complete enough. Efforts to improve it are made using the existing mechanism, for example the CCM.

Trust points reports: aggregated data of the number of clients of needle exchange services, distributed commodities and referrals. Every 6 months the counting starts from 0 and thus data represent the cumulative results for 6 months. This form was developed to conform to the reporting requirements and periodicity of the TGF grant. The form is filled based on the register for primary data collection where the unique identifier is used. The GO based trust points are reporting on a quarterly basis to the upper level AIDS centres. The data are then centralized at national level. The NGO based trust points use the same reporting form, but their data are not aggregated with governmental based trust points. The data reported by the Republican AIDS Centre are not covering the NGO sector data. Data from GO and NGO sectors are summed up for global reporting purpose. In 5 localities where trust points are led by both governmental and NGO sectors, duplications may occur. The duplication has never been measured. To improve the quality of national data in terms of completeness and reduce the duplications, the Republican AIDS Center and the Principal Recipient of the TGF grant (UNDP) already have plans for joint monitoring visits to check data from both

sectors . Because of exclusive donor funding, the trust points report does not have the status of an official statistic form and becomes mandatory on a contracting basis (imposed by the donor).

A few years ago, the country reached consensus on the formula for the unique identifier. The next step in improving the use of the unique identifier system is the development of software to be used as a national reporting tool by all providers of anonymous services in the HIV field across the country. The software implementation will offer the possibility to diversify the available reports, covering not only the 6 months period, but to get data on new comers (never covered before), follow up of clients, some cohort analysis on HIV incidence (if HIV testing will be available at trust points level), etc.

STI friendly services reports: aggregated data of the number of clients of STI friendly services, of distributed commodities, referrals and stocks of drugs for syndromic STI treatment. All STI friendly services are based in governmental STI clinics. The reporting form was developed to comply with the reporting requirements and periodicity of the TGF grant. From the STI friendly services data are reported to the upper level STI service facility and then compiled at national level and submitted to the PR of the TGF grant. The form is filled in based on the register for primary data collection where the universal unique identifier is not used. Because of the confidential or anonymous approach in registering clients, one person may approach different facilities. The duplication has never been measured. Because of exclusive donor funding, the STI friendly services report does not have the status of an official statistic form and becomes mandatory on contracting basis (imposed by the donor). Taking into account the type of the epidemic it is not worth to implement software-based case reporting at the level of STI friendly services. Aggregation of the data gathered at national level might be done in a simple excel format.

Electronic system for HIV patients tracking is a database where the HIV cases are entered and followed up. The available data on HIV cases ever registered are already there, but the retrospective data of the medical follow up part are not yet completed because of missing data from the field according to the data base structure. The field level staff were trained on data entry, but not yet on report generation. Screening the built in reports, there is not a full set of reports that will allow assessing the quality of the clinical management of HIV cases in the country. It created problems in assessing the ARV treatment component during the mission. It is recommended to initiate the development of such set of indicators and then to adjust the software accordingly. Unfortunately there are no international recommendations for that.

Vital registration

The vital registration system in Tajikistan is described in the HMN report available at http://www.who.int/healthmetrics/library/countries/HMN_TJK_Assess_Final_2010_01_en.pdf.

The country is using ICD 9. When asked about data on mortality among PLWH registered by the AIDS centres, we were told that actually they are not getting data from vital registration sources. The information on the death of a PLWH under medical surveillance is caught based on proactive investigations conducted by the medical doctor. During the visits we saw death certificates glued to the individual records of the respective patient.

Data quality assurance

The Republican AIDS Centre in partnership with the Principal Recipient of the TGF conducts the supportive supervision visits. According to the schedule the team should visit each oblast on semiannual basis. The visits are covering the governmental based service providers funded through the TGF grant. The process of visit is registered in a checklist and feedback is provided to the visited institution. There are no protocols in place for supportive supervision visits.

Once the MoH wants to be recipient of the TGF grants in the future, it is recommended to develop monitoring visits protocols that would standardize the process and will ensure sustainability. A good example is the protocols for HIV/TB monitoring visits (available at Republican AIDS Centre) developed within the TGF grant framework.

Data auditing is conducted within the implementation of the TGF grant. This is another area to be strengthened if the MoH becomes recipient of the TGF grant.

Analysis, synthesis and use of data

Annual reports (available on request) on progress of national response implementation are submitted by the Republican AIDS Center to the MoH. They combine the HIV surveillance data and progress on the National Programme implementation.

There are no reports available on all IBBS rounds that would allow assessing the methodological consistency over time. For next rounds of IBBS a standard structure of the report should be developed and used in the future for better documentation of the process and results.

A longitudinal cohort analysis is conducted strictly according to the key indicators that are part of the set of global reporting (ART survival at 12, 24 and 60 months). Spectrum estimates are conducted per UNAIDS request on annual basis.

The staff outside of AIDS centres complained that they do not benefit from regular dissemination of reports produced by the AIDS centres.

During the mission, a lack of analytical skills and correct interpretation and use of existing data was identified. A programme should be designed with input from international partners aiming to increase analytical skills of staff at all levels. In the short term a minimum set of recommendations to be used in the interpretation of HIV surveillance data should be created.

Key recommendations

Short term – to be addressed within a 6 – 12 months period

1. To improve the quality of the next round of IBBS among PWID, SW, prisoners and MSM through:
 - Adjustment of the newly developed protocols: it is strongly recommended to adjust the approved protocol where the methodological assumptions are presented and field procedures are standardized.
 - Strengthening of the biological component.
 - Extension of the sampling frame for prisoners to get representative data for the entire penitentiary system.
 - Assurance of an external quality control during field data collection period.
 - Integration of the size estimation component in IBBS protocol and its regular implementation.
 - Improvement of the analysis and dissemination of IBBS process and results: a report should be produced after each IBBS round where each site results should be analysed and should contain chapters on methods and limitations.
2. To conduct an advanced statistical analysis (trend analysis) of available IBBS in key population databases to help understand the trends and to contribute to the end-term review of the National Programme.
3. To review the HIV M&E framework and to develop HIV M&E related documents through:

- Reviewing the set of indicators according to the mission recommendations.
 - Reshaping the current table of HIV M&E plan into a results framework format.
 - Reshaping the Indicators Manual into a HIV M&E plan according to 12 components framework for a functional HIV M&E system and add country specific technical details to the indicators (data sources and data collection forms, data flow, data validation, other data for triangulation, etc.).
 - Developing an HIV M&E work plan where the timeline of the data generating activities will be harmonized with the periodic reviews of the National Programme.
4. To harmonize the HSS HIV indicators with the National Programme HIV M&E framework
 5. To speed up the implementation of the electronic system for HIV patients' follow-up (retrospective data entry) and review the reports built in to inform the quality assessment of clinical management of HIV patients.
 6. To conduct in 2014 a validation of data collected through routine statistics in preparation for the end-of-term review of the National Programme.
 7. To develop a minimum set of recommendations to be used for correct interpretation of available HIV surveillance data.
 8. To ensure broad dissemination of the M&E and HIV surveillance information and make it publicly available.

Mid-term – to be addressed within a 12 – 24 months period

9. To develop software for the unique identifier system and to implement it for countrywide universal use by GO and NGO based service providers.
10. To develop protocols for supportive supervision visits and data auditing. Comprehensive protocols for monitoring visits would help to standardize the processes and ensure the methodological sustainability.
11. Conduct additional studies to determine the extent of the HIV epidemic among the MSM population.

Strengthening community systems

Are CBOs/networks meaningfully participating in joint national programme reviews?

First of all, the terminology needs some clarification. In the Tajik language, “CBO” and/or “NGO” are acronyms that do not have a proper translation. Non-profit organizations are legally defined as ‘Public organizations’, and public organizations need to be registered at the Ministry of Justice. This Register was instituted in 2007, when the Tajik government felt the need to obtain a better picture of the situation concerning nongovernmental bodies. Prior to that, starting in the mid-1990s, many NGOs were founded when international donors focused their interest towards central Asia, a few years after the war between the Russian Federation and Afghanistan had come to an end. International funding was a good opportunity to starting new activities and therefore many groups in the region, and also in Tajikistan, founded NGOs. In 2007, the Government requested a new registration for those organizations that had survived the first wave of international donors’ funding, in order to control their continued existence and their compliance to tax regulations. The Ministry of Justice established a register of “Public organizations”.

Public organizations vary a lot among themselves. The definition applies both to very big NGOs acting as 'umbrella organizations', the privileged contact of international funders and main grant recipients, and very small community based groups made by the vulnerable people themselves, with very scarce financial and human resources.

Although there was no chance to conduct an in-depth analysis of public organizations currently registered and active in the country, big public organizations seem to have a mission that is broader than the HIV/AIDS issue. Big international NGOs are for instance IOM (an international, intergovernmental organization mainly dealing with migrant issues), Fidokor (once national, but recently registered as an international organization for capacity building of local NGOs), Apeiron (another large organization with focus on migrants). Big NGOs have a long history and started to work in the 1990s around the issues of women and gender equality, refugees, migrants and children.

During the review public organizations of the different kinds and geographical areas were invited to take part in meetings and discussions and they indicated they had been part of previous similar initiatives.

Are CBOs meaningfully participating in joint national review committees?

The regulations of the National Coordination Committee for prevention and control of HIV/AIDS, tuberculosis and malaria in Tajikistan (NCC) include participation of civil society organizations.

The NCC was established in 1997 to take care of AIDS epidemic only; at that time it enrolled representatives of the governmental structures and international organizations. In 2003, after the establishment of the Global Fund, it was restructured in order to include all three infections: AIDS, TB and malaria. In 2005, the composition of the Committee was changed and included 19 representatives, 4 of them representing NGOs. The last change occurred in 2010, when a rotation of the members took place and, upon the advice of the Global Fund, the NCC was enlarged to include 8 public organizations and 1 representative of religious leaders. Therefore, the new composition counts 22 representatives as follows: 10 seats for governmental structures, 3 seats for international organizations and 9 seats for public organizations. The Deputy Prime Minister of the country chairs the Committee. The deputy chairman is the Minister of Health. Although it is not a mandatory requirement, the Global Fund strongly recommends assigning stakeholders from two sectors to the leading positions within CCM; this is not currently the case, since governmental officials take both leading positions.

The working body of the NCC is the Secretariat, supported by TGF. It ensures activity coordination and assistance in performing the function of the Oversight Committee; it takes care of preparing the materials for review at the Committee meetings. The Committee is supposed to meet at least 4 times a year, but additional meetings can be scheduled if necessary. It assists and supports the work of the regional bodies, the Regional Coordination Councils.

The NCC set up four technical working groups (TWG): 1. Monitoring & Evaluation; 2. National Policy and Legislation; 3. Harm Reduction; 4. Treatment, Care and Support.

Within this institutional frame, participation of NGOs and CBOs is ensured through a correct and transparent election process, to ensure their meaningful and productive contribution. The findings of the review, however, indicate that existing procedures are not properly followed.

The people interviewed (NGO representatives, members of international organizations, international recipients, other stakeholders involved in HIV prevention programmes) mentioned the fact that only 2 or 3 members out of the 9 presently representing public organizations in the NCC Board belong to 'real' NGOs. The other 6-7 members have been selected by the government officials and represent

institutional interests. The public organizations they represent, in the opinion of the interviewed individuals, have been constituted for this purpose. Therefore 'real' NGOs do not feel adequately represented in the NCC and do not perceive their participation as being meaningful. Moreover they report that policy documents are presented at the NCC meetings after having been approved, and that there is no discussion prior to the introduction of changes. Their opinions and points of view are not taken into consideration.

Such issues were already raised during a workshop organized earlier this year by the Eurasian Harm Reduction Network, held in Varzob on 26 April 2013: 'Communication with the Global Fund: problem resolution in community systems strengthening and HIV/TB control in Tajikistan'. The outcome of the workshop was a document with recommendations addressed to the NCC Board; such documents ask for an improvement in the representation and participation of NGOs in the HIV/AIDS issues at the institutional level, and for a more transparent election process for NGO representatives in the NCC. (The protocol is available). To date, the NCC did not give any answer to the issues raised. Apparently, the document will be discussed at the next NCC meeting, scheduled after the presidential elections, probably in December. The representatives of NGOs interviewed during the mission are not confident that things can change in the future.

On the other hand, Tajik institutional representatives expressed negative comments about NGO participation in HIV policy development and especially in the reporting tasks related to their work. They underlined that public organizations only report to donors and fail to give feedback to national and regional institutions, being mainly interested in performing the tasks they receive money for.

All the above can be summarized as an evident lack of communication, synergy and trust between health governmental institutions and NGOs, on both sides, and on scarce appreciation on the part of NGOs of their present representation in the CCM, and of members' election procedures.

Do community-led advocacy campaigns lead to a targeted policy change?

Advocacy efforts have been described as very problematic and sometimes ineffective. The interviews with civil society representatives evidenced that advocacy activities are perceived as being almost counterproductive to the achievement of a set goal. Political dialogue with the institutions is preferred, in theory, because it could bring some positive results. If, as previously mentioned, there is a lack of mutual trust at national level; things seem to work better at regional and local level. In the words of many people, the Regional Coordination Council of the Sogd Oblast seems to be an example of good practices and effective integration between institutions and NGOs, where the issues raised by civil society are taken into consideration.

Another example of a context where advocacy efforts received some recognition is the Technical Working Group on Harm Reduction. The members of this TWG are actively involved in the delivery of harm reduction services in different regions and they belong to the vulnerable groups. Over the past few years they have advocated for the improvement of harm reduction services and for the introduction of OST in the country, and succeeded in their efforts.

Do CBOs/networks receive adequate support?

It is important to make a distinction between umbrella organizations and big NGOs on one side, and small, local NGOs mainly involved in delivering services to clients on the other side. In some cases, the definition 'sub-sub-subrecipient' was used, and in such circumstances it was clear that these NGOs were quite small and weak. Such small NGOs usually receive some support by umbrella organizations that at the beginning of their activity train them in capacity building, reporting requirements and M&E skills. In most cases, small NGOs are the ones delivering outreach services to the population in remote, rural areas. They heavily count on volunteers who, on their part, count on the fact that the high turnover of workers might one day lead to their promotion to paid staff. Such organizations suffer a lot during the periods of funding interruptions and some of them are forced to close their services to clients. This is of course getting worse since international grants are diminishing due to the economic crisis; in Tajikistan, as in many other countries, the withdrawal of international funding is not supported, on the other hand, by the takeover of some services on the part of the government. New programmes and services start as 'pilot projects' but remain 'pilot' for many, many years and they are never converted into regular services provided to citizens by the state. When new pilot projects are initiated, they are provided at the risk of replacing the old 'pilots' which do not have capacity to be continued and sustained without the donors' grants.

Are networks of key groups adequately trained to deliver HIV services and empowered to advocate for their rights?

As already indicated above, training for civil society organizations is provided at least initially in various areas: in the delivery of the required services, in capacity building, in M&E and reporting requirements. Training is usually delivered by grant recipients at the start of new grants and projects, or by umbrella organizations, which have in their mission the task to provide services to smaller NGOs.

However, such training is usually insufficient for a number of reasons, mostly because of the high turnover in staff. The capacity building and reporting competencies are often lost within a short period of time. In addition, reduced funding leaves little time and resources to take care of complex reporting requirements that often change a lot according to the different donors.

The highest turnover is probably encountered in the outreach work, where apparently teams of workers delivering services in remote, rural areas need to change every month because they can cover only one specific area and cannot work in the neighbouring ones. Very often the language differs, people do not want to be contacted by "strangers" and therefore a new team of local outreach workers needs to be constituted and trained. This turnover mechanism contributes to poor service delivery and to very weak civil society organizations. This is the case of sub-sub-subrecipients, which are enrolled to deliver outreach prevention services in very remote areas.

Apart from these "extreme" situations, also bigger NGOs are lately encountering more difficulties than in the past due to restricted funding. They often explained they do not have sufficient time to devote to advocacy or to policy development. They have trouble complying with the reporting requirements and with the operational work itself. Their attention is mostly concentrated on client needs and on the quality of the service provided. When asked if they would like to be involved in additional and more comprehensive prevention services, they often feared they could be requested to add more to their daily routine, without being given recognition for it.

NGOs have high competences in the needs of the groups they get in contact with, and they often involve peers in outreach work. Such competence should be valued as a precious asset in future steps to be undertaken in order to control the HIV epidemic in Tajikistan. Outreach workers are the best prevention tools in a country where many people in rural areas remain illiterate, where in the winter frequent electricity black-outs prevent regular access to information channelled through radio and TV. Door-to-door prevention messages and campaigns are still today one of the most effective ways to transmit prevention messages to people along with radio and TV.

Are CBOs/networks adequately coordinated in a sustainable manner?

We had some occasions to meet with NGOs targeted to the different vulnerable groups, which count on the contribution of peers to deliver their services. This is the case of NGOs targeted to IDUs, sex workers, MSMs. In some cases, these organizations are not strongly organized and future sustainability represents great concern. NGOs working with migrants, women and children (often with no specific focus on HIV/AIDS prevention) are usually much bigger and have a longer history; often they act as umbrella organizations and offer some support to smaller ones. There was no chance to meet with NGOs working with prisoners, even though the Director of the Dushanbe prison explained there are at least six of them active in this sector; he mentioned Marvorid¹³ as one of the most active.

Most NGOs are linked to health institutions since they closely collaborate in the referral of clients to testing facilities, AIDS centres and other health structures. In some cases, it was observed that peer workers have adopted the point of view of the institution they work with. For instance, some previous drug users employed in a Trust Point for IDUs declared that OST is another type of drug and they would never recommend it to clients. They either offered NSP or detoxification; methadone was not an option and was described as useless and dangerous. A representative of the hospital where the facility is located reinforced such statement and added other facts in support of the peers' opinion.

In general, there is not a strong and coordinated civil society capable of advocating for the rights of vulnerable populations and to join efforts towards mutual objectives. Consortia of NGOs are functional in the distribution of grants and funds; they start and close their relations in accordance to the grant periods, trying to keep in contact only in view of future possible working collaborations. Only NGOs working on harm reduction seem to have developed a stronger coordination mechanism among themselves and are better represented in the Regional and National Coordination Councils/Committee.

In the opinion of the representatives of international organizations acting as grant recipients, the present situation is rather difficult for most NGOs: NGOs do not receive enough money, not in a way that allows sustainability; staff are forced to leave during interruptions. Another open issue seems to be the lack of coordination among donors. Different donors put in place different reporting requirements and this creates a huge workload for data collection and reporting which drains all the residual energies of NGO staff members. Required indicators are often too ambitious and do not take into account actual resources, that allow hiring only a limited number of staff, thus putting at risk the quality of services. Extensive technical and capacity building training is still required. If it is true that training has been provided in the past, the present situation of great uncertainty, high turnover and decreased funding requires renewed attention, otherwise 'only the big fishes will survive'. On the other hand, training should be offered to those NGOs which really need it and should be tailored to the actual needs; complaints were raised because in some instances people had to repeat training sessions more than once where there was no need for them, or people who could have benefited from them were not invited.

¹³In a different communication the director of 'Marvorid' reported that there is no more funding for their prison activities.

In the words of international organizations/recipients' representatives, NGOs are not influencing decision-making processes, they cannot advocate for their rights, or protest. In the opinion of some of them, the Tajik government officials consider NGOs as competitors, not as partners, and they actually try to build legal and bureaucratic obstacles for the delivery of HIV prevention services on the part of NGOs. New regulations for the storage of syringes and condoms are apparently under negotiation and would introduce a specific license, costing over USD 2,000. If such new regulations were enforced at the beginning of 2014, many NGOs would not be able to comply with such new requirements.

There is therefore a strong need to work on the development of a better relationship among the different NGOs at all levels, aiming at the construction of a common advocacy culture and platform and not focused only on coordinating the participation to funded projects. Of course, the financial aspect is paramount in a society where poverty still affects the majority of the population and funding mechanisms should be common ground for discussion and action. NGOs should take steps towards the acquisition of a stronger role in the policy decision process. They should take steps together, joining efforts, in order to feel comfortable, strong and protected from the threat of being wiped out by the upper levels of society. A bottom-up approach is strongly recommended in order to bring the point of view of those who know all about key issues of the vulnerable groups at higher levels. Civil society deserves to be valued and respected much more than now in a country which aims to implement effective actions in the HIV/AIDS field; goals will not be reached without the meaningful contribution of a strong and empowered civil society.

Gender issues

HIV prevalence among pregnant women was between 0.1%- 0.5% (data of 2009). Each year, there are several cases of HIV among women who were retrospectively identified after HIV detection in their children. Such data are alarming since more than 200,000 women get pregnant each year, and home deliveries are still very common, especially in remote areas.

The results of the first Regional Forum of women living with HIV in central Asia conducted in Tajikistan (2012) focused on the significant percentage of women infected by their IDU partners and on the limited access of women to HIV services, particularly the women from key affected populations and from rural areas.

Several national studies showed a low level of awareness among women about HIV and existing services on PMTCT, limited access of pregnant women to antenatal care, their low motivation to enter antenatal care services and, furthermore, high levels of stigma, discrimination and gender based violence (GBV)¹⁴.

In Tajikistan, the adoption of HIV prevention behaviours for women remains a difficult objective to achieve due to multiple socio-cultural factors: a traditional sexual culture that is not in favour of condom use; the subordinate role of women in the family and their economic dependence on their husbands and older family members¹⁵; the low level of education and (consequent) little or no awareness on HIV/AIDS issues; the low access to voluntary HIV testing.

¹⁴ Gender Assessment of HIV response in Tajikistan , 2013

¹⁵ Reproductive Health staff reported that family members like brothers or mothers-in-law frequently forbid taking HIV tests in pregnant women.

Given these factors, the possibility of a consistent spread of the HIV infection outside the most at risk groups (IDUs, MSMs, SWs) through heterosexual intercourse has to be taken into serious consideration; in the opinion of many women belonging to NGOs, the present prevalence rate of HIV infections in women might be largely underestimated.

Prevention of HIV infections in women cannot be treated as an HIV/AIDS issue in itself. If the socio-cultural context does not change, prevention efforts will lead to little improvement. Women should be allowed to attend school until they complete their education; they should grow-up in a society that give them equal rights, allows them to work and obtain economic independence from their husbands' families; they should have equal access to health structures and receive non-judgmental counselling, care and support. All such changes are independent from HIV prevention efforts in themselves, but HIV prevention efforts cannot be effective if the conditions of women in Tajikistan will stay the same as now.

The interviews conducted during the review among women belonging to NGOs who offer support to other women point to the fact that the low prevalence rate among the female population could be explained with the low percentage of women seeking care during pregnancy in antenatal clinics, and the extremely low percentage of non-pregnant women who test for HIV.

Two representatives of UN Women reported very alarming data for which, so far, no confirmation was given. Apparently, in 2010 Tajikistan experienced a serious outbreak of polio and UNICEF conducted 7-8 rounds of polio vaccination door-to-door. In the period from 2010 to 2011, 60,000 non-registered children were 'discovered' only in the Dushanbe Region, i.e. the area with the best health facilities. The women interviewed went on explaining that in many cases children are registered only when they enter the school system; a small fine is the only problem encountered by their parents for late birth registrations. UNICEF subsequently published a report on the polio outbreak highlighting such data (report not available to the evaluators). If this were the case, a huge number of women still do not receive antenatal care, deliver at home and do not take their children to health services in the first years. Many of them may be living with HIV.

Other findings during the interviews refer to the fact that prevention of vertical transmission from mother to child is not adequately addressed and women are not aware of the risks for themselves and their children. In addition, many believe that women refuse to access medical care because they know that HIV positive women are badly discriminated in health services.

Roundtables, meetings, workshops that aim to empower women have been conducted and are still being foreseen; they gather those women who have a leading role in their community and/or NGO workers. Such efforts are useful but so far they have been insufficient to produce effective changes.

In March 2013 UNAIDS, in cooperation with main stakeholders, conducted a gender assessment of the national response to HIV. Recommendations were addressed to decision-makers, requesting them to improve gender based approaches in the national response in order to meet the needs of key populations and vulnerable groups, particularly women and girls. Recommendations were agreed upon by all key stakeholders. This review strongly recommended addressing findings and recommendation of this assessment, which would strengthen and incorporate gender concerns into the national response to HIV/AIDS in Tajikistan.

Recommendations

Immediate – requires immediate and priority attention within a 3-6 months period

- Review of CCM functions and procedures with regard to a more transparent election mechanism for NGO members and definition of TOR for NGO CCM members
- Grants (1) Definition of clear, balanced and transparent procedures for the application to grants. Wide promotion of funding opportunities (CCM website and other)
- Grants (2) For the Global Fund: uninterrupted provision of services within the TGF projects; proportionality of funding/resources and related indicators, with the possibility to discuss them and to introduce quality indicators; improvement of communications between civil society and Global Fund
- Grants (3) For principal recipients: transparency of procedures for the selection of recipients, procurement; optimization of grant management system (terms of agreements with sub-recipients, buffer funding; capacity building for grant recipients)
- Support to new NGOs; continued investment in services provided by “old” NGOs with strong motivation to maintain HR services for their clients and need to ensure continuity

Short-term – Should be addressed within 6-12 month period

- Promotion of a bottom-up approach to empower civil society and improve NGOs involvement in policy development, their meaningful contribution to the HIV/AIDS Programme and M&E process
- Reflection on actual good examples and best practices (good relations and cooperation within the CCM members in the Sogd oblast; good achievements of the TWG on harm reduction) for their replication
- Improvement of relations among NGOs at all levels; development of effective networking mechanisms; better representation of people from vulnerable groups; increase in sustained and joint advocacy campaigns and efforts
- Funders and international agencies should improve mutual cooperation, ensure dissemination of data to both governmental institutions and NGOs and simplify/unify reporting requirements to avoid overload with data collection for NGOs
- Address gender issues such as the restrictions placed by the family environment to perform tests and access treatment, care and support (in line with existing recommendations). Address implementation of findings and recommendation of a “Gender Assessment of HIV response in Tajikistan “, 2013¹⁶
- Within the CCM structure, consider a technical working group for improving capacity building and advocacy for civil society
- Identify effective interventions to reduce stigma and discrimination particularly in health settings and include them in the further plans as one of the priorities to improve access of key populations and vulnerable groups to HIV services.

Mid-term – maybe addressed within a 12 – 24 months period

- Involvement of NGOs in the delivery of services that are presently inadequate due to lack of staff in the health sector (e.g. counselling on treatment adherence) or insufficient (offer of rapid testing to vulnerable groups)

¹⁶ Gender Assessment of HIV response in Tajikistan , 2013

HIV testing and counselling

In accordance with National HIV Testing policy (Decree №171 of 01.04.2008) several groups and conditions are subject to mandatory HIV testing including entry visa seekers, foreigners staying for longer than 3 months, pregnant women, patients of STI and settings serving high risk group populations (no specificity is given); mandatory testing is also pre-employment requirement for several medical occupations. Foreigners tested HIV positive are subject to deportation, medical doctors tested positive require changing the occupation. It is strongly recommended to carefully review and eliminate any form of mandatory and compulsory HIV testing. Leadership of National HIV Programme shows understanding and willingness to do so and plans to initiate revision of national testing policy as soon as new law being currently under review has been adopted.

Confidentiality, anonymity: There is a need to promote correct understanding of terms “anonymity” and “confidentiality”. Services cannot be considered anonymous if clients are supposed to provide home address and phone number (while not disclosing names) and could be visited home and almost mandatorily “invited” for follow up service if found positive. At the same time the term “anonymity” does not mean that anonymous services should not collect data such as age, sex, transmission rote, behaviour, etc. as these data are vitally important and would contribute to better understanding of current epidemic and elaboration of effective prevention and control measures.

