Central Asia Region

Operational Plan Report

FY 2013

Note: Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.

Operating Unit Overview

OU Executive Summary

CAR Regional Operational Plan FY 2013: Executive Summary

Country Context

Central Asia is one of the few regions in the world where the HIV epidemic is still on the rise. While HIV incidence is declining globally, WHO estimated in 2011 that the number of people newly diagnosed with HIV in the Central Asia Region (CAR) increased 14-fold between 2000 and 2011 (WHO European Action Plan for HIV/AIDS for 2012-2015, 2011).

HIV transmission in CAR is driven by people who inject drugs (PWID) located in urban centers and along drug transport corridors from Afghanistan through Tajikistan (TJ), Turkmenistan (TK), Uzbekistan (UZ) Kyrgyzstan (KG) and Kazakhstan (KZ). The United Nations Office on Drugs and Crime (UNODC) estimates that 20% of heroin shipped from Afghanistan passes through CAR and approximately 11 metric tons per year are consumed in the region, where PWID constitute up to 1% of the adult population. In towns on the Afghan border of TJ, the cost of an average dose of heroin is reported to be less than a bottle of beer, although the cost rises each time the contraband crosses a border on its way north to KZ, Russia and beyond. In TJ, the cost of sterile injection supplies compared to the cost of heroin is significant, and the reported prevalence of HIV infection among PWID is 17-23%. In KG, the cost of a syringe at a pharmacy is four times higher than the cost of a dose of heroin, and the Republican AIDS Center reports that as of February 1, 2013, 2,635 PWID, or 59.7% of all registered PWID, were infected with HIV. In KZ, where the per capita GDP is considerably higher, the additional cost of a clean syringe is less significant, and HIV prevalence among PWID is 3-4%.

While the primary driver of HIV transmission has been the use of contaminated injection supplies, there are indications that the epidemic is expanding, primarily through sexual transmission from PWID to their sex partners. The proportion of newly registered HIV cases in Kazakhstan attributable to sexual transmission increased from 20% in 2006 to 51% in 2011, and in Kyrgyzstan, from 30% in 2006 to 33% in 2010, and mirrors the general trend in the neighboring countries of TJ and UZ. (Triangulation of the data from Kazakhstan suggests that the proportion of sexually-transmitted infections may be overstated, but the trend is genuine.)

The overlap between unsafe injecting practices and unsafe sexual practices is manifested in high HIV infection rates in CAR's key populations: approximately 8% of UZ sex workers inject drugs, 50% of female PWID in TJ have provided sex services in exchange for drugs, money or food, and less than 50% of TJ

PWID reported use of a condom during intercourse with sex workers. In KG, syphilis prevalence, another marker for unsafe sexual practices, was 32% among SW, 16% among prisoners, and 13% among MSM and PWID. High prevalence of HIV among prisoners and detainees is related to high rates of incarceration of PWID, as well as unsafe injecting and sexual practices during incarceration. In 2010, 3% (KZ) to 9% (TJ) of all registered HIV cases were among prison populations.

Recent surveillance data shows declines in HIV incidence in KZ and KG, but triangulation of these data with information on coverage and quality of prevention programs suggests that the declines may be an artifact of increased testing among low-risk groups and decreased testing among key populations. Recent USG-supported assessments of integrated bio-behavioral surveillance (IBBS) also revealed problems in sampling methodology and biases in data collection that could significantly skew the true incidence among key populations.
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KG: Between 2009 and 2011, the number of officially registered cases of HIV infection increased by 43%, from 2718 to 3887, respectively (source ICAP 2012 Care and Treatment Assessment), with an estimated 12,040 people living with HIV (PLHIV). (Source: 2012 UNGASS Report). In 2011, 60% of registered cases were attributed to injecting drug use, and 6% to nosocomial transmission. The HIV prevalence at surveillance sites, according to 2010 IBBS data, is 14.6% among PWID and 3.5% among SW. As of February 1, 2013, the Republican AIDS Center had registered 4.643 cases of PLHIV, with 66.8% of cases attributed to parenteral transmission, 29.8% to sexual transmission, and 3% to vertical transmission.
KZ: As of December 2012, the Ministry of Health (MOH) had registered a total of 19,778 PLHIV, including 2215 new cases in 2012. The HIV prevalence at surveillance sites, according to recent IBBS data, is 3.8% among PWID, 1.5% among SW, and 1% among MSM.

TJ: According to the 2012 UNGASS Report 3,846 PLHIV had been registered since 1991; however, the Republican AIDS center estimated in 2011 that the total number of PLHIV was over 12,000. Most HIV infections are in PWID, although the proportion with sexually transmitted infections increased from 17% in 2006 to 30% in 2011. The HIV prevalence at surveillance sites, according to recent IBBS data, is 16.2% among PWID, 4.4% among SW, and 1.7% among MSM.

UZ: The CAR nation with the highest number of persons living with HIV/AIDS is Uzbekistan. As of December 2011, the Ministry of Health (MOH) had registered a total of 21,542 PLHIV, including 3584 new cases in 2011. The estimated number of PLHIV was 28,000 in 2009, when UNAIDS put the prevalence at 0.15% of the adult population. In 2012, UNAIDS adjusted the estimated prevalence up to 0.5%, suggesting that the number of PLHIV may be upwards of 75,000. The HIV prevalence at surveillance sites, according to recent IBBS data, is 8.4% among PWID, 2.2% among SW, and 0.7% among MSM.

Other Contextual Factors
Gender norms among most-at-risk populations in CAR countries, and in particular gender-based violence, play a significant role in limiting access by both males and females to prevention, treatment and care services. However, there continues to be limited knowledge of gender-specific needs and gaps in country HIV/AIDS programs, with little or no gender-specific data to inform policies and approaches. As a result, programs generally pay limited attention to gender needs. For example, since PWID are predominantly male, harm reduction services for PWID tend to focus on the needs of male injection drug users (IDUs) but pay little attention to the needs of their female sexual partners or to those of female IDUs. Stigma and discrimination, as well as gender-based violence, are also gender-linked in CAR, most acutely against female IDUs, female sex workers and men who have sex with men (MSM), and must be addressed in increasing access to services

Daunting challenges in implementing effective HIV services for key populations in CAR remain. In Kyrgyzstan and Tajikistan, HIV programs are supported almost entirely by GFATMREDACTED . In TJ, GFATM grant funds are almost depleted, and the Transitional Funding Mechanism has no capacity for scale-up of pilot activities. In KG, despite greater openness to the expansion of Medication-Assisted Treatment (MAT), there is political support to cover no more than 10% of PWID with this service. In KZ, while a USG assessment was instrumental to a high-level policy decision modestly expanding MAT pilots, coverage was capped at 500 PWID REDACTED In 2014, KZ faces the end of its GFATM grants, which provide nearly all funding for the NGOs that are the primary means of reaching key populations. In UZ, although 4200 PLHIV are currently receiving ARV treatment, over 1700 are on the waiting list, with a total of 8000 expected to be in need of treatment by the end of 2013. As a result, the GFATM has redirected its resources entirely to the procurement of ARV drugs, eliminating previously-planned technical assistance (TA) for the effective implementation of treatment protocols. In all CAR countries, the lack of effective referral and tracking systems among HIV, TB, STI, reproductive health, narcology, and other vertical programs important to key populations, underlines the need for health systems strengthening work if greater coverage and retention of key populations is to become a reality. In all CAR countries, the relationship between government providers and NGOs needs REDACTED to strengthen the policy and regulatory foundations, as well as the organizational and institutional capacities needed to support an effective continuum of care from NGO-implemented prevention activities to facility-based health services.

How USG fits into CAR Country HIV/AIDS Responses
Countries across the region do not consistently have in place national HIV/AIDS programs with the resources and approaches needed to effectively contain the growth of the epidemic. Kazakhstan, for example, does not have a National HIV/AIDS Program, although HIV/AIDS is incorporated into its national

health program. Kyrgyzstan, Tajikistan and Uzbekistan have National HIV/AIDS Programs that recognize the concentrated nature of the epidemic and support scale up of prevention, treatment and care services. Turkmenistan's recently approved 2012-2016 National HIV/AIDS Program acknowledges the country's HIV/AIDS epidemic and the need to harmonize national laws with international practices. REDACTED Concentrated work REDACTED to improve national HIV/AIDS investment decisions and policies is key to making inroads into the epidemic across the region.

KZ: The Government of Kazakhstan does not have a specific HIV strategy. The State Program of Healthcare Development for 2011-2015 covers some aspects of HIV prevention, ART, laboratory equipment and test kits, annual integrated Bio-Behavioral Surveys, and MAT pilots, all paid for out of the State budget. REDACTED According to the 2012 UNGASS report, 83.3% of PLHIV eligible for ART are being treated.

KG: In December 2012, the Government of Kyrgyzstan approved a National AIDS Program for 2012-2016 which increases the government's share of the financing for anti-HIV activities. At present, Kyrgyzstan is totally dependent on Global Fund and other donor resources for procurement of ART, laboratory supplies, and other commodities. According to the 2012 UNGASS report, 31% of PLHIV eligible for ART are being treated.

TJ: In 2010, the Government of Tajikistan approved its fourth National AIDS Program (NAP) for 2011-2015, financed largely by international donors. The GF finances all ART, test kits and equipment, but GF support is currently limited to transitional funding and, according to the 2012 UNGASS report, the budget deficit for the NAP is more than $98 million.

UZ: In 2011, the Government of Uzbekistan approved the National HIV/AIDS Program for 2012-2016, 39% of which is funded by the GF and other donors. According to the 2012 UNGASS report, 81% of PLHIV eligible for ART are being treated.

The USG is focusing on improving the quality of HIV/AIDS sentinel surveillance systems, which have been fully owned and implemented by host governments since 2010. Assessments of IBBS conducted by USG in KZ, KG, TJ, and UZ have been followed by public presentations of findings and development of targetedTA work plans to address identified weaknesses. During the planned IBBS in FY2013 and 2014, additional data will be gathered on non-injecting sexual partners of PWID to generate a more complete description of the epidemic and key affected populations in CAR. The USG has also conducted trainings in the region on size estimation for key populations. REDACTED

PEPFAR Coordination with Other Donors, Other USG Programs, the Private Sector

There are limited numbers of other donors or partners currently involved in HIV/AIDS in CAR. The World Bank (WB) Central Asian AIDS Control Project ended in December 2010, and the WB does not currently support HIV/AIDS-specific programs in any CAR countries. In prior years, the USG worked closely with the WB on efforts to support the broad reform of national health systems and the implementation of

reformed health care models. The USG also provided significant technical assistance to support Kyrgyzstan's sector-wide approach to health sector reform and financing. Looking forward, however, the USG believes that it will use resources more efficiently and achieve greater impact in HIV/AIDS by working with appropriate donors and stakeholders on strategically targeted activities to improve the capacities, systems, and policies needed to strengthen the availability and quality of HIV/AIDS services for key populations.

The USG has evaluated each country's national HIV response strategy, mapped other development partner initiatives, and reviewed current USG programs against CAR PEPFAR strategic objectives to identify areas of intervention with greatest potential impact on the epidemic. To refine detailed country plans for USG assistance, USG agency representatives and implementing partners hold ongoing on-the-ground consultation meetings and discussions with country HIV/AIDS development partners and stakeholders, including host-government agencies (MOH, Republican AIDS, Narcology and Blood Centers, and the penitentiary system); the Global Fund to Fight AIDS, TB and Malaria (GFATM); UNAIDS; UNODC; other bilateral and multilateral donors such as GIZ; NGOs; PLHIV coordinating bodies; and other civil society representatives. The USG tailors country work plans to meet the unique circumstances of each country in order to support national program priorities, leverage resources of the GFATM and other donors, and build on areas of USG comparative advantage to further PEPFAR CAR's overarching goals and objectives.

In KZ, KG, TJ, and TK, the USG conducts joint planning with GFATM Principal Recipients (PRs) and Sub-Recipients. In KZ, KG, and TJ, the USG PEPFAR team has initiated formal PEPFAR consultation and work plan reviews to strengthen collaboration between the USG, Ministries of Health, GFATM and other key development partners. USG representatives and USG-funded partners meet frequently and informally with the GFATM PRs to share work plans, jointly plan specific activities, map out coverage for each program, and identify areas of specific technical support for grant implementation.

During FY 2013, the USG will intensify efforts to collaborate more effectively with the Global Fund so that successful models developed by USG in service-delivery pilots, as well as in targeted capacity-building activities, can be scaled up to achieve greater impact in coverage, testing, treatment, and retention of key populations. In order to achieve better collaboration with the Global Fund, especially in light of the challenges mentioned above under “Contextual Factors,” USG is re-tooling its Global Fund Liaison position and will be recruiting a senior US PSC with the necessary skills to interface with PRs and fund portfolio managers (FPMs) for more substantive and strategic leveraging of PEPFAR's technical strengths with GFATM's financial resources.

During FY 2013, the USG will continue its successful leveraging of non-PEPFAR-funded global health

programs in the fight against HIV in CAR. For example, USG programs will combine PEPFAR and non-PEPFAR TB funding streams to address HIV-TB co-infection; will use TB funding that supports migrant programs to identify and refer individuals at high risk of HIV infection for testing and services; and, in selected areas of high concentrations of key populations, will utilize targeted PEPFAR resources to strengthen linkages between HIV outreach and appropriate primary and specialized services, building on prior non-PEPFAR investments to enhance the delivery of primary care service systems. CDC also trains MOH officials in practical epidemiology through its Field Epidemiology Training Program (FETP), and FETP students and graduates are utilized to investigate clusters of HIV infection in clinical settings, identify practices contributing to nosocomial transmission, and make recommendations for improvements in infection control policy and practice. CDC's Global Disease Detection program also supports self-assessment of injection safety practices in all five CAR countries, and in Uzbekistan supplies UNDP (GFATM PR) with protocols and instruments to conduct independent Injection Safety assessments.

Although it has had limited success to date in working with the private sector on HIV/AIDS programming, the USG will continue to attempt to identify, as feasible, opportunities for targeted public-private partnership in HIV/AIDS. USG's work with Chevron in Turkmenistan is a notable example of collaboration, in which Chevron jointly supports HIV prevention activities targeted at high-risk youth and injection drug users through a program which is fully endorsed by the Government of Turkmenistan. However, private sector partners in general continue to hesitate to engage in work with key populations REDACTED Nonetheless, despite the stigma associated with HIV/AIDS and prevention among at-risk populations, the USG will continue to target local, national, regional and international companies working in the region to advocate for collaboration in support of HIV/AIDS prevention work with key populations.

Progress against the CAR Regional Strategy

The USG interagency team reviewed progress toward the regional PEPFAR CAR strategy goals with the aim of identifying areas of focus for ROP 13 to further regional strategic objectives. To improve access to services by key populations as outlined in Objective One, ROP 13 resources will continue to support and expand comprehensive outreach activities. During FY 2013, the USG will also intensify efforts to improve service quality and comprehensiveness by expanding public sector – NGO collaboration to increase access to services; improving referral linkages and systems; and, as feasible, continuing to promote country uptake and institutionalization of evidence-based approaches. In support of Objective Two, the USG will continue to provide targeted technical assistance, training and mentoring to strengthen the capacities of public and NGO providers to provide and manage improved services, improve HIV diagnostics and contain nosocomial transmission. Finally, through Objective Three, the USG will continue to support activities to improve the quality, availability and utilization of strategic information for program management and policymaking.

Changes from the 2012 ROP

During FY 2013, PEPFAR CAR will give greater focus to the expansion of outreach services that promote sexual prevention, counseling and testing and HIV-TB interventions among greater numbers of key populations. The USG will eliminate HIV work with migrants REDACTED and will increase essential prevention work with PWID, MSM, SW and prisoners to contain growth of the epidemic. In addition, building on foundational policy work and capacity development initiated during FY 2012, PEPFAR CAR will blend support for pilot interventions, systems strengthening and capacity building activities to expand access to rapid testing as a potential tool to reach increased numbers of key populations and link individuals with services. FY 2013 programs will build on limited prior year support for pilot activities by strategically expanding the implementation of models that demonstrate improved access by key populations to more comprehensive, higher quality services. The USG will promote country ownership and institutionalization of successful models through more effective policymaking and increased NGO engagement in advocacy and service quality improvement.

Response to FY 2013 funding level priorities

Refocusing the Investment Approach: The USG will address priority investment approaches highlighted in the FY 2013 funding level letter by: a) expanding outreach prevention activities to reach greater numbers of beneficiaries; b) continuing to support pilot and demonstration activities and related targeted policy advocacy to enhance the service continuum and expand access by key populations to comprehensive services such as rapid testing; and, c) promoting institutionalization of best practices into indigenous and donor-funded services and systems. The USG will review progress to date and expand the use of multidisciplinary teams to additional sites; assess the effectiveness and consider scale up of pilot entry points (targeted at areas of high concentrations of MARPs), as mechanisms for linking and referring key populations to appropriate services and care; and undertake other approaches to build partnerships between public and NGO institutions to enhance access to services. PEPFAR CAR will also strengthen the capacity of AIDS centers to provide quality services to key populations by: a) defining a minimum package of services to be offered at trust points, MAT dispensaries, drop-in centers and mobile units; b) improving linkages and referrals to other vertical systems that provide care to key populations, including TB, narcology, STI and reproductive health systems; c) building data-sharing capacity to ensure tracking of referrals and allow follow-up of missed referrals; and d) promoting the engagement of NGOs that represent key populations in the design, delivery and improvement of preventive, diagnostic and treatment services for greater uptake and adherence.

Ensure Timely Replacement of the PEPFAR Coordinator: The USG submitted a Position Description (PD) for a CAR PEPFAR Coordinator to OGAC in December and is prepared to finalize, advertise and recruit a Coordinator as soon as the position is approved by OGAC. In the short-term, the USG interagency team

recruited a highly experienced interim Coordinator who is arriving o/a March 1 for approximately three months and who will assist the team to recruit and select a Coordinator.

Demonstrate Meaningful Multilateral Engagement: The USG continues to work closely with the GFATM. USG implementing partners and USG PEPFAR team members meet regularly with Global Fund counterparts at the country level to discuss opportunities for leveraging resources and collaborating on approaches. As one example of collaboration, a USG implementing partner uses a voucher referral system to link key populations to condoms, naloxone, syringes and other commodities and services provided through the GFATM. During 2012, USG partners in KG also provided TA to the GFATM to support the development of guidelines for the provision of rapid testing by NGOs, to evaluate the readiness of selected NGOs to participate in GFATM-led rapid testing pilots; and to assess supply chains for test kits. During FY 2013, the USG intends to expand activities in support of oral rapid testing services by NGOs and selected public facilities, building on lessons learned from rapid testing pilots.

Conduct a Portfolio Review: The USG country team conducted a review of progress against the CAR strategy to highlight areas of focus in ROP 13. After submission of the FY 2013 ROP, the USG will conduct further program portfolio reviews, both by partner and program area, to assess performance and inform detailed planning for FY 2013 activities.

Optimize the Quality and Usage of Strategic Information: CAR PEPFAR programs will continue to focus on improving the quality and use of data for evidence-based planning and policymaking. Technical assistance will aim to enhance knowledge of the epidemic (including size of key populations), to improve approaches to surveillance of behaviors and seroprevalence among key populations, and to strengthen information systems at HIV/AIDS service delivery sites to enable improved management of clients.

Continue to Manage Excess Pipeline: CAR PEPFAR has utilized nearly all available pipeline in planning for implementation of ROP 2013 programs.

PEPFAR Focus/Program Overview for FY 2013
Building on efforts to date, USG programs in FY 2013 will concentrate on the following:
Targeted Expansion of Prevention Services
USG programs will provide direct support to scale up high-impact, evidence-based prevention services for key populations -- particularly people who inject drugs (PWID) and their sexual partners, people living with HIV/AIDS (PLHIV), sex workers (SW), men who have sex with men (MSM), and prisoners. The USG will utilize existing partners and one new partner to expand outreach efforts to new geographic areas within Tajikistan and Kyrgyzstan, undertake targeted in-reach activities to PWID prison populations in two CAR countries, and support other approaches partnering NGOs and the public sector to reach greater numbers

of at-risk individuals and link them to services. In order to provide key populations contacted with coordinated care, the USG will use models that integrate outreach with facility-based services. USG-supported approaches such as multidisciplinary teams (MDTs), primary health care entry points in areas of high concentrations of MARPs, and NGOs based at HIV/AIDS service sites will intensify case management and enhance referral linkages from outreach to treatment, care and support services. Strengthened collaboration between government and nongovernmental sector will aim to increase access to more comprehensive services, reduce constraints to care, including stigma and discrimination, and improve adherence to treatment. Enhanced referral linkages will promote uptake by key populations and PLHIV of essential prevention, treatment and care services, including evidence-based prevention of sexual transmission, counseling and testing (HTC), medication-assisted treatment (MAT), and psychosocial and clinical support aimed at improving retention and adherence to treatment.

During FY 2013, to expand outreach to additional numbers of key populations, a new USG HIV mechanism will focus on in-reach interventions aimed at improving prison-based HIV prevention services, including MAT, and strengthening linkages between penitentiary institutions and HIV service centers. The USG may also pilot an integrated TB-HIV-MAT pilot in selected prison sites supported with TB funds The USG will also undertake additional activities with NGOs to expand MARP access to counseling and testing through approaches such as NGO peer counseling interventions at AIDS centers and NGO engagement in mobile unit activities.

The USG recognizes that treatment is not only an end goal but also a key prevention intervention; thus, USG programs will aim to both increase the number of people going into treatment and improve treatment quality through activities to enhance service guidelines, lab services and strengthened service systems. The USG will conduct enhanced TA pilots to improve quality of care and treatment services with training and mentoring support at two sites in Kyrgyzstan, three sites in Kazakhstan and three sites in Tajikistan; support revision of national protocols on HIV clinical management; and assist in the development of training materials on clinical management of HIV, including adherence support and palliative care.

Development of Systems to Expand Access to Quality Rapid Testing
Through NGO-based outreach activities as well as in selected service delivery sites in Kazakhstan, Kyrgyzstan, and Tajikistan, USG agencies will collaboratively pilot and monitor rapid testing interventions as a tool to promote access to care by key populations. To the extent possible, USG will promote regional sharing of protocols, training standards, confirmation algorithms, and quality management systems for rapid testing. Across the region, however, policies on rapid testing vary and require tailored approaches. KG: During FY 2012, the USG collaborated closely with the GFATM to promote access to rapid testing in Kyrgyzstan, leading to the revision of HIV testing policy to support implementation of a pilot activity in oral rapid testing by NGOs. USG partners collaborated in the development of clinical guidelines for the pilot,

and assessed the capacity of selected GFATM NGOs to manage the six-month pilot activity, including such factors as their capacity to store and transport test kits. During FY 2013, based on lessons learned during the initial pilot, the USG will develop targeted interventions and systems to expand access to quality rapid testing and to implement rapid testing as a screening intervention with facility-based confirmatory testing to improve knowledge of serostatus among key populations and promote entry to care.