The term “confidentiality” does not mean that treating physician or colleagues offering post-test services should be kept unaware of HIV status of patient/client. The feed back on test results should be provided to ensure quality treatment, care, support and other follow up services required.

It is vitally important to ensure effective universal coding system for those tested that will contribute to improve data quality, avoid double counting, and promote anonymity and confidentiality.

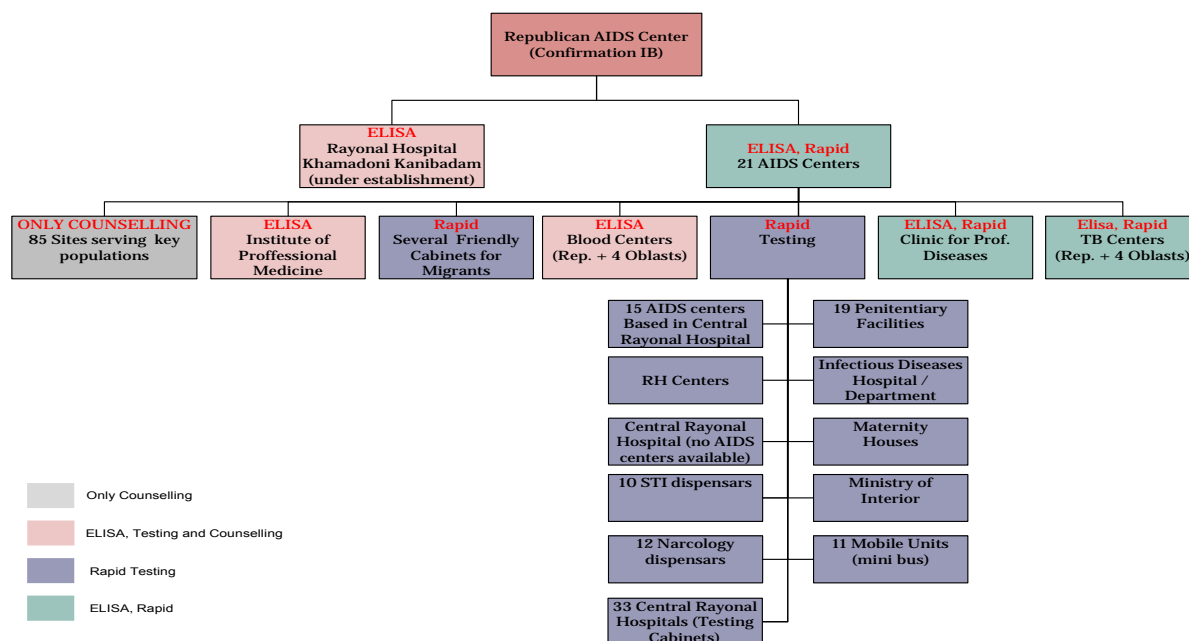
National HIV/AIDS Programme, 2011-2015

HTC issues are mainly addressed by Objective 1: Groups with high risk of exposure to HIV/AIDS (IDUs, SW, MSM, prisoners) have accepted preventive behaviour. The implementation plan for the National Programme being a separate document looks too broad and general and does not provide enough specifics on the planned actions to reach planned objectives. As an example, it is unclear what actions have been planned for HTC expansion (point 1,4 of the Plan) as well as for the HTC integration in Primary Health Care (PHC). The term VCT used in these documents also causes confusion as it is unclear whether HTC is meant or just client initiated testing. The definition of indicators given in the National Programme differs from those in the implementation plan causing confusion (translation might be an issue). The major challenge for the National AIDS Programme in a country having concentrated epidemic is to scale up access to and coverage by the HTC services for key populations primarily PWID, MSM, prisoners and SW. In order to achieve that, the Programme should have a clear picture of the existing access, coverage, understanding of existing barriers and clear, well defined plan to address these barriers, define realistic targets for HTC expansion and elaborate and implement efficient interventions to reach that target, indicators and mechanism to monitor progress towards reaching target set.

Testing and counselling services (HTC)

There is wide national network offering provider initiated (PITC) and client initiated services across the country involving state facilities, so called friendly cabinets and also some NGOs (offer only counselling) (Fig. 4). Rapid testing is widely offered across the country. By 01.07.2013 in Tajikistan there were: 38 HIV/AIDS Prevention and Control Centres, 25 laboratories offering ELISA testing, 156 testing sites including: Primary health care (71 sites), AIDS centres (38); STI settings (10); TB settings (6); Narcology (12); Penitentiary facilities (19); Service points for IDUs, SW, MSM, migrants (85).

Fig 4: Sites offering HIV Testing and Counselling services



Currently it is required that all samples found positive at initial testing in settings other than AIDS laboratories are sent to the latter for retesting. All samples found positive at retesting in AIDS laboratories should be sent to the laboratory of National AIDS Centre for confirmation as only that laboratory has authority for confirmatory testing. The rationale for such policy and practice is unknown. National AIDS Programme should consider review of algorithms currently followed in the country; it is strongly recommended to consider expansion of confirmatory testing. The National AIDS Programme should provide necessary support including test supply, capacity building, etc. to ensure high quality of testing performed across the country and quality monitoring. QA system, including external and internal quality control, should be further strengthened.

In total 400 specialists have been trained to offer HTC services. It is recommended to further improve education including continuous education for HIV laboratory personnel; there should be well-defined curricula and system ensuring availability of well-trained HIV lab specialists. Efforts should be made to institutionalize education/training of counsellors.

Here are some examples of specialized settings' involvement in HTC provision:

STI settings: HTC (rapid testing) is offered to STI patients by all STI institutions across the country. STI settings host 45 friendly cabinets offering services to migrants and their families. All those cabinets offer HIV counselling and some also testing (rapid testing). The samples found positive in initial testing are sent to AIDS centres as none of the STI clinics, not even the Republican Centre for Dermatology and Venerology (tertiary level institution), does confirmatory testing. The rationale for such current practice is unclear. Along with rapid testing several institutions have also ELISA equipment and staff and could perform confirmatory testing, but have no permission/authority for that. There is no feed back on the reactive samples sent to the AIDS Centres for confirmation – neither for individual case management or for surveillance purposes while being necessary as for management of STI/HIV co-infected patients as well as public health actions including preventive interventions.

Blood safety: There are 4 blood centres in the country: in the capital city (national Centre) and in 3 oblasts. All centres do initial testing (ELISA); reactive samples are sent to AIDS Centres. No feed back neither for individual cases nor totals (quarterly or annual) has been provided. Blood safety settings show interest, willingness to have confirmation done which would require refreshing training for staff and some equipment supply – subject for additional specification.

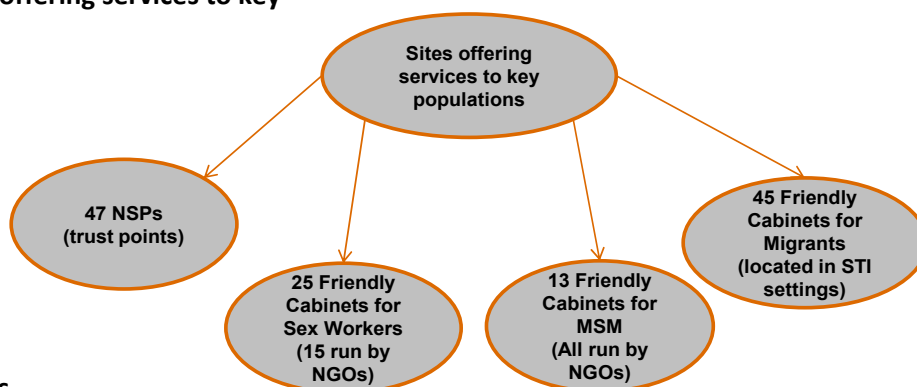
Reproductive Health settings offer HIV testing within antenatal care and also at maternities. Annually there are about 200,000 deliveries, about 9% outside of health care settings (all attended by midwives). There are also unattended home deliveries but the proportion is unknown.

Antenatal testing countrywide was initiated in 2008, prior to that testing was done for target populations (migrants and their spouses, SW, PWID, STI patients). RH settings perform HIV testing (rapid, ELISA), reactive samples are sent to AIDS centres, no feedback has been provided on test results. Serious concern was expressed because of interrupted supply of tests. Currently there are no rapid tests available, testing is performed thanks to UNFPA supplied ELISA tests, but in some settings it require patients’ referral to the AIDS centres also for initial testing. Testing is for free but sometime some amount might be charged not for tests but other materials (gloves, syringes, etc.). RH settings are interested and willing to perform confirmatory testing (currently even national level institutions has no authority to perform it), which would require training and related test supply.

Sites offering services to key population groups

There are 130 such sites across the country – see Fig 5. They include 47 Trust points /NSP (26 run by NGOs), 25 friendly cabinets for SW (15 run by NGOs), 13 friendly cabinets for MSM (all run by NGOs), and 45 friendly cabinets for migrants and their families (all based at STI settings).

Fig 5: Sites offering services to key



populations

While some trust points and friendly cabinets offer HIV testing, the rest of the 65 sites offer just pre-HIV test counselling services and none of them HIV testing. Non-medical settings, civil society is allowed to offer HIV testing services but national norms and standards should be followed. There were some attempts by civil society settings but none could offer HIV testing services at national standards. It is strongly recommended that the National AIDS Programme helps civil society settings willing to offer HTC services to create capacity/conditions to offer HIV testing. NGOs having already well established collaboration with health care settings could become initial sites for that. This could be linked to and supported by some ongoing activities and plans the NGO has including involvement of local religious leaders (also those for women), and mobile theatre to promote HIV prevention (planned by some NGOs for 1 December), but could also be supported by developing clips for local media that would promote awareness and motivation to get tested. Civil society involvement would help to promote access to HTC services for key population groups, especially those that remain hard to reach for the national AIDS Programme.

Tests supply – cost consideration

The HIV tests are supplied by AIDS centres via TGF grant. Supply interruption is an issue. In 2012 there were no tests supplied for 2-3 months and at some sites for an even longer period. Concerns were expressed also on the quality of tests supplied. Testing is not free of charge everywhere; at some sites clients are supposed to pay 6 – 20 Somoni, and prices differ from site to site. Ongoing developments suggest that testing will become even more expensive starting from 1 October 2013; so initial testing will cost 23-26 Somoni and confirmatory testing – 96 Somoni. It is strongly recommended to offer free HIV testing first of all to at risk and vulnerable populations.

It is strongly recommended to consult WHO list of prequalified diagnostic products http://www.who.int/diagnostics_laboratory/evaluations/PQ_list/en/index.html. The WHO prequalification of diagnostics programme aims to increase access to affordable diagnostic technologies of assured quality that are appropriate for use in resource limited settings. The programme provides Member States, UN agencies and other partners with technical information and advice on the quality of currently available HIV/AIDS test kits and technologies. Prequalification of diagnostics is a prerequisite for UN procurement ensuring that public monies are spent in a cost effective manner, on quality diagnostic http://www.who.int/diagnostics_laboratory/evaluations/en/. The WHO Diagnostics and Laboratory Technology team provides countries with the appropriate technical support, tools and guidance on the provision of diagnostics and laboratory services in ways which strengthen health systems consistent with the values of Primary Health Care http://www.who.int/diagnostics_laboratory/3by5/en/

Number of people annually tested for HIV is about 300,000 – 400,000

(See 2011 example in Table 5 below.)

The large proportion of those tested are pregnant women, migrants including people staying abroad for more than 3 months, medical staff, military, foreigners staying for more than 3 months and in contrast the proportion of those belonging to key population groups, including PWID, MSM, prisoners or SW is very modest.

Table 5: Testing of selected population groups, 2011

Groups tested	Number of tested	Number/proportion of tested positive
Total Tajik citizens	430,347	989 /0,2
Pregnant women	182,937	51/0,02
Migrants	67,166	49/0,06
Medical staff	37,804	8/0,02
Military	4,936	3/0,06
Foreigners staying for more than 3 months	10,699	1/0,009
People who inject drugs	5,362	205/3,8
Homo/bisexuals	790	7/0,9
Sex workers	1,678	8/0,4
Prisoners	1,431	174/3,6

There are also 2 other groups tested that show higher proportion of detected positive cases (2011 data):

- Anonymous testing – 1,3% tested positive out of 6,099 tested
- Others – 0,1% out of 31,382 tested

It is unknown what groups were tested under these categories, what the transmission routes were, whether those tested have been addressed for treatment, care or other follow up services needed.

These might be still hidden groups that remain unknown for the national HIV prevention and control efforts.

Current policy and practice to test large population groups should be reviewed and abolished as it cannot be justified neither from a human rights perspective (mandatory nature of some of those policies and practices as discussed above) nor from epidemiological and cost-effectiveness perspectives.

Major efforts should be directed to expand access to and coverage by testing for key populations including PWID and their sexual partners, MSM, bisexuals, SW, prisoners. Potential ways would be abolishment of mandatory policies and practices, involvement of non-medical personnel, non-medical settings including civil society settings in not just HIV counselling but also HIV testing performance, expansion of rapid testing, ensuring uninterrupted test supply of tests of assured quality, diminishing waiting time for test results, ensure non restricted access to free, quality HIV testing including that in rural and remote areas.

Testing of pregnant women:

In accordance with current national antenatal testing policy pregnant women should be tested twice, at first antenatal visit and at 28 weeks of gestation. Available data suggest that pregnant women are about 50% of those tested for HIV in 2010-2013, while the proportion of detected HIV positive cases is 0.02 – 0.04. Data on re-testing of pregnant women is unavailable (neither number of tested nor revealed cases).

The rationale for current national policy and practice to re-test pregnant women in the second trimester is unknown. Available data suggest very low proportion of detected cases in pregnant women out of thousand of tests performed (see Table 6). The HIV epidemic is currently in a concentrated stage. This raises serious concerns of cost-effectiveness, especially taking into account that 84% of the National AIDS Programme is covered by international donors.

Table 6: Testing of pregnant women

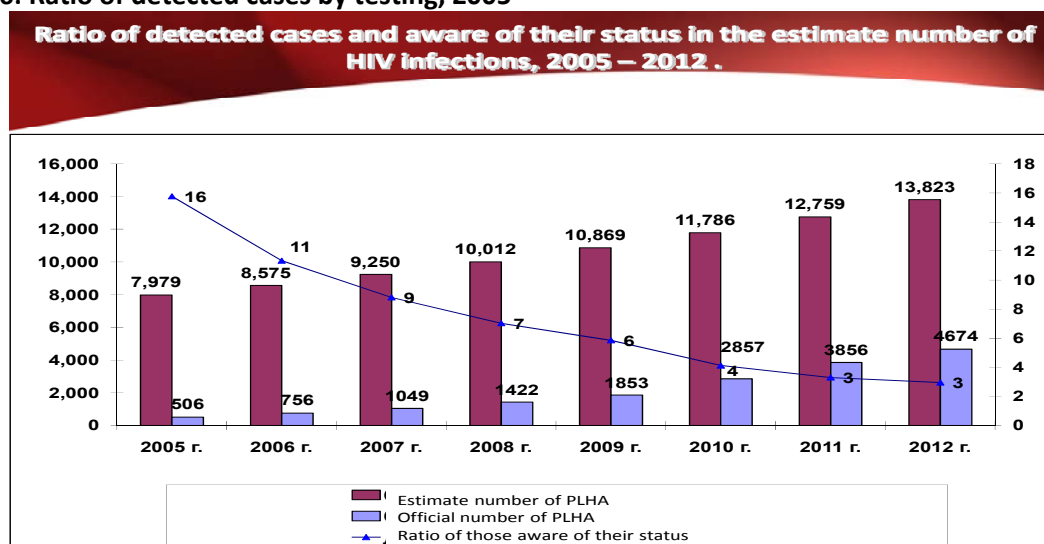
	# of pregnant women tested	Testing coverage	# of HIV pos	% of tested positive
2008	40,171	21.50%	23	0.06
2009	76,297	36.70%	32	0.04
2010	119,033	54.80%	53	0.04
2011	165,680	76%	75	0.05
2012	172,548	79.50%	100 (60 new cases)	0.06

The new national PMTCT protocol is under development. It is recommended to follow WHO recommendations: testing at the first antenatal visit (and as early as possible); retesting could be considered for some pregnant women based on epidemiological and social context. Re-testing for HIV negative pregnant women in the context of current epidemic in Tajikistan being at concentrated stage is not recommended. Re-testing is recommended with each new pregnancy or if the pregnant woman is in a high risk category that includes high risk partners whose status is unknown; has known HIV positive partner, is sex worker, or person who currently injects drugs. Re-testing is also recommended for pregnant women in settings with generalized epidemics if such settings existed in the country.

Going forward

Available data suggests that in spite of the increased number of tests performed 2/3 of PLWH remain unaware of their infection (see figure 6). Early detection of undiagnosed PLWH and early link to treatment, care, prevention and other services they would need are among the major tasks of the national HIV Programme.

Fig. 6: Ratio of detected cases by testing, 2005-



2012

Analysis of anonymous testing data, and testing of “other” groups (in accordance with testing Form#4) would potentially provide useful guidance for these efforts.

As mentioned earlier, in spite of increasing tendency, the proportion of PWID, prisoners, MSM and SW of total number of people tested remain low. Some national data also suggest increasing testing coverage of IDU and SW but there is also some discrepancy observed i.e. numbers of newly detected cases in IDUs and SW in 2010-2012 (see Tables 7 and 8 below) differ from those listed in Forms # 4 (attached) causing confusion and questioning data quality. For easy reference, an additional column containing data taken from Forms #4 has been added to tables provided by the national colleagues (marked in red below). It is recommended to improve data quality, implement efficient coding system to ensure that repeated testing of people is excluded and increased coverage and decreased proportion of newly detected cases among those tested shown in tables below reflects the true picture.

Table 7: Testing of IDUs

Estimated # – 25000	# IDU tested	Newly detected cases	# of those tested positive as listed in Form # 4	% of newly detected cases	Coverage (%) of estimated size
2008	1604	179	NA	11.16	6.416
2009	2099	220	NA	10.48	8.396
2010	4893	595	252	12.16	19.572
2011	5362	422	205	7.87	21.448
2012	7576	317	171	4.18	30.304
6 mo/2013	3650	153	71	4.19	14.6
TOTAL	25184	1886		7.49	N/A

Table 8: Testing of SW

Estimated size – 12500	# of SW tested	Newly detected cases	# of those tested positive as listed in Form # 4	% of those tested	Coverage (%) of estimated size
2008	319	0	NA	0.00	1.276
2009	467	5	NA	1.07	1.868
2010	1831	8	25	0.44	7.324
2011	4333	16	29	0.37	17.332
2012	4377	4	28	0.09	17.508
6 mo/2013	3490	4	NA	0.11	13.96
Total	14817	37		0.25	N/A

The MSM role in the current epidemic in Tajikistan remains unclear; for many years there is no or a very low number of detected cases in this population group (see Table 9). The low proportion of MSM of total number of people tested raises the question whether the available epidemiological data reflect the current situation. This group requires serious attention and efforts should be directed to scale up access and coverage by HTC services and early access to follow up services as needed.

Table 9: Testing of MSM

No size estimation	MSM tested	Newly detected cases	% of new cases
2008	78	0	0.00
2009	2	0	0.00
2010	89	1	1.12
2011	790	5	0.63
2012	613	0	0.00
6 mo/2013	247	0	0.00
Total	1819	6	0.33

The National Programme definitely should be congratulated on the continuous efforts of collecting and analysing HTC data. It would be advisable to further improve quality of HTC data including that of access and coverage, and ensure that quality data are used to guide national HTC expansion efforts.

Increasing access to and coverage by quality HTC services for key population groups require major attention and efforts of the national programme.

Recommendations

Despite progress made, 2/3 of PLWH are still unaware of their status. The major challenge and the major efforts of the National Programme should be directed to **scale up HTC access and coverage primarily for PWID and their sex partners, prisoners, MSM, and SW**. The current implementation plan for the National Programme looks too broad and general, and indicators and targets require revision. The Programme should have a clear picture of the existing HTC access/coverage, post test referrals; monitoring of just the number of tests performed is not sufficient; good knowledge of barriers and challenges; well defined plan to address these barriers and challenges; realistic targets for HTC expansion and precise action plan for implementing efficient interventions to reach targets.

Immediate – requires immediate and priority attention within 3-6 month period

- Review and abolish mandatory HIV testing policy and practice. Elaborate evidence and human rights based national HIV testing policy that follows international norms and standards and ensure that national HIV testing policy followed in practice
- Lift existing restrictions on entry, stay and residence for people living with HIV supporting the right to equal freedom of movement regardless of HIV status and contributing to move towards a world with zero HIV-related stigma and discrimination.
- Abolish testing policy and practice of testing in low risk groups (including migrants, military, foreigners, medical staff) and scale up HIV testing and counselling access and coverage for people who inject drugs and their sex partners, prisoners, men who have sex with men, and sex workers. Expand community based HIV testing and counselling, access to rapid testing primarily via civil society settings, including existing friendly services, NSP; ensuring access to free HIV testing; expand access to quality pre- and post HIV test counselling. Ensure HIV testing and counselling for patients having signs and symptoms suggestive of underlying HIV infection and for patients with diagnosed or suspected viral hepatitis.
- Universal re-testing of HIV negative pregnant women in the context of current epidemic in Tajikistan being at concentrated stage is not recommended
- Re-testing should be recommended with each new pregnancy or if the pregnant woman is in a high risk category; this includes: high risk partner with unknown status; HIV positive partner; sex worker or currently injects drugs

Mid-term – maybe addressed within a 12 – 24 months period

- Ensure access to truly confidential and anonymous HTC services. Confidentiality should not pose barriers for information sharing among care givers to PLWH. Nationally approved normative documents (including HIV testing policy, guidelines, treatment clinical protocols) should address confidentiality and anonymity issues, should be well known in all settings involved in HIV/AIDS control, prevention, treatment and care. Relevant national capacities should be developed/strengthened and maintained.
- Optimize HTC network, testing algorithms, expand confirmatory testing starting from STI, RH, blood safety, TB, narcology settings. Ensure effective linkages, referrals to post-testing services
- There is a need to further improve data on HIV testing access and coverage, post test referrals primarily for key populations and their sex partners, prisoners, men who have sex with men, and sex workers; better knowledge of barriers and facilitators and well defined plan to address them; realistic targets for HTC expansion and precise action plan to reach these targets.
- Uninterrupted supply of quality tests should be ensured; WHO list of prequalified tests should be consulted to get guidance required
- Professional education for HIV lab personnel should be improved. Capacity building of staff performing HIV testing, including that of civil society settings, should be ensured and monitored

It is recommended to consult WHO Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach, World Health Organization 2013 (<http://www.who.int/hiv/pub/guidelines/arv2013/download/en/>), WHO HIV Testing and counselling documents (<http://www.who.int/hiv/topics/vct/en/> <http://www.euro.who.int/en/health-topics/communicable-diseases/hiv-aids/publications/2010/scaling-up-hiv-testing-and-counselling-in-the-who-european-region.-policy-framework>) that would guide national HIV testing and counselling scaling up efforts.

HIV transmission through injecting drug use

Target indicators of **the Programme on the response to the epidemic of HIV in the Republic of Tajikistan for the period 2010-2015**¹⁷ were defined as following:

- 65% of IDUs have adopted behaviour that reduces the risk of HIV transmission, such as not sharing needles and using condoms
- At least 60% of most-at-risk populations (IDUs, SWs, MSM) have received an HIV test in the last 12 months and know their results
- 60% of IDUs covered by HIV prevention programmes
- At least 80% of prisoners covered by HIV prevention programmes
- 75% of IDUs have access to friendly VCT
- At least 75% of most-at-risk populations correctly identify ways of preventing HIV transmission
- At least 75% of most-at-risk populations reject major misconceptions about HIV transmission

Existence of national policies/strategies/plans for prevention of HIV infection through IDU

Needle-syringe programmes (NSP), as part of harm reduction activities and outreach were included in the *Programme on the response to the epidemic of HIV in the Republic of Tajikistan for the period of 2010-2015*. Though the order of MOH 2006 06 07 Nr 485 described NSP as part of narcological system, NSP activities so far were not financially supported from the government, except for providing premises in health care institutions.

The *Programme on the response to the epidemic of HIV in the Republic of Tajikistan for the period 2010-2015* positioned the expansion of OST as a pilot programme¹⁸. The Law of the Republic of Tajikistan “On Narcological Care” Nr 67, approved by the President of Tajikistan December 8, 2003, included OST among the responsibilities of the medical institutions that provide narcological care¹⁹. In 2006, the Ministry of Health issued the decree “On improving narcological care in the Republic of Tajikistan”. It defined OST as the basic component of standard drug treatment services²⁰. Therefore, according to legislative acts of the Republic of Tajikistan, OST was an integral part of the health care system in the country. Nevertheless, by 2013 OST in its implementation remained fully dependent on donor funding in narcological medical institutions and continued to work only as a “pilot project”.

Regarding NSP in *penitentiary system*, the *Programme on the response to the epidemic of HIV in the Republic of Tajikistan for the period 2010-2015* included planned activities “to review the regulatory

¹⁷Programme on the response to the epidemic of HIV/AIDS in the Republic of Tajikistan for the period 2011-2015, Oct 2010 Government of the Republic of Tajikistan, p.35

¹⁸Ibid, p.35

¹⁹Assessment of Medication Assisted Therapy Programme in the Republic of Tajikistan, Dushanbe, 2003, p.14

²⁰Ibid, p.14

framework with the purpose of considering the introduction of needle exchange in the penitentiary system”²¹.

Regarding OST in penitentiary institutions, neither the *Programme on the response to the epidemic of HIV in the Republic of Tajikistan for the period 2010-2015*, nor other strategic documents included any activities or targets. In 2012 the Ministry of Justice of the Republic of Tajikistan, Ministry of Health and Agency for Drug Control at the Office of the President have signed a 3 year Action Plan to introduce OST in the penitentiary system in the framework of cooperation with the UN Office on Drugs and Crime²²²³.

A *Comprehensive Package* of interventions for the prevention, treatment and care of HIV among people who inject drugs and its 2012 revision has been endorsed widely by WHO, UNAIDS, UNODC, the UN General Assembly, the Economic and Social Council, the UN Commission on Narcotic Drugs, the UNAIDS Programme Coordinating Board, the Global Fund and PEPFAR²⁴. The Comprehensive Package of 9 modules will be used in this report to assess the progress of scaling-up and quality implementation of the Comprehensive Package.

Existence of national operational guidelines for prevention of HIV infection through IDU, which meet international standards

NSPs were operationally regulated by the “**Methodological guidelines for implementation of harm reduction programmes**”, approved by MOH 2010²⁵. These guidelines included the philosophy of harm reduction, role of the civil society organizations, tasks and components of NSP, equipment for delivery to IDU, activities, mobile NSP, minimum services provided in NSP, etc. The order of MOH 2008 02 13 Nr. 60 and 2012 08 23 Nr 415 provided legal background for the operation of NSP operating under the health institutions.

Implementation of the pilot OST programme in the Republic of Tajikistan was regulated by the Decree of the MOH No. 500 as of July 24, 2009 “**On introduction of OST therapy**”, which governed also the development of the “**Operational Guidelines on Substitution Methadone Maintenance for Opioid Dependence**” (further Operational Guidelines on OST) in coordination with the Agency for Drug Control at the Office of the President²⁶. The Operational Guidelines on OST was an organizational and clinical protocol developed by a team of professionals under the coordination of the Republican Clinical Center of Narcology (RCCN).

There are some key principles with regard to access of IDU to OST, most of which are also reflected in WHO Guidelines for Psychosocially Assisted Pharmacological Treatment of Opioid Dependence (2009)²⁷ as recommendations on OST provision for health systems. To increase access and to make OST *universal*, interventions should be:

- Physically **accessible** – broad geographical distribution e.g. OST should not only be available in the major cities or unavailable in hard to reach locations such as prisons
- **Affordable** – cost at the point of service should not be a barrier e.g. patients should not be expected to pay for OST or other ancillary services, OST should be available to disadvantaged populations

²¹PROGRAMME on the response to the epidemic of HIV/AIDS in the Republic of Tajikistan for the period 2010-2015, Oct 2010 Government of the Republic of Tajikistan, p.36

²²Personal communication from the Republican Clinical Centre of Narcology

²³Interview with medical focal point for prisons

²⁴Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, 2012 revision. WHO, UNODC, UNAIDS, 2013. http://www.who.int/hiv/pub/idu/targets_universal_access/en/index.html

²⁵Methodological guidelines for implementation of harm reduction programmes”. Approved by MOH 2010.

²⁶Operational Guidelines for substitution methadone maintenance for Opioid Dependence, MOH, Dushanbe, 2009

²⁷Guidelines for Psychosocially Assisted Pharmacological Treatment of Opioid Dependence, WHO, Geneva, 2009.

- **Equitable and non-discriminatory** – there should be no exclusion criteria except medical ones e.g. OST should not be limited to those over a certain age or only to those opioid dependent individuals who are HIV infected or who have “failed” other drug dependence treatment
- **Non-rationed** – the supply of OST should be determined by need and not limited by cost or other considerations – ideally there should not be waiting lists

Operational Guidelines on OST of Tajikistan do not comply fully with these international/WHO principles. They restrict access to OST for a significant part of IDU. Only IDU, who were injecting opioids longer than 2 years, experienced 2 more attempts of unsuccessful treatment and are older than 18 years of age are eligible for OST²⁸. This discrepancy with international/WHO standards was disclosed by previous assessment reports²⁹ and recommended to be amended.

Resources and procurement for IDU-related services

NSPs are provided by Trust Points (TP) and NGOs. TPs are managed and procured by the Republican AIDS Control Center (RACC). NGOs are managed and procured by the UNDP in Tajikistan, the primary recipient of the TGF project. During site visits, both TPs and NGOs indicated that they were satisfactorily and timely procured with needles, syringes, and condoms. Operation on the basis of limited-duration projects reduced the sustainability of services.

OST sites were funded by the UNDP in Tajikistan. Both RCCN and Sogd ONC indicated that they were timely funded and procured with medication.

The typical staff of TP, which consisted of a manager, a social worker, a physician-consultant and 3 outreach workers, was appropriate to deliver NSP, refer to other services, including HTC, and to provide syndrome treatment of STIs. During site visits to TP and NGOs they were fully staffed with managers, social workers, physicians – consultants and outreach workers as required.

OST sites were staffed with one full-time doctor (narcologist) per 50 patients, two full-time nurses; one pharmacist; one social worker; 3 security guards; one full-time cleaning person. TGF also supported one consultant/coordinator in each OST site, the role of which was usually performed by the chief doctor of the health facility. The responsibilities of a pharmacist included to control the turnover of methadone and safe storage of supplies. OST sites were not staffed with specialists for psychosocial assistance (social workers and psychologists). The reason was absence of professional social workers and psychologists as they were not trained in satisfactory number by the local universities and colleges. In RCCN the position of a social worker was filled by a physician as the number of patients outnumbered the number of OST slots.

As indicated by the staff of TP and NGOs visited the provision of needles/syringes/condoms for prevention of HIV infection among IDU was in satisfactory quantities and timely.

One of NGOs’ regular reports for 2012³⁰ showed that there were intervals in the availability of HIV testing of IDU clients. The longest interruption was experienced in the period from July to December (6 months), during which HIV testing could not be offered.

Methadone was procured by the UNDP, the Primary Recipient of the TGF grant aimed at fighting HIV. Procurement was done based on the forecast provided by the RCCN that collected information on methadone stock and potential demand from each OST site on a monthly basis. The potential demand for methadone was calculated based on the assumption that each OST patient required a daily dose of 100 mg of methadone. Since the very start of the project, methadone was procured well in advance, enabling uninterrupted provision of OST.

²⁸Operational Guidelines for substitution methadone maintenance for Opioid Dependence, Dushanbe, 2009, p.22

²⁹Assessment of Medication Assisted Therapy Programme in the Republic of Tajikistan, Dushanbe, 2003, p.14

³⁰NGO regular report for 2012-2013

Penitentiary institutions indicated that there were no shortages of needles/syringes in a small-scale pilot NSP programme in one of the prisons. The representative of the medical service of the penitentiary institution indicated that condoms were available in sufficient quantities.³¹

Distribution of services to IDU population and coverage indicators

NSP was provided by 43 TP nationally (21 National AIDS Center managed and 22 NGO based). Both TPs and NGOs included services in allocated premises as well as outreach work.

According to data of Sogd Oblast Narcological Center, in all 18 districts of Sogd NSP were operational in 8 districts through TPs, operated by RACC and Oblast AIDS Center³². In 7 other districts of Oblast NSP was provided by NGO DINA. 3 districts out of 18 *were not covered* by NSP. The covered districts consisted 83% (high level indicator NSP.A.1f > 80%).³³ Sogd Oblast AIDS centre had mobile team to provide services to areas that are not covered. The extent of the regular access of NSP to IDU was unknown.

The calculation of the available administrative data (registered clients at NSP) and against estimated IDU population in visited areas indicated that NSP coverage could reach around 25-27% of the estimated IDU population in these areas. As recommended by WHO, UNODC, UNAIDS Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, 2012 revision (2013), these were modest indicators against recommended high level coverage target of 60% or more of IDU population.

Some site visits suggest that outreach should be developed and scaled-up as a main model of work to increase the coverage of IDU to reach the recommended target (>60% of estimated IDU number), especially in remote places.

Findings also suggest that in some city's TP, physician-consultant for IDU, sometimes with the consultation of STI specialist, provided the syndrome treatment for STI. The existing framework of registering NSP clients excluded IDU partners from receiving the assessment on STI symptoms and medication. IDU partner could officially receive STI syndrome treatment. As it was revealed during discussion at TP, the staff solved this problem "unofficially" by giving an IDU client medication for him/her and a partner.

By September 2013 there were 3 OST sites in the country: in Dushanbe RCCN and Sogd and Khorog Oblast Narcological Dispensers (OND). Each of them had capacity of 100 patients. As of 1 September 2013 there were 261 patients (24 women). The RCCN had 153 (21) patients (capacity for 100 patients) and a waiting list. There were 49 (5) patients in Sogd ONC and 64 (0) in Khorog ONC. With the total of 261 patients in OST against the estimated number of IDU³⁴ the coverage nationally was around (261/25,000) 1% (coverage indicators are defined as low <20%, midlevel 20-40%, high > 40%).

A system for referral to **HIV testing and counselling (HTC)** was established through a *voucher* system. This system allowed NSP to control the number of IDU referred for HTC against the number of clients who actually received HTC. These indicators were required to be monitored on monthly basis.

³¹Interview with medical focal point for prisons

³²S. Bobojanov, presentation at Sogd Oblast AIDS Center

³³Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, 2012 revision. WHO, UNODC, UNAIDS, 2013.

³⁴UNDP (2009). Report on population size estimation and risk behavior among IDUs & CSW in Tajikistan, APMG.

Table 1: HIV rapid testing among IDU in 2008-2013³⁵

	6 months 2013	2012	2011	2010	2009	2008
HIV rapid testing among IDU in total	2,555	5,837	3,867	2,802	1,185	788

In table 1 data indicate that rapid HIV testing increased 5-fold from 2009 to 2012. Staffs of TPs and NGOs were formally trained in pre-test counselling. The quality of the service was unknown. NSP sites referred IDU clients to the nearest AIDS centre or other medical facility for rapid HIV testing. An interviewed outreach worker indicated³⁶ that due to the geographical distance (sometimes substantial) some of IDU clients did not reach HIV testing sites due to unstable motivation of many IDU for HTC and behavioural priorities concentrated on drug use. The geographical remoteness of NSP and rapid HIV testing sites implied a significant barrier for IDU to access HTC.

Another important barrier for HIV testing was a potential breach of confidentiality at AIDS centres³⁷ or even stigmatization from the AIDS centre staff. A third barrier for HIV testing was queues, as in many medical facilities (e.g. Dushanbe) HIV tests were performed on a commercial basis, e.g. when HIV testing is required by employers and many people address these facilities to get tested³⁸.

As observed some TPs are located in the premises of City Central Hospital. The Hospital had all necessary medical licenses, including medical care and laboratory tests. As TP had medical staff, HIV tests could be easily done on the premises of TP. This would significantly increase the access of IDU to rapid HIV tests.

At OST sites according to Operational Guidelines for OST all patients should be tested for HIV infection at least once per year. This was part of the signed contract of participation in OST³⁹. The pre-test counselling was provided by the medical staff of the OST site. The staff were trained for counselling and patients were referred to HIV testing site.

In 2013 there were around 10,000 inmates in prisons with an annual turnover (coming in and out) of around 14,000. The administration of penitentiary institutions acknowledged that IDU was a problem in penitentiary institutions. An estimated showed that during the last year 40-70% of inmates were incarcerated due to charges related to illegal drug offences⁴⁰. HIV counselling and testing was available in prisons. In 2011 18,000 tests for screening purposes were performed in prisons, which resulted in detecting many new HIV cases. During previous years roughly 1/3 of inmates were tested for HIV. HTC was supposed to be not mandatory.

A pilot NSP programme was available in one prison since 2012. NSP was implemented through 2 volunteers. A coding system protected the anonymity of clients. There were 20 inmates using NSP. During the last quarter 2300 syringes were distributed. This implied that NSP reached more than 20 clients. The return rate was estimated around 70-80%. It was obvious that some needles/syringes were retained among inmates and could be potentially used many times. It also suggested the potential existence of a needle/syringe "black market" inside prisons due to their poor availability to IDU in prisons. Disinfectants for needles and syringes were indicated as being widely available in all prisons⁴¹.

³⁵Scutelnicuic, O. IBBS findings, 2013, unpublished document

³⁶Interview with outreach worker.

³⁷Interview with NGOs

³⁸Ibid.

³⁹Operational Guidelines for substitution methadone maintenance for Opioid Dependence, Dushanbe, 2009, p.26,28.

⁴⁰Interview with medical focal point for prisons

⁴¹Ibid.

Trust points (TPs) operated at the premises of different health care institutions (polyclinics, general hospitals, etc.). Though the order of MOH 2006 06 07 Nr 485 described NSP as part of the narcological system, NSP activities were so far not fully financially supported from the government, except for providing space in health care institutions and salaries for staff. Their operation should be in the framework of primary health care level and accessible to IDU in most (if not all) communities.

OST was delivered so far at Republican Centre and 2 Oblast Narcological Centres (ONC) as a pilot project.

In provision of NSP a range of NGOs were involved. The cooperation between the NGOs is fragmented; they speak with many different voices instead of forming a coalition and coordinating advocacy of the needs of their clients, including IDU. There was a variation in the attitudes towards OST among members of NGOs, which ranged from very supportive attitudes to hostile.

On the other hand, NGOs had little support from the Ministry of Health and other government institutions. They were hardly seen by MOH as partners in ACSM activities. Nevertheless, many NGO members who were HIV infected, used to speak openly in public and to the media in this way reducing the stigma.

As indicated by the one NGO religious leaders in its past educational project were educated about the urgency of HIV prevention. Religious leaders supported HIV+ women organizations and viewed women as victims. At many mosques HIV prevention issues were addressed a few times per year. On the other hand, religious leaders were not supportive for HIV prevention efforts among IDU via NSP and OST. NGOs thought there was a need for more educational activities about HIV prevention among IDU via a wider involvement in religious settings. At OST sites there were no formal agreements on cooperation between OST sites and NGOs. With the absence of psychosocial care for OST, occasionally it was provided by NGO on an individual case basis.

Prisons allowed NGOs to come into prisons and do educational activities on HIV infection prevention in prisons. There were agreements between prisons and NGOs in the past, though the effectiveness of this partnership was not known. At the moment of the review these activities were interrupted for 3 months due to the funding shortage to above-mentioned NGOs.

Quality indicators for NSP and OST are listed in detail in the Technical Guide⁴². To our best knowledge quality indicators recommended in this Technical Guide were not incorporated in any national or institutional quality standards documents.

There were many achievements in the provision of quality NSP services. E.g., in planning of services, IDU clients were involved, especially in NGOs. NSP was provided at the stationary premises and also through outreach work as recommended in the national operational guidelines. IDU clients at NSP both in TPs and NGOs were recorded using the unified code and their confidentiality was respected. There were no any requirements/criteria to attend NSP. Needles/syringes were not rationed while delivered to clients. Obligatory return of needles/syringes was not required in order to receive needles/syringes/condoms, etc. It was indicated that NSP were sensitive to requests of IDU on types of needles and syringes. All NSP sites were distributing condoms. Some NGOs providing NSP were very active in peer support to PLWHA in ARV therapy, which significantly complemented the regular NSP functions.

The information/education materials were distributed among IDU in large quantities and it was observed that in some cases naloxone ampoules were given for the prevention of opioid overdose. There was a voucher system for referral to rapid HIV tests. Outreach workers if needed accompanied clients to other health care institutions, and referrals were documented in their monthly reports.

⁴²Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, 2012 revision. WHO, UNODC, UNAIDS, 2013.

NSPs were well instructed which information to gather and fill in the required data for monitoring and evaluation as needed.

According to the regulations TPs and NGOs that provided NSP had their own capacity for STI syndrome treatment in cooperation with STI specialists in policlinics. NSP sites had supplies of necessary medications to be prescribed for STI treatment without disclosing personal identity. Referral for TB was problematic, because screening was not always available and free of charge.

At the same time there was space for improvements in the quality of NSP. By 2013 NSPs were continuously funded only by external funds. There was no national strategy which ensured the sustainability of NSP. Feedback from NSP clients were not collected by NSP sites by anonymous questionnaires on regular basis. Staff of TPs and NGOs indicated that they attended a number of different trainings, however it seemed that there was not enough practical skills training under supervision of more experienced peer workers. During meetings it was not possible to identify a national or regional resource centre, which would provide supervision on the quality of NSP services, promotion of best practice and regular advice.

Quality indicators for OST, which are listed in the Technical Guide, were so far not included in the Operational Manual on OST or any other documents.

There were substantial achievements in the provision of OST services. In RCCN the board of OST service users was established by OST patients. The board was consulted by OST managers on questions of provision of services. It had good working relations with specialists at OST in RCCN. The board consisted of stable OST patients, who were “long timers” in OST. Some of them were also PLWH. The Board tried to prevent grouping of unstable OST patients and drug dealing near OST sites. The board was also active in negotiating with the police to prevent harassing of OST patients, what happened from time to time.

According to the Operational Guidelines on OST, patients had to prove their identity before starting OST. They had to undergo periodically comprehensive assessment, though in reality this was not routine practice in any of the OST sites.⁴³ All patients gave informed consent to enter OST as required by the Operational Guidelines. Confidentiality of patients was ensured, except if there was a case of court investigation. Patients were seen regularly (as indicated by Operational Guidelines on OST) by narcologists. OST was not limited in duration.

The system of referral of patients to other services (HTC, ART for HIV infection, TB, any other inpatient treatment) was in place. If a patient was hospitalized for an infectious or any other disease, a nurse transported 3-7 daily doses of methadone on a case-by-case basis to corresponding institutions, and left under the responsibility of the nurse there. This was positioned in operational guidelines.

The number of people who received OST for 6 months continuously as provided by the RCCD was 67% (mid-level quality indicator 60 – 80%) and in Khujand ONC 60% as indicated in the previous report.⁴⁴

The proportion of patients in RCCN receiving the minimal effective methadone dose (60 mg or more) was 87% (mid level quality indicator 60 – 90%). Qualitative methods (FGD with methadone patients^{45,46}) confirmed adequate methadone dosing at RCCN and Sogd ONC. They indicated that there were no routine problems with provision of adequate methadone doses at RCCN and Sogd ONC, and physicians were responsive to patients’ requests.

⁴³Assessment of Medication Assisted Therapy Programme in the Republic of Tajikistan, Dushanbe, 2013, p.22

⁴⁴Assessment of Medication Assisted Therapy Programme in the Republic of Tajikistan, Dushanbe, 2013, p.23

⁴⁵Focus group discussion with OST patients at RCCN

⁴⁶Focus group discussion with OST patients at Sogd ONC

The OST site at RCCN had established cooperation links with the AIDS Center to refer OST patients to HIV test twice per year as well as to refer patients for CD4 counts. Of the total number of 261 OST patients 125 (18 women) were HIV infected, and 39 (8 women) undergoing ARV therapy.

The Republican Clinical Center of Narcology (RCCN) was in charge of the organizational and methodological management of the OST programme in the country. RCCN was a major resource centre for supervision and advice. Methodological guidance to regional specialists was provided by the RCCN workers during their site visits to regional sites every three months. The chief RCCN physician clearly had sufficient clinical expertise to advise other physicians at RCCN and oblast OST sites. RCCN had the overall responsibility for the OST pilot project.

There was also some place for further improvement in delivering the OST with sufficient coverage and quality. So far there was no national strategy on how ensure sustainable funding. Methadone was not registered by the State Pharmacological Committee at the Ministry of Health. It is worth to note, that both methadone and buprenorphine for treatment of opioid dependence were included by WHO in the Model List of Essential Medication (MLEM) in 2005⁴⁷ due to the robust evidence of their effectiveness in treatment of opioid dependence and HIV prevention. Based on WHO MLEM all countries were encouraged to include the listed medications in their National List of Essential Medications.

All narcologists, who prescribed methadone under the pilot project, were trained on OST in various trainings, seminars at RCCN and study tours organized by international development partners within and outside of the country. However, nurses who participated in the survey, indicated that they have not participated in any workshops or training on OST, which in turn affected the quality of their performance. Training of nurses was limited to the medication induction training at the workplace⁴⁸. There were no national standards on training of the medical staff on OST. By the time of the mission training on OST was not introduced in the regular training curricula for narcologists.

The major barrier for IDU to access OST included the “narcological dispensary registry”, as indicated in previous reports. In Tajikistan, as in most post-soviet states, the procedure was continued to register people with drug dependence, when they apply for treatment. People who undergo medical treatment, by the requirements of the legal acts, were included into the “dispensary registry” by a narcologist upon diagnosing mental and behavioural disorders related to drug use⁴⁹. Although patient information under the existing laws was confidential, there were a number of legal options to circumvent the requirements of medical confidentiality and disclosure of personal information when the patient received narcology treatment services. This included the requirement for narcology institutions to cooperate with law enforcement agencies in the delivery of patient care and potential transfer of information about substance-related disorders of patients in response to written requests from prosecutor, judicial and investigative bodies^{50,51}. This, according to both OST patients, and active IDU, discouraged many from using narcological services and enrolling in OST programmes in earlier stages of drug use.

At the time of the mission, the dispensary registry was used mostly to monitor statistical trends of drug use and the number of drug dependent persons. It provided the “official” statistical information. On the other hand this register was used when a person needed to undergo medical examination in many different life situations, e.g. obtaining a driver’s license, before taking certain jobs, etc. Many employees and other organizations, though not required by the legal acts, practiced

⁴⁷WHO (2011). WHO Model List of Essential Medicines, 17th edition. Geneva.

<http://www.who.int/medicines/publications/essentialmedicines/en/index.html>

⁴⁸ Assessment of Medication Assisted Therapy Programme in the Republic of Tajikistan, Dushanbe, 2013, p.17

⁴⁹ Ibid., p.16

⁵⁰ Law No. 67 “On Narcological Care”, approved by the President of the Republic of Tajikistan as of December 8, 2003.

⁵¹ Final report and recommendations for Tajikistan. Accessibility of HIV prevention, treatment and care services for people who use drugs and incarcerated people in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan: legislative and policy analysis and recommendations for reform. UNODC, 2010.

asking a potential employee to bring a “certificate” from a narcological dispensary/cabinet about not being listed in the “dispensary registry” following the long-established tradition from Soviet times.

By the end of 2012, there were 7,231 drug dependent persons in the national “dispensary registry”, 4,882 (67%) injected heroin. With the estimated IDU number in the country of 25,000, national narcological dispensary registry clearly did not represent the real statistical trends of the morbidity with drug dependence. On the other hand, the existence of such register as a “protective filter” could create a false sense of security in the society as the majority of IDU were still not on the government register and were eligible for higher risk activities, e.g. driving, certain jobs, etc. To avoid the register, many IDU used to seek drug treatment abroad, including in the Russian Federation or even China⁵².

According to the Sentinel Epidemiological Surveillance (SES) findings among IDU in 2011⁵³ 35.8% of IDU indicated that they were on the narcological dispensary registry (46.2% in 2010, Table 1).

Table 2: The proportion of IDU, who were in the narcological registry, IBBS, 2013⁵⁴

	2011	2010	2009	2008	2007	2006	2005
Sample	2,000	1,655	1,657	1,355	1,405	600	600
Proportion of IDU who were on narcological dispensary registry (%)	36.4	46.0	27.3	35.9	25.0	20.0	N.A

Both the “dispensary registry” and restrictive criteria for OST (more than 18 years, 2 previous attempts of treatment, 2 years of injecting drug use) in Operational Guidelines on OST created barriers to satisfactory access to OST to all IDU.

Some OST patients in Dushanbe travelled daily more than half an hour each way and had to pay 4 Somoni per day, if they switched from one vehicle to another. Travel expenses could reach 120 Somoni (or 24 USD) per month. In Sogd ONC patients had to travel 20-30 km and longer daily to take their methadone. In Khujand the overall number of OST patients has been reduced from 92 at the end of 2012 to 40 in September 2013. The reason to discontinue OST for a number of patients as indicated by OST manager was migration to the Russian Federation for work as well as geographical remoteness of OST from places IDU lived.

OST patients in focus group discussion (FGD) expressed their strong wish that stable patients would be allowed to take medication for home use on at least weekends⁵⁵. Operational Guideline on OST allowed giving methadone to stable patients to use at home. Nevertheless, at the pilot phase of OST this right for OST patients was not granted, because of the potential diversion and follow-up sanctions to treatment facility and staff from law enforcement⁵⁶.

Methadone was dispensed from 8.00-15.00 on workdays and from 8.00-12.00 on weekends. Shorter hours could restrict the ability to work of some patients. OST was provided free of charge. The initial dose of 20-25 mg of methadone as indicated by the Operational Guidelines on OST was safe. Nevertheless, according to international/WHO recommendations it could be flexible up to 30 mg. Psychosocial assessment and support was not provided either in RCCN or Khujand OND. There were no social workers and psychologists in the staff of OST. The main reason was given that there no professional social workers had been trained at universities or colleges. Psychosocial support was only provided by NGOs on a case-by-case basis. The Operational Guidelines on OST indicate the

⁵² Interview with narcologist at Isfara City Central Hospital narcological service

⁵³ Scutelnicuic, O. IBBS findings, 2013, unpublished document

⁵⁴ Ibid.

⁵⁵ FGD with OST patients at RCCN

⁵⁶ Meeting at RCCN

following obligatory medical examinations/interventions: 2 times per year a general blood test, twice per year a general urine test, once per year a liver enzyme test (ALT, AST); 4 consultations with a psychotherapist, once per year an ECG, once per year an ultrasound scanning of liver and kidneys, once per year test for diastase enzyme, twice per year consultation of neurologist, etc.⁵⁷. These mandatory medical examinations/interventions for each OST patient significantly increased the overall cost of treatment (covered by the state budget or by the patient). They should be considered as excessive.

According to the Operational Guidelines on OST, each patient should be examined for syphilis, gonorrhoea, trichomoniasis, Chlamydia twice per year. For female patients it was obligatory to have twice per year gynaecological exam for gonococci. In practice these services were not always available and free of charge. In the Operational Guidelines on OST there was no position on the obligatory screening for TB.

OST sites established commissions (both in RCCN and Sogd OND) with many stakeholders to enrol IDUs into OST. Commissions included representatives from the local AIDS centre, TB treatment facility, NGOs and OST site representatives. The reason given⁵⁸ was to involve stakeholders in the multidisciplinary and comprehensive care of the patient. To gather the whole commission to enrol a patient into OST seemed formal and time-consuming. It could become an additional barrier for patients to access OST, as such a commission would gather once in one or two weeks. Instead patients could be enrolled in OST by a local physician, if they met the criteria for OST and in the process of OST could be referred to other services.

The cost of methadone in the provision of OST

According to the TGF Project Implementation Unit (PIU) under the United Nations Development Programme in Tajikistan, the cost of a recommended average daily dose of methadone (100 mg) was as low as 0.77 USD⁵⁹ as a result of purchases in 2012. However, according to the TGFPIU under UNDP in the Kyrgyz Republic, the cost of an average daily-recommended dose of methadone (100 mg) was as low as USD 0.28 USD.⁶⁰ as a result of procurement in 2012. In Kyrgyzstan, methadone was imported as a substance (powder) used for the preparation of methadone solution inside country pharmacies. The large price difference in methadone cost would be important if OST in Tajikistan would be scaled-up significantly and methadone covered by the government or patients/families. According to the representative of the State Pharmacy Control unit at the Ministry of Health for institutionalization of OST at lowest possible price of methadone, it would be beneficial to organize the manufacture of methadone solution from the substance (powder) in the local designated pharmacies in Tajikistan. Therefore it would be practical to observe the procedures of methadone import and manufacture of the solution in Kyrgyzstan and consider the applicability of this practice in Tajikistan.

The previous analysis⁶¹ has shown that OST has significantly reduced the frequency of heroin use among OST patients, as well as the frequency of injections, shared needles and other injection equipment. The average daily amount of money spent on heroin was reduced from 109.68 Somoni (roughly 22 USD) before OST to 2.39 (less than 1 USD) after enrolment in OST.

The uptake of IDU services in the target populations

Data for the uptake of services among IDU population are available from IBBS for the years 2005-2011 (available separately). Both the officially reported incidence of new HIV cases transmitted through injecting equipment among men, as in Fig. 2, and IBBS data indicated the trend of decreasing HIV infection detection in IDU population.

⁵⁷Operational Guidelines for substitution methadone maintenance for Opioid Dependence, Dushanbe, 2009, p. 26-27

⁵⁸Meeting at RCCN

⁵⁹Assessment of Medication Assisted Therapy Programme in the Republic of Tajikistan, Dushanbe, 2003, p.16

⁶⁰Assessment of Medication Assisted Treatment in the Republic of Kyrgyzstan, Alma Aty, 2012, p.16

⁶¹Assessment of Medication Assisted Therapy Programme in the Republic of Tajikistan, Dushanbe, 2003, p.30

This could show that targeted HIV prevention activities among IDU were effective. On the other hand, available data showing lack of HIV testing access and coverage suggest that many HIV cases among IDU potentially could be still unknown.

Recommendations

Immediate – requires immediate and priority attention within a 3-6 months period

To Ministry of Health:

- Implement rapid HIV testing of PWID at NSP sites (Trust Points, NGOs)
- Revise national OST Guidelines in accordance with WHO and other internationally agreed standards

Short-term – should be addressed within a 6-12 months period

To Ministry of Health:

- Establish positions of social workers and psychologists at existing OST sites to provide, comprehensive psychosocial assessment and support
- Consider reduction of methadone costs by importing methadone substance and preparing it in local pharmacies
- Register methadone as a regular medication at MOH; include methadone in the Essential Drug List of MOH
- Focus on PWID's sex partners, MSM and female injectors working as sex workers in order to prevent sexual transmission of HIV.
- Extend STI services organized as "friendly services" to all STI service points in the country
- Abandon all name based national registers of STI.