KZ: In Kazakhstan, USG will support development of rapid testing standardization and quality management protocols. Since rapid testing is available only in medical settings, the USG will support efforts to expand rapid testing within targeted Primary Health Care facilities, Trust Points, and other service-delivery points utilized by key populations, and will also support approaches to link key populations accessed through outreach activities to rapid testing.

TJ: In Tajikistan, the USG will work with the GFATM to promote and monitor pilot use of rapid testing in PHCs and through NGOs.

UZ: Responding to requests from the MOH and GF PR, USG will provide TA to develop quality management systems to expand access to quality rapid testing, and will share lessons learned from rapid testing pilots in KZ, KG and TJ.

As part of its preparation for ROP 2013 and in recognition of the importance of assessing the potential application and scale up of rapid testing in CAR countries, the USG is also prepared, if approved by OGAC, to submit an implementation science grant proposal to support the piloting and monitoring of rapid testing as a screening tool.

Impact Assessment: As part of its preparation for ROP 2013, and in recognition of the importance of locally-generated evidence in advocating scale up of rapid testing in CAR, the USG plans to conduct a small study on the impact of availability of rapid testing on uptake of HCT and knowledge of HIV status among key populations. The USG is also prepared, if invited to apply, to submit an implementation science grant proposal to support the piloting and monitoring of rapid testing as a screening tool.

Continued Support for Pilot and Demonstration Activities to Expand Access to Services

During FY 2013, the USG will support the continued identification, development and implementation of pilot and demonstration activities and related targeted capacity development activities to provide countries with models for implementation and, assuming available resources and political will permit, for potential scale up to expand access by at-risk-populations to HIV/AIDS services. To achieve this end, the USG will review the effectiveness of, and assist country institutions (public organizations and NGOs) to expand collaborative partnerships in areas such as: a) targeted ‘entry points’ or localities which bring together government officials, medical staff, NGOs and MARP representatives to link MARPs with a range of facility-based testing, treatment, care and support services; b) “one-stop shops”, through which MARPs can receive, on a pilot basis, antiretrovirals and other services in one location, at selected polyclinics, as well as referrals to other services; and c) placement of multidisciplinary teams or NGO social workers on

site at HIV/AIDS service centers.

Pilot and demonstration activities will aim to address logistical, regulatory and attitudinal constraints to services by identifying approaches through which to: expand reach to key populations and link key populations with comprehensive services; utilize NGOs to increase access to comprehensive prevention, treatment and care services (including MAT); and assist countries to institutionalize evidence-based approaches to improving access to care by key populations. In KG, at three civilian and two penitentiary pilot sites, the USG will support the Narcology Center to offer a package of services to clients at MAT delivery sites, including testing and treatment of TB and STIs, rapid testing and counseling for HIV (once rapid testing quality controls are developed and instituted), and distribution of GF-procured needles, syringes and condoms. In TJ, USG will support Trust Points in four sites run by the RAC where distribution of GF-supplied needles and syringes, informational/educational materials, condoms, and rapid testing (once protocols for quality management are in place) will be supplemented by referrals to clinical services.

USG programs will improve the quality of data collected and use of data to use data from pilot and demonstration activities to shape programming and policy development.

Continued Development of Country Capacity to Increase Access to Comprehensive Services
During FY 2013, the USG will continue to strategically allocate resources to strengthen the capacity of country institutions, including Regional AIDS Centers, Ministries of Health, Country Coordination Mechanisms, and NGOs, to: steward and implement a national AIDS response directed at addressing the needs of key populations; to plan, deliver and manage more comprehensive services for PLHIV and key populations; to improve adherence to treatment and care; and to reduce the risk of HIV transmission in medical settings. Through targeted technical assistance and capacity building as well as continued support for comprehensive outreach services to link key populations with appropriate care, USG activities will aim to progressively enable countries to assume greater leadership of HIV/AIDS programs implemented jointly by public and NGO partners to reach and serve key populations. In TJ, the USG will support the MOH to conduct surveillance that can no longer be paid for by GF, including size estimation for MSM, PWID, and SW; and IBBS for SW and PWID. In KG, KZ, and TJ, the USG will finalize detailed IBBS guidelines and SOPs; conduct IBBS among sexual partners of PWID, and develop an ART planning and forecasting module for the Electronic HIV Case Management System (EHCMS). As part of a broader effort to improve laboratory services, USG programs will also work to establish systems for quality assured testing and to improve the effectiveness of specific HIV testing procedures such as CD4 counts and HIV viral load counts. To promote more sustainable allocations of resources for continued treatment of PLHW and in light of continuing increases in HIV/AIDS infection, the USG will advocate for expanded country and GFATM budget allocations to support management of increased numbers of patients in need

of ARTs and treatment of opportunistic infections.

To strengthen the enabling environment to improve access by PWID to high impact prevention services, the USG will work with Kazakhstan, Kyrgyzstan and Tajikistan to develop key policy documents to support the scale up of services for male and female IDUs as well as other key populations. USG technical assistance will work with countries to support, as appropriate to the context, the development of policy documents such as national plans for MAT implementation and scale up; national strategies on HIV testing and counseling that support a range of counseling and testing models, including rapid testing, within public facilities and in collaboration with NGOs, and which include quality assurance measures; policies and procedures to support the delivery of a comprehensive package of services for MARPs and improved referral systems between facilities; policies and procedures to strengthen coordination between HIV and TB prevention and treatment services; policies and procedures to strengthen the delivery of MAT services; and policies and procedures to support the delivery of prevention services by NGOs. At an operational level, to influence policy development, the USG will assist in the creation of multisectoral working groups that will progressively identify and address policy and regulatory barriers to MAT services (such as narcological registration protocols, limited availability of point of service counseling and testing). The USG will also support continued targeted training of NGOs to enhance their capacity to engage in HIV/AIDS policy dialogue and to advocate for improved services for MARPs.

The USG will enhance systems to reduce risk of nosocomial infection/medical transmission through clinical laboratory quality improvement, expansion and refinement of hemovigilance software, support for transfusion committees in clinical settings, and support for voluntary donor organizations. The USG will continue to provide TA to promote expanded MAT implementation in Kazakhstan, KG and TJ, including TA to strengthen mechanisms for the procurement of methadone and engagement of NGOs in the provision of psychosocial support to MAT patients and families. During FY 2013, the USG will increase the engagement of PLHIV associations and other MARP communities in promoting support groups, social support, referral, and follow up of clients. USG programs will also continue to give significant focus to working with communities, health service providers, law enforcement officials and other groups to reduce the stigma and discrimination that constrains access to services.

REDACTED REDACTED GHI, Program Integration, Central Initiatives, and other considerations
CAR countries are not Global Health Initiative (GHI) countries and thus do not have GHI strategies. However, as outlined in the FY 2012 ROP, USG programs work to operationalize core GHI principles to promote a progressive transition to country ownership that is appropriate to the CAR PEPFAR Technical Assistance model and the needs of a concentrated epidemic.

Population and HIV StatisticsKazakhstan

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	19,000	2011	AIDS Info, UNAIDS, 2013			
Adults 15-49 HIV Prevalence Rate	00	2011	AIDS Info, UNAIDS, 2013			
Children 0-14 living with HIV	00	2011	AIDS Info, UNAIDS, 2013			
Deaths due to HIV/AIDS	1,200	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults	2,600	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults and children	00	2011	AIDS Info, UNAIDS, 2013			
Estimated number of pregnant women in the last 12 months	344,000	2010	UNICEF State of the World's Children 2012. Used "Annual number of births as a proxy for number of pregnant women.			
Estimated number of pregnant women living with HIV needing ART for PMTCT	350	2011	WHO			
Number of people living with HIV/AIDS	19,000	2011	AIDS Info, UNAIDS, 2013			
Orphans 0-17 due to HIV/AIDS	2,600	2011	AIDS Info, UNAIDS, 2013			
The estimated	6,784	2011	WHO			

number of adults and children with advanced HIV infection (in need of ART)						
Women 15+ living with HIV	7,900	2011	AIDS Info, UNAIDS, 2013			

Population and HIV StatisticsKyrgyzstan

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	12,000	2011	AIDS Info, UNAIDS, 2013			
Adults 15-49 HIV Prevalence Rate	00	2011	AIDS Info, UNAIDS, 2013			
Children 0-14 living with HIV	00	2011	AIDS Info, UNAIDS, 2013			
Deaths due to HIV/AIDS	500	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults	2,900	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults and children	00	2011	AIDS Info, UNAIDS, 2013			
Estimated number of pregnant women in the last 12 months	130,000	2010	UNICEF State of the World's Children 2009. Used "Annual number of births (thousands) as a proxy for number of pregnant women.			

Estimated number of pregnant women living with HIV needing ART for PMTCT	500	2011	WHO			
Number of people living with HIV/AIDS	12,000	2011	AIDS Info, UNAIDS, 2013			
Orphans 0-17 due to HIV/AIDS	1,000	2011	AIDS Info, UNAIDS, 2013			
The estimated number of adults and children with advanced HIV infection (in need of ART)	2,207	2011	WHO			
Women 15+ living with HIV	4,200	2011	AIDS Info, UNAIDS, 2013			

Population and HIV StatisticsTajikistan

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	9,900	2011	AIDS Info, UNAIDS, 2013			
Adults 15-49 HIV Prevalence Rate	00	2011	AIDS Info, UNAIDS, 2013			
Children 0-14 living with HIV	00	2011	AIDS Info, UNAIDS, 2013			
Deaths due to HIV/AIDS	1,000	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults	1,400	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among	00	2011	AIDS Info, UNAIDS, 2013			

adults and children						
Estimated number of pregnant women in the last 12 months	192,000	2010	UNICEF State of the World's Children 2012. Used "Annual number of births as a proxy for number of pregnant women.			
Estimated number of pregnant women living with HIV needing ART for PMTCT	350	2011	WHO			
Number of people living with HIV/AIDS	11,000	2011	AIDS Info, UNAIDS, 2013			
Orphans 0-17 due to HIV/AIDS	2,000	2011	AIDS Info, UNAIDS, 2013			
The estimated number of adults and children with advanced HIV infection (in need of ART)	3,554	2011	WHO			
Women 15+ living with HIV	3,500	2011	AIDS Info, UNAIDS, 2013			

Population and HIV StatisticsTurkmenistan

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	00	2011	AIDS Info, UNAIDS, 2013			
Adults 15-49 HIV Prevalence Rate	00	2011	AIDS Info, UNAIDS, 2013			

Children 0-14 living with HIV	00	2011	AIDS Info, UNAIDS, 2013			
Deaths due to HIV/AIDS	00	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults	00	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults and children	00	2011	AIDS Info, UNAIDS, 2013			
Estimated number of pregnant women in the last 12 months	109,000	2010	UNICEF State of the World's Children 2012. Used "Annual number of births as a proxy for number of pregnant women.			
Estimated number of pregnant women living with HIV needing ART for PMTCT	00	2011	WHO			
Number of people living with HIV/AIDS	00	2011	AIDS Info, UNAIDS, 2013			
Orphans 0-17 due to HIV/AIDS	00	2011	AIDS Info, UNAIDS, 2013			
The estimated number of adults and children with advanced HIV infection (in need of ART)	00	2011	WHO			
Women 15+ living with HIV	00	2011	AIDS Info, UNAIDS, 2013			

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Population and HIV StatisticsUzbekistan

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	00	2011	AIDS Info, UNAIDS, 2013			
Adults 15-49 HIV Prevalence Rate	00	2011	AIDS Info, UNAIDS, 2013			
Children 0-14 living with HIV	00	2011	AIDS Info, UNAIDS, 2013			
Deaths due to HIV/AIDS	00	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults	00	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults and children	00	2011	AIDS Info, UNAIDS, 2013			
Estimated number of pregnant women in the last 12 months	587,000	2010	UNICEF State of the World's Children 2012. Used "Annual number of births as a proxy for number of pregnant women.			
Estimated number of pregnant women living with HIV needing ART for PMTCT	750	2011	WHO			
Number of people living with HIV/AIDS	00	2011	AIDS Info, UNAIDS, 2013			
Orphans 0-17 due to HIV/AIDS	00	2011	AIDS Info, UNAIDS, 2013			
The estimated	30,608	2011	WHO			

number of adults and children with advanced HIV infection (in need of ART)						
Women 15+ living with HIV	00	2011	AIDS Info, UNAIDS, 2013			

Partnership Framework (PF)/Strategy - Goals and Objectives

Number	Goal / Objective Description	Associated Indicator Numbers	Associated Indicator Labels
1	The overarching goal for the Regional Initiative is to prevent new HIV infections and provide high quality HIV services for affected populations through a strengthened and sustainable health system in the five Central Asian Republics		
1.1	Objective #1: Improve access in public and private sectors to quality HIV prevention, care and treatment services to reduce the transmission and impact of the HIV epidemic in Central Asia	P8.1.D	P8.1.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required
		P8.3.D	P8.3.D Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required
1.2	Objective #2: Strengthen the capacity of the health system to deliver improved, expanded, equitable and sustainable	H2.3.D	H2.3.D Number of health care workers who successfully completed an in-service

	HIV/AIDS services for MARPS, PLHIV and their families, and other affected populations		training program within the reporting period
		H3.1.N	H3.1.N Domestic and international AIDS spending by categories and financing sources
1.3	Objective #3: Strengthen the capacity of public and private sectors to collect, analyze, manage and utilize data for evidence-based planning and policymaking at all levels	H3.1.N	H3.1.N Domestic and international AIDS spending by categories and financing sources

Engagement with Global Fund, Multilateral Organizations, and Host Government Agencies

How is the USG providing support for Global Fund grant proposal development?

For the past ten years, USG country teams have played an active role at virtually every stage in the development and oversight of Global Fund (GF) grant proposals in the Central Asian Republics (CAR). USG teams also participate in formulating countries' strategic plans for combating HIV, on which GF grant proposals are based. In Uzbekistan, USG technical specialists wrote sections on Treatment and Care and Strategic Information for the national HIV strategic plan, and also wrote significant portions of the last successful HIV grant proposal. In all countries, the USG has been a voting member of the Country Coordinating Mechanism (CCM) since these bodies were established in 2002 and 2003, although in Uzbekistan USG membership lapsed in 2009. Per the request of the CCMs in each country, technical experts in HIV/AIDS and TB from USG and USG-funded projects work closely with the government and non-governmental organizations in technical working groups to develop country applications to GF grants. USG members of their respective CCMs have, over the years, helped strengthen the functionality of the CCMs and improve their compliance with GF requirements for representation of PLHIV and civil society, scheduling of regular meetings, and adherence to due process. USG implementing partners have also provided TA to CCM Secretariats aimed at building their organizational capacity to support grant proposal development and oversight.

Are any existing HIV grants approaching the end of their agreement (Phase 1, Phase 2, NSA, CoS, or RCC) in the coming 12 months?

Yes

If yes, please indicate which round and how this may impact USG programming. Please also describe any actions the USG, with country counterparts, is taking to inform renewal programming or to enable continuation of successful programming financed through this grant(s).

UZ: Rd 9 Phase 1 ends 12/31/13
KG: Rd 10 Ph.1 ends 12/31/13
KZ: Rd 7 Ph.2 ends 12/31/13. Linked to:
KZ: Rd 10 Ph.1 ends 12/31/13
TJ: Rd 8 Ph.2 ends 9/30/2014

CAR countries have focused GF grants on expanding access to testing and treatment. In 2012 pre-award discussions, Rd 8, Phase 2 in UZ was reduced by 10% at GF's request, taken from Health Systems Strengthening. In response, PRs and host country partners requested USG support for implementing activities such as training and systems strengthening. With the decision to defer, and ultimately cancel, Rd 11, CAR country potential for the expansion of services was severely constrained. There is also continuing concern among HIV NGOs in CAR that as countries take up responsibility for direct funding of HIV/AIDS programs, there may be diminished funding to marginalized groups (e.g. MSM) and more need for USG funding of these groups.
It is anticipated that all Ph. 1 grants will be continued into Ph. 2. As CAR countries transition to GF's new funding model, they may set new priorities, revise strategies and reallocate budgets. Assuming countries will prioritize increased access to treatment, they may look to PEPFAR for continued and complementary support to GF implementation.
The USG provides direct input to and TA on GF programs. In TJ, KG and KZ, USAID and CDC sit on the CCM and are involved in discussions on GF proposals and Ph. 2 transitions (in UZ, USG led two TWGs in the Rd 9, Ph.1 proposal). PEPFAR funding is planned collaboratively to complement GF grants through support to: a) build national institutional and staff capacity; b) expand programming for vulnerable populations; c) strengthen the capacity and role of NGOs in service delivery and enhance systems and policies to strengthen the national program. In FY 2013 the CAR program will hire a Global Fund Liaison Officer to strengthen coordination with GF and enhance country investment strategies.

Redacted

To date, have you identified any areas of substantial duplication or disparity between PEPFAR and Global Fund financed programs? Have you been able to achieve other efficiencies by increasing coordination between stakeholders?

No

Public-Private Partnership(s)

Created	Partnership	Related Mechanism	Private-Sector Partner(s)	PEPFAR USD Planned Funds	Private-Sector USD Planned Funds	PPP Description
2012 COP	Youth Centers GDA	13976:Youth Centers GDA (Turkmenistan PPP)	Chevron Nebitgaz B.V.			The Drop-in and Youth Centers Project is a 7-year PPP between USAID and Chevron Nebitgaz. Initiated in 2009, the project was extended for an additional 2 years to October 2015. The 2 project-supported Youth Centers provide HIV outreach and prevention services to at-risk youth, helping them to gain the skills and knowledge needed to lead healthy lifestyles.

						Education topics include HIV/AIDS prevention, stigma reduction, responsible behavior and information on the consequences of drug use. The Drop in Center provides HIV outreach services, technical assistance, and training for PWID and SWs who inject drugs. Chevron Nebitgaz funds the Youth Centers and outreach activities; PEPFAR funds the Drop-In Center and all project-supported HIV prevention activities.

Surveillance and Survey Activities

Surveillance	Name	Type of	Target	Stage	Expected

or Survey		Activity	Population		Due Date
Survey	Assessment of data quality in Electronic HIV case Management System in Kazakhstan	Evaluation	Other	Implementatio n	12/01/2013
Survey	Assessment of data quality in Electronic HIV case Management System in Kyrgyzstan	Evaluation	Other	Planning	12/01/2013
Survey	Assessment of data quality in Electronic HIV case Management System in Tajikistan	Evaluation	Other	Planning	12/01/2013
Survey	Assessment of Health Care Related Injection Practices in Kazakhstan	Evaluation	General Population	Data Review	03/01/2013
Survey	Assessment of Health Care Related Injection Practices in Kyrgyzstan	Evaluation	General Population	Data Review	03/01/2013
Survey	Assessment of Health Care Related Injection Practices in Tajikistan	Evaluation	General Population	Data Review	03/01/2013
Survey	Assessment of policy regaulations for injecting safety practices in Tajikistan	Evaluation	Other	Planning	05/01/2013
Survey	Assessment of policy regulations for injecting safety practices in Kazakhstan	Evaluation	Other	Planning	05/01/2013
Survey	Assessment of policy regulations for injecting safety practices in Kyrgyzstan	Evaluation	Migrant Workers, Other	Planning	05/01/2013
Survey	Assessment of VCT for MARPs (PWID, FCSW,	Evaluation	Female Commercial	Planning	09/01/2013

	MSM) in Kazakhstan		Sex Workers, Injecting Drug Users, Men who have Sex with Men		
Survey	Assessment of VCT for MARPs (PWID, FCSW, MSM) in Kyrgyzstan	Evaluation	Female Commercial Sex Workers, Injecting Drug Users, Men who have Sex with Men	Planning	09/01/2013
Survey	Assessment of VCT for MARPs (PWID, FCSW, MSM) in Tajikistan	Evaluation	Female Commercial Sex Workers, Injecting Drug Users, Men who have Sex with Men	Planning	09/01/2013
Survey	Final TRaC study for PWID for Kazakhstan	Population-based Behavioral Surveys	Drug Users	Planning	09/01/2014
Survey	Final TRaC study for PWID for Kyrgyzstan	Population-based Behavioral Surveys	Drug Users	Planning	09/01/2014
Survey	Final TRaC study for PWID for Tajikistan	Population-based Behavioral Surveys	Drug Users	Planning	09/01/2014
Survey	Final TRaC study for SW for Kazakhstan	Population-based Behavioral Surveys	Female Commercial Sex Workers	Planning	09/01/2014
Survey	Final TRaC study for SW for	Population-ba	Female	Planning	09/01/2014

	Kyrgyzstan	sed Behavioral Surveys	Commercial Sex Workers		
Survey	Final TRaC study for SW for Tajikistan	Population-based Behavioral Surveys	Female Commercial Sex Workers	Planning	09/01/2014
Surveillance	IBBS among FCSW in Kazakhstan	Sentinel Surveillance (e.g. ANC Surveys)	Female Commercial Sex Workers	Development	12/01/2013
Surveillance	IBBS among MSM in Kazakhstan	Sentinel Surveillance (e.g. ANC Surveys)	Men who have Sex with Men	Development	12/01/2013
Surveillance	IBBS among non-injecting sexual partners of PWID for Kazakhstan	Sentinel Surveillance (e.g. ANC Surveys)	Other	Development	12/01/2013
Surveillance	IBBS among non-injecting sexual partners of PWID for Kyrgyzstan	Sentinel Surveillance (e.g. ANC Surveys)	Other	Development	12/01/2013
Surveillance	IBBS among non-injecting sexual partners of PWID for Tajikistan	Sentinel Surveillance (e.g. ANC Surveys)	Other	Planning	12/01/2014
Surveillance	IBBS among PWID in Kazakhstan	Sentinel Surveillance (e.g. ANC Surveys)	Injecting Drug Users	Development	12/01/2013
Survey	IBBS Assessment for IDUs in Kyrgyzstan	Evaluation	Injecting Drug Users	Other	09/01/2012
Survey	MAT Assessment in Kyrgyzstan	Evaluation	Injecting Drug Users	Other	11/01/2012