Mid-term – may be addressed within a 12-24 months period

To Ministry of Health:

- Develop mechanisms of mixed (government/donor) funding of NSP/OST
- Increase accessibility of NSP by expanding services to all areas with injecting drug use as well as increase the coverage through outreach
- Replace "narcological dispensary registry" with national case-based statistical database (unique identifier code)
- With cooperation of donors, open new OST sites in narcological centres/cabinets; decentralize existing OST where possible to make OST geographically close to IDU. Promote integration of HIV/TB/OST services.
- Use existing narcological infrastructure and existing staff at primary and secondary level to provide more OST programmes
- Consider introducing OST issues into curricula of narcologists, nurses and psychiatrist at medical schools, medical colleges and institutions of post-graduate training.

To Ministry of Justice:

- Expand existing NSP programme to all prisons
- Open OST in prisons (including remand prisons) so that OST patients can continue OST and inmates could initiate OST in prisons and continue in the civil sector

To Ministry of Education:

- Increase the number of trained professional social workers at universities and colleges to be employed for drug dependence and HIV infection treatment medical facilities, as well as in NSP in Trust Points and NGOs
- Include provision of OST in curricula of undergraduate and post-graduate training at medical universities and medical colleges for narcologists, psychiatrists and nurses

Sexual transmission of HIV

The programme targets for sexual transmission of HIV relate to IDUs, men who have sex with men, sex workers and migrants as defined in the strategic plan and related operational plans.

However, sexual transmission of HIV in Tajikistan occurs predominantly from male injecting drug users to their female sex partners – to their wives, girlfriends, lovers and these cases are still not adequately found: while about 3,800 men are registered, only about 1,400 women are detected so far; this is only 1/3 of women probably infected. The programme targets, the strategic plans and operational plans need to be changed to focus on these missing infections.

The general focus on female sex workers is important for STI control, in the current stage of the epidemic not so important for HIV control. While male IDU do not frequently visit SW due to their drug use or contract STIs, female IDU who work as SW earning money to buy their drugs are potentially high frequency transmitters of HIV. They need special attention.

The programme targets for prevention in MSM are completely inadequate and the potential for unrecognized epidemics in this community is very high. Out of 75 infected men in Sogd Oblast 51 are IDU, 24 are registered as sexually infected: 1/3 of infected men has not injected and claims to be sexually infected. This should trigger an epidemiological investigation to determine whether this is a manifesting MSM epidemic. Among MSM, male sex workers are potentially very important for the epidemic and need also special attention.

Migrants do not significantly contribute to the epidemic transmission of HIV in Tajikistan; they are, however, listed erroneously as key populations for sexual transmission in strategic and operational plans.

Are we doing the right things?

As pointed out above the focus to prevent sexual transmission should be on male injecting drug users: current Behaviour Change Communication (BCC) programmes do not adequately address sex partners of IDU. This is a common finding in other countries as well. If injecting is made safe through clean needles and syringes PWID do not get infected by HIV and thus do not infect their sex partners – this seems to be the easiest prevention strategy. In Tajikistan, however, with inadequate harm reduction programmes and with significant numbers of young men already infected a focus on BCC programmes for IDU is needed.

BCC programmes seem to work well for female SW where outreach services exist. The coverage has improved in recent years and with the current programmes of youth friendly services, but is still far from being adequate.

The BCC programmes among MSM are completely inadequate and should become an immediate focus for programme activities. In this context male MSM sex workers need special attention. Such programmes can only work effectively if implemented by community groups themselves. Syndromic treatment has been established for youth friendly cabinets and treatment of female sex workers, but it seems not to be extended to MSM (this complaint was raised by a MSM group).

Substantial progress has been made providing commodities for prevention of HIV. Condom and syndromic drug supply systems seem to work and these commodities plus information materials were available at any site visited.

Transient shortages of certain drugs (e.g. Metronidazole) exist in both the national government system as well as the project system. Logistic supply systems should be merged into a national system, rather than keeping parallel project systems. Limitations in prevention activities are due to the lack of coverage of the BCC programmes rather than failing logistics.

As recommended in the testing and counselling section rapid tests should be performed at any point of entry into services: BCC (NGO outreach), friendly cabinets (STI facilities), and youth friendly services. The current system of testing is inadequate: it leads to loss of people who want to be tested, or are tested, but do not get their results, nor do the attending physicians get the results. This needs immediate attention.

Substantial progress in STI prevention and care is made where “friendly services” exist, either for ‘migrants’, youth or sex workers, in reproductive health clinics or at STI clinics. The set-up of the “friendly” services should become the blueprint for national STI services: free of charge, without entering names into national registers, using the syndromic approach with immediate start of treatment. Further improvement is required, e.g. often it seems not possible to treat family members in the same way (the same is true when infections in pregnant women are detected).

National name-based register for STI should be abandoned (as should name-based HIV and narcology registers); such registers are counter-productive for the control of STI.

In contrast to fund availability, available personnel and sustainable supply, the underutilization of the visited services is striking. These services are overly bureaucratic, not responsive to special needs of clients and not trusted. For example if a friendly cabinet for sex workers has not seen or treated STI for 2 years something must be wrong with the services offered. Where NGOs are involved in services the underutilization seems to be less prominent; more involvement of NGOs and community members is therefore needed. Higher government cadres seem to perceive NGOs as competitors whereas cadres on the level of service provision seem to appreciate and understand the valuable function of NGOs. All STI and reproductive health professionals observe growing demand for services if offered anonymous (this only means that the name is not entered into the national STI register), free of charge and with information sessions by NGOs. If NGO project funding ends, utilization also drops drastically.

A complaint heard in all service points visited is the “lack of coordination”, meaning that services are not integrated enough, referral leads to loss of patients or clients and feedback of results is unreliable or not functioning. The upcoming joint annual review of the *National Health Strategy of the Republic of Tajikistan 2010-2020* is an opportunity to correct some of these issues and misunderstandings, re-organize services and adjust resource allocation accordingly.

The prevailing myth among professionals that migrants are among the key groups of HIV transmission and the unnecessary stigmatization of migrants in general needs special attention and advocacy nation-wide, paradoxically this group of society contributes about 1/3 of the GDP of Tajikistan.

Recommendations

- Focus on PWID’s sex partners, MSM and female injectors who work as sex workers in order to prevent sexual transmission of HIV
- Extend STI services organized as “friendly services” to all STI service points in the country
- Abandon all name based national registers of STI

Mother-to-child transmission of HIV

PMTCT programme targets as outlined in the national AIDS programme include:

- 70% of pregnant women receive full course of ARV
- 80% of HIV exposed new-borns receive ARV
- Annual rate of HIV transmission from mother to child remains under 8%
- 80% of women who receive antenatal care are offered HIV test
- 95% of pregnant women receive antenatal care

Are the essential programme elements of eMTCT included in description of the national programme?

Prevent HIV among women of reproductive age

Several initiatives, including analytical work to address gender specific aspects of HIV prevention have been undertaken in Tajikistan. Gender issues are addressed in the chapter “Strengthening community systems”.

No information was provided about prevalence and pregnancy management among women who use drugs, who are most likely to test HIV positive, or specific targets on women within harm reduction programmes.

Prevent unintended pregnancies among women living with HIV

The mission found very little attention to family planning for HIV positive women, as part of a comprehensive PMTCT strategy. Although Tajikistan is seeing an increasing number of repeated pregnancies (33/92 and 40/100 in 2011 and 2012 respectively) among HIV positive women, no data were provided to understand if those are planned pregnancies and to which extent HIV positive women have access to effective contraception. Visited reproductive health centres report good and continued availability of free contraceptives including oral contraceptives, injectable and implants. However, they were not able to count HIV positive women to have been enrolled into such programme.

Prevent HIV transmission from women living with HIV to their infants using ARV prophylaxis or treatment

Tajikistan has developed a national programme for prevention of MTCT, which was further adapted following the global call for elimination of MTCT. The pilot programme of MTCT was initiated in 2008, covering 18 priority districts, and was further scaled up nationally in 2010. The priority districts have been selected to include high epidemic burden regions and cumulatively accounted for up to 70% of all pregnancies in the country. The number of women tested and counselled in pregnancy is constantly on the rise, reaching up to 70% in 2012.

The programme was designed to integrate PMTCT into MCH setting and a wide reaching training programme for maternities and reproductive health staff was conducted using a cascade model and training of trainers. The national PMTCT programme envisages universal testing in pregnancy, followed by ARV for prevention for mother and child and safe delivery and infant feeding procedures. However, in May 2011 the government issued an order to ensure repeated HIV testing for all women during pregnancy. International partners expressed their concern regarding this policy considering low resources available for testing and existing procurement and supply management challenges, which is constantly burdened by test shortages and interruption of supply. Moreover, there was a concern that this policy will constraint limited resources and result in repeated testing for some, while the actual universal coverage will not be reached. According to the data, this has led

to a slight decrease of coverage of HIV testing in 2012 compared to 2011. In 2013, the government decided to revise this policy and offer second HIV testing in pregnancy for women under increased risk. However, the definition of women under increased risk has been quite broad, and there is a concern that the majority of women in Tajikistan may fulfil the criteria of enrolment. It is yet to be seen what impact this policy will have on achieving universal testing in pregnancy.

Provide appropriate treatment, care and support to mothers living with HIV, their children, partners, and families

Women and children in need of ART will most likely be enrolled and will receive follow up by AIDS centres. Following the situation analysis conducted by PLWH networks, with support to UNICEF, the government introduced a system of monthly cash transfers to families caring for HIV positive children. The monthly allowance is 40\$ and is aimed at covering additional costs of care for children with HIV. The allowance is paid regardless of the family economic status and as of now covers 64% of eligible families. Due to stigma related to HIV and fear of status disclosure, some families are opting out of this programme, but the regular monitoring indicates that the programme is reaching those most vulnerable and in need of assistance.

Apart from health services, families have access to limited psychosocial assistance in Dushanbe and several other major regional centres. There is one NGO (Gulisur) that provides support and counselling for HIV positive women and those caring for HIV positive children. The support group organized by NGO is meeting once a month and the services depend largely on insecure donor funding. No special programmes to secure adherence to treatment have been reported.

ARV and OI treatment using the more efficacious regimens for pregnant women living with HIV and all HIV-exposed infants

Technical guidance has been regularly updated and option B (triple ARV regimen), along with enrolling women on ART has been recommended for prevention of MTCT. The table below shows data on use of different regimens as reported in Universal Access report.

Regimen	2011	2012
# of women initiated ART in current pregnancy	32 (not segregated in the report)	12
#of women already on treatment		15
Triple ARV (Option B)	3	16
AZT (Option A)	41	21
SdNVP	0	2

There is progress towards use of more efficacious regimens for pregnant women and it is expected that data from 2013 will show additional progress.

Women who test HIV positive in pregnancy have access to treatment and the treatment depends on CD4 counts, which are getting increasingly available in the country.

Early Infant Diagnosis (EID) of HIV-exposed infants

Early Infant Diagnosis is burdened with weak performance of laboratory services that have seen a major improvement lately. In late 2012, laboratory in the National AIDS Centre started conducting PCR diagnostics including qualitative and quantitative measurements. In spring 2013 the laboratory started conducting PCR tests for HIV exposed infants and has conducted over 80 analyses since, which is a major increase compared to 0 children tested for HIV before the age of 2 months (Universal Access report, for 2011). With support of UNICEF and TGF the government is in the process of improving EID by introducing dry blood spot technology and improving laboratory performance.

Tajikistan opted for replacement feeding of infants and seeks to provide incentives in terms of distribution of milk formula for HIV exposed infants. Available data on infant feeding indicate that the vast majority of infants are formula fed, but there is consensus among professionals that this information is virtually impossible to verify. The concern is that women may be breast-feeding under the pressure of the family and friends, which is likely to lead to mixed feeding practices that are the most risky for virus transmission. In addition, there is a concern that replacement feeding was recommended without analysing whether or not replacement feeding fulfils the AFASS criteria (WHO, 2010, Guidelines on HIV and Infant Feeding). If not, those can actually decrease the survival of HIV exposed infants due to the diarrheal diseases. In addition, there is no analysis of survival of HIV exposed infants who are HIV negative and their morbidity and mortality. Recently, sufficient evidence exists that exclusive breast-feeding under ARV reduces the risk of MTCT to a minimum. This calls for countries to revise infant feeding policies and consider exclusive breast-feeding under ARVs as one of the safe infant feeding options for HIV exposed infants. Recently WHO and UNICEF have offered technical assistance to Tajikistan to conduct operational research to study the impact of infant feeding on HIV free survival of HIV exposed infants in order to further inform infant feeding policy development.

National eMTCT/PMTCT plan developed for implementation of the Global Plan

Tajikistan is committed to elimination of MTCT. However, further progress will depend on availability of sufficient resources, staff capacity across the country and increased focus on improving the quality of the programme.

Updated policies and technical guidance (e.g. clinical and operational guidelines)

The technical working group on PMTCT and Paediatric AIDS has been established and is operational in the country. The group is engaged in constant revision of guidance and protocols, which have been updated relatively quickly following frequent changes in WHO recommendations.

Are there adequate funds to implement PMTCT as planned?

Funding gaps and funding insecurity, in particular for testing commodities, continuously burden PMTCT. Considering a commitment of the country to eliminate MTCT, it is critical to ensure sufficient funding to achieve an AIDS free generation in Tajikistan. While PMTCT programme in young, low and concentrated epidemics may not be the most effective way of curbing HIV epidemic, due to its high effectiveness it remains a moral imperative. In addition, universal testing coverage is challenged by weak laboratory performance and poor blood transportation system. Therefore, the national planners suggested use of rapid HIV tests in areas where ELISA tests cannot be performed with sufficient quality. A costing exercise has been conducted to inform this policy (available in the package of documents for desk review under PMTCT).

Are there adequate human resources in both HIV and RH sections to deliver PMTCT services as planned?

PMTCT has been implemented system wide and the MCH system has been increasingly accountable for its results. Large-scale training programmes have been delivered and the capacity of staff is on rise. Moreover, PMTCT is now fully integrated into the routine work of antenatal care and maternity services.

Is there an adequate system for improved access to drugs and diagnostics?

Currently, the Global Fund has procured all drugs and diagnostics and as of recently UNFPA has secured rapid tests for testing in maternities and antenatal care. The government expressed the commitment to secure supply of rapid tests but it is not clear when exactly this will happen.

Is there an adequate information system to track progress in PMTCT services?

The national M&E system provides data on testing in pregnancy and access to PMTCT services. The data collection system is harmonized with Universal Access indicators and the data submitted are increasingly becoming available.

The system tracks data on HIV testing in pregnancy and segregates between women testing in pregnancy, delivery and postpartum. Repeated pregnancies among HIV positive women are also recorded.

Furthermore, data on ARV coverage for both mothers and infants are available and reported (segregated by regiments for mothers), along with mode of delivery and infant feeding practices.

Is the model of service delivery appropriate to scale up PMTCT as required?

PMTCT is now fully integrated into MCH services, and antenatal care and maternity staff are increasingly competent and accountable for programme implementation. However, as the health care reform envisages that family medicine will be increasingly responsible for pregnancy management, there is an emerging challenge to train primary health care staff to conduct HIV counselling and testing in pregnancy, and ensure access to HIV positive women to adequate services.

Are key factors of vulnerability being addressed in service provision?

Due to the number of cultural norms, women have little power to negotiate safe sex and often depend on their husbands and mothers in law for any decision including decisions on sexual and reproductive health. Little data are available to understand the risk profile of women who test positive in pregnancy. There is a widespread opinion that women under increased risk are those living with their migrant husbands. However, no solid data have been available to suggest that the percentage of women who use PMTCT services and who are married to migrant husbands exceed the percentage of women married to migrant husbands in general population. Although migration is likely to have some impact on epidemic trends in Tajikistan, this impact is poorly studied and documented and likely overestimated.

Are PMTCT services sufficient and appropriately distributed? (Outputs)

Antenatal care coverage in Tajikistan is reportedly 89% (at least one visit during pregnancy), and 49% for at least 4 visits. The access to neonatal and postnatal services is reportedly lower in remote areas of the country, while reaching almost universal coverage in large urban centres. PMTCT is now fully integrated in MCH settings and is delivered across the country. However, there is a difference of the level of integration and quality of services between sites that have been enrolled into the programme since its inception and those that started more recently.

According to national data (as reported in Universal Access report 2013), 77% of women have received HIV testing in pregnancy and know the result, which is a slight decrease from 79%, as reported in 2012. The majority of women have been tested in pregnancy, and only 2850 in delivery. However, according to the report, 10 HIV positive cases were diagnosed in delivery, indicating that women who receive test in delivery have much higher probability to test positive. No information was made available on the risk profile of these women and, such data would be a valuable contribution for identification of women who are most vulnerable to HIV.

Visited MCH facilities reported almost universal coverage in pregnancy. It is not clear where the discrepancy of data comes from compared to AIDS centres data, but it would be advisable to explore this issue further. The interviewed maternity staff reported that 10-15% of women deliver without being HIV tested in pregnancy. This is also inconsistent with Universal Access report, according to which only 1% of women are tested in delivery.

Is there sufficient coverage and utilization of ART services by the intended populations? (Outcomes)

In 2012, 64% of women received ARVs, along with 61% infants. If the country is to reach elimination targets this coverage needs to increase further.

Out of 334 children cumulatively diagnosed with HIV, 119 are considered to have acquired the virus from their mothers. The following table shows the number of children diagnosed with HIV per year.

	2002-2006	2007	2008	2009	2010	2011	2012
Children	17	12	7	12	17	74	138

Additional 57 children have been already diagnosed in 2013.

There is little information on the recent increase of number of children with HIV that would help understand if this is a limited outbreak or continued system failure that is likely to reveal additional children with HIV. Rapid increase of the number of HIV diagnosed children is likely a result of large scale contact tracing and case finding that was conducted by the AIDS Center, but no details on the process have been disclosed.

To what extent did PMTCT services contribute to reduction of new infections in children and improvement of quality of life for HIV positive mothers?

PMTCT is a relatively new programme but very good progress was achieved already. Due to the lack of Early Infant diagnosis it is not possible to calculate transmission rates among children based on service data without a significant delay. According to the AIDS Centre statistics, out of 273 infants born to HIV positive mothers, 3 tested positive, 104 tested negative, 12 have died and 4 moved out of the country. The impact of PMTCT on HIV free survival of HIV exposed infants, and roughly calculated transmission (assuming that all children who died were positive and taking into account only confirmed cases) is likely in the range around 12%, which is slightly lower than Spectrum estimated (14,39%). It is therefore likely that Tajikistan will reach national programme target of 8% HIV transmission, by the end of the programme. However, to achieve elimination of HIV prevention from mother to child, the coverage with testing in pregnancy, as well as access to PMTCT interventions, should increase considerably.

What is working well and needs to be continued or expanded?

Integration of PMTCT into the routine work of MCH services has proven to be a good strategy that led to rapid increase of coverage with PMTCT services. Further capacity building in the areas where the programme was initiated later is advisable.

What is not working well and needs to be reformulated or discontinued?

There is a concern that women referred from reproductive centres to AIDS services for ARV initiation may be lost to follow up. In order to ensure better follow up the government is considering integration of ARV into the reproductive health centres where women will be able to receive all services at one place. This will require additional training of staff and careful monitoring and provision of technical support by AIDS centres. It would be advisable to assess the readiness of the reproductive health centres and provide further technical support for them in order to ensure a smooth transition of the treatment system.

What else needs to be introduced to improve performance?

No information was provided neither by governmental nor nongovernmental sectors regarding the strategies and services aimed at improving adherence to treatment. Considering that HIV prevention from mother to child depends largely on adherence to ARV, this issue will need to be addressed in order to further improve effectiveness of PMTCT programme.

Recommendations

1. The trend of increasing coverage with PMTCT services will need to be continued and scaled up to achieve elimination of mother to child transmission.
2. More attention needs to be paid to issues of adherence to ARVs for pregnant women and in general women of reproductive age including but not limited to: adherence support counselling, peer based interventions, use of mobile technologies etc. A number of innovative and effective approaches available across the world can be tested and adapted for use in Tajikistan.
3. Additional efforts need to be undertaken to harmonize data collection and analysis system between antenatal services and maternities and AIDS centre, to ensure quality data collection and analysis and inform further programme development.
4. Introduction of Early Infant Diagnosis system, using Dry Blood Spots is highly encouraged to ensure early diagnosis and early access to ARV treatment for HIV positive infants. The anticipated progress in laboratory diagnostic will also enable measuring of HIV transmission rates on annual basis, without reporting delays.
5. To adopt such policies for HIV testing in pregnancy that ensure equitable universal access to HIV testing for all women, considering limited available resources. Reinforce MOH Decree #259 (06.05.2013).
6. Conducting operational research and comprehensive data analysis to evaluate existing interventions and improve policy development is strongly encouraged.

HIV treatment, care and support

Programme targets related to ART as defined in the strategic plan and related operational plans

- 90% of demanding PLWH receive ARV therapy.
- 80% HIV-infected adults and children live after 12 months after enrolment in ART;
- 75% of HIV-infected adults continue treatment after 12 months after enrolment in ART;
- 90% of registered PLWH undergo annual medical check;
- 100% of patients on ART receive social and psychological support;
- 100% of HIV/TB co-infection patients have to receive ART;
- 85% health specialists demonstrate willingness to provide health care services to PLWH and vulnerable populations.

Current activities in treatment and care

National HIV AIDS programme activities in treatment and care area are focusing on adults and children infected by HIV, patients with co-infection HIV/TB, HIV/HCV. Out of a wide range of key populations, only a small proportion of IDUs receive ART (as of 1 July 2013 355 IDUs out of all 1,181 patients on ART or 30%) and so called labour migrants although there is no official data on a number of migrants receiving ART. There are no data about ART in female sex workers and MSM.

- In total 5,144 HIV cases detected since the beginning of epidemic in 1991, including male – 3,774 (73.4%), female – 1,370 (26.6%); children under 18 – 311 (6.1%)
- Total number of death among HIV-positives – 862 (17.8%)
- Patients registered in the national database – 4,282

- Patients under permanent medical follow up – 2,125 (only 50%)
- ART started in 2006 and prescribed to 1,782 (84% out of 2,125 of permanent follow-up) patients, including 763 (43%) IDUs
- Patients died – 370
- Patients stopped ART – 231
- Continue ART – 1,181 patients (66% out of all enrolled in ART since 2006), including IDUs – 355 (30%)
- Child diagnosed with HIV – 335, 33 died, 195 received ART and 188 continue treatment

Are there adequate policies, and operational guidelines in place?

The national policy formulates equal access to ART for adults and children, men and women free of charge. National guidelines (ART clinical protocols) are developed on the basis of the WHO Regional Office guidelines and approved by the Ministry of Health of Tajikistan. Immunological criteria adopted by the WHO guidelines 2010, using a CD4 cell count cut-off of 350 cells/ μ l, were implemented since the start of the TGF Round 4 HIV grant. New WHO 2013 criteria on ART initiation using 500 cells/ μ l cut-off mean that a much greater proportion of PLWH will respond to the eligibility criteria and therefore the number of people in need for ART will be considerably higher in the country in the nearest future.

Are there adequate funds to implement ART and management of common health complications of people living with HIV as planned?

The Global Fund covers all cost related to treatment giving main concern for sustainability of treatment coverage.

According to the information provided by the Republican AIDS Center (RAC) the overall National HIV/AIDS Programme budget in 2012 was 10,4 million TJS (local currency), which is equal to around 2,167,000 USD (exchange rate 4.8 TJS for 1USD).

About 11% of the overall NAP expenditures are provided from the state budget covering mainly staff salary, utilities, premises maintenance, and minor costs of drug procurement for OI treatment and prevention. Thus, 85% is external funding from the TGF R8 grant. The remaining 1% is private sector contributions and voluntary donations.

All drugs and diagnostic supplies are procured in time with exception of ARVs stock-out for 1.5 months in 2012 in Dushanbe city AIDS Centre because of TGF PIU delays with procurement (personal communication with responsible staff).

ART is provided in 38 AIDS centres (1 – national, 4 regional and the rest – local at the district level). The staffing structure of the oblast AIDS Centres is developed based on MoH regulations and approved by the resolution of the local governments given the local context and needs. The standard structure of all AIDS centres consists of the several departments, including clinical outpatient unit. The clinical unit of the AIDS centres usually includes the head of the department, one infectious diseases specialist and one nurse. The same units in different AIDS centres differ in staff numbers depending on workload and local funding availability. The outpatient department at the Republican AIDS Center has 5 infectious diseases specialists posts (head of department, paediatrician, gynaecologist, and 2 infectionists).

Proportion of patients per health workers providing ART

In Dushanbe City AIDS Center 195 patients currently receive ART and 3 staff (head of out-patient unit, infectious diseases specialists and obstetrician) provide all types of treatment services. In the Khatlon regional AIDS centre (Kurgan-Tube city) 2 infectious diseases specialists provide services to

259 patients on ART. In City AIDS Centre of Tursunzade town 22 patients continue ART with 1 infectious diseases specialist providing a full range of medical services and working part-time as a laboratory specialist. The RAC provides services to 418 patients on ART and have 5 specialists in out-patient unit.

Training & skills of personnel involved in delivering treatment

Most centres have a team of service providers trained in a multidisciplinary management modality. The 5-day course on the multidisciplinary approach of HIV care provided by the RAC specialists allows an overall introduction on all aspects of care for PLWH receiving ART. However, taking into account the increasing numbers of newly registered HIV cases and those requiring treatment, as well as setting up of new AIDS Centres and significant staff turnover, the RAC conducts every year training sessions on HIV clinical management, including ART issues to the clinicians, infectious diseases specialists from the local AIDS Centres, with financial support from the TGF project. Such trainings are usually of 3 days duration, which does not allow trainers to fully cover all of the issues. The opportunity to train specialists at the Tajik Institute of Post-Graduate Medical Education is limited due to lack of funding from the AIDS Centres. Therefore trainings are either not affordable nor available to the majority of specialists who cannot obtain state certificates of their professional development.

A serious problem is the absence of specialists at the national and local levels who passed through specialized trainings in ART planning and forecasting. Specialists assigned to be in charge of drug planning face challenges in drugs demand estimations. Besides, there is no approved standard tool (electronic database, calculations table) to use for ART forecasting and planning at either the national or local levels.

Is there an adequate system for improved access to drugs and diagnostics?

All ARV and TB drugs, and diagnostics supplies (rapid tests, ELISA tests, Western blot, CD4 counting and VL tests) are purchased from the TGF grant. ARVs are available in the country according to the TGF R8 grant and implementation plan. Drugs to treat opportunistic infections and HCV are also available but in insufficient quantities. Therefore patients have to purchase these drugs at the commercial pharmacies at their own expense.

All diagnostics supplies are provided using TGF R8 grant – rapid tests, ELISA tests, Western blot, CD4 counting and VL tests.

Is there an adequate information system to track progress in ART and common health complication on people living with HIV services?

The Republican AIDS Center facilitates HIV data collection and analysis. Data collection (individual clinical case records) is performed by republican and local (district and oblast-level) AIDS centres. Reporting is done on a monthly, quarterly and annual basis. Aggregated data are collected by the RAC and further used to report HIV treatment and care indicators (complete list separately available).

Is the patient monitoring system standardized?

Clinical case management and examination records, information regarding treatment initiation, results of laboratory and other tests are documented in the individual medical records. A calculation of PLWH number eligible for ART is done based on clinical protocols that consider patient clinical status, CD4+ cells count (<350 cells/mm³), and presence of any opportunistic infections. Primary sources of information (patient medical charts, registers, etc.), although completed, are disseminated in variety of blanks, recording forms, etc., which makes it difficult for data collection and analysis. This practice significantly reduces data quality and complicates its aggregation and

analysis. On a level of service-delivery, monitoring of treatment is performed by clinicians based on their own analysis of individual treatment results. Paper-based reporting limits follow-up and trend analysis (e.g. viral load in a cohort of patients, average initial level of CD4 in patients registered or those who start ART, etc.). Lack of standard medical record cards, that would allow easy analysis of patient-level data, increases chances for clinicians to miss important information concerning any change in patient's CD4+ count and viral load, and complicates monitoring timing of patient follow-up.