Survey	MAT Assessment in Tajikistan	Evaluation	Injecting Drug Users	Implementation	03/01/2013
Survey	TRaC surveys for IDUs for Kyrgyzstan	Population-based Behavioral Surveys	Injecting Drug Users	Publishing	12/01/2010

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source			Total
	GAP	GHP-State	GHP-USAID	
HHS/CDC	2,785,090	4,153,410		**6,938,500**
PC		123,000		**123,000**
USAID		5,938,500	1,000,000	**6,938,500**
Total	**2,785,090**	**10,214,910**	**1,000,000**	**14,000,000**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency				Total
	HHS/CDC	PC	USAID	AllOther	
HBHC	453,479		121,097		**574,576**
HLAB	1,247,010				**1,247,010**
HMBL	190,289				**190,289**
HMIN	50,289				**50,289**
HTXS	494,479				**494,479**
HVCT	188,670		119,539		**308,209**
HVMS	2,488,361		1,581,055		**4,069,416**
HVOP	258,671	123,000	845,953		**1,227,624**
HVSI	875,433		79,315		**954,748**
IDUP	683,438		3,478,164		**4,161,602**
OHSS	8,381		713,377		**721,758**

	6,938,500	123,000	6,938,500	0	14,000,000

National Level Indicators

National Level Indicators and Targets

Kazakhstan

Redacted

National Level Indicators and Targets

Kyrgyzstan

Redacted

National Level Indicators and Targets

Tajikistan

Redacted

National Level Indicators and Targets

Turkmenistan

Redacted

National Level Indicators and Targets

Uzbekistan

Redacted

National Level Indicators and Targets

Central Asia Region

Redacted

Policy Tracking Table

Kazakhstan

Policy Area: Access to high-quality, low-cost medications						
Policy: National ARV Treatment Policies and Protocols on ARV Treatment						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	n/a	n/a	n/a	3.1.12	3.1.17	3.1.19
Narrative	The country has recognized that ARVs are an essential part of treatment for PLHIV			At baseline, the country is in stage 4 of the development and implementation of a national ARV treatment policy. The Global Fund supports the purchase of ARVs, which are provided free of charge.	The program expects to move into stage 5 in a five-year period. The country will need time to develop and train health care specialists on ARV treatment protocols including initiation, adherence and use of second line drugs	The country will need time to fully train and implement its protocols before the services and facilities can be evaluated.
Completion Date						
Narrative						

Policy Area: Counseling and Testing
Policy: National HIV Testing and Counseling Strategy

Stages:	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	Stage 6
Estimated Completion Date	3.1.13	3.1.14	3.1.16	3.1.17	3.1.19	n/a
Narrative	A National Testing and Counseling strategy is needed. It should provide guidance on CT models and settings, promote rapid testing for key populations, endorse quality assurance (QA) standards and systems and link NGO and public sectors. The need for an overall strategy is recognized.	CDC, through Columbia University's SUPPORT project, is developing recommendations from an assessment of C&T services in KZ, KG, TJ and UZ. The project will also evaluate the existing HIV rapid test systems. The recommendations will inform the development of a national strategy.	The country will take time to come to agreement on CT models, quality assurance and regulatory systems that are embodied in a national strategy	The country will need time to obtain the legislative and regulatory endorsements from the Ministry of Health	Additional time will be required to implement CT in all facilities providing this service. Training and mentoring will be required to ensure quality.	
Completion Date						

Narrative						

Policy Area: Laboratory Accreditation						
Policy: National Policy and Framework on Laboratory Accreditation						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	n/a	3.1.12	3.1.14	3.1.16	3.1.18	3.1.20
Narrative	The country does not currently provide accreditation according to international standards. However, there is interest in addressing the issue in order to improve the quality of laboratory services for HIV and other health issues	The country is trying to define accreditation in a standardized way with support from CDC	The country will need time to come to agreement on laboratory accreditation standards and to develop a policy necessary to elevate the quality of current laboratory services	The country will require time to obtain all legislative and regulatory endorsements once it has developed a policy	The country will need time to train laboratory staff and facilities on accepted standards before it can begin to implement and enforces its policies and standards	The country will need time for consistent implementation before it can evaluate whether or not the quality of laboratory services has increased and whether new laboratory accreditation standards are consistently being met by facilities and staff involved in laboratory

						services.
Completion Date						
Narrative						

Policy Area: Most at Risk Populations (MARP)						
Policy: Comprehensive Service Package for MARPS: strategy, protocols and referral systems to support delivery, including services for HIV-TB co-infection.						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	3.1.13	3.1.16	3.1.18	n/a	n/a	n/a
Narrative	Services for MARPS and PLHIV in CAR are provided through vertical systems. Referral systems are poorly coordinated and data systems unlinked to other services, contributing to losses to follow-up and drop-outs. Services for HIV-TB are not formally	The development and delivery of a comprehensive package of services requires a long-term commitment to working with the national and local government and health facilities to identify model facilities, analyze existing systems and	The country will take time to move from facility-based or oblast strategies to a national strategy for a comprehensive package of services for MARPs.			

	linked. Protocols and strengthened referral and data systems are needed to support the delivery of a comprehensive package of services to MARPs.	advocate for the delivery of a comprehensive package of services, backed by a national or oblast-level strategy. This will take time to achieve.					
Completion Date							
Narrative							

Policy Area: Most at Risk Populations (MARP)						
Policy: National Medication-Assisted Therapy strategy that endorses expansion of MAT services and coordinated MAT/ART treatment						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	3.1.13	3.1.16	3.1.18	3.1.20	n/a	n/a
Narrative	HIV infection in the CAR is driven by PWID, with indications that the epidemic is expanding to their sex partners.	This issue requires a long-term commitment to working with government, facilities and NGOs to identify barriers to	The country will take time to develop and agree on a strategy for national expansion of MAT	Endorsement of this policy and the allocation of funds to achieve national expansion, is also a long-term		

	There is a high prevalence of HIV among prisoners and detainees. But long-term therapy for drug use is limited, with restrictions on the expansion of MAT services. Coordinated MAT/ART treatment for HIV and PWID is also needed to reduce infectivity and the spread of the epidemic.	political and institutional change, promote the allocation of funds, demonstrate results from model projects and advocate for a national strategy to expand MAT and joint MAT/ART treatment.		objective that will require ongoing data to demonstrate its efficacy, and buy-in from the Ministry of Health		
Completion Date						
Narrative						

Policy Area: Other Policy
Policy: National HIV/AIDS Operational Plan, Investment Framework and/or Prevention Strategy

and Policy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	3.1.13	3.1.14	3.1.16	3.1.18	n/a	n/a
Narrative	This comprehensive policy will be focused on key populations, support provision of comprehensive services, including harm reduction services, incorporate accessible testing, endorse expanded role of NGOs, address reduction of stigma/discrimin-ation and gender-based violence and endorse	No comprehensive plan currently exists so HIV/AIDS programs are fragmented and lack a cross-sectoral national mandate. It will take time to build a consensus to support the plan.	Building support for a comprehensive national operational plan will take time and will require input and commitment from KZ government, MOH, and donor agencies.	Endorsement from legislative agencies will most likely run concurrently with plan development, since regulation of issues such as provision of services will be developed independently to deal with specific issues. The major endorsement required will be the KZ Ministry of Finance and from external agencies such as the Global	Implementation will be ongoing, and primarily enforceable at the facility and oblast levels.	Evaluation of the national program should be cyclical, on a regular schedule and be timed to provide input for the next cycle of the National Operational Plan.

	centralized reporting led by MOH. It will provide a comprehensive plan that can be a base for Global Fund and outside funding			Fund.		
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: National Policy and Standard Procedures on HIV-related Laboratory Diagnostics						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	3.1.13	3.1.14	3.1.15	3.1.17	3.1.19	n/a
Narrative	At baseline, there is a recognized need for standard procedures and a national policy on HIV-related laboratory testing. This includes	Achieving consensus among medical schools and laboratories in the country will take time, as the different laboratories and institutions	The country will need technical assistance and time to come to agreement on the guidelines and regulatory oversight needed and to develop a	Obtaining legislative and regulatory endorsements from relevant institutions and ministries will take additional time	Implementation will require training and buy-in to the regulatory system, from many institutions, which will take time.	

	guidelines to link diagnosis with treatment, quality manageme nt systems, and regulatory oversight of equipment and supplies in line with internationa l standards.	have varied standards and there is not yet a recognized definition of the major barriers to standard procedures.	policy document			
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: National Policy endosing a Blood Safety system in line with WHO principles						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	n/a	n/a	3.1.13	3.1.15	3.1.17	3.1.20
Narrative	The KZ Republican Blood Center recognizes that blood safety is a problem. REDACTE D		This policy is at stage 3 at the baseline and the beginning of tracking	We envision that it will take 2-3 years to engage in advocacy and come to agreement on a prikaz	The country will need time to train individuals on a pprikaz and specific protocols for blood safety prior to	We anticipate that the country will need an independen t evaluation after a reasonable period has

				(an order from the government) and standard operating protocols that could be implemented in all health care facilities	implementation and enforcement	been provided for the implementation of the prikaz and standard operating protocols in all health facilities
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: National Protocol on IBBS						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	n/a	n/a	3.1.13	3.1.14	3.1.16	3.1.18
Narrative	CDC provided training on IBBS approximately ten year ago. While the country adopted IBBS practices when the IBBS was first	CDC, through the Columbia ICAP Support Project, recently conducted an assessment in three Central Asian countries.	After the assessments are completed, CDC and Columbia will promoted the development of a policy to standardize the IBBS	The country will need time to develop IBBS protocols and to obtain legislative and regulatory endorsements from the Ministry of	The country will require additional time to implement IBBS with technical support from the USG	The country will evaluate IBBS only after the country has had sufficient time to routinize the practice of preparing for and undertaking IBBS for

	introduced, data quality has decreased in recent years due to: (1) lack of standard operating protocols; (2) poor methodology and (3) lack of training and technical assistance to monitor assessment practices	Initial findings suggest that more intensive training and the development of standard operating protocols/procedures are necessary to improve data quality, reliability and usage.		Health.		selected key populations annually
Completion Date						
Narrative						

Policy Area: Stigma and Discrimination						
Policy: Facility Level Policies to Protect the Rights of Key Populations to Access Services						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	3.1.13	3.1.16	3.1.18	n/a	n/a	n/a
Narrative	Stigma and discrimination remain challenges to effective provision of services for	This problem requires a long-term commitment to working at the oblast	It will take time to develop model facility-level policies, to make them	A broader endorsement of this policy at a national level (requiring		

	key populations. Access to prevention, care and treatment services by key populations is inadequate, and there is limited political support for service expansion, with coverage for MAT capped at 500 PWID. Provider and community attitudes also affect access to services.	level with local facilities and communities in order to protect the rights of key populations to access services. Advocacy to expand the resources available to key populations is essential, as continued assessments of the size of unserved key populations	operational in model institutions and to expand this model at the facility level.	legislative and regulatory endorsement) is not a realistic goal. A review system at the facilty-level can be developed alongside the development of a facility-level policy.		
Completion Date						
Narrative						

Policy Area: Strengthening a multi-sectoral response and linkages with other health and development programs
Policy: Policy to Support Service Delivery by NGOs

Stages:	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	Stage 6
Estimated Completion Date	3.1.13	3.1.16	3.1.19	n/a	n/a	n/a
Narrative	NGOs are an essential component in the delivery of services to key populations at risk of HIV/AIDS, but their role is not facilitated through national technical or financial regulation. A policy to support service provision by NGOs is needed, to include VCT/rapid testing, overdose prevention, and manageme nt.	The country will need time to identify and define the components of a policy that would strengthen NGOs' role in the delivery of services to key populations. An intermediat e step will be required to build consensus on the bodies that can best represent the NGO community' s role in delivering services to key populations.	The country will need time to institutionali ze linkages between the formal health sector and NGOs as a basis for developing a policy document.			
Completion Date						

Narrative						

Policy Tracking Table

Kyrgyzstan

Policy Area: Access to high-quality, low-cost medications						
Policy: National ARV Treatment Policies and Protocols on ARV Treatment						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	n/a	n/a	n/a	3.1.12	3.1.17	3.1.19
Narrative	The country has recognized that ARVs are an essential part of treatment for PLHIV			At baseline, the country is in stage 4 of the development and implementation of a national ARV treatment policy. The Global Fund supports the purchase of ARVs, which are provided free of charge.	The program expects to move into stage 5 in a five-year period. The country will need time to develop and train health care specialists on ARV treatment protocols including initiation, adherence and use of second line drugs	The country will need time to fully train and implement its protocols before the services and facilities can be evaluated.
Completion Date						
Narrative						

Policy Area: Counseling and Testing
Policy: National HIV Testing and Counseling Strategy

Stages:	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	Stage 6
Estimated Completion Date	3.1.13	3.1.14	3.1.16	3.1.17	3.1.19	n/a
Narrative	A National Testing and Counseling strategy is needed. It should provide guidance on CT models and settings, promote rapid testing for key populations, endorse quality assurance (QA) standards and systems and link NGO and public sectors. The need for an overall strategy is recognized.	CDC, through Columbia University's SUPPORT project, is developing recommendations from an assessment of C&T services in KZ, KG, TJ and UZ. The project will also evaluate the existing HIV rapid test systems. The recommendations will inform the development of a national strategy.	The country will take time to come to agreement on CT models, quality assurance and regulatory systems that are embodied in a national strategy	The country will need time to obtain the legislative and regulatory endorsements from the Ministry of Health	The country will need time to obtain the legislative and regulatory endorsements from the Ministry of Health	
Completion Date						

Narrative						

Policy Area: Laboratory Accreditation						
Policy: National Policy and Framework on Laboratory Accreditation						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	3.1.13	3.1.15	3.1.18	3.1.20	n/a	n/a
Narrative	The country does not currently provide accreditation according to international standards. However, there is interest in addressing the issue in order to improve the quality of laboratory services for HIV and other health issues	The country will need time to be able to define accreditation in a standardized way	The country will need time to come to agreement on laboratory accreditation standards and to develop a policy necessary to elevate the quality of current laboratory services	The country will need require time to obtain all legislative and regulatory endorsements once it has developed a policy.		
Completion Date						
Narrative						

Policy Area: Most at Risk Populations (MARP)
Policy: Comprehensive Service Package for MARPs: strategy, protocols and referral systems to

support delivery, including services for HIV-TB co-infection						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	3.1.13	3.1.16	3.1.18	n/a	n/a	n/a
Narrative	Services for MARPS and PLHIV in CAR are provided through vertical systems. Referral systems are poorly coordinated and data systems unlinked to other services, contributing to losses to follow-up and drop-outs. Services for HIV-TB are not formally linked. Protocols and strengthened referral and data systems are	The development and delivery of a comprehensive package of services requires a long-term commitment to working with the national and local government and health facilities to identify model facilities, analyze existing systems and advocate for the delivery of a comprehensive package of services,	The country will take time to move from facility-based or oblast strategies to a national strategy for a comprehensive package of services for MARPs.			

	needed to support the delivery of a comprehen sive package of services to MARPs.	backed by a national or oblast-level strategy. This will take time to achieve.				
Completion Date						
Narrative						

Policy Area: Most at Risk Populations (MARP)						
Policy: National Medication-Assisted Therapy strategy that endorses expansion of MAT services and coordinated MAT/ART treatment.						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	3.1.13	3.1.16	3.1.18	3.1.20	n/a	n/a
Narrative	HIV infection in the CAR is driven by PWID, with indications that the epidemic is expanding to their sex partners. There is a high prevalence of HIV among prisoners and	This issue requires a long-term commitment to working with government , facilities and NGOs to identify barriers to political and institutional change, promote the allocation of funds, demonstrat	The country will take time to develop and agree on a strategy for national expansion of MAT	Endorseme nt of this policy and the allocation of funds to achieve national expansion, is also a long-term objective that will require ongoing data to demonstrat e its		

	detainees. But long-term therapy for drug use is limited, with restrictions on the expansion of MAT services. Coordinated MAT/ART treatment for HIV and PWID is also needed to reduce infectivity and the spread of the epidemic.	e results from model projects and advocate for a national strategy to expand MAT and joint MAT/ART treatment.		efficacy, and buy-in from the Ministry of Health		
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: National HIV/AIDS Operational Plan, Investment Framework and/or Prevention Strategy and Policy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	n/a	n/a	n/a	3.1.13	3.1.16	n/a
Narrative	The comprehen			KG has developed a	Implementation of the	

	sive policy will be focused on key populations, support provision of comprehen sive services, including harm reduction services, incorporate accessible testing, endorse expanded role of NGOs, address reduction of stigma/discr imin-ation and gender-bas ed violence and endorse centralized reporting led by MOH.			national HIV/AIDS Operational Plan. It will take the country time to complete the legislative and regulatory endorseme nts required. This process is now underway in KG and is supported by the USG.	Operational Plan, including expansion of several services, will take time. It is expected that the majority of the areas of action listed in the plan will be underway by 3.1.16.	
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: National Policy and Standard Procedures on HIV-related Laboratory Diagnostics						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	3.1.3	3.1.15	3.1.18	3.1.20	n/a	n/a
Narrative	At baseline, there is a recognized need for standard procedures and a national policy on HIV-related laboratory testing. This includes guidelines to link diagnosis with treatment, quality manageme nt systems, and regulatory oversight of equipment and supplies in line with internationa	Achieving consensus among medical schools and laboratories in the country will take time, as the different laboratories and institutions have varied standards and there is not yet a recognized definition of the major barriers to standard procedures.	The country will need technical assistance and time to come to agreement on the guidelines and regulatory oversight needed and to develop a policy document	Obtaining legislative and regulatory endorseme nts from relevant institutions and ministries will take additional time		

	l standards.					
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: National Policy Endorsing a Blood Safety System in Line with WHO Principles						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	n/a	n/a	3.1.13	3.1.15	3.1.17	3.1.20
Narrative	The KG Republican Blood Center recognizes that blood safety is a problem. REDACTED		This policy is at stage 3 at the baseline and the beginning of tracking	We envision that it will take 2-3 years to engage in advocacy and come to agreement on a prikaz (an order from the government) and standard operating protocols that could be implemented in all health care facilities	The country will need time to train individuals on a pprikaz and specific protocols for blood safety prior to implementation and enforcement	We anticipate that the country will need an independent evaluation after a reasonable period has been provided for the implementation of the prikaz and standard operating protocols in all health facilities
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: National Protocol on IBBS						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	n/a	n/a	3.1.12	3.1.17	3.1.18	3.1.20
Narrative	CDC provided training on IBBS approximately ten years ago. While the country adopted IBBS practices when the practice was first introduced, data quality has decreased in recent years due to: (1) lack of standard operating protocols; (2) poor methodology and (3) lack of training and	CDC, through the Columbia ICAP Support Project, recently conducted an assessment in three Central Asian countries. Initial findings suggest that more intensive training and the devleopment of standard operationg protocols/procedures (SOPs) are necessary to improve	After the assessments are completed, CDC and Columbia will promote the development of a policy to standardize the IBBS	The country will need time to develop IBBS protocols and to obtain leglislative and regulatory endorsements from the Ministry of Health	The country will require additional time to implement IBBS with technical support from the USG.	The country will evaluate IBBS only after the country has had sufficient time to routinize the pactice of preparing for and undertaking IBBS for selected key populations annually.

	technical assistance to monitor assessment practices	data quality, reliability and usage.				
Completion Date						
Narrative						

Policy Area: Stigma and Discrimination						
Policy: Facility Level Policies to Protect the Rights of Key Populations to Access Services						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	3.1.13	3.1.16	3.1.18	n/a	n/a	n/a
Narrative	Stigma and discrimination remain challenges to effective provision of services for key populations. Access to prevention, care and treatment services by key populations is inadequate, and there is limited political support for	This problem requires a long-term commitment to working at the oblast level with local facilities and communities in order to protect the rights of key populations to access services. Advocacy to expand the resources available to	It will take time to develop model facility-level policies, to make them operational in model institutions and to expand this model at the facility level.	A broader endorsement of this policy at a national level (requiring legislative and regulatory endorsement) is not a realistic goal. A review system at the facilty-level can be developed alongside the		

	service expansion, with coverage for MAT for no more than 10% of PWID. Provider and community attitudes also affect access to services.	key populations is essential, as continued assessments of the size of unserved key populations		development of a facility-level policy.		
Completion Date						
Narrative						

Policy Area: Strengthening a multi-sectoral response and linkages with other health and development programs						
Policy: Policy to Support Service Delivery by NGOs						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	3.1.13	3.1.16	3.1.19	n/a	n/a	n/a
Narrative	NGOs are an essential component in the delivery of services to key populations at risk of HIV/AIDS, but their	The country will need time to identify and define the components of a policy that would strengthen NGOs' role in the	The country will need time to institutionalize linkages between the formal health sector and NGOs as a basis for			

	role is not facilitated through national technical or financial regulation. A policy to support service provision by NGOs is needed, to include VCT/rapid testing, overdose prevention, and manageme nt.	delivery of services to key populations. An intermediat e step will be required to build consensus on the bodies that can best represent the NGO community' s role in delivering services to key populations.	developing a policy document.			
Completion Date						
Narrative						

Approved

Policy Tracking Table

Tajikistan

Policy Area: Access to high-quality, low-cost medications						
Policy: National policies and protocols on ARV Treatment.						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	n/a	n/a	n/a	3.1.12	3.1.17	3.1.19
Narrative	The country has recognized that ARVs are an essential part of treatment for PLHIV			At baseline, the country is in stage 4 of the development and implementation of a national ARV treatment policy. The Global Fund supports the purchase of ARVs, which are provided free of charge.	The program expects to move into stage 5 in a five-year period. The country will need time to develop and train health care specialists on ARV treatment protocols including initiation, adherence and use of second line drug	The country will need time to fully train and implement its protocols before the services and facilities can be evaluated.
Completion Date						
Narrative						

Policy Area: Counseling and Testing
Policy: National HIV Testing and Counseling Strategy.