HIV drug resistance and early warning indicators monitoring system existence

HIVDR monitoring system does not exist and collection of the early warning indicators (EWIs) is not included into the implementation plan.

Other data collecting instruments in use (cohort analyses to inform programme management)

Data on cohort analyses after 60 months, 24 and 12 months from the ART start were presented by the country to the Global HIV/AIDS report 2012-2013 (indicators 4.2c, 4.2b and 4.2a respectively) showing the percentage of patients continuing ART in year's cohort.

Achievements

During last 7 years Tajikistan has achieved progress in its national response to HIV epidemic and in particular in provision of ART and care for those in need, taking into account the extremely complex political, economic and social situation in the country, which has been through 5 years of civil war resulting in destroyed industry and agriculture, wide poverty and a weak health system.

- ART implemented and gradually scaled up
- PMTCT for pregnant women became available
- OST for injecting drug users has been initiated and serves as a promising base for their involvement in, adherence to and retention on ART
- ART became available in the prison system
- Set of national clinical protocols is developed and is under revision at the moment
- Clinicians received access to the ART knowledge using international expertise and links with leading world experts in treatment area
- Lab monitoring is set up: in 5 regions CD4 counting is available, at the national level, viral load testing is ensured
- National Reference Lab and labs in 4 regional AIDS Centres are included into the external quality assurance programme linked to the Australian NRL
- Patients have access to the basic biochemical analyses

Is the model of service delivery appropriate to scale up ART and common health complication on people living with HIV as required?

Overall HIV medical services are focused mainly on the general population, including HIV-positive women and their children, patients with co-morbidities, HIV-infected migrants and less on key populations at higher risk such as PWID, prisoners, SW and MSM. In general ART is provided in national, oblast and district level AIDS centres.

Challenges: strong vertical system of 38 AIDS centres is established, but most of them located at the district and small cities level, are weak in terms of capacity to provide adequate services to the patients and of proper quality. All, including RAC, are located in premises not originally adapted to their needs with limited number of rooms and possibilities to follow infection control requirements, lab diagnostic procedures, internet connections etc.

In case of need patients are hospitalized into the infectious diseases hospitals where special beds are allocated for them. For instance, there are 20 beds for adults in Dushanbe City infectious disease hospital where 110 patients with severe HIV-infection were hospitalized during first half of 2013. At the time of the visit only 2 patients received medical aid in the clinic. There are three rooms for 4 beds in Dushanbe City infectious disease hospital for children renovated by UNICEF. No patients were observed during our visit on 18 September. In the first 6 months of 2013 only 25 children with HIV were admitted to the hospital.

Testing for HIV because of clinical indications is rare. Out of 3,500 children entered into the hospital during 9 months of 2013 only 98 (2.8%) were tested for HIV and 3 children were found to be HIV positive and 1 child had died without ART prescription. This clearly demonstrates the existence of problem with children's late presentation to care.

The AIDS centres visited do not have separate rooms for examination and counselling of patients. Usually patients are examined in rooms shared by several doctors, which do not allow comfortable and confidential environment for counselling sessions or patient physical examination. Routine practice is to serve several patients in the same room at the same time. Waiting areas are small in size and there are no separate rooms for coughing patients.

Overall observation: there is no adequate environment in AIDS Centres for clinical management including check up, treatment and care. Existing linkages between out-patient and in-patient services for PLWH do not ensure continuum of care and should be improved.

Community mobilization/involvement in services planning, delivery and evaluation

Observation/opinion: community involvement in services planning, delivery and evaluation is very limited.

Are services being delivered of the right quality?

Mechanisms for quality assurance are in place for HIV Lab diagnosis only for NRL and 4 regional labs that are involved in the external quality assurance programme under supervision of the Australian NRL.

Retention and adherence: indirect data show that level of retention and adherence is suboptimal. Thus, RAC provided information that in 2011 ART was prescribed to 1082 patients (in total), and 782 patients continue treatment; for 2012 these figures are 1505 and 1044 respectively. The cumulative numbers do not allow assessing actual situation with patients' flow and their retention on ART, and such approach has to be changed.

NRL is equipped with FACS Count Machine for CD4 testing. Since it operates in a close manner, this excludes influence of the 'human factor' and results obtained are fully reliable. Unfortunately, existing paper-based medical records and charts do not allow to quickly analyse at what CD4 level patients eligible for ART actually initiated it. Records in the lab logbook where CD4 tests results are recorded do not differentiate between those who already receive ART and those who only initiate treatment.

Are the products and services being produced in sufficient amount?

The existing network of AIDS centres (38) is responsible for ART provision and clinical follow up of HIV/AIDS patients; the currently provided clinical care is insufficient and intentions to involve primary health care facilities are being discussed.

The only rapid tests for HIV antibodies detection are available at a variety of points of care (AIDS centres, ANC clinics, health centres, hospitals etc.). Simplified diagnostic and monitoring technologies, including CD4 cell counting, viral load testing, and usage of DBS for EID and resistance testing are not available in the country.

Is there sufficient uptake of ART services by the intended populations?

As of July 2013 1,181 patients receive ART across the country, 743 men and 438 women. The latest estimates generated in 2013 suggest that about 3,400 individuals are in need of ART. Therefore the ART coverage is 34.7%. Out of the total number of patients receiving ART 355 persons are classified as IDUs. 188 children currently receive ART out of 302 children still alive according to the RAC information (62.3%).

Percentage of children (under 15 years of age or as locally defined) with advanced HIV receiving ART is 63.2% among registered HIV cases in children.

Percentage of adults and children with HIV known to be alive and on treatment at 12, 24 and 60 months after initiation of antiretroviral therapy.

According to the data presented by the RAC, the percentage of patients with HIV known to be alive and on treatment after 60 months, 24 and 12 months from ART initiation are as follows: 56.9%, 63.5% and 74.4% respectively in 2012. This data raise doubts regarding its validity as it is based on yearly instead of monthly cohorts.

Specific tasks for Clinician

Initiation of ART: clinical and laboratory criteria

National clinical protocols on HIV treatment and care approved by the MoH of Republic of Tajikistan (order №28 as of 27.01.2010) and are elaborated on the basis of WHO Regional Office for Europe clinical protocols of 2007 and their structure and content fully correspond with European protocols.

Actual usage of ART initiation criteria was assessed on the basis of CD4 parameters. CD4 counting is available in 5 sites of RT (Dushanbe city -1, Khatlon region – 2, Sogdy region – 1, Khorog city – 1) where flow cytometers machines FACS Count BD are installed.

In total 2,153 tests were performed in 2012 for CD4 count. Based on the HIV patient clinical monitoring aggregated data it is impossible to identify what part of these tests relates to the patients on ART and what part to those who are at pre-ART stage. It was also difficult to explore frequency of CD4 counting for certain group of patients.

As 01.07.2013 a group of follow-up patients consisted of 2,125 patients with HIV-infection (data provided by the specialists of the RAC). The number of CD4 tests performed during this period was 1,344; out of these 232 tests were done on patients who are not receiving antiretroviral therapy. Thus, we can conclude about inadequate access to CD4 testing for patients under medical follow up and underutilization of immunological criteria for early initiation of ART.

Consecutive sampling of 142 patients who were tested in the NRL for CD4 first time in 2013 and according to the doctor's 'handmade' notes did not receive ART showed that 47 (33%) had CD4 level < 200 cell/mm³, 31 (21,8%) – between 201 and 350 cell/mm³, i.e. 55% were classified as eligible for ART initiation. Given the existing monitoring tool it remains unclear whether all of them started treatment after the test or not? Whether these patients were also tested in the previous year or

not? The answer to these questions makes it possible to assess the quality of services in the pre-ART period and overall quality of patients monitoring system.

Medical records of prisoners with HIV-infection were reviewed. In 2013 ART was prescribed to 10 prisoners with CD4 <350 cells/ mm³, (range from 18 to 276 cells/ mm³, including 6 patients with CD4 < 100 cells/ mm³).

Conclusion: The current system of clinical monitoring at all levels does not allow getting adequate data on patient distribution by CD4 cell count at the moment of starting ART, to determine the median CD4 count at initiation of ART at the national, regional level and at the level of the individual hospital. Simplified technologies for CD4 detection are unavailable in the country.

When reviewing medical records of patients with HIV infection, and through interviews with patients and doctors, it was found that antiretroviral therapy is given to the patients in WHO clinical stage 4, regardless of CD4 level and the possibility of CD4 testing, as recommended by the WHO and national clinical protocols.

During conversations with patients and physicians it was revealed that physicians are aware of the importance of CD4 detection, but it is not carried out systematically as prescribed by the Protocol (the main reason being that patients rarely seek medical care). Perhaps the important reasons for this situation are lack at the national and regional levels as well as at the individual hospital of adequate strategy for the formation in patients understanding of the importance of systematic follow up and care, lack of an effective system counting patients visits, lack of support to the patients focused on their individual needs and adherence to out-patient care and treatment.

ART regime: first and second lines

According to the national clinical guidelines on HIV/AIDS treatment and care NNRTI-based **first-line ART regimens** are recommended: efavirenz (the preferred NNRTI) and nevirapine. As the NRTI «backbone» recommended NRTIs are: zidovudine + lamivudine, emtricitabine + tenofovir, abacavir + lamivudine.

In case of contraindications to NNRTIs (intolerance to NNRTIs, mental disorders, liver disease with increased ALT levels more than 3-5 upper limit of normal (ULN), liver cirrhosis, co-infection with HBV and/or HCV, infection with HIV-2) the alternative first-line ART regimens of 3 NRTIs are recommended: zidovudine + lamivudine + abacavir, zidovudine + lamivudine + tenofovir.

According to the National guidelines, boosted Protease Inhibitors (PIs) are recommended for the second-line ART regimens. It is allowed to use them in the first-line regimen in exceptional cases: a contraindication to NNRTIs, the inappropriateness or unavailability of 3 NRTI-containing regimens.

According to the approved protocol, **second-line ART regimens** are “reserved” ART regimens, used after the failure of the first-line regimens. The definition of “second-line regimen”, according to the recommendations for the WHO European Region, 2007, adopted in the Republic of Tajikistan, does not include “replacement regimens” because of intolerance, toxicity of specific ARVs.

Boosted PI-based regimens are recommended as optimal second-line ART regimens: lopinavir/ritonavir, saquinavir/ritonavir, fosamprenavir/ritonavir, indinavir/ritonavir. It is recommended to change NNRTIs (first-line regimens) with boosted PI in second-line regimens. Lopinavir/ritonavir is recommended as the preferred boosted PI. 2 NRTIs of the first-line regimen are recommended to replace with 2 new NRTIs of the second-line regimen: zidovudine + lamivudine are recommended to replace with didanosine + abacavir or tenofovir + abacavir or tenofovir (+ zidovudine + lamivudine);

tenofovir + emtricitabine are recommended to replace with didanosine + abacavir or didanosine + zidovudine;
abacavir + lamivudine are recommended to replace with didanosine + zidovudine or tenofovir + zidovudine (+ lamivudine).

Salvage ART regimens recommended are: fusion inhibitor enfuvirtide (twice daily with subcutaneous application) in combination with new boosted PI (recommended ritonavir-boosted tipranavir/darunavir).

Comments and recommendations in relation to ART initiation and regimens, adopted by National Protocol in the Republic of Tajikistan:

1. Criteria for ART initiation in patients with HIV/HCV should be reviewed in line with international approaches and evidence base.
2. When updating the National Clinical Protocols on ART the WHO recommendations for the European Region (2011-2012) and the latest WHO global recommendations 2013 should be taken into account, in articulating the definition of the “second-line ART regimen. It is necessary to clarify the definition of “ART failure”, which, according to the new protocols for the WHO European Region, includes both inefficiency and intolerance to the first-line ART.
3. The combination of tenofovir + abacavir is undesirable because of the unfavourable intracellular interactions of these nucleoside analogs.
4. It may be necessary to reconsider the recommendation about combination of didanosine with abacavir in the second-line ART schemes.
5. Need to reduce the list of boosted PIs in the second-line ART schemes.
6. Need to review the recommendation regarding enfuvirtide use, and tipranavir.

Usage of ART schemes in practice

Based on data presented by the RAC specialists, interviews with patients and doctors it is concluded that ART in Tajikistan is carried out with usage of standard triple therapy. No cases with mono- or dual therapy were found. No cases with treatment interruption because of ARVs absence were registered. Procurement of ARVs is provided from the TGF grant to Republic of Tajikistan.

RAC specialists are responsible for ARV planning, ordering to the TGF PIU and further distribution by region. The initial information on ARV needs is collected from the regional AIDS centres based on a number of patients under medical follow-up and regimens types. This info is collected twice a year and heads of out-patient departments are responsible for its quality and relevance to the situation. The national application is performed with a 20% buffer by the one specialist of the RAC out-patient unit. Out of all interviewed specialists from the RAC and AIDS centres no one was trained on ARVs planning and forecasting and thus these specialists meet difficulties when counting ARVs needs and consider this work as an additional burden that do not correspond with their TORs. Indeed these specialists try to do this work as well as possible with understanding of importance of uninterrupted provision of ARVs. They even developed their own tool to calculate ARVs needs since there is no simple universal tool to develop ARV plans and projections at the national as well as at the local levels.

The ARVs procurement plan elaborated by the RACC for the second half of year 2013 was reviewed. The plan is based on ART regimens prescribed for patients with HIV-infection. The following ARVs combinations are used for the planning purposes.

Formulations for adults:

NRTIs: zidovudine/lamivudine – 1,082 Patient; TDF/FTC – 114 patients; abacavir + lamivudine – 60 patients. In total on NRTIs – 1256 patients

NNRTIs – 938 patients, of which: efavirenz (600 mg) – 610 patients; nevirapine – 328 patients. In total on NNRTIs – 938 patients, including 54 patients for whom purchasing of fix-dosed combination (TDF/FTC/EFV) is expected.

Boosted PI: lopinavir/ritonavir (200mg/50mg) – 232 patients. In total on NNRTIs and PIs – 1,170 patients

It can be assumed that the schemes based on boosted PIs (232 patients) were used for the naive patients, and not as a second-line ART regimens, which was confirmed by interviews with doctors who explained the use of boosted PIs for the naive patients because of existing contraindications to NNRTI and NNRTI intolerance. Based on the lack of didanosine and combinations of 2 NRTIs recommended for 2nd line regimens, we can assume that in the Republic of Tajikistan there are no patients on 2nd line ART regimens. This situation requires further study and additional analysis.

Access to ART for children

We explored the proposal for ARVs as of 01.07.2013 elaborated by the Republican AIDS center and based on the ART regimens that HIV-infected children receive.

Dosage forms for children:

NRTIs: abacavir (suspension) – 15 patients; zidovudine (oral solution) – 153 patients; lamivudine (oral solution) – 48 patients

NNRTIs: nevirapine (suspension) – 30 patients; efavirenz (50 mg) – 20 patients

Boosted PIs: lopinavir/ritonavir (suspension) – 16 patients

According to the official data there are 335 registered cases of HIV in children in total in Tajikistan, of which 119 are infected with HIV through vertical transmission, and remaining 216 are registered as individuals with “unknown mode of HIV transmission”. As of 01.07.2013, the registered 242 children (156 boys and 86 girls) are under the age of 4 years, 69 children (47 boys and 22 girls) aged 5-14 years and 24 children (15 boys and 9 girls) aged 15-18 years.

In 2012, HIV infection was confirmed in 111 children under the age of 4 years (78 boys and 33 girls), 25 children aged 5-14 years (18 boys and 7 girls), 2 children aged 15-18 years (2 boys). In 6 months of 2013 37 children were identified as HIV-infected before the age of 4 years (21 of them boys, 16 girls), 17 children aged 5-14 years (12 boys and 5 girls), 3 children aged 15-18 years (1 boy and 2 girls).

According to the RAC, 33 children with HIV infection died (cumulative data), 4 of them were receiving ART, and 29 – did not receive ART. According to the RAC, 195 children were assigned to ART, including 4 children died, 3 – dropped out of the ART programme as a result of the parents reluctance to continue treatment, 188 children continue ART.

It is unclear why more than 100 children with HIV did not have access to ART; about 25% of them live in the city of Dushanbe and the same proportions in Sogd region, Districts of Republican Subordination and Khatlon. Doctors explained this as the reluctance of the children’s parents to seek medical care. Another possible explanation for this situation is the high sensitivity of the problem with HIV infection in children and insufficient work with parents of these children, also existing gender inequalities, some cultural issues (husband or mother in law might not allow ART etc), as well as the shortage of clinical staff in AIDS Centres, and the excessive workload of doctors.

Based on the ARVs application explored and according to the ART regimen given to children we can conclude that their access to ART is clearly not sufficient. A possible recommendation for the short term might be to invite an international multidisciplinary team to provide assistance to the Republic of Tajikistan in the examination and counselling of children with HIV infection, advising parents of

these children, prescription of ART to children and promoting parents' adhering to treatment and systematic follow up. In long term national capacity should be developed.

Clinical management of HIV treatment: treatment regime, management of side effects

A review of patients' medical records showed that the majority of patients, including children, have basic low hemoglobin indicators in peripheral blood (anemia of varying severity, more severe forms are more common in women, which is likely to be associated with dietary patterns, as well as frequent pregnancies). Laboratory monitoring of patients, including monitoring of adverse effects is conducted at the AIDS Center free of charge, but in a limited range (general blood test, total bilirubin, ALT). No urinalysis was found in most patients' medical records. Most patients receive AZT-containing ART regimens, but there is no data on haemoglobin level in patients' medical records. For patients receiving TDF-containing regimens, monitoring of creatinine level to prior antiretroviral therapy, or in the course of treatment, was not done. Free access to the creatinine blood test does not exist.

Some comments:

The presented ART regimens for IDUs need to be revised (treatment regimes available separately) when updating national protocols, including the exclusion/limitation of the use of stavudine in line with current WHO recommendations; nelfinavir exclusion from the 2nd line regimens; the overall reduction and simplification of the recommended ART schemes. The criteria to start ART for IDUs in the future, when reviewing the national protocols, should be exactly the same as for all HIV patients and consistent with international approaches.

The actual access to ART, monitoring and care for IDUs is difficult and is not sufficient in the opinion of physicians, health care managers and other professionals and community representatives as a result of the personal interview.

According to data provided by the RAC, out of 1782 patients receiving ART during last years, 763 were IDUs (726 men and 37 women), 355 of whom continue receiving ART (20% of all patients started ART, 46, 5% of injecting drug users with HIV infection who had access to ART). To assess how regularly HIV-infected injecting drug users visited infectious disease physician at the AIDS Centre and outcomes of such visits is difficult. The information is reflected in the patients' records, but to assess the regularity of visits and the effectiveness of care within existing monitoring system is not possible at the facility, regional and national level. In addition, access to the VL tests was also not possible for a long time, and continues to be limited. Therefore, it is difficult to interpret testing results, even for individuals.

Challenges are how to "convince IDUs to enter into existing syringe and needle exchange programmes, substitution therapy, treatment programmes, care and support", "it is difficult to establish contacts with IDUs" (this is the personal opinions of the experts interviewed). There is a problem regarding access to vulnerable groups, discrimination against IDUs, including those from the medical staff, as many experts said.

There is a system of "friendly cabinets", also for IDUs; however, the range of services is limited. It includes counselling and referral with the provision of the coupon ("voucher") for HIV testing, which is good, but not enough. The current National HIV/AIDS Programme has Task 1 stated – "Groups at high risk of HIV infection (IDU, CSW, MSM, prisoners) demonstrate safe behaviour" and target – "75% of injecting drug users know where to go for VCT for HIV." It is important to note that the knowledge of where to get VCT service is not enough. VCT should result in getting HIV test or informed rejection. For IDUs it is critical to get HIV test straight after counselling in the same place where counselling was provided. Critically important is also to get test results as soon as possible and to pass through post-test counselling with a focus on safer behaviour. For HIV-positive IDUs it is

critical to ensure a continuum of services in relation to drug use and HIV infection, with the concentration of all services within one place. Access for IDUs to ART and retention in treatment, care and support is an effective preventive measure to reduce risk of HIV transmission and follow up on safe behaviour.

HIV/TB co-infection: treatment and follow up

The National Clinical Protocol on HIV/TB case management, approved by the Ministry of Health of the Republic of Tajikistan (MoH order of 27.01.2010, № 28), was developed on the basis of the clinical protocol for the WHO European Region "Treatment and care HIV/AIDS", 2007: Management of Tuberculosis and HIV Co-infection. According to the National Protocol 1) HIV testing has to be offered to TB patients in all health facilities dealing with TB patients and 2) risk of TB should be assessed in all HIV patients on a base of information about previous contacts with TB patients, tuberculin probe and specific symptoms such as cough for more than 2 weeks. TB diagnostic has to be done in patients with clinical symptoms suggesting pulmonary or extra-pulmonary TB.

The Protocol defines a strategy for ART initiation in patients with HIV-infection and active TB:

- in patients with extra-pulmonary TB, regardless of a number of CD4 cells, and with pulmonary TB with CD4 <200 cells/ml it is recommended to start ART immediately after the conviction of TB treatment tolerability;
- in patients with pulmonary TB with CD4 200-350 cells/ml – to start ART at the end of the intensive phase of TB treatment;
- in patients with pulmonary TB with CD4 > 350 cells/ml to treat TB, to monitor number of CD4 and start ART at CD4 lower 350 cells/ml.

The Protocol defines the preferred first-line ART regimens in patients with HIV-infection and active TB:

- zidovudine + lamivudine + efavirenz (it is recommended to increase EFV dose in patients weighing more than 60 kg);
- tenofovir + emtricitabine (or lamivudine) plus efavirenz (it is recommended to increase EFV dose in patients weighing more than 60 kg);

The Protocol defines alternative first-line ART regimens in patients with HIV infection and active TB consisting of 3 NRTIs:

- zidovudine + lamivudine + abacavir
- tenofovir + emtricitabine (or lamivudine) + zidovudine

Current situation:

TB is an urgent problem for the Republic of Tajikistan. According to the official statistics TB incidence is 70 per 100,000 populations. In 2012, there were 5,400 newly registered cases of TB in the general population. In 2012, 8,851 tests for HIV were carried out in TB patients, in 70 patients co-infection TB/HIV was diagnosed. In 2013 (6 months) 3,736 tests for HIV were carried out and in 42 patients co-infection TB/HIV was diagnosed.

In 2012, 1,135 patients with HIV were screened for TB, in 46 patients TB/HIV co-infection was identified. In 2013 (6 months), 768 patients with HIV were screened for TB, 38 cases of TB/HIV were identified.

Of the entire follow-up group of patients (more than 2,000 patients as of July 2013), in 2012 TB/HIV co-infection was diagnosed in 116 patients (5% of all dispensary group of patients with HIV infection, and 2% among newly diagnosed TB cases). Pulmonary TB was diagnosed in 36% of patients with HIV

infection and extra-pulmonary TB- in 64% cases. All 116 patients with HIV /TB received TB and ARV treatment.

Official HIV/TB co-infection registration data are very low, which might be explained by objective and subjective difficulties in TB diagnostic, especially in HIV- infected patients.

The problem of MDR-TB is also of high importance in Tajikistan. According to the latest drug resistance survey in 2011, the prevalence of MDR is 13% among new and 54% among previously treated TB cases. The country has registered 772 patients with MDR-TB in 2012 and 536 were covered by treatment. The desire of health professionals involved in the diagnosis and treatment of TB to provide care to patients with TB/HIV co-infection should be noted, also the presence of cooperation between the AIDS Centres and TB clinics, but the collaboration and integration of these services require further strengthening and optimization.

As for screening of HIV patients for TB and intensification of TB case detection, it is important to note that infectious disease doctors do not conduct screening of TB symptoms in all patients with HIV-infection suspected of having TB. This needs to be done in accordance with the WHO recommendations (namely: fever of any duration, a cough of any duration, night sweats, weight loss). Such type of screening has not been observed in any of the reviewed medical records of patients registered in the out-patients units of the AIDS centres visited.

Fluorography of the chest is conducted in the local health facilities for free on the basis of referrals from and agreements with the AIDS centres, but where no such agreement exists, instrumental and laboratory tests are done on a fee basis. Because of the stigma and discrimination PLWH are not always willing to disclose their HIV status and thus do not always use the opportunity of the AIDS Centres and, as a rule, patients do not have money to pay for examination. We have not seen systematic X-ray archives at the out-patient units at the AIDS centres.

One of the possible solutions to improve screening for TB in patients with HIV-infection could be the introduction of a simple questionnaire, including symptoms suggestive of TB (i.e. fever of any duration, a cough of any duration, night sweats, weight loss), with the recommendation of its completion during each patient visit and maintaining in the patient medical card. If an HIV-infected patient shows at least one of the above-mentioned symptoms it is necessary to examine patients to follow the clearly articulated algorithm.

As for TB treatment, it is modern and in line with international standards and focused on TB treatment in an outpatient settings with DOTS.

Infectious disease and TB doctors clearly understand the usefulness of Isoniazid Prevention Therapy (IPT) in patients with HIV infection. However, the overall impression is that there is lack of awareness that it is advisable to carry out IPT independently of the presence of active TB, though it is often difficult to confirm or exclude the TB diagnosis for objective reasons. IPT of duration of 6 months is recommended for all newly diagnosed patients with HIV infection, as well as to people living with HIV who have been in contact with TB patients, and HIV patients in presence of TB symptoms, but under condition if TB excluded on the basis of clinical, laboratory and X-ray examination results. We were unable to get data on the proportion of patients with HIV infection showing symptoms suspicious for TB, where TB diagnosis was excluded and IPT started.

TB clinics are responsible for the purchase and transfer of isoniazid to the AIDS Centres for particular patients, who are examined by the TB doctor. AIDS centres are responsible for provision of isoniazid and ongoing IPT monitoring. Isoniazid, like all anti-TB drugs are procured by the TGF. State budget and procurement of TB drugs for the state funds do not exist.

As medical staff stated, patients do not reach the place of testing for TB and IPT very often, they are “lost” or reach clinic too late, and those who are examined by TB specialists and prescribed IPT do not visit AIDS center to take drugs. TB screening issues, as well as implementation and monitoring of IPT effectiveness remain problematic at the individual case management level as well as at local, regional and central levels.

Co-infection HIV/Hepatitis B Virus/Hepatitis C Virus: treatment and monitoring

There are National Clinical Protocols on HIV/HBV/HCV case management, HAV, HBV, HCV and hepatotoxic factors prevention in people living with HIV/AIDS and immunization of PLWH and persons with high risk of HIV-infection (including recommendations on vaccination against hepatitis A and hepatitis B) approved by the Ministry of Health of Tajikistan (MoH order of 27.01.2010, № 28). They are developed on the basis of the clinical protocol for the WHO European Region “Treatment and care HIV/AIDS”, 2007: Management of Hepatitis C and HIV Co-infection, Management of Hepatitis B and HIV Co-infection, Prevention of Hepatitis A, B and C and Other Hepatotoxic Factors in People Living with HIV.

The Protocol identifies the following recommendations on ART initiation in patients with HIV/HCV co-infection:

- at CD4 < 200 cells/ml it is recommended to start ART;
- it is possible to start ART at CD4 200–350 cells/ml or VL > 100 000 copies/ml

Protocol defined the preferred first-line ART regimens in patients with HIV infection and HCV:

- zidovudine (or stavudine) + lamivudine + efavirenz
- abacavir + lamivudine + efavirenz
- tenofovir + emtricitabine (or lamivudine) + EFV
- zidovudine (or stavudine) + lamivudine + nevirapine
- abacavir + lamivudine + nevirapine
- tenofovir + emtricitabine (or lamivudine) + NVP

Protocol define alternative first-line ART in patients with HIV infection and HCV of 3 NRTIs:

- zidovudine (or stavudine) + lamivudine + abacavir
- tenofovir + emtricitabine (or lamivudine) + zidovudine
- stavudine + lamivudine + tenofovir

Comments on the criteria of ART initiation and regimens specified in the Protocol:

It is necessary to revise the criteria to start ART in terms of earlier initiation of antiretroviral therapy in patients with HCV/HIV, according to the current evidence base and international approaches. These ART regimens for patients with HCV/HIV need to be reviewed, including the exclusion/limitation of the use of stavudine, in line with current WHO recommendations. It is suggested to assess the feasibility of the combination of abacavir (in the ART scheme) with the mandatory use of ribavirin in the scheme of prevention of vertical transmission of HCV infection, the appropriateness combination of abacavir and nevirapine in the scheme of ART, the overall reduction and simplification of the recommended ART schemes, and others that must be taken into account when updating the National Protocols for treatment and care for HIV infection.

Protocol identifies the following recommendations on ART initiation in patients with HIV/HBV co-infection:

- at CD4 < 200 cells/ml it is recommended to start ART;
- it is possible to start ART at CD4 200–350 cells/ml or VL > 100 000 copies/ml

Protocol defined the preferred first-line ART in patients co-infected with HBV/HIV:

- tenofovir + emtricitabine (or lamivudine) + EFV

Protocol defined the alternative first-line ART in patients co-infected with HBV/HIV:

- zidovudine + lamivudine (or emtricitabine) + tenofovir

It is necessary to revise the criteria to start ART in terms of earlier initiation of ART in patients co-infected with HBV/HIV, in line with current evidence base and international approaches, according to which the co-infection of HBV/HIV is an indication to start ART regardless of the CD4 cells number. This must be taken into account when updating the National Protocols for treatment and care for HIV infection.

Clinical protocols require screening for HBV and HCV in all patients with HIV-infection and diagnostic and treatment of viral hepatitis B and C in patients with HIV infection. In real life screening for HBV and HCV infection in patients with HIV is not carried out in AIDS centres. Accordingly, vaccination against HBV is not carried out also, although in accordance with existing regulations, people living with HIV can receive vaccination against HBV in local clinics through referral system of the AIDS centres, but in reality this possibility is not implemented. AIDS centres medical personnel explained it in a way that “because of the reluctance of HIV positive people to disclose their HIV status”.

According to RAC doctors’ information testing for antibodies to HCV and HBs-antigen is held at the AIDS Center in Tursunzade city. Out of 62 patients with HIV-infection who were under medical supervision (for all years), 59 patients were screened for HBV and HCV, and in 18 persons antibodies to HCV were detected, 3 patients were HBs-antigen positive and in 2 patients antibodies to HCV and HBs-antigen were detected at the same time. In 2012, 21 patients with HIV-infection were tested at the AIDS centre of Tursunzade city. Antibodies to HCV were detected in 2 patients; one patient was HBs-antigen positive and in one patient antibodies to HCV and HBs-antigen were detected at the same time. For 6 months in 2013 there were 18 patients with HIV infection examined and in 5 antibodies to HCV were revealed, one patient was HBs-antigen positive. The data presented are very limited; there is no breakdown by sex, age, injection drug use history, etc. Still the commitment, activity and enthusiasm of doctors and the entire staff of the AIDS Centre in Tursunzade should be noted.

AIDS centres are not provided with test-kits and equipment for HBV and HCV screening diagnostics. Testing for hepatitis and treatment requires payment with a few exceptions. For instance, at the infectious disease hospital in Dushanbe city (in total 390 beds, including 20 for patients with HIV) 52 patients had access to free of charge HCV treatment with usage of Peg- IFN α -2b and ribavirin because of TGF grant and 16 continue treatment for the moment. It is interesting to note that there were 225 cases of hospitalization of HIV patients to this clinic in 2012 and 133 (59.1%) were related to chronic hepatitis C and adverse effects.

Treatment of prisoners with HIV-infection

From 2001 to 2013, 538 HIV-positive individuals have been registered in the prison system. 225 HIV-positive are serving sentences in penal institutions as of September 2013. In 2012, 40 new cases of HIV-infection were detected out of 5,080 HIV tests performed in the prisons’ settings. ART has been available to prisoners since 2007. 160 inmates with HIV infection have been prescribed ART, 75 people living with HIV are receiving ART as of September 2013.

The medical records of the patients with HIV infection were reviewed in one of the penitentiary setting. All 10 patients receive antiretroviral therapy in 2013, the CD4 count was <300 cells/ml (from 18 to 276 cells/ml), and 6 patients out of these 10 had CD4 counts <100 cells/ml). Thus, we can report late prescriptions of ART to PLWH in prisons.

Out of 10 patients whose medical records were reviewed, 3 were with co-infection HIV/TB. Tuberculosis is a problem for the penitentiary system. According to the senior TB experts data, the

TB incidence rate in the prison system is 800 cases per 100,000 prisoners' population compared to TB incidence rate 70 per 100 thousand in the general population. In Tajikistan, only three facilities in the prison system are of the modern type, others remain as in the 30s of the twentieth century; detention facilities are overcrowded with extremely poor sanitary conditions.

Monitoring of ART: clinical and laboratory monitoring; adherence monitoring

Monitoring of ART effectiveness is based on viral load (VL) detection and provided at the RAC only, where the special equipment is installed – ROTOR-GENE Q (Australia), using reagents for quantifying HIV-1 RNA by PCR hybridization- fluorescence detection with test-kit "AmpliSens HIV – Monitor – FRT" (the Russian Federation).

When reviewing patients' medical cards and during discussions with doctors and patients it was revealed that patients being on ART for several years did not have access to VL testing. After significant break VL testing was renewed in Tajikistan in 2013. According to the records in the lab logbook there were 184 patients receiving ART > 6 months and examined for viral load first time in 2013. The findings showed that 72.8% (134 patients) had undetectable viral load (<500 copies, < 500 copies or < 1000 copies depending on test-system cut-off); 7% (13 patients) had VL < 10,000 copies and 20.2% (37 patients) > 10,000 copies.

In a latter group a huge range in VL tests results (from 14.825 copies/ml to 473,896,834 copies/ml) was observed that clearly indicates needs to examine several things – quality of results interpretation by the lab staff, overall qualification of lab technicians, quality of test-kit 'AmpliSens' HIV-monitor FRT (produced in Russian Federation) and its suitability for 'Rotor-Gene Q Real Time PCR' machine produced in Australia. These findings can also be witness of low level of patient's adherence and that interruption of ART took place up to its stopping. There is a need for more in-depth analyses and independent expert evaluation of the situation.

Going forward

Does the country have a strategy for expanding and sustaining HIV treatment and care services when TGF support is over?

At present the country does not have a strategy on what should be done when TGF support ends.

To what extent did ART contribute to reduction of new infections and improvement of quality of life for PLWH?

It is too early to assess ART contribution into the new cases of HIV-infection reduction when ART coverage is low. For those who are on ART and continue taking drugs, the quality of life is improved and there is a need to design and conduct specific survey to measure this improvement.

Recommendations

Immediate – requires immediate and priority attention within a 3-6-months period

- Access to ART for ALL children must be ensured. The remaining 114 HIV-infected children who do not receive treatment should be reached in a short perspective and examined for their eligibility to ART. If there is a lack of qualified national human resources possibility of external assistance should be explored.
- Country needs support in the development of the set of indicators to ensure a proper clinical monitoring of ART effectiveness and outcomes on a regular basis.

- E-database on all patients being under medical follow up should be completed at all levels and used as a tool to assess treatment outcomes and its dynamic.
- It is recommended not to overindulgence in using cumulative epidemiological and clinical data, as this does not allow observing trends and assess current situation and thus make necessary changes in the operational plans and activities.
- External evaluation of the viral load testing quality should be conducted. Other options for test-kit procurement need to be explored.

Short-term – Should be addressed within a 6-12-months period

- Early access to ART for children, adolescents and adults must be ensured based on WHO recent recommendations: <350 or < 500 CD4 cells/ μ l. All children < 5 y.o. should get ART regardless of CD 4 count.⁶² One of the options might be to optimize treatment provision services by delegating part of it to the infectious diseases hospitals. It would require establishing of outpatient management in infectious diseases hospitals (adults and children) as it is still non-existing there.
- Strong linkages between out-patient and in-patient care management for PLWH should be elaborated to ensure continuity of care for children and adults. With this regard it is suggested that possibility of establishing: a) out-patient unit at the Dushanbe City Infectious Diseases hospital for children and b) in-patient wards for children in Dushanbe City Infectious Diseases hospital for adults should be explored and resolved. Important pre-requisite is that the same staff have to provide out-patient and in-patient services to the patient in order to ensure continuity of care.
- Expanded access to ART for IDUs and prisoners should be provided. Scale-up of OST programme could make a significant contribution in provision of IDUs access to ART, strengthening their retention in care and adherence to treatment.
- Improve TB detection in PLHIV, scaling up ART in TB hospitals, expansion of OST and further integration of ART and OST services should be given serious consideration.
- ART retention rates indicators should be calculated and compared based on analyses of the monthly cohorts of patients instead of year cohorts (for example, January 2012 cohort has to be compared with January 2013 cohort, February 2012 – with February 2013, etc.).
- In order to ensure obtaining reliable, coherent and comparable data on ART effectiveness it is recommended to strengthen capacity of the out-patient department of the RAC in a way of tailoring at least 2 epidemiologists from the epidemiology unit to this department to assist clinicians in monitoring of indicator's trends over time.
- Results of the viral load detection have to be regularly checked and verified since it is a key indicator of the treatment effectiveness.
- Monitoring and analyses of ART side effects should become a part of a routine HIV treatment case management.

Mid-term – maybe addressed within a 12 – 24-months period

- EWIs system should be set up following by HIVDR transmission survey
- Consider decentralization involving family medicine rather than “kiz” as a long-term perspective
- Operational research on HIV/TB case management is needed
- Develop system of uninterrupted support for PLWH to foster high adherence with NGO and PLWH community active participation
- Improve mechanism of integration HIV treatment and care with TB, HCV and HBV diagnostic and treatment

⁶² WHO Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach, World Health Organization 2013 (<http://www.who.int/hiv/pub/guidelines/arv2013/download/en/>)

Blood safety

To ensure safety of donors' blood and medical manipulations within the framework of National HIV programme for 2011 – 2015, following activities have been planned:

1. Promotion of development of free blood donations
2. Ensure HIV testing of donated blood at all health care facilities which have manipulations with blood, blood products or blood donations
3. All medical staff shall be provided with safety measures and PEP kits
4. Ensure safety of the all blood products (HIV, Hepatitis B and C, Syphilis)
5. Develop a programme of external quality assessment with the infected blood via establishment of national EQAS programme with further coverage of blood banks at regional (provincial) level
6. Create a national blood and blood products bank
7. Ensure optimal use of blood transfusion as an effective treatment option
8. Conduct training on use and management of blood products for staff of blood transfusion centres
9. Conduct series of trainings for medical staff and health care providers, as well as for staff at blood centres (national and provincial levels).

The main document regulation all blood-related activities, is the Law of Tajikistan "On donation of blood and its components" as of 26.03.2009. This law envisages implementation of the public policy in area blood donations through implementation of the national programme focused on development of donations of blood and its components. Due to that, in 2009, based on governmental resolution # 29 (as of 30.12.2009), a Programme to enhance blood donation and improve services of blood center has developed and adopted for period 2010 – 2014, where the main objective of that programme is to ensure safety, quality and accessibility to transfusion. Apart of given programme, another two national programmes have been developed and adopted by the Government of Tajikistan: rational clinical use of blood for 2010 – 2015, and programme to ensure blood safety in the Republic of Tajikistan for period 2010 – 2014.

Financing of activities within given programmes is envisaged from funds allocated by the state budget and TGF.

The national blood service consists of following structures: Republic Scientific Blood Center, with three branches at provincial level (Khudjand, Kurgan-tyube and Kulyab). RSBC is the leading organization for blood policy in the country, which performs scientific, clinical, organizational and educational activities. Main function of RSBC branches is to ensure donation of blood and its components, produce and ensure safety & quality of blood products, organizational support to HCF in regards of blood banking and clinical use of blood components. Blood transfusion units are substructure within HCF (Health care facilities). Preparation and processing of blood into its components is performed at two Blood Transfusion Units. Laboratory study of donated blood for blood-borne diseases is performed at Blood Centres. KTTs are the substructure of HCF, and the main function of such KTTs is to provide storage and distribution of blood and blood components to HCF, with further oversight on rational and effective clinical use of blood, as well as to conduct immune haematological typing of blood and conduct compatibility tests. All structures within the Blood services are governmental agencies.

For the period through 2011 and first 6 months of 2013, number of blood donors and donations has slightly increased, where annually 22,000 – 25,000 blood and blood components' units are prepared. Blood donors are mainly admitted to 4 Blood Centres. 60.3% out of all blood and blood component donations are performed at RSBC and 39.8% at RSBC branches (17.7% at Khudjand, 16.5% in Kurgan-tyube and 5.6% in Kulyab). In 2011-2012, blood donations per 1,000 population were around 3.2-3.5. These figures are 10 times less than minimum level recommended by WHO for full universal supply

of transfusion aid in the country. As of donors' breakdown, free blood donations correspond to 71.5%, which is 5% than in 2009 – 2010. Out of all free blood donors, 31.7% are volunteering blood donations while 68.3% are donors-relatives.

As known, donors-relatives are the most dangerous group of donors considering possible transmission of blood-borne diseases through transfusion of blood components. This fact is due to features of blood supply to patients, which envisages official payment for ready blood component, or blood components are supplied in exchange of blood donation. Such mechanism motivates (forces) relatives of the patient to seek for blood donors on more favourable conditions, rather than official payment envisaged by state. In such case, payment to blood donors is lucrative for population considered MARP as of blood-borne diseases. In addition to that, existence of such practice where relatives pay to blood donors, does not allow evaluating situation on free and paid blood donations, due to fact that official statistics reflects such motivated (paid) donor as a donor-relative. Considering all provided information on paid blood donors and donor-relatives, we might state that blood donation in the Republic of Tajikistan is still unsafe, due to higher risk of transfusion of blood-borne diseases by this category of donors.

RSBC has established the National Registry of blood donors, where examination of donors is performed on basis of epidemiological environment and in accordance with database of people, who are not allowed to be blood donors.

At National level, there is no effective system for motivation of people for volunteer free blood donations. As of public authorities there is a lack of regular and systematic approach in resolving issues related to development and enhancement of volunteer unpaid blood donations. Activities to enhance volunteer blood donations with involvement of NGOs (CSOs) do not resolve all issues. Effect of such activities is minor and applicable on a short-term manner. All these factors lead to situation where volunteer blood donation could not become a part of humanistic values within the Tajik society. One reason for that might be the fact that blood components are not free, where the patient and his family but not HCF covers all expenses. Another reason for that might be unclear understanding and use of mechanism to motivate population for volunteer blood donations. This problem requires further detailed study and analysis by Tajik Government.

Laboratory study of donated blood for blood-borne diseases is performed at equipped laboratories of Blood Centres. RSBC and its branches at provincial level conduct full range of blood study for blood-borne disease. Given facilities run ELISA tests for all donated blood on HIV 1-2, Hepatitis B and C, syphilis. NAT study of ELISA-negative blood for HIV, Hepatitis B and C is performed only at RSBC. AIAT study of donated blood, which is a kinetic method to provide indirect indication on liver pathology (including viral infection), is also performed at RSBC and its branches. So far, for given period, 1412 blood donations have been discarded (rejected), which is 4.2% of all blood donations [and 1.5% less than for period 2009 – 2010]. The main reasons for discard are: Hepatitis B (623 blood donations – 1.8% of all blood donations), syphilis (403 blood donations – 1.2% of all blood donations), Hepatitis C – (377 blood donations – 1.1% of all blood donations), HIV – (207 blood donations – 0.6% of all blood donations).

Blood centres in the country are regularly supplied with single-use disposable materials. However, not all HCF are fully supplied with disposable syringes, catheters for parenteral manipulations, gloves and etc., forcing patients to supply such materials on their own. It should be added that medical staff has low awareness on universal precaution and prevention measures on blood-borne diseases, including HIV.

The risk of HIV transmission within HCF and medical facilities is high. In medical facilities HIV might be transmitted from patient to patient, as well as from patient to medical staff and vice versa, via

blood leftovers on tools and repeated use of catheters (supply of the single use disposable catheters is not enough to cover needs of HCFs).

Donated blood is tested based on WHO recommended standards. All donated blood is tested for HIV, viral Hepatitis B and C. Blood is tested by ELISA method, where all supplies are provided through TGF, as well as some of supplies are procured by RSBC. Result is obtained upon first study of donated blood. As for HIV, antigen-antibody complex is used. Doubtful and positive results are referred to AIDS centres for further confirmation. For Hepatitis B and C antibody complex is used. Confirmatory test for Hepatitis B and C is performed only at RSBC. For syphilis study antibody complex is used. All positive results for syphilis are referred to skin-venerological diseases center for confirmation. At the same time, in case of initially positive or doubtful result, blood is discarded and such donor enters a designated list envisaging no blood donations in future.

Donated blood is tested by sensitive laboratory diagnostic tools (ELISA and PCR), and there's no necessity to quarantine blood after donation. Examination of donated blood should be performed by following unified algorithm, approved for all structures of the Blood services; PCR study for blood-borne diseases should be also envisaged. It should be mentioned about necessity to regulate national criteria for eligibility of disposable materials, diagnostic tools and laboratory reagents used at Blood Centres, where such criteria is fundamental to achieve blood safety. Blood for PCR study is drawn at all Blood Centres, while disposable tubes are used only at RSBC. Repeated use of blood tubes might lead to negative impact on quality of laboratory tests.

Each laboratory with ELISA capability has 2 sets of equipment to run ELISA by semi-automated method, but the vast majority of equipment is deteriorated and needs to be replaced. At the same time, all RSBC branches should be supplied with necessary equipment to run PCR tests.

All laboratories within the Blood Service participate in EQA exercise. External Quality Assessment of laboratory tests for HIV is performed by national reference laboratory located at National AIDS center. As for Hepatitis B and C, EQA is performed by RSBC. Each laboratory performs internal laboratory controls. A reference laboratory of a foreign state performed EQA of the RSBC laboratory. Each laboratory has an SOP, which is accessible to all staff. All visited laboratories perform their activities on basis of SOP. It must be mentioned that laboratory staff of the Blood Service are well trained on modern laboratory procedures.

Blood Centres have enough blood components to cover actual/running need of health care facilities. All blood centres and health care facilities have no developed system on effective use of supplies, including: official agreements and regular communication between blood centres and HCF on optimum stock, supply and delivery, as well as no M&E system on availability and use of blood and its components. At the same time, blood centres do not have enough supply of components and blood products, disposable materials for blood preparation and reagents to study donated blood in case of emergency situations (armed conflict, terror act, massive outbreaks and etc.)

Existing system on supply of HCF with blood products is one of the weakest links in donor-recipient chain and requires undertaking of immediate actions for resolving of that issue. Prescription of blood products is paid or provided in exchange of a blood donation. There's no clear system to supply HCF with blood products. In addition to that, there are no focal points responsible for transportation of blood components and products. In vast majority of cases transportation of blood components and products from the Blood Center to HCF is performed by relatives of the patient.

Requirements for blood components are not officially documented; relatives have only improperly filled prescriptions, where prescription indicates type and group of required blood components. Cold chain requirements are not followed; transportation is performed in tiny plastic bags for domestic use, while national programme envisages that blood and its component must be transported within

designated isothermal containers. In addition to that, during transportation, mission observed a violation of principle of separated transportation of frozen and non-frozen blood components, which poses risk of post-transfusion reactions and complications due to change in features of blood components. Non-compliance with cold chain during transportation, lack of adequate conditions for blood storage within HCF and other factors do not allow establishing a stock of blood components and management system of blood components.

At national level there are no guidelines on clinical use of blood products. Since 2013, based on WHO recommendations, country performs system of control and analysis over transfusion aid. Existing mechanism of documenting and reporting on transfusion aid allows conducting regular and full-scale analysis of adequate use of blood components, including components that are not transfused for any reason.

Each HCF has a trained doctor, who is a focal point for blood transfusion. Some of HCF has so called “transfusion committees” to oversight prescription of transfusion aid, but in general such committees only monitor transfusion activities. Analysis of issuance of blood components by Blood Centres, as well as detailed study of situation during visits to HCF has revealed cases of non-intended use of donated blood components, as well as that sometimes dosage of blood components are not effectively prescribed.

In case of lack of blood component of required group, vast majority of health care providers refrain/avoid to use components of universal blood groups (for instance, O RBC-). In such cases health care providers prefer to seek for a donor. Such situation is typical for remote and mountainous regions of the country.

HCFs lack specialized fridge equipment for storage of blood components. Many of existing fridges are not able to maintain required cold chain regime, which blocks HCFs to maintain minimum stock of blood components. Only 35 HCFs out of 73 have been equipped with adequate fridge equipment, while all that equipment was procured via TGF. In addition to that, HCFs have no specialized equipment for fast unfreezing of transfusion media.

Medical staff of the blood centres is trained on aspects of use and management of blood component stock. There are focal points responsible for transfusion aid. Counselling-therapeutic department is established at RSBC to provide transfusion aid to people with haematological diseases. That department is equipped with relevant equipment and disposable materials to conduct haemostatic and haematology studies. The main category of patients of this department – haemophilic and anemotrophic patients, and all other who require extended transfusion aid. Aid to such patients is performed on free (upon referral by the Ministry of Health) and paid basis. Haemophilic patients are treated with cryo-precipitates. Coagulation factor concentrates are not affordable for state budget.

Counselling-therapeutic department has a mobile team, which operates 24/7. The main function of that mobile team is transfusion aid to HCFs in case of haemorrhages. Mobile team is fully equipped, and has stock of essential blood components and diagnostic equipment. Mobile team is mainly serving Dushanbe city, DDR districts and Khatlon Province. Aid provided by the mobile team is paid, and in many cases payee for services are relatives of the patients. Since establishment, mobile team has dramatically increased quality of treatment of patients with haemorrhages and coagulopathies, which also lead to decrease in mortality.

Every 5 years, at RSBC, staff of blood centres undergoes training and re-training courses. RSBC has a license for such activity. In case it is required, RSBC performs on-job training.

For period 2011 – 2013, medical staff of blood centres and HCFs has participated in training courses aimed to introduce and implement WHO recommendations for blood donations and blood safety.

However, considering high level of staff turnover and migration of people to other countries, implementation of WHO recommendations is hindered due to different subsequent factors: permanent need for training of staff and newcomers of blood centres on aspects related to volunteer free blood donations, rational use of blood components via development of standards for rational use of blood products under different clinical conditions, quality management of a blood stock at HCF, quality control over blood products.

Blood Safety Conclusions

1. Existing organizational structure of the Blood Service is centralized and represented by RSBC and its 3 branches at provincial level, 3 transfusion units at provincial branches and 73 transfusion units at HCFs, where structure of the BC is in charge to provide full range of modern safety principles, quality and availability of transfusion aid. However, some regions of the country have limited access to blood services, products and components – GBAO and mountainous regions of Soghd province (Pendjikent and Ayni).
2. Regulatory framework does not cover all aspects of the Blood Service, not all documents consider best global practices and strategies in regards of organizational and technological aspects of modern blood donations. There is no National Guideline on clinical use of blood products. Existing quality standards need to be updated.
3. The Blood Service has no adequate stock of blood and blood products, as well as disposable materials, tests and reagents to study donated blood in case of emergency situations (armed conflicts, terror acts, massive outbreaks and etc.)
4. Existing financing system is not capable to adequately meet needs of HCFs in regards of blood and blood products (both quantitative and qualitative). State has stopped financing of the blood centres, and blood centres are self-financing: major income is generated via selling of blood products, counselling services and laboratory services. At the same time, vast majority of blood and blood products (80%), as well as services (80%) is covered by population.
5. At the National level there's a centralized system on procurement of equipment and disposable materials.
6. Activities of the Blood Service in the Republic of Tajikistan are mainly supported by international community (TGF, WHO), where the Blood Service receives financial, technical and methodological aid. TGF is the main donor agency for the Blood Service. For the last 6 years, TGF has provided the Blood Service equipment, disposable material and technical support.
7. At national level there's no effective system to motivate population for volunteer blood donations. There is no regular and systematic approach of public authorities in regards of resolving issues related to enhancement of volunteer non-paid blood donations.
8. Number of annual blood donations per 1000 population is 10 times less than minimum level recommended by WHO. 65% of donors are donors-relatives, which are considered as the most dangerous category of donors due to high risk of transfusion of blood-borne diseases. 28% of all blood donations (including components) are paid donors.
9. Preparation of blood products and testing of donated blood for blood-borne diseases is performed in accordance with international standards.
10. All laboratories within the Blood Services participate in EQA, while reference laboratory in this case is the laboratory of National AIDS center. All laboratories have also intra-lab QA.
11. All visited facilities have SOPs and SOPs are accessible to all staff.
12. Quality standards of donated blood components comply with recommendation of European Council as 2000. Some aspects to be updated
13. There is no clear mechanism on supply of HCFs with blood products, there are no focal points responsible for transportation of blood components, and there is no clear mechanism that documents requests of HCFs for blood products. There is a lack to follow cold chain regimen. In many cases, transportation of blood products to HCFs is performed by relatives of the patients or patients themselves.

14. Counselling – therapeutic activities of the Blood Services is performed by mobile transfusion teams, which dramatically improved quality of treatment of patients with haemorrhages and coagulopathies. However, services of such teams are paid and mainly covered by patients and/or his relatives, which dramatically limits accessibility of such service for population.
15. There is no adequate supply system of blood products to HCFs. Negative consequence of that is inadequate registry of blood products, particularly those that are supplied by patients' side.
16. Every 5 years, staff of the blood service undergoes training and re-training courses; upon completion RSBC issues a certificate to trainees.
17. Considering high level of staff turnover and migration of people to other countries, implementation of WHO recommendations is hindered due to different subsequent factors: permanent need for training of staff and newcomers of blood centres on aspects related to volunteer free blood donations, rational use of blood components via development of standards for rational use of blood products under different clinical conditions, quality management of a blood stock at HCF, quality control over blood products.

Recommendations

- Ensure stable financial support from the state budget, including activities envisaged by different programmes to be covered by central and local budget, with involvement of donors' funding.
- Ensure enhancement and improvement of regulatory and legal frameworks in regards of improvement of the Blood Service:
 - Revise legal and regulatory frameworks of the Blood Service, with further consideration of structural changes.
 - Update standards related to all technological phases of preparation of blood products, laboratory testing, storage, stocking, transportation and transfusion, in accordance with modern international standards and technologies.
 - Develop a national guideline on clinical use of donated blood and its components.
 - Develop unified set of requirements for equipment and disposables in accordance with WHO recommendations.
- Ensure centralized procurement of equipment and disposable materials for the BC at National Level.
- All transfusion units to be equipped with the specialized equipment for storage, transportation and preparation for transfusion of blood products.
- Ensure compliance and follow-up of cold chain at all stage of preparation and transportation of blood products.
- Based on assessment of need in transfusion media, ensure existence of optimal stock of blood products within HCFs; establish a system of registry and storage.
- All blood examinations for blood-borne diseases and immune-haematological aspects shall be conducted in accordance with WHO recommendations.
- Conduct a social survey/study in order to reveal motivational tools leading to volunteer non-paid donations among different groups of population, with further elaboration and based on results of the survey and relying on participation of the government, further introduce a comprehensive PR-strategy to develop volunteer blood donations.
- Ensure quality conformity of all blood products: to develop provisions on accreditation of all Blood centres and their subunits. Perform accreditation of the whole Blood Service.
- Ministry of Health shall provide haemophilic patients with modern blood products.
- Establish and ensure control on rational and effective clinical use of blood and blood products, where this control system shall rely on evidence-based medicine with further introduction of modern technologies on saving blood of the patients.
- Train staff of the Blood Service and HCFs to contribute in development of volunteer non-paid blood donations and rational clinical use of blood products via development of relevant standards. It is important to develop a quality management system for blood banks at HCF level, while quality assessment of blood products preparation shall be performed with participation of

international consultants or study tours of local staff to other countries.