Stages:	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	Stage 6
Estimated Completion Date	3.1.13	3.1.16	3.1.18	3.1.20	n/a	n/a
Narrative	A National Testing and Counseling strategy is needed. It should provide guidance on CT models and settings, promote rapid testing for key populations, endorse quality assurance (QA) standards and systems and link NGO and public sectors. The need for an overall strategy is recognized.	CDC, through Columbia University's SUPPORT project, is developing recommendations from an assessment of C&T services in KZ, KG, TJ and UZ. The project will also evaluate the HIV rapid test systems. The country will take time to develop and assess new models and practices. Recommendations will inform the development of a national	The country will take time to come to agreement on CT models, quality assurance and regulatory systems that are embodied in a national strategy	The country will need time to obtain the legislative and regulatory endorsements from the Ministry of Health		

		strategy.				
Completion Date						
Narrative						

Policy Area: Laboratory Accreditation						
Policy: National Policy and Framework on Laboratory Accreditation.						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	3.1.13	3.1.15	3.1.18	3.1.20.	n/a	n/a
Narrative	The country does not currently provide accreditation according to international standards. However, there is interest in addressing the issue in order to improve the quality of laboratory services for HIV and other health issues	The country will need time to be able to define accreditation in a standardized way	The country will need time to come to agreement on laboratory accreditation standards and to develop a policy necessary to elevate the quality of current laboratory services	The country will need require time to obtain all legislative and regulatory endorsements once it has developed a policy.		
Completion Date						
Narrative						

Policy Area: Most at Risk Populations (MARP)						
Policy: Comprehensive Service Package for MARPS: strategy, protocols and referral systems to support delivery, including services for HIV-TB co-infection.						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	3.1.13	3.1.16	3.1.18	n/a	n/a	n/a
Narrative	Services for MARPS and PLHIV in CAR are provided through vertical systems. Referral systems are poorly coordinated and data systems unlinked to other services, contributing to losses to follow-up and drop-outs. Services for HIV-TB are not formally linked. Protocols and strengthened referral	The development and delivery of a comprehensive package of services requires a long-term commitment to working with the national and local government and health facilities to identify model facilities, analyze existing systems and advocate for the delivery of a comprehensive	The country will take time to move from facility-based or oblast strategies to a national strategy for a comprehensive package of services for MARPs.			

	and data systems are needed to support the delivery of a comprehensive package of services to MARPs.	package of services, backed by a national or oblast-level strategy. This will take time to achieve.				
Completion Date						
Narrative						

Policy Area: Most at Risk Populations (MARP)						
Policy: National Medicated Assisted Therapy strategy that endorses expansion of MAT services and coordinated MAT/ART treatment.						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	3.1.13	3.1.16	3.1.18	3.1.20	n/a	n/a
Narrative	HIV infection in the CAR is driven by PWID, with indications that the epidemic is expanding to their sex partners. There is a high prevalence of HIV among	This issue requires a long-term commitment to working with government, facilities and NGOs to identify barriers to political and institutional change, promote the allocation of	The country will take time to develop and agree on a strategy for national expansion of MAT	Endorsement of this policy and the allocation of funds to achieve national expansion, is also a long-term objective that will require ongoing data to		

	prisoners and detainees. But long-term therapy for drug use is limited, with restrictions on the expansion of MAT services. Coordinated MAT/ART treatment for HIV and PWID is also needed to reduce infectivity and the spread of the epidemic.	funds, demonstrate results from model projects and advocate for a national strategy to expand MAT and joint MAT/ART treatment.		demonstrate its efficacy, and buy-in from the Ministry of Health		
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: National HIV/AIDS Operational Plan, Investment Framework and/or Prevention Strategy and Policy.						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	3.1.13	3.1.14	3.1.16	3.1.18	n/a	n/a

Narrative	This comprehensive policy will be focused on key populations, support provision of comprehensive services, including harm reduction services, incorporate accessible testing, endorse expanded role of NGOs, address reduction of stigma/discrimin-ation and gender-based violence and endorse centralized reporting led by MOH. It will provide a	No comprehensive plan currently exists so HIV/AIDS programs are fragmented and lack a cross-sectoral national mandate. It will take time to build a consensus to support the plan.	Building support for a comprehensive national operational plan will take time and will require input and commitment from TJ government, MOH, and donor agencies.	Endorsement from legislative agencies will most likely run concurrently with plan development, since regulation of issues such as provision of services will be developed independently to deal with specific issues. The major endorsement required will be the TJ Ministry of Finance and from external agencies such as the Global Fund.	Implementation will be ongoing, and primarily enforceable at the facility and oblast levels.	Evaluation of the national program should be cyclical, on a regular schedule and be timed to provide input for the next cycle of the National Operational Plan.

	comprehensive plan that can be a base for Global Fund and outside funding					
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: National Policy and Standard Procedures on HIV-related Laboratory Diagnosis.						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	3.1.13	3.1.15	3.1.18	3.1.20	n/a	n/a
Narrative	At baseline, there is a recognized need for standard procedures and a national policy on HIV-related laboratory testing. This includes guidelines to link diagnosis with treatment,	Achieving consensus among medical schools and laboratories in the country will take time, as the different laboratories and institutions have varied standards and there is not yet a recognized	The country will need technical assistance and time to come to agreement on the guidelines and regulatory oversight needed and to develop a policy document	Obtaining legislative and regulatory endorsements from relevant institutions and ministries will take additional time		

	quality management systems, and regulatory oversight of equipment and supplies in line with international standards.	definition of the major barriers to standard procedures.				
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: National Policy Endorsing a Blood Safety System in Line with WHO Principles.						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	n/a	3.1.13	3.1.15	3.1.18	3.1.21	n/a
Narrative	The TJ Republican Blood Center recognizes that blood safety is a problem.	At baseline, the country is at stage 2 in recognizing and defining the extent of the problems with the blood safety system. Approaches to strengtheni	It is estimated it will take 2-3 years to develop a policy and ensure buy-in from the government and related institutions	We envision that it will take 2-3 years to engage in advocacy and come to agreement on a prikaz (an order from the government) and standard	The country will need time to train individuals on a pprikaz and specific protocols for blood safety prior to implementation and enforcement	We anticipate that the country will need an independent evaluation after a reasonable period has been provided for the implementation of the

		ng recruitment, and establishing standard operating procedures are under discussion to ensure a national safe blood safety system.		operating protocols that could be implemented in all health care facilities		prikaz and standard operating protocols in all health facilities
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: National Protocol on IBBS.						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	n/a	n/a	3.1.13	3.1.15	3.1.17	3.1.20
Narrative	CDC provided training on IBBS approximately ten year ago. While the country adopted IBBS practices when the IBBS was	CDC, through the Columbia ICAP Support Project, recently conducted an assessment in three Central Asian	After the assessments are completed, CDC and Columbia will promoted the development of a policy to standardize	The country will need time to develop IBBS protocols and to obtain legislative and regulatory endorsements from the	The country will require additional time to implement IBBS with technical support from the USG	The country will evaluate IBBS only after the country has had sufficient time to routinize the practice of preparing for and undertaking

	first introduced, data quality has decreased in recent years due to: (1) lack of standard operating protocols; (2) poor methodology and (3) lack of training and technical assistance to monitor assessment practices	countries. Initial findings suggest that more intensive training and the development of standard operating protocols/procedures are necessary to improve data quality, reliability and usage	the IBBS	Ministry of Health.		IBBS for selected key populations annually
Completion Date						
Narrative						

Policy Area: Stigma and Discrimination						
Policy: Facility Level Policies to Protect the Rights of Key Populations to Access Services.						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	3.1.13	3.1.16	3.1.18	n/a	n/a	n/a
Narrative	Stigma and discrimination remain challenges to effective provision of	This problem requires a long-term commitment to working	It will take time to develop model facility-level policies, to	A broader endorsement of this policy at a national level		

	services for key populations. Access to prevention, care and treatment services by key populations is inadequate, and there is limited political support for service expansion. Provider and community attitudes also affect access to services.	at the oblast level with local facilities and communitie s in order to protect the rights of key populations to access services. Advocacy to expand the resources available to key populations is essential, as continued assessment s of the size of unserved key populations	make them operational in model institutions and to expand this model at the facility level.	(requiring legislative and regulatory endorseme nt) is not a realistic goal. A review system at the facilty-level can be developed alongside the developmen t of a facility-level policy		
Completion Date						
Narrative						

Policy Area: Strengthening a multi-sectoral response and linkages with other health and development programs						
Policy: Policy to Support Service Delivery by NGOs.						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	3.1.13	3.1.16	3.1.19			

Narrative	NGOs are an essential component in the delivery of services to key populations at risk of HIV/AIDS, but their role is not facilitated through national technical or financial regulation. A policy to support service provision by NGOs is needed, to include VCT/rapid testing, overdose prevention, and manageme nt.	The country will need time to identify and define the components of a policy that would strengthen NGOs' role in the delivery of services to key populations. An intermediat e step will be required to build consensus on the bodies that can best represent the NGO community' s role in delivering services to key populations.	The country will need time to institutionali ze linkages between the formal health sector and NGOs as a basis for developing a policy document.			
Completion Date						
Narrative						

Policy Tracking Table

Turkmenistan

(No data provided.)

Policy Tracking Table

Uzbekistan

Policy Area: Access to high-quality, low-cost medications						
Policy: National Policies and Programs on ARV Treatment						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	n/a	3.1.13	3.1.17	n/a	n/a	n/a
Narrative	The country has recognized that ARVs are an essential part of treatment for PLHIV	While USG is not working directly in Uzbekistan, there are opportunities to collaborate and provide informal input to the work of UN agencies and the Global Fund, in order to promote a more enabling environment for a policy	The country will take time to develop a national ARV policy, since treatment is not at present a government priority.	Realistic projections of reaching stages 4-6 cannot be provided. The USG will continue to provide input to the work of other agencies.		
Completion Date						
Narrative						

Policy Tracking Table

Central Asia Region

(No data provided.)

Technical Areas

Technical Area Summary

Technical Area: Care

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	574,576	0
Total Technical Area Planned Funding:	**574,576**	**0**

Summary:

Note: As a TA model in a MARP driven epidemic, CAR PEPFAR does not program for pediatric care and support, food and nutrition, or orphans and vulnerable children; consequently, these areas are not covered in this technical area narrative.

Overall programmatic strategy in care

For the 62,871 people living with HIV in CAR, the need for care extends through each point from diagnosis of infection; referral to and enrollment in HIV primary care services; prophylaxis, diagnosis and treatment of associated infections; initiation and adherence to antiretroviral treatment (ART); and palliative care for those with advanced HIV disease. The PEPFAR program in CAR primarily focuses on prevention among MARPs and has limited activities targeted at care and treatment, as we believe that building the capacity of state health systems to prevent new infections is a smarter use of our resources and more likely to create a sustainable, country-led approach. The USG provides TA to complement and strengthen the services funded by the local MOH and the GFATM. In Central Asia, PEPFAR supports the implementation of a minimum package of care and support services for PLWHA. This package includes appropriate use of cotrimoxazole prophylaxis, screening for and treatment of TB and other OI, prevention for people living with HIV (including couples-based counseling, RH counseling, and counseling for family members) psychological support and palliative care. Successful implementation of these services complements and enhances ART programs and contributes to national HIV prevention efforts.

Key accomplishments in the last 1-2 years

•USG and the Republican and Provincial (Oblast) AIDS Centers (RACs) jointly conducted baseline HIV Care and Treatment Assessments in KZ, KG, and TJ to obtain data on the scale and quality of existing health care interventions for PLWHA and their partners and to evaluate existing gaps and TA needs for expanding the scope and improving the quality and effectiveness of care and treatment. The USG is using the results of the assessments for program planning for FY12 and beyond.

•In KG, KZ, and TJ, the USG has implemented a multi-disciplinary team (MDT) model to improve treatment adherence among PLWHA. The MDT is a patient-centered approach conducted by a team including doctors, nurses, psychologists, social workers, peer consultants, and narcologists where MAT is available. The MDT provides a range of medical and psycho-social support services. Families of PLWHA are also brought into the team, where possible, for additional support and to build a stable home environment.

•The USG provides TA to medical staff and non-governmental organizations working with PLWHA and PWID in the use of voucher referrals for medical services. As a result, medical staff tested 2,930 PLWHA and PWID for TB in pilot projects during FY11 and diagnosed 159 new cases of active TB.

Key priorities and major goals for next two years

The USG will focus on three strategic priorities in the next two years: improving access to quality care for MARPs and PLWHA; building individual, institutional and organizational capacity in KZ, KG, and TJ to deliver high-quality facility-based and home/community-based care for HIV-infected adults and children and their families; and strengthening the collection, dissemination and use of reliable data to guide programming. Emphasis will be

given to identifying and removing policy barriers to sustainability (e.g. barriers to government-NGO partnerships) and reducing stigma and discrimination experienced by MARPs and PLWHA at all levels. Couples-based counseling and gender-based approaches will be introduced to enhance the effectiveness of prevention with people living with HIV (PwP).
The USG will provide TA in developing clinical guidelines and SOPs for delivering a minimum package of services provided by the AIDS Centers to PLWHA. The SOPs will be based on WHO recommendations for care services and will be developed through the national technical working groups to ensure national ownership. The package of proposed services will include appropriate use of cotrimoxazole prophylaxis; screening and treatment of TB; HIV prevention counseling, including couples-based counseling and counseling and testing for family members; psychological support; reproductive health counseling; treatment of OI; and palliative care for AIDS patients. Trainings on SOPs with follow-up monitoring will be conducted on a regular basis in pilot programs to enhance facility-based care, palliative and home-based care, and HIV PwP.
The USG will continue to strengthen MDTs, build human capacity at the primary care level, and increase community involvement in HIV care through organizational capacity-building for the non-governmental organizations that provide HIV services to PLWHA.
Beginning with FY 12 funds, PEPFAR CAR will work with governments in the region to strengthen country programs, policy, and budgetary support for targeted MARPs programming. Activities will help enhance government partnerships with NGOs as mechanisms through which to reach MARPs. PEPFAR CAR will also assist central and local government bodies to develop the policies and financial systems needed to contract with (or provide direct funding to) nongovernmental organizations for MARPs service delivery.
Alignment with Government Strategy and Priorities
Universal access to ART is a priority for the governments of KZ, KG, TJ, and UZ. The Government of Kazakhstan (GoKZ) purchases ARVs from the state budget under its multi-sectoral health care reform program while the GFATM purchases ARVs for TJ, KG, and UZ.
In FY12, the USG will complete comprehensive assessments of care and treatment services provided to PLWHA by the local AIDS Centers in selected sites of KZ, KG, and TJ. These assessments are conducted in collaboration with the RAC as well as selected provincial (oblast) AIDS Centers. The care and treatment programs assessed are primarily funded by the state health budget in KZ and by the GFATM in KG and TJ. Preliminary results indicate that gaps in care are legion, with services provided to PLWHA limited largely to ART. Cotrimoxazole prophylaxis is generally not provided. Although more than 80% of persons diagnosed with HIV have been enrolled in care, fewer than 50% had at least one visit to the AIDS center during the previous 6 months. Active surveillance of patients enrolled in care for ART-eligibility (at least one CD4 test result in the previous six months) is 27–46% in KZ and less than 30% in KG. Just over half of registered PLWHA are screened for TB several weeks after enrollment in care and every 12 months thereafter. Although those diagnosed with active TB generally receive treatment, referrals between HIV and TB services are inconsistent at best. Very few PLWHA receive isoniazid prophylaxis, and screening and treatment for other OI remains suboptimal. Palliative services are underdeveloped throughout the region with no home-based palliative care services available in CAR.
HIV prevention is not provided as part of routine care for PLWHA outside of USG-supported pilots. Condoms are available through USG and GFATM-supported projects upon request, but active condom promotion is rarely practiced and supplies are inconsistent. Neither effective risk reduction counseling nor safer pregnancy and family planning counseling are systematically integrated into care for PLWHA. Specialists at the AIDS Centers and primary health care providers responsible for providing care and treatment to PLWHA need additional guidelines, training, and SOP to initiate positive prevention counseling on PwP. Aside from terminally ill patients, there are no established requirements to determine which HIV-infected patients are eligible to receive community-based services, and visiting nurses at the AIDS Centers are severely understaffed.
Psychosocial and counseling support services to PLWHA are available through a network of NGOs funded by USG and the GFATM. However, availability of these services is very limited, and high levels of stigma, especially in rural areas, prevent PLWHA from utilizing them even where they are available. Referrals and linkage systems are weak: while PLWHA are referred from NGOs to facility-based services, it is rare that AIDS Centers refer patients to NGOs for support groups and counseling.
With FY12 resources, the USG will support governments in KZ, KG, and TJ to strengthen the quality of a comprehensive package of care and support services for PLWHA both at the national level through policies and

clinical practice guidelines and at the service delivery and community levels. The USG will provide technical assistance to AIDS Centers and NGOs to strengthen the linkages and continuum of care between these two vital components of patient-centered care for PLWHA. Involvement of PLWHA in planning, designing, and delivering services is an essential component of the USG approach.
Adult care and support
USG programming in CAR is directed toward prevention of new infections and building high-quality care and support services for those who are known to be capable of transmitting HIV infection - an important component of prevention efforts. Current care and support services are inadequate with low numbers and proportions on treatment, poor adherence, and high drop-out rates reported by both governmental and non-governmental sources (although hard data is scant), and an unknown number in need of second-line ART. Without targeted interventions to assess and improve care services, PLWHA have little motivation to seek care, and prevention opportunities will continue to be missed. The USG will conduct "missed opportunity studies" on the entire chain of identification and care of HIV-positive individuals from initial screening to second-line ART.
The reasons for poor coverage and loss of continuity are many, yet specific opportunities for closing the gaps have not been systematically explored. HIV-positive patients often leave care, but national statistics are difficult to obtain and definitions of lost-to-follow-up differ among ART sites and countries. In a 2009 USG-sponsored study in Almaty and Temirtau, Kazakhstan, 50% of registered PLWHA not receiving ART were lost to follow-up. The small number of service sites probably contributes to poor coverage: services are centralized in a handful of Oblast AIDS Centers (none in Turkmenistan) in each country, and travel is difficult throughout CAR. In addition, there are virtually no electronic health information management systems in any AIDS Center network in CAR, and indicators used in clinical services monitoring and evaluation vary in number and quality. How well care of HIV-infected pre-ART patients is managed, and linkages to PwP or family planning services, is uncertain, as is the content of pre-ART care.
Although government-issued guidance (prikazes) for management of PLWHA mandates a battery of tests for associated infections (UZ requires testing for hepatitis B and C, toxoplasmosis, herpes, chlamydia and TB), the extent of adherence to these guidelines is unknown. Many of these co-morbidities are likely to be common among PLWHA throughout CAR, especially in PWID. In particular, hepatitis co-infection rates are believed to be high, although few national statistics are available. The CAR HIV sentinel surveillance system provides some data, but numbers of HIV-positive patients are insufficient to give accurate data on hepatitis C virus (HCV)/HIV co-infections.   A USG-sponsored study in two sites in KZ found that in Almaty, 79% of HIV-infected patients were co-infected with HCV and 12.5% with TB; in Temirtau, 71% were co-infected with HCV and 38.1% with TB.
The KZ, KG, and TJ, the USG has introduced a patient-centered approach to care for PLWHA, MDT which consists of doctors, nurses, psychologists, social workers, peer counselors and, if MAT is available at the site, a narcologist. Working in coordination with a number of health care sectors, the team provides a range of medical and psycho-social support services. Families of PLWHA are also brought into the team, where possible, for additional support and to build a stable home environment. All members of the team sign an agreement expressing full commitment to participate in the program.
The MDTs are led by UGS supported social workers, who complete a risk assessment with the client, identify barriers to adopting safer behaviors, and develop an action plan designed to support healthier behaviors and increase uptake of "friendly" medical and social services. Services for PLWHA provided by the MDTs also include information, education, and communication (IEC) materials disseminated to reinforce key messages through interpersonal communication (IPC) activities. IPC activities include individual educational sessions, educational mini-sessions, group discussions, educational peer trainings, informational campaigns, and other events held with the help of professional outreach workers, community-based volunteers, and multidisciplinary team specialists. Condoms donated from GFATM, along with information on their use, are distributed among PLWHA to prevent secondary HIV transmission to their partners.
PLWHA are provided with information on health services with referrals to providers trained in "MARPs friendly" services. Services include testing and treatment of STIs, ART, and TB testing and treatment services as needed. The USG also refers PWID to TPs and NSPs, to DICs, and to MAT, where available. The USG provides reproductive health and family planning service referrals and messages on prevention of mother-to-child transmission (PMTCT). As many PLWHA are distrustful of providers and face discrimination when they reveal their status or behaviors, outreach workers escort PLWHA to services.

With FY12 funds, the USG will continue to support nine MDTs, three each in KZ, KG and TJ to increase coverage of PLWHAs and advocate to institutionalize and scale up this model in other regions of each country. Inclusion of MDTs at the national level will help ensure sustainability and take this approach to scale.
With FY12 funds the USG will use guidelines developed jointly with the MOHs to conduct a series of trainings for clinicians at the Oblast AIDS Centers to deliver high-quality, facility-based and home/community-based care for HIV-infected adults and children and their families. Models of home-based care by MOH providers may be included through a clinic-based visiting nurse program funded by existing national resources or by the GFATM. To further facilitate the use of newly developed guidelines, the USG will target two sites each in KZ, KG, and TJ with direct assistance to the Oblast AIDS Centers in implementing evidence-based care and support services for PLWHA. As part of this technical assistance and capacity building, the USG will establish regular supervisory and monitoring visits to these pilot sites. It is expected that the proposed package of services and integration of the newly developed clinical care guidelines into the daily practice of the AIDS Centers will result in higher retention rates, improved quality of life, and better treatment outcomes for PLWHA.
TB/HIV
Despite the fact that TB is the major cause of mortality among PLWHA in CAR, TB screening in this population is inconsistent. In general, TB screening is not done at ART sites, although according to approved protocols, all PLWHA enrolled in care should be referred out for chest X-rays. In general, there are no TB-related infection control practices in place at ART sites. In Kyrgyzstan, only 56% of PLWHA were screened for TB within the first two weeks following enrollment into HIV care services, and the average time between enrollment and screening was 75 days. In Kazakhstan, the figures are 49-60%, and 60 days, respectively. Isoniazid prevention therapy (IPT) is in theory available at TB centers for PLWHA who are confirmed not to have active TB disease. However, IPT continues to be controversial in CAR, in part due to high Isoniazid (INH) resistance rates among new TB cases. It is not commonly prescribed; when it is prescribed, ART centers do not monitor adherence.
To strengthen TB/HIV clinical services in CAR, USG employs a patient-centered approach to treatment adherence among PLWHA, a MDT which consists of doctors, nurses, psychologists, social workers, peer counselors and, if MAT is available at the site, a narcologists. Patients who are co-infected with HIV and TB enrolled in these programs and receive intensified follow-up and support by outreach workers (supported with non-PEPFAR funds) to monitor TB treatment adherence. Tuberculosis infection control is part of the outreach conducted by NGOs: MARPs are informed about infection control if a TB case is identified, including the need for adequate ventilation, symptoms of active TB, and the need for regular TB testing for contacts. Finally, the USG trains community leaders to act as TB “treatment supporters” and to recruit family members and friends of TB patients as treatment supporters. These volunteers provide direct observation of TB treatment and coach patients to improve adherence. The USG provides counseling on accepting one’s HIV positive status and overcoming internal stigma as well as opportunities for PLWHA to receive added community support through peer and self-help groups.
USG currently supports a regional project to enhance national capacity to implement the Three I’s (intensified case finding, isoniazid preventive therapy and infection control) as part of comprehensive national planning to address TB-HIV co-infection. KZ was selected to participate in an international workshop to develop requests for follow-on TA to strengthen implementation of this important work, and five KZ country representatives have been trained to serve as a resource for scaling-up the Three I’s principals for the entire CAR region.
Significant challenges remain to strengthening TB/HIV services, including lack of coordination between HIV, TB, primary care and other clinical services to better serve the needs of PLWHA; discriminatory attitudes among some health providers in regard to ARV and TB treatment; isolation of penitentiary health services from the civilian system; outdated legislative and clinical protocols on TB/HIV co-infection; and a lack of confidential working space for social workers at the AIDS Centers. With non-PEPFAR funds, the USG will continue advocating and working to improve coordination between HIV, TB, and primary care services at the national through trainings and capacity building for service providers and key stakeholders to address these issues. The USG will continue to build local case management capacity for co-infected patients, including M&E activities, and introduce important new diagnostic instruments for rapid TB diagnosis, particularly for PLWHA, such as the GeneXpert system. The USG will continue to conduct regular trainings for MDT specialists and routine monitoring site visits to support the work of the MDT.
Gender and MARPs
The USG has found that twice as many men have been provided with the minimum of care service as women (as

reported in the Annual Program Results). These data are based on a program targeted toward MARPs, primarily PWID, who make up 45-50% of PLWHA across the region. While PWID are more likely to be men, the USG will focus more on identifying female PWID to improve their access to care and support services. In doing so, the USG will build on a recent assessment on women's access to harm reduction and other services in KZ and KG. Current USG care services target PLWHA by providing or referring them to a comprehensive package of medical and psychosocial support services through the multi-disciplinary approach described above, in coordination with a range of healthcare sectors in KZ, KG, and TJ. The MDTs also refer and link PLWHA to community-based support groups.

In FY12, the USG will prioritize reducing the stigma and discrimination that MARPs experience when accessing HIV-related care and support services. The USG supports capacity building for health service providers, which includes training in communication skills to improve the quality of services MARPs receive. This type of capacity building will be expanded to include special attention to female PWID and MSM; both populations face compound barriers to care and support services as a result of transgressing gender norms and engagement in perceived immoral behavior. Through the Gender Challenge Fund, the USG will expand its referral and voucher program to include GBV care and support services. MARPs often face sexual violence and coercion to engage in risky behaviors which puts them at increased risk of acquiring HIV. In TJ, the USG will add a GBV module to the current training program for outreach workers, specifically in relation to female sex workers, female PWID, and MSM. This module will be based on identified needs but may include awareness-raising, the health consequences of GBV, exploration of how the community responds to the issue, understanding where to go for assistance, and self-defense. Outreach workers will be educated on how female SW, female PWID, and MSM are at risk for GBV, how to respond to GBV in their work, and where and how to refer people from these groups for services related to GBV. Outreach workers will in turn transmit this information to their clients as well as provide them referrals for HIV STI testing for sexual assault survivors; crisis housing and/or legal services through USG and PPP supported drop-in centers; and psychosocial support services.

In addition, data from a care and treatment assessment in Kazakhstan, Kyrgyzstan, and Tajikistan will be used to inform development of a comprehensive care and treatment program in pilot sites. This will include analyzing sex-disaggregated data and assessing how the care components can better reach populations currently lacking access.

Human Resources for Health (HRH)

The USG will strengthen the capacity of social workers to serve the unique needs of MARPs, and will support training for medical and non-medical personnel to assess MARP risks and encourage VCT. The USG will work to address the challenges of accessibility and quality of HIV care for MARPs through training, mentoring, and other expert support to providers as well as NGOs and other MARP coordinating bodies to assist in the formation of family support groups for PWID. Issues surrounding the special social support needs of female MARPs will be identified and regular mentoring will be provided to strengthen the quality of services available for female MARPs, including family-based approaches.

Outreach workers play a central role in providing coordinating care and treatment services for PLWHA, yet their role, responsibilities, and development needs are barely acknowledged in CAR. Through the many activities described above and in other TANs, the USG will work to raise the profile of outreach workers and ensure they are adequately considered in human resource planning to address the epidemic.

Laboratory

In Central Asia, laboratory issues are not coordinated by a special department within the MOH structure, and laboratories operate without a central supervisory or regulatory body. For example, laboratory services related to diagnostics of HIV, TB (including liquid culture) and HIV-related opportunistic infections are provided through a series of vertical systems of the AIDS Centers, TB institutions, Blood Banks, Sanitary–Epidemiology Services, and STI services. The architecture of each vertical laboratory system is a tiered-lab network that includes 3 laboratory levels including the National, Provincial (Oblast) and District (Rayon) levels; these tiers are based on geographic coverage instead of functional capacity. The national level laboratories usually have reference laboratory status within their respective vertical structure; however, none have been accredited by an international accrediting organization. Each country has its own mélange of quality assurance measures, none of which meet International Standards Organization TC212 (ISO/TC212). The designated reference laboratories do not have the capacity to assume responsibility for external quality assurance for the labs they oversee. Coordinating mechanisms directed by

MOH are essential for an effective laboratory network, and the lack of integrated management of laboratory services among vertical structures reduces the distribution and sharing of experience, best practices, and common challenges; it precludes opportunities for collective purchasing or distribution arrangements to reduce costs and shortages of supplies.
The USG will encourage CAR countries to develop coherent strategic plans for improving integrated lab services for public health and clinical care services. The USG will also support the review of existing laboratory policies and use the assessments to help each MOH formulate a five-year National Laboratory Strategic Plan.
Laboratory workers in CAR have very few opportunities for pre- and in-service training. Most medical colleges and related institutions lack the ability to train laboratory specialists, and do not provide comprehensive post-graduate programs for these scientists. The USG will provide assistance to fill the training gaps identified at during laboratory assessments.
The CAR Republican AIDS Centers oversee all sites where testing for HIV/AIDS is performed. Each Republican AIDS Center is mandated to monitor the quality of laboratories that diagnose and monitor patients for HIV and co-infections, for example to provide standardized plasma samples for proficiency testing (PT). However, they have difficulty managing quality assurance (QA) even for the Oblast AIDS Centers which they directly oversee. There is an urgent need to expand QA programs to all testing sites including VCT, ART clinics, National Blood Transfusion Centers, and clinical laboratories. The USG will work closely with each MOH to reinforce existing Quality Assurance/Quality Control (QA/QC) programs and to push out external QA programs, including PT and site visits, to the oblast level to ensure broad national coverage. The USG will assist MOH in enrolling in supranational PT for rapid testing, ART clinical monitoring and other monitoring as necessary.
Strategic Information
Currently, the use of unique identification code (UIC) to track the provision of services across facilities and community-based programs at the individual level is geographically limited. The lack of a bidirectional referral tracking system between care and treatment services continues to be a challenge with the limited UIC roll-out. The capacity to collect high quality data and the demand for data use remain limited. In FY12, the USG will continue to support the improvement of strategic information under care and support by continuing to expand integration of UIC into the national HIV programs and national health information system (HIS); strengthening patient tracking systems to improve referral and monitoring among various services; and conducting on-site training, supportive supervision, and data quality assessments to improve data quality and use at facility and community-levels. The USG will also support workshops on M&E at the national and oblast levels to promote the National M&E system; assist the MOH to integrate HIV program monitoring tools and standardize national data collection forms across program areas; provide TA to improve the frequency and content of data feedback to community and facility level staff and program implementers; and train national and local partners on data collection, analysis, and dissemination of data.
Capacity Building
While trying to address the increasingly divergent capacity-building needs of five Central Asian countries, the PEPFAR program's primary approach has been the provision of strategic and targeted TA to local MOHs, to the GFATM, which is the largest funder for HIV/AIDS activities in the region, as well as to other donors. The PEPFAR program in Central Asia primarily focuses on prevention and has limited activities targeted at care, especially as other donors are focused on this issue. Technical assistance to improve the care of PLWHA has focused on the improvement of linkages between treatment and care services and the development of policies and protocols targeted at reducing stigma and discrimination.
The PEPFAR CAR team took its first major step toward a strategic framework in FY11, setting a key objective to strengthen the capacity of the health care system to deliver improved, expanded, equitable, and sustainable HIV services for MARPs, PLWHA, and their families. In FY12, we have continued to critically examine our strategic priorities and refine our activities in order to make more effective gains toward this objective. Sustainability of care services for PLWHA will require much greater attention to removing policy barriers to access and quality of care, to strengthening capacities of institutions, organizations and individuals to plan and manage services for MARPs, and to significantly broadening the basis for collaboration between governmental agencies and non-governmental organizations. Improving access to care by MARPs will require wide-ranging efforts to reduce stigma and discrimination at all levels. Better data collection, aggregation, and analysis for decision-making is a pressing need that cuts across all interventions and objectives.

The USG will focus on responding to requests from the MOH in Kazakhstan, Kyrgyzstan, and Tajikistan, to provide TA to enhance individual, institutional, and organizational capacity for HIV care and treatment. Technical assistance will target provision of high-quality comprehensive HIV care and treatment packages, including ARV, cotrimoxazole prophylaxis, TB screening, and treating persons dually infected with TB/HIV, including when to initiate ART. In FY12, the USG will complete assessments of the care and treatment systems in Kazakhstan, Kyrgyzstan, and Tajikistan. Based upon these three assessments, the USG will develop recommendations for system improvement and conduct in-service trainings for medical staff on ARVs, treatment schemes, and adherence. On-site supervisory visits will follow to ensure that skills and knowledge obtained during trainings are translated into practice.

Technical Area: Governance and Systems

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	1,247,010	0
HVSI	954,748	0
OHSS	721,758	0
Total Technical Area Planned Funding:	**2,923,516**	**0**

Summary:

While each Central Asian republic must be considered individually overall, the region faces a broad range of strategic challenges to implementing effective national HIV/AIDS responses. First, countries have largely vertical, specialized systems of health care delivery that lack the coordination or referral mechanisms needed to facilitate access to a continuum of HIV/AIDS prevention, treatment, and care services. The HIV epidemic in the Central Asia region is concentrated in most at-risk populations (MARPs). Policy, legislative, and regulatory environments and practices across the region fail to address MARP service needs; constrain MARP access to services and violate the rights of MARPs; limit implementation and scale-up of evidence-based prevention, treatment and care services such as medication assisted therapy (MAT) and overdose prevention; and generally overlook the potential role of non-state actors, including nongovernmental service organizations (NGO) and coordinating bodies, civil society, and the private sector in the delivery of HIV/AIDS services. In countries across CAR, there are high levels of social stigma and institutional discrimination against MARPs, which affect both service supply and demand. Moreover, there is inadequate political commitment, leadership, and fiscal support for HIV programs focused on MARPs. Institutions, organizations, and individuals across the region lack the capacities and systems needed to effectively plan, implement, manage and monitor HIV/AIDS programs.

A number of cross-cutting systems issues also constrain the achievement of national HIV/AIDS program objectives in CAR countries. Uneven capacity in drug and commodity procurement and supply chain management limits the ability of governments to ensure reliable and continuing access to medications and commodities. Service providers, social workers, and other health professionals who interface with MARPs often lack the information and skills needed to provide quality services and referrals. Laboratory diagnostic capacity and quality are also inadequate, and ongoing problems associated with blood and injection safety have continued to result in sporadic nosocomial infections. In addition, CAR does not yet have the systems in place to ensure scientifically sound analyses of, and responses to, this epidemic. There is limited capability to oversee the collection, analysis, dissemination, and use of data, which seriously constrains both monitoring of the epidemic and the development of programs that are appropriately targeted to achieve prevention impact and respond to the epidemiology of HIV/AIDS.

CAR PEPFAR countries have either a national health program, which includes an HIV/AIDS strategy (KZ, KG) or a separate HIV/AIDS Strategy (TJ) that prioritizes and addresses prevention for MARPs. However, governments do not allocate the technical, human, and financial resources essential for targeted HIV/AIDS programming, relying instead on external resources including externally funded nongovernmental partners, to address program coverage

for MARPs. Beginning with FY12 funds, PEPFAR CAR will work with governments in the region to strengthen country programs, policy, and budgetary support for targeted MARP programming. Activities will help enhance government partnerships with NGOs as mechanisms through which to reach MARPs. PEPFAR CAR will assist central and local government bodies to develop the policies and financial systems needed to contract with or provide direct funding to NGOs for MARP service delivery.

For the past several years, USG programs have worked with national governance structures such as Country Coordinating Mechanisms (CCM), oversight entities such as Republican AIDS Centers (RAC), public sector facilities, NGOs, and civil society. Activities have supported the targeted delivery of outreach and HIV/AIDS prevention services to MARPS, helped improve the quality of HIV/AIDS care at the facility level, sought to reduce community and organizational stigma related to MARPs, and helped strengthen laboratory systems. While much has been achieved, additional, intensive work is needed to make the inroads necessary to contain the spread of HIV.

The USG will concentrate its efforts on three strategic priorities. First, it will aim to expand the availability of and access to comprehensive HIV/AIDS prevention, treatment, and care services for MARPs and reduce the policy, program, and attitudinal barriers (including stigma and discrimination) that constrain MARP knowledge of their HIV serostatus and limit access to services. Second, the USG will focus on systematically strengthening the capacities of institutions, organizations and individuals to enable them to more effectively plan, deliver, and monitor quality services for MARPs. This effort will include targeted support to ensure the quality of blood and infection control systems to prevent nosocomial transmission of HIV/AIDS in health care settings. Finally, the USG will build the capacity of public health institutions to collect, analyze, disseminate and utilize data in order to obtain accurate and complete information about the HIV/AIDS epidemic in CAR; to support policy development, program planning, and implementation; and to improve outreach prevention efforts and facility-based HIV/AIDS care and treatment services.

In line with these strategic priorities, the USG CAR PEPFAR program will support targeted activities which enhance national and decentralized leadership on HIV/AIDS; improve governance of the national HIV/AIDS response and increase local resources for HIV/AIDS programs; foster health policies and systems that facilitate access to more comprehensive care and address the legislative, regulatory and attitudinal barriers that constrain MARP access to services; strengthen the technical and management capacity of institutions, organizations and individuals to plan, deliver, manage, monitor and sustain HIV/AIDS services and commodities for MARPs; and develop the information systems needed to support policy and program planning and to measure the quality of, access to, effectiveness, and efficiency of HIV/AIDS services. In developing and implementing programs during the next few years, the USG will pay close attention to ensuring that approaches across the region support national program goals and are leveraged with efforts of other development partners to maximize impact and further the sustainability of USG investments while ensuring efficient use of USG resources.

In implementing FY12 HIV/AIDS programs in line with PEPFAR guiding principles, PEPFAR CAR will also operationalize core Global Health Initiative (GHI) principles. PEPFAR CAR programs will strategically coordinate its efforts to support country programs with those of key development partners including the GFATM, UN multilateral agencies and other donors in order to enhance efficiencies and returns on USG investments. USG partners will also focus on engaging private sector collaborators to support HIV/AIDS programs. PEPFAR CAR activities will further program sustainability by partnering with national and local leaders to build policies that promote gender equity in HIV/AIDS activities and services. For example, through a survey on PWID planned for KZ, KG and TJ, interviewers will also question non-injecting female sexual partners of PWID. These data will help shape HIV prevention programs to address the knowledge, behavioral and attitudinal needs of this group as well as issues of gender-related violence. Finally, in line with GHI's mandate, PEPFAR CAR will utilize ongoing monitoring processes and targeted evaluations to ensure that program activities and approaches are effective and contribute to the achievement of results.

The CAR PEPFAR program was initially developed to provide assistance in all five countries in the region; however, both TK and UZ took steps during the past several years to significantly limit external partner engagement in national HIV/AIDS programs. As a result, the USG PEPFAR program will focus most of its efforts on KZ, KG, and TJ, the three countries where it can currently make an impact. At the same time, the PEPFAR program will use regional activities, including regional meetings, to engage and influence HIV/AIDS policymakers and stakeholders in TK and UZ.

Leadership, Governance and Capacity Building, and Systems Strengthening

PEPFAR CAR's overall regional goal is to reduce new HIV infections and provide adequate treatment and care services for affected populations through strengthened and sustainable health systems. PEPFAR CAR will use FY12 funds to partner with countries to build national HIV/AIDS programs that are inclusive, that have the capabilities to increase access by MARPs to HIV/AIDS services, and that can attain planned results. Achieving this end will require a number of intensive, targeted approaches. PEPFAR CAR will work to advocate for and advance policies that facilitate the expansion of services for MARPs and promote MARP access to these services. CAR interventions will also assist countries to strengthen the technical and management systems that are essential to effective planning, implementation, and monitoring of the national HIV/AIDS response. To improve the continuum of HIV prevention, treatment, and care for MARPS, FY12 funds will support the development of protocols on integrated service delivery and help build the referral systems and linkages across services needed to provide more comprehensive care for MARPs. With FY12 funds, PEPFAR CAR will also strengthen the technical and management capacity of institutions, organizations, and individuals to plan, deliver, manage, and oversee HIV/AIDS services for MARPs. PEPFAR resources will support development of a national laboratory strategy to improve diagnostic effectiveness and lead to laboratory accreditation; the design and dissemination of standards of care that ensure the quality of facility-based HIV/AIDS treatment services; and the development of algorithms to operationalize evidence-based practices in blood safety. The USG will strengthen NGO internal management systems, organizational processes, and leadership and the initial rollout of a unified 'one monitoring and reporting system' that can be utilized by both government and NGO partners to monitor indicators for the national HIV/AIDS programs.

The USG will build on the training and mentoring efforts supported to date to undertake a more strategic, systematic, and coherent approach to capacity development, fostering national and sub-national ownership of HIV/AIDS programs. USG programs will help build the policies, systems, and capacities needed to engender more capable country level institutions, organizations and individuals that are better able to develop and implement national HIV/AIDS programs that can respond to the epidemic and achieve planned outcomes. PEPFAR CAR recognizes that to achieve this end, capacity building efforts will need to be designed, implemented and monitored in close collaboration with local partners and allow for the progressive transition of leadership to local partners during the next few years. Accordingly, CAR will use FY12 funds to partner with country level stakeholders from MOH, National HIV/AIDS Programs, GFATM, UN and other donor partners, in addition to NGO and MARP representatives to conduct rapid, structured diagnoses of key institutional and organizational cohorts. National and sub-national CCMs, local governance structures such as regional coordinating committees, organizations including RACs and NGOs implementing GFATM grants will be included in the assessments. The USG will also support rapid assessments of training needs for service providers, outreach workers and NGO technical and management staff. Data from these assessments will guide the collaborative development of capacity building strategies that will contribute to strengthened national HIV/AIDS program performance. FY12 funds will also be used to initiate implementation of country level strategies. Through this approach, strategies will guide systematic efforts to progressively enable countries to assume greater leadership, accountability, policy and financial sponsorship of targeted national HIV/AIDS programs. In light of the limited resources, PEPFAR CAR will work with stakeholders to prioritize efforts and identify ways to collaboratively finance and leverage resources in support of capacity building efforts.