CONCLUDING REMARKS

This document is the report of a mid-term evaluation of the national HIV programme in Tajikistan for 2011 to 2015. The evaluation was conducted by a team from the WHO Regional Office for Europe, WHO headquarters and WHO country offices (Tajikistan and Ukraine), the WHO Collaborating Centre for Harm Reduction in Vilnius, UNAIDS, UNICEF, the Civil Society Forum (European Commission), UNDP, TGF, ICAP, other partners and independent consultants. The objective of the evaluation was to assess the progress and direction of the National AIDS Programme 2011-2015 by focusing on key areas at mid-term.

During the last 7 years Tajikistan has achieved good results in its national response to the HIV epidemic and in particular in providing treatment and care, taking into account the extremely complex political, economic and social situation in the country after 5 years of civil war and resulting destroyed industry and agriculture, wide poverty and a weak health system. Numerous pilot projects of friendly services demonstrate how well the health system can work with civil society groups, especially at regional and local level. The Regional Coordination Council of Sogd Oblast seems to be an example of good practices and effective integration between institutions and NGOs, where the issues raised by civil society are taken into consideration.

Another good example is the Technical Working Group (TWG) on Harm Reduction. The members of this TWG are actively involved in the delivery of harm reduction services in different regions and they belong to the vulnerable groups. Over the past few years they have advocated for the improvement of harm reduction services and for the introduction of OST in the country, and succeeded in their efforts.

Substantial progress has been made providing commodities for prevention of HIV. Condom and syndromic drug supply systems seem to work and these commodities plus information materials were available at any site visited.

Substantial progress in STI prevention and care is made where “friendly services” exist, either for ‘migrants’, youth or sex workers, in reproductive health clinics or STI clinics. The set-up of the “friendly” services should become the blueprint for national STI services: free of charge, without entering names into national registers, using the syndromic approach with immediate start of treatment. Further improvement is required, e.g. often it seems not possible to treat family members in the same way (also true when infections in pregnant women are detected).

The progress achieved in the area of treatment and care includes access to ART being gradually scaled up; OST for injecting drug users has been initiated and serving as a promising base for their involvement in, adherence to and retention on ART; availability of ART in the prison system; development of WHO recommendations based on a set of national clinical protocols that are currently under revision to follow latest WHO recommendations; clinicians got access to the international clinical expertise contributing in national capacity building; availability of treatment laboratory monitoring in 5 regions (CD4) and viral load at the national level.

The introduction of HIV rapid testing, variety of HIV Testing and Counselling (HTC) models including mobile units, involvement of civil society settings in provision of HIV counselling provision, on-going efforts to revise HTC normative basis are among current positive developments in this area.

Preparation of blood products and testing of donated blood for blood-borne diseases is performed in accordance with international standards. All visited blood facilities have SOPs and SOPs are accessible to all staff. All laboratories of blood centres have internal quality control and participate in EQA.

However, the HIV epidemic in Tajikistan continues to grow. Issues of verticalization, fragmentation and a lack of integration with other health programmes continue to impede significant progress the country could make in halting the spread of HIV. Despite enormous investments and efforts to control the HIV epidemic both the government and international donors HIV is continuing to spread in Tajikistan, particularly among injecting drug users, their sexual partners and probably among men who have sex with men. This continued spread constitutes a significant public health problem for Tajikistan. If uncontrolled, HIV, TB and viral hepatitis could threaten life expectancy gains envisaged under the national health strategy 2010-2020 because of significant numbers of young lives lost.

The epidemic is spreading mainly among injecting drug users and their sexual partners. Although some targeted HIV prevention measures have been introduced in the community, for example needle and syringe programmes and pharmacotherapy with methadone, these have not yet been implemented at a large enough scale to fully control the spread of the epidemic, and these important programmes have not yet been sufficiently introduced in prisons.

Focusing on effective prevention, care and treatment services on injecting drug users and their sex partners will not only control the spread of HIV in Tajikistan among people who inject drugs, but it will also protect the entire population from the risk of HIV transmission. There may be a significant second hidden epidemic among men who have sex with men. Special efforts are needed to limit transmission in this community as well.

Because of the financial constraints the government and donors should focus control efforts not only on these key populations, but also in areas with the highest prevalence of drug injecting and HIV. To implement the same measures in all geographic areas spreads resources too thin and jeopardizes the possible success and progress. HIV infections and resulting co-infections and illnesses should be treated as any other disease and prioritized for integration into the general health system.

Anti-retroviral treatment shows insufficient coverage and high rates of late diagnosis: the estimated number of individuals needing treatment is 3,400; only 30% of the 1,181 HIV patients currently treated are infected through drug use, which indicates limited access for IDUs and prisoners; 302 children are currently living with HIV, and only 188 are on treatment; death rates are too high and initial CD4 cell counts are very low.

One of the key issues of the HIV control programme in Tajikistan is the need to improve detection of HIV infections through testing and counselling services. 2/3 of PLWH are still unaware of their infection. The testing system is overly bureaucratic, inflexible and fragmented, with lack of coordination and strategic vision. For example, the peak of new infections detected in 2010 was made possible by special incentives for prisoners to come forward for voluntary testing; it is unclear why this programme was not continued or repeated since then. Rapid scale up of HIV testing and counselling access and coverage to the main risk groups of people who inject drugs, their sex partners, prisoners, MSM and SW is needed; and better targeting and organization of the testing system is required. Testing, however, is not a goal in itself; effective referrals to post-test services including treatment and care need to be ensured.

Name based national registries for people who inject drugs seeking treatment for sexually transmitted infections or who are HIV infected are counter-productive for effective and cost-effective public health control measures of these conditions. Modern systems of case-based databases with usage of unique identifiers would be more cost-effective and efficient.

There is a need to address fragmentation of functions, concentration of activities in the AIDS centres and service delivery. It remains unclear why more than 100 children with HIV do not have access to ART; actual access to ART, monitoring and care for PLWH is difficult and is not sufficient; the system of 'friendly cabinets' provides good services, however, the coverage is very limited.

Service delivery is structurally disconnected; the same client is sent to different centres for testing, counselling and treatment depending on the type of illness, e.g. HIV, TB, STIs, narcology; services are organized in silos, and diseases are addressed instead of using a person-centred treatment approach.

The underusage of services is striking in all service delivery points visited; services do not always nor fully meet the expectations and needs of the clients. This is extremely prominent in the narcological services, which need urgent reforms.

The Global Fund was founded as new financing mechanism for three infections, HIV, TB, and Malaria. The governing function 'Coordinating Country Mechanism CCM' is needed to support civil society organizations' essential work in the communities. The promotion of this principle and the necessary support of civil society organizations in Tajikistan are still lacking. NCC functions and election procedures need to be urgently reviewed, and a new technical working group for improving capacity building and advocacy for civil society organizations should be considered. The role of NGOs should be further promoted, they should not be perceived as competitors but as complementary to government services; there should be active career paths from state services to NGOs and back into government to ensure that the control of HIV in Tajikistan becomes cost-effective and efficient. A "compact" among government, development partners and civil society may help to work together more effectively to deliver priorities in the overall national health sector strategy.

There is no shared understanding among government, service providers and donors of the roles civil society should play. Such roles should include reaching key populations, building trust, providing entry points into the health system, to ensure continued engagement with services, and advocacy for better support to fulfil these roles. There is no predictable, long-term funding which means that NGOs have to focus on short-term project funding, have limited financial and management capacity, and have no real influence on decision-making in their area of work. A technical working group in the NCC improving capacity building for NGOs and advocacy for civil society, as active as the current one on Harm Reduction, would urgently be needed to solve some of these problems.

It is hoped that the recommendations from this mission will help to further strengthen the national HIV control, prevention, treatment and care programme in the Republic of Tajikistan. They could serve as the basis to adjust activities in the remaining two years of the programme and in the formulation of the new programme beginning in 2015 – a process that should start immediately with a national discussion of these findings with all stakeholders.

Political commitment, MOH leadership, technical competence, dedication of leading staff of the National HIV/AIDS Programme, national technical and public health experts, awareness of existing challenges, willingness to address issues in a comprehensive way and following evidence and human rights' based policies, practices, norms and standards form a foundation for the future success of the National HIV/AIDS Programme.

ANNEX 1: TERMS OF REFERENCE

Mid-term review of the National AIDS Programme 2011-2015 of Tajikistan

ASSESSMENT TOOL and TERMS OF REFERENCE

Background:

A mid-term review in 2013 of the National AIDS Programme 2011-2015 was requested by the MoH of the Republic of Tajikistan and the National AIDS Centre.

WHO was asked for assistance to conduct the mid-term review in order to monitor whether implementation of the national HIV/AIDS programme is going in the right direction and is on course to meet the targets defined by the national programme, whether activities are in line with internationally recognized recommendations, and to identify gaps and give recommendations for further effective implementation of the programme to achieve set goals and targets of the National AIDS Programme as well as the European Action Plan for HIV/AIDS 2012-2015.

The Programme Review will be conducted jointly with UNAIDS, UNDP/TGF, UNICEF and USAID HIQP.

The objectives of the HIV/AIDS Programme in Tajikistan for 2011-2015 are linked to the Poverty Reduction Strategy for 2010-2012, the National Health Strategy for 2010-2020, and a set of national indicators presented in the M&E Plan of the Programme on the response to HIV/AIDS epidemic in Tajikistan for 2011-2015.

This assessment should complement the findings of the TB & HIV/AIDS and Health System Strengthening mission end of 2010 by focussing on practical recommendations how to improve programme implementation despite the systems weaknesses noted in previous reports⁶³. While it is desirable to improve the systems, this will take some time, but direct improvements are still possible: for example despite lack of financial resources more participation of People living with HIV (PLWH) is possible and will improve quality of services. Or although HIV and TB services are free of charge, in a system that relies heavily on out-of-pocket payments HIV and TB patients are particularly deprived because they cannot pay such inducements: the challenge is to take into account these realities and still improve their services. Under financial constraints it is most important to targeting investments where they will have maximum impact.⁶⁴

Objective and scope of the evaluation

The **objective** of the evaluation is to assess the progress and direction of the National AIDS Programme 2011-2015 at mid-term by focusing on key areas in order to

- give practical recommendations for improving performance in these areas,
- identify whether activities are in line with international recommendations,
- find gaps and necessary changes,
- give guidance for donor and overall health sector coordination to improve the quality and cost-effectiveness of HIV service delivery, consistent with objectives and benchmarks outlined in the National HIV Programme for 2011-2015
- identification of priority shortcomings and areas where increased international support would be most beneficial.

The **scope** of the evaluation is focussed on key areas as listed below and by reviewing inputs, process, outputs, and outcomes of these areas. Additionally the evaluation should contribute considerations of what changes need to be done in the direction of the National AIDS programme after 2015.

Key areas and settings of the evaluation

The following **key areas** – as defined by the European Action Plan for HIV/AIDS 2012-2015 – will be assessed:

⁶³ From the mission report: "What is striking in all the recent Tajikistan reports and policy documents, referenced in this mission report, is that they are all very good, listing most issues in a frank way, proposing suitable and sometimes very ambitious activities but **none of these have an implementation plan attached, that can be incorporated and implemented within operational plans of relevant stakeholders with clear priority setting based on explicit criteria ...**"

⁶⁴ See Godwin, Dickinson: "A large part of the problem is that countries are still focused on funding what they want to do, rather than doing what they need to do with the funds they have."

The following priority areas of *optimizing HIV prevention, diagnosis, treatment, care and support outcomes* will be selected:

- HIV transmission through injecting drug use (EAP 1.2) in the following **settings**:
 - Needle and syringe programmes
 - Opioid substitution therapy
 - HIV testing and counselling
 - Prisons, non-medical and community-based services
- Sexual transmission of HIV, in the context of sex work and among migrants, MSM and young people (EAP 1.3) in the following **settings**:
 - Behaviour change communication to key populations
 - Provision of services and commodities for prevention of HIV
 - HIV testing and counselling
 - STI prevention and care
- HIV treatment, care and support (EAP 1.5) in the following **settings**:
 - Early enrolment and retention with emphasis on people who use drugs
 - Support to improve adherence to treatment
 - Screening for co-infections with TB, Hepatitis C and B
 - Monitoring HIV drug resistance
 - Common health complication on people living with HIV
- Mother-to-child transmission of HIV (EAP 1.4) in the following **settings**:
 - Pregnancy, labour, delivery, postpartum, newborn services
 - Unintended pregnancies, abortion services
 - Provider-initiated HIV testing and counselling
- HIV testing and counselling (EAP 1.1) in the following **settings**:
 - HIV testing and counselling services, including prison services
 - HIV prevention, health care
 - Non-medical, community-based

The following priority areas of *leveraging broader health outcomes through HIV responses* will be selected:

- Blood safety (areas will be added)

The following priority areas of *building strong and sustainable systems* will be selected:

- Leadership, governance and management (EAP 3.6) in the following **settings**:
 - HIV and public health programmes
 - Intersectoral HIV coordination structures
 - Prison health services
- Strategic information obtained through surveillance, monitoring and evaluation (EAP 3.1) in the following **settings**:
 - Data collection, analysis and presentation
 - Capacity building
 - Patient monitoring systems
 - Surveillance among migrants
 - Sentinel surveillance survey

The following priority areas of *reducing vulnerability and removing structural barriers to accessing services* will be selected:

- Civil society involvement (EAP 4.3) in the following **settings**:
 - HIV coordination mechanisms
 - Policy development and decision-making processes
 - Coordination of national strategies and plans
 - Delivery of HIV and related health services
 - M&E of the national HIV response
- Laws and regulations related to the HIV response
- Gender equity and Stigma and Discrimination

Type of expected results

The following outputs will be produced:

- De-briefing to discuss preliminary findings and recommendations

- Evaluation report with simple, actionable recommendations
- National consultation to discuss the implications of the findings in the report

Methodology of the evaluation

The review team will use the tools provided in the annexes, especially Annex 1, Ref. 3: *Programme Review Guide for the Health Sector response to HIV/AIDS* and the methodology described in this document.

The mid-term evaluation will have the following components:

- Preparatory meeting (see also “**Optional checklist for preparation to the Review**”) of all relevant national institutions, stakeholders, donors and beneficiaries* to determine
 - All relevant documents, reports and other material related to HIV/AIDS in Tajikistan
 - Available data and analysis to be included
 - Organizations, institutions, sites to be visited
- Desk review of all relevant documents, reports and other material related to HIV/AIDS in Tajikistan
- Site visits and interviews with key informants in institutions, organizations and service providers
- De-briefing on preliminary findings and recommendations with all stakeholders, including those visited
- Draft evaluation report which is circulated to all stakeholders for comments, clarifications, corrections
- Final evaluation report with simple, actionable recommendations
- National consultation* to discuss the implications of the findings in the report

The evaluation will be focussed on the services delivered (outputs) and coverage of interventions (outcomes) using the following questions:

- Are we doing the right things
- Are we doing them right
- Are we doing them on large enough scale

In considering implications of the findings, taking information on impact at this stage into account, the following questions will be used in moving the programme forward:

- Are we making a difference?
- What works well and needs to be continued or expanded?
- What does not work well and needs to be reformulated or discontinued?
- What new things can be done to improve performance?

These questions define the analytical framework how the analysis will be carried out.

Timeframe of the Review

1. Preparatory meeting: Define relevant materials, data, potential institutions to be visited, level of services to be assessed, and people to be interviewed according to priority areas chosen (Date + 0 weeks)
2. Preliminary review of data, study results, documents, reports in country (+ 4-8 weeks)
3. Final timetable with detailed information on sites and people finalized, there will be time for daily team feedback and preparation for the debriefing (+ 9 weeks)
4. In-country mission for evaluation team 6 working days, including an initial briefing and at the end a de-briefing session with MOH and stakeholders (+ 12 weeks),
5. Draft evaluation report (+ 15 weeks)
6. Feed-back and comments received (+ 17 weeks)
7. Final report published (+ 18 weeks)
8. National consultation (+ 21 weeks)

Format for the Evaluation Report

- Executive summary, including main recommendations

*To be attended by those external review members who reside in Tajikistan and all in-country experts, staff and stakeholders involved.

- Introduction and background, including description of the status of the HIV epidemic in Tajikistan, the health system structure and institutions, the coordination mechanisms and related policy frameworks.
- Objective, scope and methodology of the evaluation
- Findings (each chapter will be structured according to the list of key questions and issues defined for each area)
 - *Optimizing HIV prevention, diagnosis, treatment, care and support outcomes*
 - *HIV transmission through injecting drug use*
 - *Sexual transmission of HIV*
 - *HIV treatment and care*
 - *Mother-to-child transmission of HIV*
 - *HIV testing and counselling*
 - *Leveraging broader health outcomes through HIV responses*
 - *Blood safety*
 - *Building strong and sustainable systems*
 - *Leadership, governance and management*
 - *Strategic information obtained through surveillance, monitoring and evaluation*
 - *Reducing vulnerability and removing structural barriers to accessing services*
 - *Strengthening community system*
- Conclusion and recommendations (a proposed progress and urgency scale will be used for recommendations)
- Annexes
 1. ToR for the evaluation, time-table
 2. List of organizations and people interviewed
 3. Complete list of documents reviewed

Progress Scale (for measuring progress and performance of technical areas/issues):

High Features one or more of the following dominant characteristics:

- Excellent progress and outcomes
- Measurable results that have consistently met or exceeded targets
- Programme design and implementation largely consistent with needs
- Minor shortcomings can be quickly and easily overcome
- Programme merits duplication and scale-up

Substantial Features one or more of the following dominant characteristics:

- Strong progress and adequate outcomes
- Some results that have occasionally met targets, and/or significant progress towards targets
- Programme design and implementation partially consistent with needs, some modifications recommended
- Moderate shortcomings to be addressed, requiring limited time and effort

Moderate Features one or more of the following dominant characteristics:

- Adequate progress and some partial outcomes
- Limited progress towards targets
- Programme design and implementation only partially consistent with needs, requires significant revisions and improvement
- Significant shortcomings to be addressed, requiring moderate time and effort

Inadequate Features one or more of the following dominant characteristics:

- Marginal progress and few outcomes
- Insufficient progress towards targets and/or inadequate targets
- Programme design and implementation suboptimal, and largely inconsistent with needs, requires extensive revisions and improvement
- Widespread shortcomings to be addressed, requiring substantial time and effort

Unacceptable Features one or more of the following dominant characteristics:

- Little or no progress and/or negative outcomes
- No targets and/or inappropriate targets
- Programme design and implementation seriously flawed, and wholly inconsistent with needs, requires wholesale revisions
- Widespread critical shortcomings to be addressed, requiring extensive time and effort

B. Urgency Scale (for implementation of main recommendations):

Immediate Requires immediate and priority attention

Must be addressed within 3-6 month period

Short-term Requires short-term attention
Should be addressed within 6-12 month period

Mid-term Requires consistent attention
Maybe addressed within 12 – 24 month period

Composition of the Review Team (to be adjusted according to the finally decided key areas of the review)

External review members

- Expert on HIV transmission through injecting drug use-
- Expert on sexual transmission of HIV
- Expert on Treatment and Care
- Expert on prevention of mother to child transmission
- Expert on HIV Counselling and Testing
- Expert on strategic information through surveillance, monitoring and evaluation
- Expert on strengthening community systems
- Expert on strengthening health systems (Human Resources, Financing, Leadership, Governance and Management)
- Leading author of the report (optional)

The external review members could be drawn from the agencies involved in the programme review: WHO, UNAIDS, UNDP, TGF, ICAP, UNICEF, civil society organizations and independent consultants.

There will be at least one expert from civil society and/or **person living with HIV/AIDS**.

One of the experts will be acting as **team leader** during the mission. A **lead author** and editor will be involved. The team leader and the lead author will be responsible for the timely submission of the report.

The **team leader** could have the following tasks:

- Appointing the Review Team and define responsibilities
- Compile relevant documents for desk review as outlined above
- Develop a detailed plan for the programme review process, including selection of field sites for visits and key informants to be met and interviewed together with the national counterparts and the Review team
- Overseeing implementation by the Review Team
- Draft an executive summary of the review, including key findings and main recommendations, for presentation to MOH and MOJ officials by the end of the review process;
- Facilitate development of the Review Report

Internal review members

Each external expert will have a national counterpart with expertise in the same area assigned to this expert for the entire mission in country and for consultations until the final report is finalized.

The external and internal experts in one area will do all site visits and interviews together.

ANNEX 2: TOOLS USED, DOCUMENTS REVIEWED

Checklists and tools for the assessment of each area of assessment

1. *Planning guide for the health sector response to HIV*: The guide to planning for the health sector response to HIV sets out essential considerations for developing robust national plans for an effective response to HIV in the health sector. It serves as a tool for translating the tenets of the Global health Sector Strategy for HIV 2011-2015 into national priorities strategies and plans.
<http://www.who.int/hiv/pub/guidelines/9789241502535/en/index.html>
2. *Guidelines for conducting a review of the health sector response to HIV/AIDS*. A programme review is a systematic assessment of the National AIDS Programme, including its relevant and adequacy. It helps countries to assess the achievements of the NAP in the health sector, and provides recommendations for improving strategies and interventions. It also helps to develop multisectoral partnerships in planning and coordinating the response to HIV/AIDS. These guidelines will help review teams to carry out the different components of a programme review. They can be used as a stand-alone instrument to evaluation/review the health sector in particular, or for broader multisectoral reviews.
<http://www.searo.who.int/entity/hiv/documents/9789290223184/en/index.html>
http://203.90.70.117/PDS_DOCS/B2150.pdf
3. *Programme Review Guide for the Health Sector Response to HIV/AIDS*. WHO draft October 2012, provided by WHO Regional Office for Europe
4. *M&E Toolkit for key populations*, TGF <http://toolkit.aidsprojects.com/monitoring-and-evaluation/>
5. Joint Reviews of national AIDS response, UNAIDS, 2008
<http://www.unaids.org/en/ourwork/programmebranch/programmeeffectivenessandcountrysupportdepartment/strategiccountryssupportdivision/>

Specific Tools

6. *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, 2012 revision*. Since the publication of the first version, the Technical Guide has been endorsed by high-level political bodies including the UN General Assembly, the Economic and Social Council, the UN Commission on Narcotic Drugs, and the UNAIDS Programme Coordinating Board. In addition, donor agencies, including the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), have committed to using this framework. WHO Jan 2013
http://www.who.int/hiv/pub/idu/targets_universal_access/en/index.html
7. *Policy guidelines for collaborative TB and HIV services for injecting and other drug users: An integrated approach*. Evidence for action series, WHO 2008
http://www.who.int/hiv/pub/idu/evidence_for_action/en/index.html
8. *WHO policy on collaborative TB/HIV activities*: guidelines for national programmes and other stakeholders. These policy guidelines on collaborative TB/HIV activities are a compilation of existing WHO recommendations on HIV-related TB. WHO 2012
http://www.who.int/tb/publications/2012/tb_hiv_policy_9789241503006/en/index.html
9. *Three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV: standardized minimum data set and illustrative tools*. WHO Nov 2009.
http://www.who.int/hiv/pub/imai/three_patient_monitor/en/
10. *Patient monitoring guidelines for HIV care and antiretroviral therapy*. WHO July 2006
<http://www.who.int/hiv/pub/imai/patientguide/en/index.html>
11. *WHO global strategy for the surveillance and monitoring of HIV drug resistance 2012*. WHO Nov 2012
http://www.who.int/hiv/pub/drugresistance/drug_resistance_strategy/en/index.html
12. *Assessment of WHO HIV drug resistance early warning indicators*. WHO July 2012. Early warning indicators (EWIs) of HIV drug resistance (HIVDR) are a key component of WHO public health strategy to minimize and assess HIVDR in countries scaling up antiretroviral therapy. EWIs are quality of care indicators which specifically assess factors at individual antiretroviral therapy clinics associated with emergence of HIVDR. Where widely implemented, EWIs provide the necessary programmatic context to interpret results of surveys of transmitted and acquired HIVDR.
http://www.who.int/hiv/pub/meetingreports/ewi_meeting_report/en/index.html
13. *ECDC meeting report: Responses to HIV and migration in western industrialised countries: current challenges, promising practices, future directions*. ECDC Jan 2013
http://ecdc.europa.eu/en/press/news/Lists/News/ECDC_Dispatch.aspx?List=32e43ee8-e230-4424-a783-85742124029a&ID=831&RootFolder=%2Fen%2Fpress%2Fnews%2FLists%2FNews
14. *Community Systems Strengthening (CSS)*. The Framework defines the terminology of CSS and discusses the ways in which community systems contribute to improving health outcomes. TGF Aug 2011
<http://www.theglobalfund.org/en/civilsociety/reports/>

National Documents

1. *National Health Strategy of the Republic of Tajikistan 2010-2020*, Dushanbe 2010
2. *Programme on the response to the epidemic of HIV/AIDS in the Republic of Tajikistan for the period 2011-2015*, Oct 2010 Government of the Republic of Tajikistan
3. *HIV National Programme Action Plan 2011-2015*, April 2011 Government of the Republic of Tajikistan
4. *National plan of monitoring and evaluation of the Programme on the response to HIV/AIDS epidemic in the Republic of Tajikistan for 2011-2015*, April 2011 Government of the Republic of Tajikistan
5. *TAJIKISTAN TB & HIV/AIDS and Health System Strengthening, Report of mission 29 November – 5 December 2010*
6. *Poverty Reduction Strategy for 2010-2012*, Government of the Republic of Tajikistan, to be provided
7. *National Development Strategy for period to 2015*
8. *National study on stigma and discrimination*, 2012
9. *Tripartite Partnership Strategy on HIV/AIDS prevention in the World of Work in the Republic of Tajikistan*, 2012
10. *National Development Strategy for period to 2015*
11. *Report, Joint Annual Review of the national Health Strategy for 2011-2012*
12. *National report on progress in implementing the measures in response to AIDS Tajikistan*, 2012
13. *Regulation on HIV C&T*, 2008
14. *Gender Assessment of HIV response in Tajikistan*, 2013.
15. *Gender Analysis of national policy for HIV/AIDS prevention in Tajikistan*, 2010
16. *Tajikistan national AIDS spending assessment: 2010-2011*
17. *Tajikistan national AIDS spending assessment: 2008-2009*
18. *Tajikistan, TB&HIV/AIDS and Health System Strengthening, Report of mission*, 2010
19. *Capacity assessment of public aids service providers and capacity enhancement plan*, 2011
20. *Tajikistan: Opportunities for harmonization of national legislation related to HIV with best international standards and practices*, analytical report, 2013
21. *Report on costing of supply component-diagnosis of the prevention of mother -to-child HIV transmission (PMTCT) programme in Tajikistan*, 2012
22. *Costing of PMTCT programme, Supply: diagnostic component*
23. *PMTCT National Clinical protocol*, 2012
24. *MoH Decree on PMTCT*, 2013
25. *PMTCT Monitoring Card*, 2013
26. *Methodological guidelines for implementation of harm reduction programmes*, 2010
27. *Assessment of OST in Tajikistan*, 2012
28. *Costing analysis of Tajikistan harm Reduction services*
29. *Report of WHO Technical Mission to Assess STI laboratory diagnostics in Tajikistan*, 20 – 25 February, 2012, Consultant Report
30. *Tajikistan Assessment of Syndrom Treatment at PHC level*, 2011, Consultant Report
31. *Report on Assessment of HIV/AIDS Surveillance system*, 2011, Consultant Report
32. *Assessment of HIV Sentinel Surveillance Survey*, 2010.
33. *Rapid Assessment and Response on HIV/AIDS among Especially Vulnerable Young People in Tajikistan*
34. *HIV KAP Study among 15-49 years old population*, Tajikistan, 2012.
35. *Report on Project: 'Support to National AIDS Response to Scale Up HIV Prevention and Care Services in Tajikistan*, 2009
36. *Report of the Study: KAP among MSM in Dushanbe city*, Tajikistan 2011
37. *Final Evaluation Report: Objective 3 of the Round 4 GFATM HIV grant addressing provision of treatment, care and support to people living with HIV/AIDS (PLHIV)*
38. *United Nations Development Programme (UNDP) Tajikistan*
39. *Stigma and discrimination among PLHIV*, draft Report, 2007
40. *National Study on the stigmatization of and forms of discrimination against people living with HIV*
41. *Stigma and discrimination among PLHIV*, Report, 2012
42. *HIV Counselling and Testing Guideline*, 2012.