A primary focus of USG assistance with FY12 funds will be to enhance leadership and governance of national HIV/AIDS programs. Best practice indicates that both national and regional officials should play key roles in planning and overseeing the national HIV/AIDS program efforts that are implemented at the local level. USG support will build on its TA efforts to systematically strengthen the operations, management and oversight effectiveness of national level CCMs as multi-sectoral governing bodies on HIV/AIDS. FY12 TA will target issues identified during the rapid assessment and will seek to build competencies of CCM members in core CCM functions, strengthen mechanisms for internal and cross-sectoral coordination and communication, and enhance the role of CCM structures in advocating for and shaping policies that support the national HIV/AIDS response. USG FY12 resources will also be used to build the planning, coordination, management and advocacy capacities of selected sub-national governance structures, such as regional coordinating committees. USG assistance will aim to enable local governance bodies to support local HIV/AIDS efforts in areas such as monitoring the implementation and effectiveness of HIV/AIDS activities; tracking progress against local HIV/AIDS targets and indicators; managing the collection of sound data; engaging in HIV/AIDS policy advocacy efforts; and, as appropriate, supporting the

development of regional HIV/AIDS strategies or plans.
Strengthened capacity of public sector facilities and NGOs providing HIV/AIDS services for MARPs will improve the quality and effectiveness of services. At the organizational level, USG activities will systematically enhance the management, organizational, programmatic and technical capabilities of public sector facilities and NGOs. Funding will prioritize NGOs providing services through GFATM grants and assistance will focus on assisting these organizations to better plan and provide services to MARPs and strengthen approaches to increase MARPs' access to quality services. Systematic capacity development efforts will be structured to progressively assist HIV/AIDS NGOs to become stronger and more mature organizations that are better able to network, collaborate, and contribute to national HIV/AIDS efforts.
The USG will focus on building the leadership and capacities of NGOs and other organizations working with PWID, MSM, SW and other MARPs, as well as MARP coordinating bodies such as the Kazakhstan Union of People Living with HIV/AIDS. Assistance to strengthen the core competencies of these organizations will enable them to function as advocates for MARPs and participate more effectively in HIV/AIDS policy advocacy and program development, implementation, and management. USG assistance will strengthen capacity to identify policy needs, develop policy advocacy agendas, dialogue with national and local government on advocacy issues, and plan and implement policy advocacy activities. USG assistance will also enable these organizations to actively engage in stigma reduction efforts, help shape MARP services program approaches, and participate in trainings on stigma reduction for health care providers, government bodies, media and selected other groups.
Strategic Information
The USG goal is to strengthen the capacity of public and private sectors to collect, analyze, manage, and utilize data for evidence-based planning and policymaking at all levels. To achieve this goal, the USG will support (1) the collection, analysis, interpretation, reporting, and use of SI to monitoring trends in the HIV epidemic to plan targeted prevention and focused care and treatment programs; and (2) the use of routine monitoring and survey data to rapidly improve program quality. USG CAR recognizes the need to build functional and integrated national health information systems (HIS) for planning and decision-making, and will leverage contributions of other major development partners in this area while directly contributing to systems that support MARPs programming.
During the past several years, the USG has played a significant role in supporting the governments of Central Asia to strengthen strategic information (SI) systems and outputs through collaboration with MOHs, National AIDS Centers, other government organizations, major international donors, local and international partners, and civil society. HIV/AIDS Sentinel Surveillance (HASS) has been standardized in KZ, KG, TJ, and UZ based on the UNAIDS/WHO Guidelines for Second Generation HASS. Since 2007, MOHs have conducted HASS without technical or financial assistance from the USG. This transition to host government ownership has been only partly successful, as the reliability and usefulness of the data have deteriorated. In FY09, USG renewed its commitment to assisting the MOHs to conduct country-led, high-quality surveillance and will continue to provide technical support in FY12. As HASS systems are now completely government-owned and managed, the USG will focus on continuing to build national capacity to improve the quality and usefulness of surveillance data. TA will be provided to expand HASS coverage in TJ and KG, both geographically (using pilot rural areas) and through additional sentinel groups (e.g., MSM). Standard Operating Procedures (SOPs) will be developed and TA will be provided based on the results from the national HASS assessments.
The USG recently completed comprehensive assessments of Integrated Biological and Behavioral Surveillance (IBBS) in KZ, KG, TJ and UZ; the results will help shape USG interventions to further improve the quality of surveillance data. The USG also provided assistance to produce accurate MARPs size estimations; these data will inform program target setting for specific MARP interventions. It should be noted, however, that the lack of transparency and data sharing by Central Asian governments, especially on surveillance and survey data, remains a major challenge in effective programming for MARPs. In FY12, the USG will intensify efforts to improve the overall IBBS systems. The USG will support MOH staff in revising and developing SOPs for IBBS in KZ, KG, TJ, and UZ. It will provide technical support to MOHs in KZ, KG, and TJ to conduct IBBS among sex partners of PWID, and will assist in the integration of size estimations into IBBS for PWID, SW, and MSM. The USG will support additional surveys and assessments focusing on PWID, SW, and MSM to effectively monitor and track HIV prevalence and related co-infections. In FY12, the USG will also support a survey focusing on non-injecting sexual partners of PWID to be integrated into the existing IBBS among PWIDs in the selected sites only (two per country) in KZ, KG, and TJ. Participants of the survey will be tested for HIV only. This activity will match the activities under the

successful application to the Gender Challenge Fund.
As noted, despite the institutionalization of HIV sentinel surveillance in the region, and the elevated importance of routine data collection, publicly available and reliable data on the burden of HIV and reliable size estimations among MARPs are still limited. The lack of a data sharing culture from Central Asian governments remains a major challenge for evidence-based programming in the region. In FY12, the USG will continue to play a leading role to build national capacity in data analysis, dissemination, and use of surveillance data. In collaboration with other donors, including UNAIDS and GFATM, the USG will work closely with MOHs to address the importance of data dissemination and data use to inform evidence-based programming in HIV prevention, care, and treatment.
With little national leadership in developing an integrated HIS, data collection is still largely paper-based and vertical across the health sector. The development of a national HIS to improve the integration and interoperability of data collection and reporting is at a nascent stage in this region, but progress has been made in recent years. The USG introduced the use of unique identifier code (UIC) in PEPFAR-funded MARPs programs as a pilot project in 2009. In FY12, at the request of the host governments, the USG will continue the expansion and roll-out of UIC into HIV programs and national HIS. The integration of UIC and HIS into the national M&E system will serve as a standardized and universal tool for the assessment of enrollment and service coverage in a range of HIV programs. The electronic patient-monitoring HIV case-based management system (EHCMS) is currently being scaled up and strengthened in KZ and KG with USG support. The USG will provide TA to MOHs in EHCMS in HIV clinical facilities. As part of USG's HIS technical support, PEPFAR will conduct trainings on the effective use of EHCMS to improve surveillance and clinical management of PLWHA and will develop data analysis algorithms and guidelines for EHCMS.
Currently, most nationally-collected and reported data are based on HIV testing and case reporting, and there is a great need to strengthen M&E capacity across CAR. The USG is supporting country-led implementation of national M&E systems and developing standard data collection methods in KZ, KG, and TJ. To enhance national program accountability, the USG will support approaches to strengthen M&E systems. The USG will also continue to improve the quality of routine data through strengthening the monitoring capacity of organizations involved in the national HIV/AIDS response; and developing and supporting routine program monitoring and evaluation capacity with an emphasis on data use and quality will be central to USG support in FY12. The USG will continue to conduct national M&E system strengthening workshops with participants from various ministries (including but not limited to MOH, Labor, Social Protection, Justice, and Education) and NGOs to assess the strengths and weaknesses of the current national M&E systems and to develop M&E strengthening plans to address these gaps.
These workshops should result in revision and streamlining of data collection and reporting formats, and targeted TA will be provided to the MOHs in the implementation of these plans. The USG will also continue to strengthen the MARP service monitoring capacity of NGO partners in KZ, KG, and TJ through training on the use of management information system (MIS), supportive supervision, and regular data quality assessments. The USG and its implementing partners will continue to provide TA to improve the frequency and content of data feedback to site-level staff, program implementers, and other stakeholders through regular reporting and dissemination of PEPFAR-supported sites. Local capacity in data collection and analysis will be built through training of representatives from national partners and MOHs on data analysis and dissemination of collected data.
The USG will also provide ongoing training on the Next Generation indicators to MOH staff. The USG will continue to strengthen the abilities of MOH staff to conduct behavioral assessments and analyze data to inform program development. The USG will strengthen utilization of a USG-provided electronic HIV case-based surveillance management system by providing on-site training to continue to improve data quality, consistency, and system functionality. With FY12 resources, the USG will intensify support for the elaboration and collaborative rollout of a unified 'one monitoring and reporting system' that can be utilized by both government and NGO partners to monitor indicators for the national HIV/AIDS program.
The USG will continue to closely monitor the impact of PEPFAR-funded programs by conducting periodic targeted behavioral surveys such as Tracking Results Continuously (TRaC) surveys in geographic areas where USG supported activities are being implemented. These surveys are designed to evaluate the effectiveness of PEPFAR programs for PWID, SW, and MSM based on changes in high-risk behavior and service coverage/uptake for these populations. In addition, the USG will also work closely with GFATM to assess the feasibility of harmonizing, to the extent possible, PEPFAR indicators with GFATM indicators used in the region.
Service Delivery

Throughout CAR, there are a number of challenges to the effective provision of comprehensive prevention, medical, and social support services required to provide quality care for MARPs and in particular for PLWHA. Services are provided through both NGOs and the public sector. For the most part, these services are not well coordinated even within facilities, and NGOs are not linked effectively to public sector facilities. Only limited progress has been made in reaching the prevention, treatment, and care targets needed to make an impact on the HIV epidemic.
Prevention programs for MARPs, which take place through outreach efforts largely outside of facilities, remain inadequate to contain HIV transmission in countries across the region. There are imbalances in geographic coverage as well as coverage of specific risk groups, irregular quality of interventions, and gaps in the availability of interventions. For example, interventions such as MAT are not widely implemented in CAR. Prevention programs are not sufficiently effective in reaching bridge populations nor the most marginalized and hidden MARPs, nor do they systematically address the gender dynamics influencing MARP behaviors.
Medical and social support services for MARPs are provided through vertical public sector facilities, which lack the horizontal linkages needed to ensure a continuum of care. As a result, care is fragmented, and MARPs do not receive the comprehensive services they should be provided in line with international standards and evidence-based best practices. Service quality is irregular due to the lack of updated protocols and guidelines needed to guide the effective delivery of services for MARPs, and due to the widespread stigma and discrimination against MARPs, which influences the care behaviors of many providers.
In response to these challenges, USG assistance to strengthen the effectiveness of service delivery is two-pronged. First, the USG supports limited direct prevention, treatment, and care service delivery through nongovernmental and public sector partners to help address critical gaps in the short term and to develop feasible models for service scale up. Second, the USG strategically targets service delivery resources towards improving the delivery of prevention, treatment, care, and support services supported by governments, the GFATM, and other donors. USG assistance will concentrate its efforts on strengthening key cross-cutting service-related systems that directly improve the availability, quality, and efficiency of services for MARPs. In response to country level needs and priorities, and in close collaboration with country counterparts and stakeholders, USG assistance will strengthen systems such as service referrals, service delivery protocols, drug procurement and supply chain management, quality assurance, HIV testing, blood and injection safety, case management, health information, and supervision and monitoring. In addition, the USG will work with country stakeholders to identify and prioritize key policy needs and catalyze the development of policies that will facilitate MARP access to care and reduce MARP barriers to care. Finally, the USG will systematically build the leadership, capacities, and core competencies of institutions, organizations and individuals to steward, deliver, monitor, and sustain improved quality services.
In addition to building effective referral systems at the facility level, a key focus of USG assistance will be on expanding and strengthening linkages between public and civil society service providers to assure a continuum of care (COC) able to address the needs of vulnerable populations from prevention through care. In FY12, the USG will assess current COC networks to enhance service access by identifying the strengths, weaknesses, and barriers to service expansion. Building on the results of the assessment, the USG will progressively build COC referral networks and strengthen COC network communications to ensure cohesive patient care, follow up, and support.
USG assistance to improve services will target both public sector and NGO entities, particularly NGOs implementing GFATM grants, to strengthen coordination between the public sector and NGOs in the delivery of comprehensive care for MARPs. In FY12, the USG will pilot, monitor, and assess the impact of NGO-public sector collaborative service models as mechanisms to increase access to care. Approaches might include placing NGO counselors or social workers within public sector facilities providing HIV/AIDS services or enabling a public sector physician to work through NGO networks to expand the availability of testing. FY12 funds will also support the design, implementation, and assessment of other small scale pilot activities aimed at improving access to services by selected high risk, highly marginalized populations.
In KZ, KG, and TJ, the USG will provide TA to the National Blood Services aimed at implementing evidence-based practices that ensure the safety of blood collection and supply. At the national and local level, we will undertake efforts to improve facility-based HIV services for MARPs along with HIV-related laboratory services.
Human Resources for Health
To address issues of human resources in health, the USG focuses on improving the systemic weaknesses and capacity deficits that prevent MARPs from accessing high-quality HIV prevention, care, and treatment services. USG activities in FY12 will continue to strengthen the technical knowledge of providers through targeted training

and mentoring. The USG will help institutionalize improved practices through the development and dissemination of enhanced standards of practice and continue to build the capacity of national-level providers (e.g. RAC staff) and managers (e.g. NGO directors) to expand the range and quality of services being provided through public and NGO settings. The USG will work to ensure that a range of social support services are introduced and continually improved to meet the needs of the populations they serve. We will pilot approaches such as using trained social workers for MARPs, services delivered by NGOs and Community Based Organizations (CBOs), and self-help groups, and working with stakeholders to institutionalize these approaches.

Laboratory Strengthening

In post-Soviet countries, including CAR, laboratory issues are not coordinated by a special department within the MOH structure, and laboratories operate independently with a lack of integration between different laboratory systems. Laboratory operations are regulated based on numerous executive orders (prikazes) issued by health care authorities at different (central and local) organizational levels; however, comprehensive strategic plans on the development of laboratory services do not exist. Coordinating mechanisms directed by MOHs are essential for an effective laboratory network and the failure to provide integrated management of laboratory services between the vertical medical services structures (of CAR countries) reduces the distribution and sharing of advanced accumulated laboratory experiences. CAR laboratories have been relatively ignored with respect to pre- and in-service training. Medical colleges and related educational institutions of most CAR countries lack the ability to adequately train laboratory specialists and do not provide comprehensive post-graduate programs for these scientists. Thus, restructuring and strengthening healthcare laboratories, including enhancing laboratory technical and managerial expertise, is a priority for healthcare reform processes in CAR.

The USG will provide TA to improve laboratory capacity in CAR. The USG will encourage CAR countries to develop coherent strategic plans for improving integrated laboratory services for public health care. The USG will support the review of existing laboratory policies and use the assessment documents to collaboratively formulate a national laboratory strategic plan for HIV and other related diseases for CAR countries. The USG will work at the organizational level with different vertical structures of CAR MOHs (HIV/AIDS services, blood transfusion services, TB control services, and others) to ensure integration and broad capacity building. USG efforts will concentrate on providing technical support to implement robust Laboratory Quality Management Systems (LQMS). The USG will help develop laboratory quality indicators and implement internal focused audits to monitor effectiveness of LQMS and quality improvement initiatives. National reference and oblast-level laboratories will be targeted and supported to initiate the unique accreditation process similar to that of the WHO-AFRO laboratory accreditation scheme. The USG will support development and adequate coverage of external quality assessment (EQA)/proficiency testing programs.

The USG will support reinforcement of local referral networks and linkages throughout the vertical systems (HIV/AIDS, TB, blood transfusion services, and others), through development of effective mechanisms for specimens and patients' referrals to ensure laboratory services are easily accessible and able to provide accurate and reliable results in a predictably quick turnaround time.

The USG will collaborate with all national and international partners to coordinate activities and to ensure that donor funds are being leveraged.

Despite the MOH requirement that all laboratories be directed by a medical doctor, there are shortages of trained physicians. In general, senior laboratory staff are committed, enthusiastic, and well-trained in the general laboratory disciplines but lack specialized training in operating modern, state of the art, laboratory equipment. The USG will provide assistance to fill the immediate training gaps identified at laboratories including assistance with laboratory training and development of a quality-assured system associated with providing reliable and accurate CD4 testing and viral load (VL) measurements. The USG will support capacity building of quality management personnel to ensure sustainable and continued expansion of the LQMS that meet internationally accepted standards. In collaboration with MOHs, USG partners will determine the types of training most appropriate to each country and will incorporate several different methods of training, such as in-service training, mentorship, and preceptor programs at different levels of the laboratory structure. To ensure sustainability and country ownership, the USG will support the development and implementation of curricula for pre-service training for laboratory practitioners. The pre-service curricula will incorporate a full spectrum of testing, LQMS, and HIV-related content in the laboratory curricula.

Health Efficiency and Financing

To strengthen national and sub-national program fiscal accountability, FY12 funds will support TA to improve financial and accounting systems and capacities within both the public and NGO sector. The USG will also give greater focus to enhancing the financial viability and sustainability of NGOs by assisting NGOs to diversify funding through approaches such as social contracting with governments, corporate support, and community contributions. Targeted TA will strengthen the soundness and transparency of NGO financial management systems. For more mature NGOs, USG assistance will also support the development of financial systems to facilitate NGO funding through a variety of donors to enable these NGOs to provide sub-grants to other NGOs or HIV/AIDS organizations.
Creating an enabling HIV/AIDS policy environment – both at the macro and operational level - and facilitating effective policy implementation are instrumental to efforts to expand access to and utilization of high quality services targeted to MARPs. USG activities will support comprehensive approaches that engage multi-sectoral public, multilateral, nongovernmental and private sector stakeholders to promote policies which expand MARP access to comprehensive care and reduce key policy, legal, regulatory and fiscal barriers that constrain MARP access to services. Where feasible, the USG will leverage policy efforts with those of other USG agencies and programs to intensify impact and results.
The HIV/AIDS policy environment across Central Asia ranges from prohibitive in UZ and TK to progressive in KG. However, in all Central Asian countries, MARPs are stigmatized and have limited access to health care institutions. To improve MARP access to HIV services, the USG will also take new steps to address stigma and discrimination in the region.
The USG will support a strategic approach to policy development which will strengthen the capacity of national and local policymakers and stakeholders to analyze and address key policy barriers; improve collaboration between NGO, private and public stakeholders to plan and advocate for needed policy and legislative reforms; and build the systems needed to ensure transparent and participatory policy development and implementation.
Concentrating on fostering policies that enhance access by MARPs to more comprehensive and higher quality care, the USG will work with key HIV/AIDS stakeholders to jointly undertake a rapid desk review of policy assessments conducted during the past few years and prioritize policy needs; develop a strategic policy agenda; establish mechanisms and processes for inclusive development and formulation of evidence-based policies; and advocate to a broad range of policymakers, including parliamentary leadership, to support policy reform. Where appropriate, the USG will leverage programs that support Parliamentary development, both to educate HIV/AIDS stakeholders on the complex policy process and engage Parliamentary Health Committees as key participants to this process.
Reliable costing data is key to the development of HIV/AIDS program policies as well as for program decision-making about service and system priorities. With FY12 funding, the USG will provide targeted TA aimed at enabling national and local HIV/AIDS stakeholders to analyze, interpret, and utilize costing data, to support policy advocacy efforts, and to assess and promote more effective and efficient resource allocation.
The USG will collaborate with government, nongovernmental and donor stakeholders, and decision-makers on targeted activities to inform country resource allocations on HIV/AIDS. The USG will introduce a strategic planning model that links national program goals and resource levels to program outcomes and provides information on the cost and effect of different approaches on the achievement of national goals. The USG will use this activity to improve understanding of the effect of resource allocation on program results and build capacity in developing realistic budgets that support the achievement of national goals.
To strengthen the financial sustainability of the National AIDS Program in CAR, the USG will explore the feasibility and potential to introduce national accounts service assessments (NASA) during the final two years of the regional program. The aim would be to build capacity at the national and local levels in using NASA data to support ongoing programming, financial planning, and budgeting for increased government contributions to HIV/AIDS.
Supply Chain
A critical element of effective service delivery, and a critical component of a national health system, is having the appropriate systems in place to ensure that HIV/AIDS services have reliable access to a steady supply of essential drugs and commodities. CAR governments have uneven capacity in drug and commodity procurement and supply chain management, which limits their ability to ensure reliable and continuing access to medications and commodities. The GFATM provides resources to support country commodity and drug procurement and distribution. KZ has taken over and resourced, from the government budget, selected procurement functions. However, all countries in CAR would benefit from targeted assistance to enable them to accurately quantify needs, procure quality drugs and commodities from reliable suppliers at reasonable prices, and maintain the supply

systems needed to ensure the right commodities in the right place at the right time. The USG will continue and intensify assistance on procurement and supply management with the aim of building country capacity to independently ensure reliable supplies of HIV/AIDS drugs and commodities in years ahead.
Gender
USAID/CAR supported a gender assessment in all five countries in 2009 which revealed the need for gender-related HIV/AIDS training, monitoring of program impact to measure relative changes of interventions on both men and women, and the development of targeted approaches to address gender in the framework of HIV/AIDSAIDS programs. With FY12 resources, the USG will give strategic focus to reaching both male and female MARPs, including sex workers, IDUs, and MSMs, as well as to assisting clinic-based and outreach providers to strengthen how they work with both male and female MARP groups, including MSM. Prevention activities among MARPs will provide both males and females with support and services to prevent sexual transmission while promoting approaches such as peer outreach and positive prevention to access additional MARPs and protect MARP 'bridge' partners from HIV-infection. The core packages of services for MARPs, HIV infected or otherwise, will be expanded to include referrals to reproductive health services as well as screening for gender-based violence.
As one of its key strategic approaches, the USG builds capacity of healthcare providers (including female health care and outreach workers) at all levels of the health system. The USG will continue building health workers' skills in undertaking HSS activities and strengthen competencies in the collection, analysis and use of data. Female health workers have conducted sentinel surveillance on treatment and care, and in FY12, they will use these skills to assess data quality assurance in KZ, KG, and TJ. In addition, female health workers are trained on conducting IBBS. In FY12, through the gender challenge fund, the USG resources will support efforts to survey non-injecting sex partners of PWID, who are often women. In addition to being offered HIV testing, survey subjects will receive information on HIV transmission particularly related to their sexual relationships with PWID. Results from the survey will be used by USG partners to inform HIV programming.
At the community level, the USG trains outreach workers on reaching MARPs, including female sex workers, MSM, and female PWID, with a referral and voucher system for accessing HIV and other services. In FY12 a pilot in TJ, through the gender challenge fund, will provide outreach workers with special training on GBV, designed to equip them with skills to refer MARPs to GBV services and to hold workshop sessions with MARPs on GBV and other health topics. Since GBV is an issue that requires a multi-sectoral response, the project will engage police through special sessions on GBV integrated within a larger program on HIV related to MARPs. These sessions will assist police in better understanding GBV, its roots and health consequence, and local resources available for survivors of GBV. In doing so, police will also be linked with outreach workers, so they can seek their assistance as needed and provide a comprehensive response to GBV. Engaging this sector will promote a more enabling policy environment for MARPs at risk of experiencing GBV and HIV transmission.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	4,069,416	0
Total Technical Area Planned Funding:	**4,069,416**	**0**

Summary:
(No data provided.)

Technical Area: Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
HMBL	190,289	0

HMIN	50,289	
HVCT	308,209	0
HVOP	1,227,624	0
IDUP	4,161,602	0
Total Technical Area Planned Funding:	**5,938,013**	**0**

Summary:

Central Asia is one of the few regions in the world where the HIV epidemic is still on the rise. HIV prevalence rates among the general population are low, estimated at about 0.1%. However, in KZ, HIV prevalence increased from 0.05 % in 2006 to 0.1 % in 2010, although HIV annual estimated incidence has remained fairly constant at approximately 2,000 new registered cases per year. High rates of HIV prevalence are observed among MARPs including PWIDs, SW, MSM, and prisoners.
HIV/AIDS in the region is primarily driven by injection drug use with most HIV cases registered among young, unemployed males. Estimated HIV prevalence among PWID ranges from 3% in KZ to 18% in TJ and 14% in KG (2009 data). The proportion of HIV infection attributed to PWID is estimated at around 60% in Kazakhstan, Tajikistan, and Uzbekistan and 72% in Kyrgyzstan. Data are not available for Turkmenistan.
While these prevalence rates are higher than those reported for other populations, they do not include all PWID-associated HIV cases, e.g., HIV transmission from PWID to their sex partners. High-risk behavior has been confirmed through survey and HIV/AIDS sentinel surveillance (HASS) data, which show a high level of equipment sharing among male PWID and between female SWs and their partners; low levels of condom use by PWID with their regular sex partner; and high levels of sexually transmitted infections (STIs) among PWID. HIV prevention service availability and utilization has increased. In 2010, a majority of PWIDs (67%) surveyed in Kazakhstan during the annual IBBS survey were covered under some form of HIV preventive services, including safe needle supply points; in 2006, only 46% of surveyed PWID had been covered.
Recent data indicate a steady increase in the percentage of sexually transmitted HIV infections in CAR from 2006 to 2009; in KZ, from 20% to 43%, and in KG, from 30% to 33%, respectively (MOH data). Many of the cases are believed to be sexual partners of PWID (UNAIDS Eastern Europe and Central Asia AIDS Epidemic Update Regional Summary 2007). Homosexual transmission among MSM has also increased, though it represents only 1% of total officially registered transmissions in 2010 in Kazakhstan. In Kyrgyzstan, the last IBBS among MSM (2008) showed a 2% prevalence of HIV. Due to restrictive cultural and social environments, reaching MSM with prevention messages and health care services, and collecting related data, remains a challenge not adequately addressed in the region. HIV morbidity and transmission among MSM continue to be understudied. Accordingly, in FY12, the USG will support initial analytical work on this topic.
Prevalence of HIV among prisoners is of concern because of high rates of incarceration of PWID as well as unsafe injection and sexual practices during incarceration. According to the annual IBBS surveys, HIV prevalence among inmates was 3% in Kyrgyzstan (2009), 3% in Kazakhstan (2010), and 9% in Tajikistan (2010). High rates of migration particularly from Tajikistan and Kyrgyzstan to destinations within and outside the region complicate the epidemic. While migrants are considered to be a risk group in the region, little prevalence data is available. Tajikistan reported 0.5% HIV prevalence in 2008. Both migrants and their partners and family are considered to be at increased risk for HIV infection and other STIs. Reaching itinerant workers with prevention messages and health care services is a challenge not adequately addressed in the region.

While injecting drug use remains the central focus of USG-supported prevention efforts in CAR, addressing the sexual risk behaviors of PWID, SW, MSM, and as feasible, among migrants and prisoners is a critical prevention priority. Ensuring access to a comprehensive range of services including programs supporting primary prevention of drug abuse, outreach, drug and sexual risk reduction counseling, referral for counseling and testing, STI screening and treatment, and drug and ARV treatment remains an HIV prevention imperative in CAR. Stigma,

discrimination, gender, and legal and policy barriers pose significant challenges for HIV prevention, especially related to PWID, SW, and MSM populations. The concentration of HIV in stigmatized and marginalized populations has prompted the USG and other donors to prioritize peer outreach approaches to efficiently bring HIV services such as condoms, information, and service referrals to those with the greatest needs. In addition to PEPFAR, GFATM, UNODC, GIZ, AIDS Foundation East West (AFEW), the International Federation of Red Cross (IFRC), and United Nations Population Fund (UNFPA) all fund peer outreach programming in the CAR region, including technical support to strengthen local peer outreach capacity.

Medication Assisted Therapy (MAT) is currently offered on a limited scale in Kazakhstan, Kyrgyzstan and Tajikistan. Of CAR's estimated 263,000 PWID, only 1,225 are receiving MAT. The USG estimates that at least 20-40% of PWID must be on MAT to have an impact on the epidemic. In all countries in Central Asia, with the exception of Kyrgyzstan, many policy makers are reluctant to the scale up methadone programs, so opportunities for increasing the number of individuals on MAT may be a challenge.

In FY11, the CAR PEPFAR team supported interventions to reach 36,725 MARPs with a comprehensive package of HIV and TB prevention, testing and referrals to access health services in KZ, KG, and TJ. In close partnership with the GFATM grants, which supplied condoms, needles and syringes, and other commodities, the USG focused on linking MARPs to HIV and TB prevention, care and treatment services. As a result, 2,930 PLWHA and PWID were tested for TB, and 159 new TB cases were detected among MARPs. The USG trained 591 medical providers on HIV prevention and reduction of stigma and discrimination. The USG team also supported 36 NGOs that provide services for MARPs through grants and training on technical and financial management, and monitoring and evaluation. Despite the efforts by the USG, the GFATM and other development partners, coverage for all services throughout CAR remains low and is only reaching a small number of the estimated number of MARPs.

With HIV still concentrated among a small high-risk group, there is a window of opportunity to stem the growth of the epidemic to the general population. Given the modest PEPFAR resources available to the region, the USG will focus aggressively on leveraging PWID services with PEPFAR-funded expertise and scaling up best practices in collaboration with GFATM, MOHs, and other larger programs. In FY12, the USG will continue efforts to improve MARP access to comprehensive HIV prevention services; strengthen the collection and use of data related to MARP use of HIV prevention services; and strengthen the policies and organizational and individual capacities needed to provide quality, stigma-free prevention services for MARPs. USG support will provide ongoing TA to institutionalize the locally-led application of evidence-based proven interventions, build quality improvement mechanisms that enhance the quality of services provided by governmental and non-governmental organizations, and continue to promote and support outreach to MARPs and referrals to services. The USG will closely monitor and evaluate the performance and results of these interventions to generate evidence on these models and assist governments, GFATM, and other partners to scale up successful approaches to reach more target populations.

HIV Testing and Counseling (HTC) - In programming HIV testing and counseling resources, the USG uses a regional approach based on country environment, various needs of MARPs, and existing resources. Geographic regions are defined by a combination of different factors: HIV-registered cases in the region, HIV prevalence rates in project sites, available testing services, and areas in which MARPs have insufficient access to services. To address these issues, the USG actively collaborates with national partners and other donor projects to leverage resources to cover MARP service needs (e.g. mobile HIV testing points and Trust Points) and avoid duplication of activities with the GFATM and other donors.

In this region, HTC services are supposed to be provided at all levels of health facilities. However, there are few HTC services provided outside of the national AIDS centers. There is no routine HIV screening of PWID within Narcology services. Since HTC has been targeted towards the general population, the number of MARPs tested is low. MARPs are hesitant to use HTC services due to issues of fear about confidentiality and stigma. In addition, the lack of legal documents or registration can restrict MARPs from receiving the services for free. In Kyrgyzstan, only 10% of total MARPs are estimated to have been tested, but it is unknown how many of them return to receive their test results. There is no similar estimate in other countries, but it is expected to be low as well. TB patients are required to be screened for HIV, but this requirement is not consistently implemented by TB dispensaries.

In Central Asia, NGOs are not allowed to perform HIV testing, thus their role is largely restricted to counseling MARPs on risky behaviors and referring them to testing facilities, which are all government operated. In FY12, the USG will support pilot collaborative public-NGO service delivery interventions to expand MARPs' access to HTC. The USG supports activities to provide case management assistance and referrals to legal services to help MARPs

in obtaining the legal documents required to receive health services. To reduce stigma and discrimination towards MARPs and to improve understanding of MARP service needs, the USG supports training for service providers on communication skills, stigma reduction, provision of accurate information on HIV and HIV/TB co-infection, and the use of a referral system to link MARPs with testing services. In FY12, the USG will continue to support these activities. The USG will also track the effectiveness of voucher referrals in contributing to increased use of HIV services; will advocate for and facilitate government management and funding of service referral vouchers; and will work to address policies related to registration which constrain access to care.

Since there are no national standards for counseling, it is uncertain what quality of counseling MARPs receive. In addition, after testing, MARPs are referred back to NGO sites to receive post-test counseling. Consequently, there is a significant loss to follow-up between pre-test counseling and testing and between testing and post-test counseling. Furthermore, HTC has not been integrated with national testing algorithms, so upon receiving test results, MARPs are referred to testing facilities of National AIDS Centers where they go through another series of HIV tests before their HIV status is confirmed. This further contributes to the significant loss to follow up.

Most of the counseling and testing services for MARPs are provider-initiated, and a system to monitor the quality of the counseling being provided to patients is not in place. Providers have significant missed opportunities to ensure adequate access to risk reduction information and materials for those individuals at high risk of infection. In addition, there is no standardized system to track MARP use of HTC services, which limits understanding of the current epidemic among these populations. USG activities will work with doctors, nurses, and other medical providers, including specialists such as narcologists working with high-risk populations, to increase their engagement in the provision of high quality HIV counseling and testing. The USG will use FY12 funds to support provider-initiated counseling and testing for key MARP groups and other approaches to increase MARP access to HTC services. For example, the USG will work with AIDS Centers in Kyrgyzstan and Kazakhstan to expand government-supported mobile HTC for MARPs not reached by traditional counseling and testing centers. In addition, with non-PEPFAR funds, the USG will advocate that HTC services incorporate TB screening, particularly in prison settings. The USG will train and support HTC providers so that MARPs who are referred to HTC services will encounter a receptive, non-discriminatory environment.

In FY12, the USG will assist countries to incorporate strategies for counseling and testing for MARPs into their National HIV Plans. In addition, the USG will support policy advocacy for the scale up of counseling and testing activities to ensure that PWID, their sex partners, and other MARPs receive access to high-quality and accurate counseling and testing services. Introduction of rapid testing and integration of the rapid test HTC algorithm into the national testing algorithm will be a USG priority. Building on this effort, the USG will focus on improving the availability of HTC services at both the community and service delivery levels.

A key focus of the USG in FY12 will be to ensure that test results are accurate. The USG will strengthen the government's ability to monitor testing quality and establish proper screening and diagnosis algorithms. A longer term goal is to support country-led development of comprehensive national HTC policies regarding MARPs and to enable national AIDS centers to tailor HTC strategies to each country's context.

The USG also supports efforts designed to ensure that MARPs who receive HTC services are enrolled in HIV prevention programs. This is done through a targeted outreach package of services in which outreach workers and case managers conduct risk assessments with MARPs and develop individual activity plans to link them to all needed services, including providing follow-up and added support.

Condoms - In light of global evidence on the impact of condom availability and use on the transmission of HIV and STIs, condom promotion and distribution is a key component of the core set of HIV prevention interventions for MARPs. The USG supports implementation of outreach services which include distribution of condoms among all target MARPs (PWID, SWs, and MSMs). Condoms are also distributed among PLWHA to prevent secondary HIV transmission to partners. All condom distribution activities are accompanied by information and education to improve knowledge on how to correctly and consistently use condoms to ensure safe sexual behavior.

Through its country level grants, the GFATM supports the procurement of all condoms used in harm reduction programs for the region. The GFATM also donates condoms for distribution through USG programs when supplies are available in countries. Through its outreach activities, the USG builds demand for condoms; through distribution of donated condoms, the USG promotes consistent condom use among MARPs.

There are a number of constraints to the timely and consistent availability of and use of condoms by MARPs. First, since condom procurement is linked to the availability of GFATM funds, gaps in GFATM funding phases have at

times led to condom stockouts. Condom quality is also a concern; MARPs comment that they don't want to use condoms donated by GFATM, as they perceive them to be low quality.
For the longer term, government-supported procurement of condoms will be essential to HIV/AIDS prevention efforts. However, uneven government capacity in drug and commodity procurement and supply chain management, as well as extended government procurement processes that are not transparent, limits the ability of governments in CAR to ensure reliable and continuing access to medications and commodities. This deficiency has important implications for government procurement of condoms, and indicates the need for intensive TA to improve country capacity in forecasting of needs, procurement, and management of HIV/AIDS program commodities.
To increase reliable access to essential HIV/AIDS drugs and commodities such as condoms, the USG will assist, where needed and feasible, to improve the efficiency of government-managed or financed systems for HIV/AIDS drug and commodity quantification, procurement and supply management. With FY 12 funds, the USG will support development of country strategies for HIV/AIDS drug and commodity procurement and supply management and, through targeted TA, develop the functional systems and capacities needed to enable governments to procure the most cost-effective drugs in the right quantities, select reliable suppliers of quality products, ensure the timely delivery of products, and manage the timely distribution of HIV/AIDS drugs and commodities, including monitoring performance of the overall procurement and supply management system. The USG will also promote good governance principles by working with governments to improve transparency and accountability in selecting, procuring, and distributing drugs and commodities. The USG will assist countries to establish enhanced practices for purchase tenders and to involve MARP stakeholders, including representatives of PLWHA, in procurement and tender processes. As appropriate, the USG will assist governments to assess the potential for use of pooled procurement schemes or other approaches to reduce costs and improve quality.
Positive Health Dignity and Prevention (PHDP) - In FY12, the USG will continue to support PHDP services as elements of National AIDS strategies of Central Asian countries. PHDP services are delivered to PLWHA through the MDT approach, which include doctors, nurses, psychologists, social workers and outreach workers who coordinate with medical facilities to make the health care system more user-friendly and to link PLWHA to more comprehensive services. The assistance provided to clients includes IEC materials, training and educational sessions, condom distribution, referrals for HTC for partners of PLWHA, STIs, and, as needed, drug treatment, ARV treatment, and TB testing and treatment services, as well as referrals to family planning and reproductive health services and self-support groups. For PLWHA who also inject drugs, the USG supports referrals to Trust Points for testing, NSP, DIC, and MAT services where available. To optimize the quality of services, the MDT employs a patient-centered approach, which is based on the individual needs of each client and integrates family and community members, home-based care, and PLWHA support groups.
MARPs - To address the rapidly growing HIV epidemic, Central Asian countries have developed national programs aimed at stopping the spread of the disease through improving and expanding access of MARPs to HIV prevention services. In addition to USG-supported outreach services, in KZ, KG, and TJ, MARPs can receive HIV prevention services through a number of vertical service delivery systems: oblast and city AIDS centers, TB centers, Narcology and STI clinics, polyclinics and through NGOs. Although, in theory, services are available at different facilities, the system and process of accessing services are not patient-friendly and MARPs often face significant barriers to care. In FY12, the USG will continue providing TA to the MOH in Kazakhstan, Kyrgyzstan, and Tajikistan to implement USG-funded comprehensive HIV prevention services for PWID, their sex partners, and sex workers in selected sites. Technical support will help guide the formulation and implementation of service approaches and provide on-site training and mentorship to build technical competence to initiate and provide quality counseling related to injection and to sexual practices, as well as the ability to monitor and evaluate services provided. Technical assistance will focus on incorporating evidence-based behavioral and combination strategies into daily work. Core interventions implemented by the Republican AIDS Centers in Kazakhstan and Kyrgyzstan and the Republican Narcology Center in Kyrgyzstan include government-run mobile units delivering individual protection items and offering rapid HIV testing (syringes and needles will be provided by GFATM client-friendly drop-in centers for sex workers and PWID, and MAT distribution sites. All interventions will also include HIV and drug use information dissemination and counseling (including gender-based counseling and couple-counseling); counseling for HIV testing; PwP, including sexual prevention education, and ART support for PWID/PLWHA; case management and referral to TB diagnosis and treatment; referral for other medical services not available at the site; peer support; and psychosocial care. USG will promote peer-driven interventions to increase service coverage of MARPs.

Through its MARP outreach services, the USG will continue to support a referral voucher system which plays a key role in strengthening NGO-public sector partnerships and linking MARPs to needed medical, psychological and social support services. Participating service providers are trained to implement referral protocols so that individuals who, for example, enter the system through an AIDS Center with symptoms of TB are referred to the TB Center for testing and further treatment if diagnosed with TB. Social workers and outreach workers escort MARPs through the network, identifying the need for and making referrals to health and social services. Referral vouchers are given to MARPs at the time of referral and collected by the providers at the time of service. Program partner NGOs routinely collect redeemed referral vouchers as a way of monitoring the effectiveness of the referral system and its uptake. Currently, dialogue is underway with government officials in some countries to promote government policy support for and financing of the voucher system. During FY12, the USG plans to assist governments to establish systems for funding, implementing, and managing voucher referral mechanisms. The USG will also work to address policies related to registration which constrain access to care.

To better determine coverage gaps and facilitate partner coordination, the USG is conducting geographical mapping (GIS) of all HIV prevention services for key MARP groups in Kazakhstan, Kyrgyzstan, and Tajikistan. Services for GIS mapping will include sites funded by the national governments, the GFATM, USG, and other donors, and services implemented by both governmental and NGOs. The USG will also map PWID services in pilot areas to determine areas and facilities where PWID can access comprehensive services and assist stakeholders in the appropriate evaluation, interpretation, dissemination, and use of mapping data. Aside from mapping physical locations, mapping activities will describe the spectrum of services available and assess the physical availability of services against the potential demand for services. Working with the MOHs, Ministries of Justice and community organizations, the USG will develop an M&E program to track PWID service scale-up which assimilates information from both governmental and nongovernmental sites to analyze the performance and impact of MARP service delivery programs.

PWID - The USG prioritizes improving access for MARPs to high-quality HIV services. In FY12, the USG will conduct country-specific consultations to agree on strategies for HIV prevention among PWID and to gain buy-in from policymakers. The USG will work with MOHs, donors and implementers to collectively provide a comprehensive prevention package of services for PWID and sex partners: MAT services and referrals to MAT and other voluntary detoxification assistance; STI screening and treatment; HTC; drug demand reduction and overdose prevention and management; ART; targeted IEC for PWID and their sex partners; and referrals to NSP programs. During FY12, outreach workers will continue to identify and refer PWID to locations that provide a minimum package of HIV prevention services. Targeted IEC will be provided for PWID through street outreach, peer education, interactive events, drop-in centers and support groups to build PWID demand for HTC, STI testing and treatment, drug treatment and TB services. Drug-using SW will be reached with IEC and escorted to gynecologists trained in communicating with SW for STI screening and treatment.

Although the USG will not directly support NSP in light of current Congressional prohibitions, NSP is legal in all CAR countries and within the context of national strategies, serves as a cornerstone of HIV prevention efforts. MAT reduces needle/syringe use and enhances PWID access to ART. ART services that offer MAT achieve higher ART adherence, which in itself may reduce HIV transmission. The USG will conduct intensive policy dialogue at all levels to change the legal framework and build support to scale up MAT services to improve the quality of care for PWID. To foster a policy environment that supports MAT, USG activities in FY12 will sensitize key policymakers, health providers, and community leaders to the essential use of MAT as a medical intervention, increase awareness of the impact of MAT, and reduce stigma and discrimination toward PLWHA and PWID. The USG will also provide assistance to develop operational policy documents, or prikazes, to guide the delivery of MAT services. Further, to improve service delivery for PWID, the USG will support the development of referral linkages and operational policy guidance and the training of providers to ensure that PWID and their sex partners have access to comprehensive care and treatment services. The USG will also support health provider training on stigma and discrimination reduction and HTC, develop protocols and algorithms for appropriate STI care and ART, and establish support and follow up systems to enhance ART adherence. Efforts will be coordinated to enhance coverage and minimize duplication.

As part of its FY12 strategy, to the extent possible, the USG will work closely with oblast and city AIDS Center, Narcology dispensaries and Trust Points to build capacity to deliver patient-friendly services for PWID. Oblast and city AIDS Centers are the key implementers of the National HIV Program on a local level. Every suspected case or

confirmed case of HIV is referred to the city/oblast AIDS Center for proper confirmation and further management. AIDS Centers organize a range of preventive and diagnostic services (clinical, biochemical, serological and immunological tests), including outpatient treatment and care for PLWHA, ART, as well as treatment of opportunistic infections. With the support of the GFATM, AIDS Centers also run Trust Points for the distribution of disposable syringes and condoms and Friendly Cabinets to provide specific services to MARPs. Within their prevention terms of reference, AIDS Centers are expected to implement outreach programs for their target populations (PWID, SW, and MSM).

Narcology dispensaries are another specialized vertical program with the responsibility of early detection and enrollment of drug-users and alcohol-addicted patients and the organization of counseling, diagnostic, treatment, and rehabilitation services through either outpatient or inpatient services. Among HIV and TB related services, narcological dispensaries draw blood for HIV testing, collect sputum or sometimes perform sputum smear microscopy, and perform Wasserman tests for syphilis. Also, consultation and counseling on HIV/AIDS, TB and STIs are reportedly provided.

Government-run TP operate in medical facilities such as polyclinics and at NGO based facilities. There are a total of 168 TPs in Kazakhstan, 46 in Kyrgyzstan, and 47 in Tajikistan. Despite the wide range of distribution of TPs, the coverage of PWID with HIV prevention services remains low. According to the data retrieved from HIV Sentinel Surveillance (2009), coverage of PWID in KZ, KG, and TJ, on average is 44%; of SWs is 17%; and MSM is 50% (no data on MSM for Tajikistan). MAT has been piloted in Kyrgyzstan since 2001; however, the coverage of PWID with MAT remains very low (about 4 % of estimated number of PWID). In addition, MAT was just recently piloted in Kazakhstan and Tajikistan and at present covers less than 1 % of PWID.

SWs and MSM - As described for PWIDs, in FY12 the USG PEPFAR team will focus on outreach and capacity development to improve access to high quality HIV services for SWs and MSM. The USG will continue its outreach, policy, and advocacy work to reduce stigma and discrimination to continue to reach more SWs and MSM with HIV prevention packages. At the service delivery level, to the extent possible, the USG will work closely with oblast and city AIDS Centers, STI dispensaries, and friendly clinics to build capacity to deliver patient-friendly services for SWs and MSM. HIV prevention services to SWs are mainly provided through outreach activities conducted by outreach worker of AIDS Centers or NGO AIDS service organizations. In addition, "friendly clinics" provide free diagnosis of STI and treatment for MARPs. A Friendly Clinic is a room in a medical facility specifically focused on providing free-of-charge STI testing and treatment services, HIV testing services, and basic information support and condoms to MARPs. It is usually located at AIDS Centers. Similar to the Trust Points, the original meaning of the term has been diluted in the atmosphere of a post-Soviet clinical facility, which can be described as anything but friendly.

Services of local Dermatovenereal Dispensaries (here referred as STI dispensaries) include early detection and all relevant preventive, diagnostic, and treatment services for STIs (both outpatient and inpatient). They also draw blood for HIV testing and require mandatory fluorography for patients referred to inpatient care.

According to reported available data (2009), the size of the MSM population in CAR is relatively small (71,200 total, with 91% residing in Kazakhstan). This group is highly stigmatized and has limited access to HIV prevention services. According to HIV Sentinel Surveillance (2008), 1% of MSM in Kazakhstan were HIV positive. In contrast, preliminary results of surveys using rapid HIV tests have shown 20% HIV prevalence among MSM. There are a few NGOs providing HIV services to MSM in all three countries; these provide approximately 50% coverage of the estimated number of MSM in Kazakhstan and Kyrgyzstan. However, due to the fact, that there is no reliable data on the total MSM population, it can only be assumed that large proportions of MSM remain underserved across the region. USG will provide TA to MOH to estimate the size of MSM populations in Kazakhstan, Tajikistan and Kyrgyzstan and what are the needs for this group to receive necessary HIV prevention services. With FY12 funds, the USG will identify key barriers and opportunities for HIV prevention among this group and, based on the evidence, will provide TA to pilot MSM-friendly HIV services in four sites in KZ based at GFATM/Government –supported friendly clinics. In all three countries, the USG will also support HIV prevention outreach for MSM through NGOs.