General Documents

1. *European Action Plan for HIV/AIDS 2012-2015* WHO Regional Office for Europe 2011
<http://www.euro.who.int/en/what-we-publish/abstracts/european-action-plan-for-hivaids-20122015>
2. *The new European policy for health – Health 2020*. EUR/RC62/9 Health 2020: a European policy framework supporting action across government and society for health and well-being WHO Regional Office for Europe 2011
<http://www.euro.who.int/en/who-we-are/governance/regional-committee-for-europe/sixty-second-session/documentation/working-documents/eurrc629-health-2020-a-european-policy-framework-supporting-action-across-government-and-society-for-health-and-well-being>
3. *Global health sector strategy on HIV/AIDS 2011-2015*. The strategy guides the health sector response to human immunodeficiency virus (HIV) epidemics in order to achieve universal access to HIV prevention, diagnosis, treatment, care and support. WHO 2011 http://www.who.int/hiv/pub/hiv_strategy/en/index.html
4. *Joint Assessment of National Health Strategies, or JANS*, is a shared approach to assessing the strengths and weaknesses of a national health strategy or plan.
<http://www.internationalhealthpartnership.net/en/tools/jans-tool-and-guidelines/>
5. *Five ways to begin the end of AIDS*: Peter Godwin and Clare Dickinson, February 2013. Is recent optimism about the 'end of AIDS' justified? This short commentary argues that radical re-thinking of critical elements of global, regional and country AIDS programming is needed for the end of AIDS to become a reality. It proposes five ways forward that AIDS policy-makers, programmers, implementers and thinkers should take on board.
<http://www.hisp.org/Home/Resources/EndofAIDS.aspx>

6. *Practical tips on how to strengthen National Evaluation Systems* aims to provide both technical and non-technical staff in the UN system with ideas on how to link to national evaluation capacity systems and on the role that UN Agencies could play to support their strengthening. It is not meant to be prescriptive but is intended to highlight key elements to consider when working on national evaluation capacity development (NECD). It draws from the NECD experiences of the last twenty-plus years, many, though not all of which, have been appropriately documented. http://www.unevaluation.org/necd_practicaltips

ANNEX 3: AGENDA, SCHEDULE OF PEOPLE, INSTITUTIONS INTERVIEWED

REVIEW OF THE NATIONAL AIDS PROGRAMME IN TAJIKISTAN, 16 – 25 Sept 2013

AGENDA

Review team members:

#	Name	Area expertise	email	Cell phone #
1.	Lali Khotenashvili	Team leader, WHO Regional Office for Europe, HIV C&T	LKH@euro.who.int	90 5000231
2.	Ulrich Laukamm-Josten	Co-team leader, ST of HIV	ulrich@jostenweb.de	90 0007023
3.	Emilis Subata	HIV transmission through IDU	emilis.subata@vplc.lt	90 0001968
4.	Svetlana Antonyak	Treatment and Care, clinician	antonyaksn@gmail.com	
5.	Iurii Kobyshcha	Treatment and Care, WHO Ukraine	YKO@euro.who.int	90 0007024
6.	Jadranka Mimica	PMTCT,	jadrankamimica@gmail.com	90 0007027
7.	Otilia Scutelnicuic	M&E	ScutelnicuicO@unaids.org	90 5000242
8.	Lella Cosmaro	Strengthening community systems	l.cosmaro@lilamilano.it	90 0007034
9.	Sowmya Kadandale	Health system strengthening 1	kadandales@who.int	90 5000234
10.	Baktygul Akkazieva	Health system strengthening 2	akb@euro.who.int	907 78 15 01
11.	Svetlana Cebotari	Blood safety	cebotaris@mail.ru	
12.	Sayohat Hasanovas	WHO Programme Coordinator	hasanovas@euro.who.int	907 78 15 68

16 Sept, first day, Monday, first day		
03.40	Arrival to Dushanbe, Hotel Atlas	
12:00– 13:00	Working Lunch at Hotel Atlas	
13:30– 14:00	Security briefing at WHO office <i>Accompany: Rustam Bobojanov, logistic assistant, WHO TJK</i> Venue: WHO office	All team
14:00– 14:30	Meeting with TJK WHO WR Pavel Ursu <i>Venue: WHO Office, VEFA Center, 6th floor</i>	All team
14.30 – 17:30	Meeting with MOH and AIDS Center:	All team,

Break for coffee/tea at 16:00– 16:15	<ul style="list-style-type: none"> - Overview of Health system in Tajikistan, Bakhtigul Akazieva, Health Policy advisor, WHO Tajikistan - National Coordination Committee: Coordination and Governance of AIDS Programme, Firusa Nazarova, NCC Secretary - General situation with HIV/AIDS in Tajikistan; Programme implementation by Objectives, Ruziev Murodali, Director of National AIDS Center <p>Venue: WHO Office, VEFA Center, 6th floor</p>	National Team, NCC Secretariat
17:30 – 18:00	Finding of the first day and planning for the next	
17 Sept 2013, Tuesday, second day (Dushanbe, National AIDS Center)		
09.00 – 11.30	- Governing of the AIDS Programme, Ruziev Murodali, Head of the National AIDS Center	All team
11:30– 13:00	Visit to the National AIDS Center: Meeting with focal points	
	<p>Meeting with focal point: Alijon Soliev</p> <ul style="list-style-type: none"> - HIV C&T policy, coverage, access, equity, gender issues (and risk groups, general population, pregnant women); HIV prevention among risk and vulnerable groups (IDUs, SWs, MSM, migrants, youth); Monitoring of prevention programs among risk and vulnerable groups, including OST programme; M&E <p><i>Venue: Nat AIDS Center</i></p>	IDU; Sexual transmission HIV T&C M&E Civil Society HSS (BA)
	<p>Meeting with focal points: on ART, paediatric care and PMTCT</p> <p>Zukhra Nurlaminova and Tatyana Majitova, Shukhrat Gafarov, Mavzuna Murodova</p> <ul style="list-style-type: none"> - ART, PMTCT, policy and strategy, protocols and instructions, budgeting, drug procurement, service delivery; ART for infant and children, policy, strategy, service delivery; Treatment of TB&HIV co-infection); PMTCT Service provision Coverage with programme; PMTCT HIV T&C strategy, coverage 	ART (C&PH), PMTCT HSS (SK)
13.00– 14:30	Lunch Close to the AIDS Center	
14.45 – 17.15	<p>Visit to Dushanbe city Prison. Meeting with Rustam Nurov, focal point for Health in Prison</p> <ul style="list-style-type: none"> - HR programme including OST; ART; HIV C&T; M&E 	ART (Clin); IDU; M&E; Civil Society; HSS (SK)

	<i>Accompany: Alijon and Zukhro</i>	
14:45– 17:15	<p>Visit to Maternity Hospital #1</p> <ul style="list-style-type: none"> - PMTCT programme implementation - HIV C&T – - Reporting and recording <p>Accompany: Tatyana and Munira</p>	<p>PMTCT</p> <p>ST HIV C&T</p> <p>HSS (BA) ART (PH)</p>
17.15– 17.50	Transportation from prison to the Hotel	
17.15– 17.30	Transportation from Maternity House to the Hotel	
18:00– 18:30	Finding of the day and planning for the next day	All team
18 Sept, Wednesday (Dushanbe)		
09.00 – 12.30	<p>Visit to Republican Clinical Narcological Center after Minkhoj Gulyamov: Treatment of drug dependence (Malakhov M, Head of the Center)</p> <ul style="list-style-type: none"> - OST delivery (Irina Kim, focal point for OST) - Interview with patients 	<p>IDU</p> <p>Civil society involvement</p> <p>HSS (BA)</p>
09.00 – 11.00	<p>Visit to National STI Centre. Meeting with Director Azizullo Kosimov</p> <p>STI treatment; Coordination of Trust points for migrants and their family members; STI Laboratory; HIV T&C; Financing; integration with other services</p> <p><i>Accompany: Ahmadjon Sidikshoev</i></p>	<p>Sex transmission</p> <p>HIV C&T</p> <p>HSS (SK)</p>
11:15 – 12:30	<p>Visit to National scientific Blood Center, Aziz Odinaev, Director: donor blood testing for HIV and Hepatitis; Blood donorship development in Tajikistan; Visit to lab on blood processing; Financing, integration with other services</p> <p><i>Venue: National Blood Center</i></p> <p><i>Accompany: Ahmadjon Sidikshoev</i></p>	
09.00 – 11.00	<p>Visit to Dushanbe AIDS Center, Kobiljon Bukhoriev – Director</p> <ul style="list-style-type: none"> - ART; Implementation of electronic tracing of HIV cases 	<p>ART clin&PH</p> <p>PMTCT</p>
11.20 – 12.30	Visit to City Children TB Hospital: Sharipov Bobojon,	

	- Treatment of TB&HIV co-infection in children <i>Accompany: Tatyana Madjitova and Mavzuna Murodova</i>	
09.00 – 12.30	Sentinel surveillance Survey Meeting with M&E focal point Alijon Soliev <i>Venue: National AIDS Center</i>	M&E
12:30 –14:00	Lunch	
14.15 – 16.00	Visit to Reproductive Health Center - antenatal care of HIV positive pregnant - PMTCT programme implementation - HIV C&T - Reporting and recording <i>Accompany: Tatyana Madjitova</i>	PMTCT;HIV C&T; Sexual transmission ; HSS (BA)
14:00 – 16:00	Visit to the Infectious Hospital (Zarafshon): - Preparation to ART; Treatment of opportunistic infection	ART (Clin&PH)
16.30 – 17.30	Visit to Children Infectious diseases hospital (Kalandarova Surayo, Chapaeva hosp): - treatment of HIV+ children <i>Accompany: Zukhra Nurlaminova</i>	HSS (SK)
14:00 – 16:00	Visit to Dushanbe Trust point for IDUs (NGO SpinPlus) - N&S programme; Involvement in OST; Social support; Interview with IDUs and PL HIV; Involvement in CCM mechanism Venue: Pivzavod, Health Center #13 <i>Accompany: Alijon Solioev</i>	IDU; M&E; Civil soc
18.30– 19.20	Departure to Sogd oblast Group #2 Mode: Air	IDU, M&E, T&C; SexTrans, HSS (BA), SH
19 – 20 Sept, Thursday – Friday: Field work in Khatlon obl, and RRS Group 1		
19 – 21 Sept, Thursday- Saturday: Field work in Sogd oblast, Group 2		
Detail agenda for field visits attached		

21 Sept, Saturday (Dushanbe)		
09.00– 10:00	Laboratory monitoring of ART: visit to NRL AIDS (Hanifa and Zukhro) <i>Venue: Nat AIDS Center</i>	ART Clin&PH
10.15 – 11.15	Visit to Dushanbe city Polyclinics # 12 and 10 - Service delivery; Integration of services <i>Accompany: Tatyana Madjitova</i>	PMTCT HSS (SK)
11.30– 12.30	Visit to NGOs sites working with PL HIV involved in ART NGO Guli Surch – work with SW and PL HIV <i>Venue: Office NGO Guli Surch, Sherozi 27, apt 86, after Circus cycle, bus stor Agroinvertbank tel:</i>	
09.00 –	Meeting with OIM representative, Rukhshona Kurbanova and NGO representatives: Positive and Imdod (working with labour migrants and their family members) <i>Venue: WHO Office</i>	Civil society involvement
12.30 – 14.00	Lunch	
14.00 – 16.00	HIV under and post-graduate education. Meeting with: <ul style="list-style-type: none"> - head of infectious department of Tajik Institute of Post Graduate Education (Avzalsho Sharipov) - Epidemiological dept. of Tajik State Medical University after Avicenna (Aziza Pirova) - Medical colleague (nurse education) - MoH staff department <i>Venue: WHO office Accompany: Alijon Soliev</i>	All team
16:00– 18:30	Finding of the field trips Venue: Hotel Atlas	All team
22 Sept. 2013, Sunday (day off)		
23 Sept, Monday (Dushanbe)		

09.00 –10.15	Meeting with Dep. Minister Dr Azamjon Mirzoev and NCC Secretary Murotboki Beknazarov - MoH policy on HIV/AIDS; MoH collaboration with other ministries and agencies; MoH collaboration with development partners; High level coordination Venue: MoH Conference hall	All team
10.15 – 11.00	Meeting with Drug Agency Abdulazizov S. Accompany: Murotboki Beknazarov Venue: MoH Conference hall	IDU
10.30– 12.20	Visit to Maternity House N3 Accompany: Tatyana Majitova and Mavzuna Murodova	PMTCT ART
10.25 – 11.20	Meeting with Ministry of Labour Venue: WHO Office	Sex trs;HIV C&T, HSS; Civil society
11.25 – 12:20	Meeting with Committee for Youth, Sport and tourism, Miraliev Kiemiddin Venue: WHO Office	All team except PMTCT and ART
12:30 –14:00	Lunch	
14.10 – 15.10	Meeting with Committee for women and family	All team
15.10 – 16.10	Meeting with Religious Committee	Venue: WHO Office
16.20 – 17.20	Meeting with Ministry of Education	
16.20 – 17.20	Visit to NGO Legal Support providing services to MSM	ST
17:30– 18:00	Finding of the day and planning for the next day Venue: Hotel Atlas	All team

24 Sept, Tuesday		
09.00-10.00	Meeting with Ministry of Defense, Tamara Sharofovna Venue: WHO Office	HIV T&C; IDU, M&E
09.00-10.00	Visit to Dushanbe Youth friendly service center, Dushanbe city Reproductive Center, Bobokhojaeva Masuda	Sex trans Civil soc inv

09.00-10.00	Integration of HIV education in family medicine curricula Husniya – Dep for family physician, PGI Rahmatova Nargis – Rep Center for family physician	HSS
09.00-12.00	Visit to City AIDS Center	ART team
10.10- 12:30	Meeting with Tatyana, National AIDS Center Venue: WHO office	LKH
10.10–12:30	Meeting with AIDS service NGOs working with SWs, MSM, PL HIV 1. NGO “Legal support” (SW and MSM), Aziza Pirova 2. NGO “Guli Surch” (SW, PLHIV) Zevara Komilova 3. NGO “SpinPlus” (IDUs, PLHIV) – Pulod Jamalov 4. Center on Mental Health and HIV/AIDS, Manizha Haitova, Tajikistan 5. etwork of Women leaving with HIV, Takhmina Haidarova, 98 866 1900 (Dushanbe) 6. NGO “Marvorid” Mahmud Majidov 7. NGO “Fidokor”, Dilbar 8. NGO “Ruhavzo”, <i>Venue: WHO Office</i>	HSS, Lella, Sex trans
12.30 -14.00	Lunch	
14.00- 16:30	Meeting with international partners: <ul style="list-style-type: none"> - UNDP/GF – Ulugbek Aminov - HQP/USAID – Alisher Makhmudov, Zarina Musaeva, - UNICEF - Nisso Kasimova - UNAIDS – Nasiba Saidova - UNFPA – Firuz Karimov - USAID – Dilorom Kasimova - UNODC – Mutabara Vohidova - ICAP – Saidmumin Kholov - CDC – Aziz Nabijanov - IOM – Rukhshona Kurbanova - Tajikistan OSI Soros Foundation - Nigora Abidjanova - AFEW – Ibragimov Ikrom and Dilshod Pulatov - PSF, Khursheda Rahmatova - UN Woman – Barno Mukhamadiev/UN Women National Programme Officer and Zarina Urakova/Programme Associate - ILO, Takhmina Mahmud - GIZ – Mavjigul Azizulloeva <i>Venue: VEFA Center, WHO Office</i>	All team
15:00	MoH, Mother and child, Rahmatulloev Sherali	LKH
17:00	Meeting with Ryan, UNDP laboratory consultant	LKH
17.00 -17.30	Wrap up: conclusions and recommendations	All team

	<i>Venue: Hotel Atlas</i>	
25 September, Wednesday		
09.00 -12.00	Discussion of main findings and recommendations. Preparation to the De-briefing Venue: WHO Office	All team, TJK WHO HoO Pavel Ursu
12:30-14:00	Lunch	
14:00-16:00	<p>Debriefing:</p> <ul style="list-style-type: none"> - MoH: Dep minister, head of all departments - Team of the National AIDS center - TSMU, TPGI, medical colleague - MoJ, MoE, Mo Defence, Youth Committee, NCC Secretariat, Religious Committee, Women and Family - UNDP/GF – Tedla Mezemir, Ulugbek - HQP/USAID – Alisher Machmudov, Zarina Musaeva, - UNICEF - Leila Moshiri, Nisso Kasimova - UNAIDS – Nasiba Saidova - UNFPA – Aziza Hamidova, Firuz Karimov - UNODC – Mutabara Vohidova - ICAP – Saidmumin Kholov - USAID – Dilorom Kasimova - CDC – Aziz Nabidjanov, Rezida Ashurova - IOM – Rukhshona Kurbanova - Tajikistan OSI Soros Foundation - Nigora Abidjanova - AFEW – Ibragimov Ikrom and Dilshod Pulatov - PSF, Khursheda Rahmatova - UN Woman, Barno Mukhamadieva/UN Women NPO - ILO, Takhmina Mahmud; - GIZ – Manzura Mirsaidova, Mavjigul Azizulloeva - NGO SpinPlus, Pulod jamolov - NGO Guli Surch – Sevara Komilova - Legal support, Aziza Pirova - Nabzi Solim, Bobokhojaeva <p>Venue: UNDP Office, 39 Aini str</p>	

AGENDA FOR FIELD VISIT

19 – 20 Sept, Thursday – Friday, Group 1, Khatlon Oblast

I. External Review Group

1. Yurii Kobyscha, Team leader, Expert on Treatment and Care
2. Svetlana Antonyak, Expert on Treatment and Care
3. Jadranka Mimica – Expert on prevention of mother to child transmission
4. Lella Cosmaro, Expert on strengthening community systems
5. Sowmya Kadandale- Expert on strengthening health systems (Human Resources, Financing, Leadership, Governance and Management)
6. Zafar Khamidov – Communicable disease assistant, WHO Tajikistan, logistic support

II. National Team

1. Ruziev Murodali – director of National AIDS Center
2. Murotboki Beknazarov – NCC Secretary
3. Zuhra Nurlaminova, head of Dispancery dep-t, National AIDS Center
4. Tatyana Majitova – Focal point for HIV among newborn and childhood, National AIDS Center
5. Mavzuna Murodova – Focal point for PMTCT, National AIDS Center

III. Other partner: UNICEF – Nisso Kasimova

19 September, Thursday (Khatlon oblast)		
08:00 – 10:00	Departure/arrival to Khatlon oblast, Kurgan-tube Regional AIDS Center	All Team
10:00 – 10:30	Meeting with Oblast Health Dep-t: Sherali Buzmakov, Head	All team
10:30 – 11:00	Visit to Oblast AIDS Center: Meeting with the Director - HIV epidemiological situation in Oblast; Programme response; – integration with other services	All team
11:10 – 12:50	Work in the District AIDS Center to cover: - treatment and care - PMTCT - HIV C&T - TB/HIV Co-infection treatment - HIV and Hepatitis, STI	Treatment, care and support PMTCT (11.10-11.50)
11:10 – 12:50	Meeting with NGO and CSOs representatives: Visit to NGO Fidokor Office: NGO Orzu+ (interview with PL HIV); NGO Fidokor; <i>Subhi Tandurusti (Parvina Giyasova; NGO Akhtary Backt (working with migrants)</i> - Visit to Trust point for SWs. Brunch of Guli Surch, Ali Kurbongul, <i>Venue: Trust point for SWs</i>	Civil society involvement
11:10 – 12:50	Health system issues: Health Financing and AIDS programme financing at Oblast level; integration of services - meeting with Head of Oblast, Oblast Finance dep-t and Director Oblast AIDS Center	HSS
13.00 – 14.00	Lunch	
14.00 – 17.00	Visit to Oblast Infection Hospital (treatment of opportunistic diseases)	ART PMTCT

	Visit to Oblast Center for Reproductive Health Visit to Oblast Maternity Hospital	
14.00- 15.30 15.30 -17.00	Coordination, Governance and financing - Meeting with Oblast NCC Secretary - Meeting with Oblast Health dep-t (member of NCC) - NGO representative at CCM (NGO Subhi Tandurusti))	HSS Civil society involvement
17:30 – 18:30	Return to Dushanbe	All team
20 Sept, Friday (Tursun-zade district)		
08:00 – 09.00	Departure/arrival to dist	All Team
10:00 – 11.00	Meeting with dep Head of district Health department Visit to district AIDS Center, meeting with the Director - HIV epidemiological situation; Programme response; Epidemiological surveillance; Integration with other services; Programme financing	All team
11:00 – 12.00	Visit to district AIDS Center - treatment and care; HIV C&T, interview with patients - TB/HIV Co-infection treatment - HIV and Hepatitis, STI - laboratory follow-up - PMTCT	Treatment, care and support PMTCT
12:00 – 13:00	Visit to district Reproductive Center	ART, PMTCT
11:00 – 12:00 12.00- 13:00	Service Delivery - Visit to Friendly cabinet for SW (focus group) - Visit to Youth Friendly Services cabinet	Civil society involvement; HSS
13.00 – 14.30	Lunch	
14:30 – 15.30	Visit to Trust point for IDUs - involvement in HR programme, OST, C&T, ART and treatment adherence; Interview with clients	ART, PMTCT Civil society involvement
15.30 – 16.30	Visit to district Maternity House	ART, PMTCT

15.30 – 16.30	<p>Visit to NGO site providing social support Gender and development, Nargis Saidova, 988252505</p> <ul style="list-style-type: none"> - HIV counseling and transferring to testing; Support to treatment, treatment adherence; Awareness raising; collaboration with Health services - <i>Venue: YFS</i> 	Civil society involvement
14:30 – 16:30	Meeting with Head of district Hospital Dilbar Burakova	HSS
16:30 –	Departure to Dushanbe	All team

AGENDA FOR FIELD VISIT

19 – 21 Sept, Thursday – Saturday, Group 2, Sogd Oblast

I. External Review Group

1. Lali Khotenashvili, Team Leader, Expert on HIV Counselling and Testing,
2. Ulrich Laukamm-Josten, Co-team leader, Expert on sexual transmission of HIV
3. Emilis Subata, Expert on HIV transmission through injecting drug use
4. Otilia Scutelnicuic, Expert on strategic information through surveillance, monitoring and evaluation
5. Bakhtigul Akazieva, Expert on HSS
6. Sayohat Hasanova – Communicable disease assistant, WHO Tajikistan, logistic support

II. National Team

1. Alijon Soliev, Head of M&E dep-t, National AIDS Center

19 September, Thursday (Sogd oblast)		
09:00 – 09:30	Meeting with: <ul style="list-style-type: none"> - Oblast Health Dep-t, Sobirov Sobirjon Islamovich - Dep Head of Oblast Khukumat, Babaeva Mavjuda Valievna <i>Venue: Oblat Khukumat</i>	All Team
09:45– 10:45	Visit to Oblast AIDS Center: Meeting with the Director, Abduv Abdukarim Salimovich <ul style="list-style-type: none"> - HIV epidemiological situation in Oblast - Programme response - integration with other services <i>Venue: Oblast AIDS Center</i>	All team
11.00 – 12.30	Meetings at Oblast Khukumat level: financing, integration of services	HSS
10:50 – 12:30	Work with focal point of Oblast AIDS Center, Babajanov said Madjotovich <i>Venue: Oblast AIDS Center</i>	HIV T&C, M&E, IDUs,
11.00 – 13:00	Visit to: <ul style="list-style-type: none"> - Friendly cabinet for SWs in AIDS Center, Albina, NGO “Rohi Zindagi” 	Sexual transmission

	<ul style="list-style-type: none"> - Friendly cabinet for migrants and their family members, NGO AntiAIDS, NGO "SAID" OIM NGO (Махмудов Мансур 92 792 56 00) and "Chashmai Najot", OIM NGO - Interview with NGOs <p>Accompany: staff from AIDS Center</p>	
12.30 – 14.00	Lunch	
14.00 – 17.30	Visit to Spitamen district: possibility of integration of HIV/AIDS services into PHC services	HSS
14:10 – 15.10	Visit to Oblast STI Center: STI treatment, laboratory, Syndrom treatment of migrants and their families	Sex transmission HIV C&T
15.20-16.20	<p>Visit to Youth friendly cabinet, Oblast Center for Reproductive Health</p> <ul style="list-style-type: none"> - YFS work - PMTCT <p>Visit to NGO Akson working MSM</p>	
16.20 – 17.20	Jabarova Azimjon, 927072927, р-н Шелкомбината)	
14.00 – 17.30	Meeting per request: Sentinel Surveillance and electronic tracing	M&E
14:00 – 15:30	<p>Visit to Narcological center: – Treatment of drug dependence</p> <ul style="list-style-type: none"> - OST delivery - Interview with patients <p>Visit to Trust point: N&S exchange programme. NGO Dina</p>	IDU
15.45- 17.30	27 mikrorayon, NSE point, Drop-in Center, Nematov Ilhom,	
18.30 – 20.30	Dinner	All team
20.00 – 22.00	Outreach work	All team
20 Sept, Friday (Isfara district)		
08:00 – 10.00	Departure/arrival to dist	All Team
10:00 – 11.00	<p>Visit to district AIDS Center, meeting with the Director</p> <ul style="list-style-type: none"> - HIV epidemiological situation in Oblast - Programme response - integration with other services 	All team

11:15 – 12.00	Visit to Reproductive Health Center	Sex transmission
12.00 – 13.00	Visit to Friendly cabinet for migrants and their family members (MoL working together with the MoH providing outreach, Hasanova Kholbibi, 93 500 54 77)	HIV C&T
11.15–13.00	Visit to Trust point for IDUs, NGO DINA: N&S Exchange programme, social work, interview with PL HIV	IDU, HSS
11:05 – 13:00	Meeting with M&E focal point M&E; Reporting and recording; Sentinel surveillance, electronic tracing	M&E
13.00 – 14.00	Lunch	
14.15 – 15.15	Visit to district Friendly Cabinet for SWs	Sex.transmission
15.20 – 16.20	Visit to Trust point for migrants and their family members	HIV T&C;M&E, HSS
14.00 – 16.20	Meeting with manager and social worker of the Trust point for IDU	IDU
16:20 – 18.20	Departure to Khujand and overnight in Khujand	
21 Sept, Saturday		
08.00 – 09.00	Departure to Dushanbe Mode: air	All team

ANNEX 4: Key indicators, PWID, SW, MSM and prisoners, IBBS 2005-2013

To be provided separately

ANNEX 5: HIV M&E plan – comments on indicators

To be provided separately



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