Youth - The USG supports limited numbers of programs for youth, since the region faces a concentrated epidemic and USG limited resources must be used for higher at-risk groups. PEPFAR CAR supports limited youth activities in KG, where Peace Corps is present. In KG, national youth health education programs have been developed by the MOH, Ministry of Education and Science, and the Ministry of Youth, Labor, and Occupation. These programs

include lectures on HIV/AIDS prevention in training courses of secondary general, vocational, and higher educational institutions and are based on the needs of young people and national cultural traditions. In May 2011, a targeted training course containing HIV prevention information was integrated into the national health education program. It covers sexual and reproductive health, HIV, STI and drug use prevention, tolerance, and life skills to avoid risky behaviors associated with HIV and drugs. A new teacher's manual has been pilot tested in four schools in Bishkek, Kara-Balta and Karakol.

PC volunteers will help raise awareness of HIV at the community level. In FY12, teaching English as Foreign Language volunteers will continue to integrate themes of HIV/STI/drug use prevention into their English classes. PC recently issued a teacher's manual "Teach English, Prevent HIV" which will help teachers create a safe environment to talk about HIV and safe sex in addition to building life skills to resist peer pressure and increase self-esteem. Volunteers will organize and implement community-based projects to increase knowledge of Kyrgyzstani youth about HIV transmission, help them increase tolerance and develop positive attitudes towards people living with HIV/AIDS and most at-risk populations, teach life skills and focus on reducing risky behaviors.

HSS/HRH - HSS and HRH are key cross-cutting areas; specific HSS and HRH interventions are described throughout the TAN. With FY12 funds, the USG will expand the number of facilities where MARPs can access basic care services and the range of services they can receive. The USG will work with civil society partners to increase the range and quality of counseling services available to MARPs through regular mentoring with NGOs on a range of MARPs support topics. The USG will provide a drug counseling train-the-trainer for NGO workers based on the "Pathways to Recovery" model, which provides basic counseling skills to assist drug dependent clients to move towards sustainable abstinence from drug use. The trainings, for over 100 service providers, will be conducted on counseling and communication skills for stigma reduction and communication with MARPs. These trained providers will conduct trainings for the peer service providers in their countries.

Medical Transmission - To build an effective blood safety portfolio, it is critical to have access to and use of accurate and comprehensive information about a country's blood services. Local specialists and institutions must be able to collect and use timely and accurate data to reveal gaps in different parts of the blood process chain and identify the most urgent areas to address to improve and sustain blood safety services. In FY12, the USG will work to address data gaps by increasing local capacity in data collection, data analysis, and interpretation of blood services performance. In FY12, the USG will continue to support blood safety improvements by institutionalizing Transfusion Committees. The USG will support the development of guidelines, protocols, standards of practice, and data collection tools for use by local partners in leading Transfusion Committees. Assistance will include capacity building to improve data quality and use through on-site trainings and routine data quality assessments.

The USG also recognizes the need to address blood safety at the policy level. As such, the USG will work with governments to develop strategies for voluntary non-remunerated blood donor programs (VNRBD) using results of knowledge, attitude, and practice (KAP) surveys conducted by WHO, undertaken in collaboration with the USG. The USG will support the development of an evidence-based strategy on VNRBD, including an IEC campaign for recruitment of blood donors. Throughout this process, the USG will work with stakeholders to develop training materials for donor recruiters, along with recruitment materials for potential donors. In addition, the USG will advocate for closer collaboration between MOHs and nongovernmental organizations on VNRBD recruitment, especially for recruitment efforts involving youth.

The USG also addresses injection safety through its medical transmission program. National assessments of injection and related procedures and practices undertaken in 2010 revealed gaps in practices, trainings, and existing norms and standards. Healthcare workers lack knowledge of the risks of transfusion-transmitted infections through unsafe injections. In FY12, the USG will use the results of these assessments and others to assist MOHs in improving injection safety. The USG will provide TA to MOHs in developing curricula for students of medical schools and nursing colleges. Topics will include injection safety, healthcare worker safety, and healthcare waste management safety, and will be in line with international standards but specific to the local context. The USG will also use this information to support pre-service and in-service training for healthcare workers and support the development of quality management systems. Finally, the USG will provide TA to create IEC materials related to injection safety for distribution to healthcare facilities at national, oblast, and district levels.

Gender - The USG applies gender-specific approaches to both sexual and biomedical prevention activities with MARPs. With the biomedical prevention program, the gender approach focuses on reaching female PWID as well as female sex partners of PWID. A recent USG-funded assessment in KZ and KG helped identify ways to increase

the engagement of female PWID in harm reduction and health services. The USG will take steps, including targeted outreach efforts, to increase female PWID use of harm reduction, HIV, STI and TB services through referrals and vouchers for services. Also, in FY12, USG funds will be used to pilot family-friendly services for PWID which facilitate links with reproductive health care services for female PWID.
Through the Gender Challenge Fund, the USG will pilot an activity in TJ to expand access for female SWs, female PWID, and MSM to gender based violence (GBV) services such as HIV/STI testing for sexual assault survivors; crisis housing and/or legal services through USG-supported and/or partner-run drop-in centers; and psychosocial support services. The USG will support integration of a GBV component into the current voucher and referral program for HIV and other related services. Specially-trained outreach workers will provide referrals and conduct special training sessions with MARPs on GBV. Training sessions will include the health consequences of GBV, how communities can respond to the issue, raise awareness of where to go for assistance, and self-defense approaches. This activity will use Unique Identifier Codes (UIC) to track program activities through a management information system (MIS). Also through the Gender Challenge fund, the USG will pilot a new survey in KZ, KG, and TJ that will be integrated into the existing IBBS for PWID but will be focused on their non-injecting sex partners, the majority of whom are women. Participants of the survey will be tested for HIV and will also receive HIV education sessions, which will include information on the risks of HIV transmission through injecting drug use. Results from the survey will inform HIV programming of USG partners. If found useful and informative, the USG will work with MOHs to integrate this survey into regular IBBS surveys with PWID.
Strategic Information - Accurate and comprehensive information about the epidemic and response is critical to building an effective portfolio of HIV prevention interventions. To increase the effectiveness and sustainability of the USG program with limited resources, local individuals and institutions must be able to collect and use timely and accurate data to identify the right people to receive targeted prevention interventions; the right package of services to address their needs; and the most sustainable and cost-efficient ways to deliver such services. In FY12, the USG will help the region address data gaps, increase the local capacity in strategic information, and identify prevention priorities by assisting MOHs in improving the quality of routine sentinel surveillance surveys and integrated biological and behavior surveys (IBBS) and integrating size estimation into IBBS among MARPs for more effective and focused prevention planning. The USG will provide ongoing technical support in planning and designing the next round of IBBS among MARPs including non-injecting sexual partners of PWID and conduct periodic targeted behavioral surveys (TRaC) to evaluation the effectiveness of PEPFAR prevention and care programs for PWID, SW, and MSM. The USG will also provide technical support for timely and accurate HIV case and routine data reporting at the national, provincial, and district levels and advocate for a more open data sharing culture from host governments and work closely with MOHs to address the importance of data dissemination and use, especially for surveys and surveillance data.
USG assistance will support development of a monitoring and evaluation system, including the elaboration of indicators, development of data collection forms and reporting tools, training of staff, and use of supervisory monitoring visits to the sites. USG assistance will also focus on the establishment and development of central and facility level quality assurance mechanisms that will include peer supervision, client needs, and satisfaction surveys.
Capacity Building – To address the capacity building needs of CAR, the PEPFAR program's primary approach to date has been the provision of targeted training and mentoring of selected organizations and individuals. In FY12, the USG will undertake more strategic and targeted capacity building approaches at different levels of the systems—institutional, organizational, and individual - with the aim of fostering national ownership of prevention programming and enabling countries to lead the process of improving MARP access to prevention services through effective implementation of combination prevention strategies. As part of the planned rapid organizational diagnostic assessments and rapid assessment of training needs planned for FY12, the USG will work closely with a wide range of prevention stakeholders to ensure that their input on prevention capacity needs is included in the development and implementation of country strategies for capacity building. In implementing country strategies, the USG will implement systematic capacity building approaches that enable countries to increase ownership of and leadership on HIV/AIDS prevention efforts through national programs.
At the individual level, the USG will continue to strengthen the capacity of public healthcare providers to deliver prevention services to MARPs. FY12 efforts will include expanded training of health providers to reduce stigma and discrimination, which has been identified as a barrier for MARPs seeking HIV prevention services. The USG will engage MARPs, particularly PLWH, to develop and participate in these training efforts. In addition, the USG will

work at the organizational level, continuing to build skills of NGO outreach workers and clinic-based providers to successfully refer MARPs to HIV prevention and other services. Activities will increase outreach worker knowledge of HIV and related health issues, build understanding of how to encourage MARPs to use health services, and improve communication with health providers at referral facilities. At the organizational level, the USG will also support structured approaches to develop NGO technical and organizational capacities to develop, implement and manage effective programs to prevent HIV transmission among MARPs, including outreach approaches. At the institutional level, the USG will continue to work directly with MOHs and NGOs to enhance and operationalize HIV prevention protocols and services USG programs will also assist CCM sub-committees, MOH institutions and NGOs to advance targeted prevention activities. USG assistance will support policy advocacy and pilot activities to promote improved public sector-NGO collaboration to deliver HIV prevention services for MARPs and provide targeted capacity building activities to strengthen NGO capabilities to partner with government on collaborative prevention services.

Technical Area: Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HTXS	494,479	0
Total Technical Area Planned Funding:	**494,479**	**0**

Summary:

Note: PEPFAR CAR does not program specifically for pediatric treatment, nor for procurement of ARV drugs; consequently, these areas are not covered in this narrative.
Adult treatment
The PEPFAR CAR program primarily focuses on prevention and has limited activities targeted at care and treatment, as other donors are focused on these programs. The primary donor institutions providing treatment services in CAR are the local Ministries of Health (MOH) and the GFATM. Following PEPFAR principles, the USG treatment activities are designed to maximize access to antiretroviral care and treatment programs, while ensuring that quality services are delivered in a timely manner. Effective treatment programs can decrease mortality, morbidity, and improve the quality of life among PLWHA, and also prevent further HIV transmission.
CAR countries have updated their national clinical protocols in accordance with revised WHO guidelines for ART for HIV infection in adults and adolescents. The three approved ARV regimens for first line therapy include zidovudine (AZT) + lamivudine (3TC) + efavirenz (EFV) or nevirapine (NVP); tenofovir (TDF) + 3TC; and emtricitabine (FTC) + EFV or NVP. According to government data in CAR, 5,616 (63%) of 8,920 persons eligible were receiving ART, including 1,336 of 1,793 (75%) in Kazakhstan, 356 of 548 (65%) in Kyrgyzstan, 424 of 579 (73%) in Tajikistan, and 3,500 of 6,000 (58%) in Uzbekistan. Turkmenistan does not report cases of HIV infection. However, these data reflect persons already enrolled in care, and hence are not representative of the true number in need of ART. Based on the preliminary results of USG's Care and Treatment assessments conducted in FY11 in Kazakhstan, Kyrgyzstan, and Tajikistan, enrollment and retention in care, as well as coverage with ARV, remains very low. In Kyrgyzstan, only 43% of eligible PLWHA were receiving ARV in accordance with the approved guidelines. In Kazakhstan, the proportion of eligible PLWHA receiving ARV varied from 23% in Astana, Kazakhstan's capital city, to 77% in Uralsk. Laboratory monitoring of ARV effectiveness is suboptimal – the proportion of PLWHA on ARV who had at least one viral load during the last six months was as low as 23% in one of Kazakhstan's sites and only 7% in one of the surveyed sites in Kyrgyzstan. Access to cotrimoxazole prophylaxis also remains inconsistent, as there is limited awareness among health care providers about the clinical indications for the drug. Preliminary assessment results in Kazakhstan indicate that 58% of PLWHA in Karaganda, 81% in Uralsk, and 10% in Astana received cotrimoxazole in accordance with approved protocols. In Kyrgyzstan, only 32% of PLWHA were receiving prophylactic cotrimoxazole.
Despite the fact that TB is the main cause of mortality among PLWHA in CAR, TB screening in this population is

not done consistently. In general, TB screening is not done at the ART sites, and according to approved protocols, all PLWHA enrolled in care are to be referred out for chest X-ray screenings. There are no TB-related infection control practices in place at ART sites. In Kyrgyzstan, only 56% of PLWHA were screened for TB within the first two weeks following enrollment into HIV care services, and the average time between screening and enrollment was 75 days. In Kazakhstan, figures are 49-60%, and 60 days, respectively. Isoniazid prevention therapy (IPT) is available for PLWHA who are confirmed not to have active TB disease. Isoniazid (INH) prescriptions are written by the TB specialists, and the TB centers are responsible for isoniazid distribution. Antiretroviral therapy centers do not monitor adherence. However, IPT continues to be controversial in CAR and is not commonly prescribed. The USG is actively addressing TB and MDRTB in the region, including cases among incarcerated populations and HIV co-infected patients, through the use of non-PEPFAR funds. The USG provides TA on TB to GFATM and other large donor programs, and is promoting referrals between both clinical programs. Given the modest PEPFAR funding available to CAR and significant USG and other non-PEPFAR TB funds already mobilized in the region, PEPFAR resources will not support TB interventions under this ROP, although PEPFAR staff will continue to advise TB programs and gather much-needed data about HIV/TB co-infection.

In Kazakhstan and Tajikistan, ARV treatment failure is determined predominately by viral load testing, although resistance testing is occasionally performed usually in a research setting. In Kazakhstan, only three second -line drugs are available; didanosine (DDI), lopinavir/ritonavir and abacavir, with DDI being phased out. Outside of these drugs, few other options are available. Currently, 88 people in Kazakhstan, including 25 children, are receiving second-line drugs. In Kyrgyzstan, VL testing is not generally available, and treatment failure is not readily diagnosed.

Antiretrovirals in Kazakhstan are fully funded by the government of Kazakhstan, while the GFATM covers most of the ARV needs in Kyrgyzstan, Tajikistan, and Uzbekistan. PEPFAR plays a major role as the primary provider of TA to support the existing treatment programs. The USG will support national ARV conferences to inform clinicians and MOH staff about new ARVs, the results of latest studies and trends in ARV usage, and recommended regimens. Based on requests from the MOHs in Kazakhstan, Kyrgyzstan, and Tajikistan, the USG will focus on providing TA to enhance individual, institutional and organizational capacity for HIV care and treatment. Technical assistance includes the provision of high-quality comprehensive HIV care and treatment packages, including ARV, cotrimoxazole prophylaxis, and TB screening. In FY12, the USG will complete assessments (begun in FY11) of the care and treatment systems in Kazakhstan, Kyrgyzstan, and Tajikistan. Based on these three assessments, the USG will develop recommendations for system improvement and conduct in-service trainings for medical staff on proper use of ARVs, treatment schemes (including guidance for ARVs in persons dually infected with TB/HIV), and adherence. On-site supervisory visits will follow to ensure proper use of skills and knowledge obtained during the trainings are properly applied. The USG will support national ARV conferences to inform clinicians and Ministry of Health staff about new ARVs, the results of latest studies and trends in ARV usage, and recommended regimens. Antiretroviral forecasting and planning remains a challenge throughout the region. In order to make the ARV forecasting and planning process data-driven, transparent and sustainable, the USG will incorporate a forecasting module into the electronic HIV cased-based surveillance management system (EHCMS), now being rolled out at local AIDS Centers in CAR. This will allow automated calculation of ARV needs based on the current ARV demand and predicted enrollment of new clients. This system, once deployed, can also provide a basis for pharmacovigilence. The USG will provide TA to the MOHs in implementing the EHCMS entry of clinical data and will support selected AIDS Centers in Kazakhstan, Kyrgyzstan, and Tajikistan implement comprehensive patient-centered, multidisciplinary, service-delivery approaches. These pilots will seek to improve patient retention and adherence to ARVs, cotrimoxazole prophylaxis, and TB screening recommendations. The USG's TA will involve strengthening the multidisciplinary team approach (active participation of clinician, nurse, epidemiologist, counselor, and psychologists at the AIDS Center) while managing patients through in-service trainings, task shifting, and development of standard operating procedures. The USG will conduct on-site supervisory visits and develop M&E systems to track and evaluate outcomes using data from EHCMS and client interviews. Adherence obstacles will be addressed using gender-based approaches, and will be closely linked with the GFATM and PEPFAR-supported PLWHA support groups. Couples-based counseling and involvement of treatment supporters will be introduced to improve patient retention. Performance measurement data from the EHCMS will be closely monitored and used to refine treatment programs in each of the countries. All treatment-related activities will be closely coordinated and implemented in collaboration with other PEPFAR partners, as well as Principle Recipients

(PRs) of the GFATM projects.

Laboratory

Currently, CD4 and viral load testing is primarily performed at the national level and in some regional (oblast) level laboratories. Due to this centralized laboratory structure, the high cost and irregular delivery of kits and necessary supplies, and lack of trained personnel, only a fraction of people on ART are being properly monitored. The absence of effective and accessible laboratory monitoring for PLWHA (CD4 count testing and viral load testing) prevents effective clinical management of patients. The USG will provide training on proper usage of the laboratory equipment needed for laboratory monitoring for PLWHA on ART to MOH laboratorians. As countries lack SOPs for key patient monitoring tests, the USG will work closely with all partners to develop and implement laboratory quality management systems (QMS), QA and QC procedures, protocols, and SOPs, including those for viral load and CD4 testing. All documents will be developed through national TWGs to ensure sustainability of efforts and national ownership. Following development of the SOPs, the USG will provide on-site training and mentoring on implementation of the SOPs as well as formal national workshops on such topics as viral load testing and improved laboratory diagnostics of OI for HIV laboratory technicians. Technical assistance will also be provided for strengthening referral linkages, networking between clinical and regional and national reference laboratories, and during quarterly monitoring visits at the regional and sub-regional level conducted jointly by USG and national reference laboratory staff. The USG will work closely with the MOH and the GFATM PRs to develop and implement effective systems for forecasting and planning for laboratory supplies, which will include training on how to use the newly developed systems.

Through the provision of TA, in-service trainings, and development, dissemination and implementation of standard operating procedures and other documents, knowledge and skills will be transferred to the host Ministries of Health to assure sustainability of ARV service delivery, including laboratory support.

Laboratory operations in CAR are regulated based on numerous executive orders (prikazes) issued by government health care authorities at central and local organizational levels, but comprehensive strategic plans on the development of laboratory services do not exist. The USG TA will be provided to assist with development of national strategic plans to create sustainable tiered laboratory services and integrated referral networks with uniform quality assurance measures. The USG will assist the MOH to review and revise existing national laboratory policies and guidelines and align them with international standards. To assure quality laboratory testing and services, the USG will support national reference and oblast level laboratories through accreditation training using the Strengthening of Laboratory Management towards Accreditation (SLMTA) scheme. This scheme is designed to strengthen laboratory management, achieve stepwise laboratory improvement, and accelerate the process towards accreditation. The SLMTA process includes the laboratory infrastructure and baseline accreditation assessments, followed by a series of training workshops, and finally implementation of specific improvement projects. As a monitoring and evaluation tool, training follow-up assessments will be conducted to measure the level of improvement on focus areas completed by each laboratory. Upon completion of the training cycle, each laboratory will be assessed by comparing the scores from the baseline assessment to monitor progress made during the program.

At both the national and regional levels, the procurement of laboratory kits, reagents, supplies and equipment in CAR is out of date and poorly managed. Decisions made during the tendering process for kits and reagent purchasing are frequently based not on externally evaluated criteria regarding the quality of products but simply the cost --the lowest price is accepted. Additionally, many of the test kits that are registered for HIV screening in CAR have not been validated and their quality remains uncertain. The current system requires that testing kits be registered with the government; however, registering a product (reagent, supply, consumable or equipment) does not include a reviewer evaluation of product performance by either local experts or laboratories. Kazakhstan and Tajikistan do not have regulations to prevent product registration with inadequate validation. In Uzbekistan and Kyrgyzstan, reference laboratories provide reliable test kit validation before and after registration. However, these reference laboratories have not been accredited by international organizations and their activity is limited to test kits validation for sero-diagnosis of HIV, viral hepatitis and other infectious diseases.

Supply Chain

The USG will provide TA on mechanisms for commodity procurement of government-registered items including supplies, equipment and reagents, and will support efforts to improve laboratory logistics systems. The USG will also provide TA in development and implementation of an effective system of forecasting and planning for

laboratory supplies which will be integrated into SOPs for selected procedures, and local laboratorians will be trained accordingly.

Gender

PEPFAR in CAR does not currently address three of the five gender strategies: engaging men and boys, increasing women's access to income and productive resources and legal rights and protection, and increasing women and girls' access to income and productive resources including education.

Treatment is targeted by the CAR PEPFAR Program only for TA, not implementation, and no APR results are provided in this area. Data on PLWHA receiving ART, adherence, and retention in care in CAR is not available by gender.

The USG provides training and TA to governmental and nongovernmental partners to improve HIV treatment, including adherence to ART. Recognizing that healthcare providers are not always equipped to treat MARPs—including female SW, and female PWID—we will continue to build the capacity of the healthcare workers to better understand these populations and meet their treatment needs. This type of capacity building will include a focus on reducing stigma and discrimination, as these populations face barriers to accessing treatment that are related to their complex identities—ranging from stigma for engaging in drug use or sex work to discrimination for stepping outside of gender norms through differing sexual practices.

In addition, the USG facilitates access to treatment of HIV, STI, and TB through a referral and voucher system. PWID, female SW, and MSM are engaged in this system. In FY12, we will expand our reach to include female PWID based on a recent USG-supported analysis of females' access to drug treatment and other health services in Kazakhstan and Kyrgyzstan. This will include working with NGOs to provide family-friendly MAT services for women—both female PWID and SW who also inject drugs—along with appropriate links to reproductive health (RH) services. MARPs referred for HIV treatment will be linked with relevant support groups to help ensure adherence to ART, which presents unique challenges for PWID.

Lastly, the USG will use sentinel surveillance data and results of care and treatment assessments to inform development of a comprehensive care and treatment program in pilot sites in Kazakhstan, Kyrgyzstan, and Tajikistan. Among the targeted analyses from the assessment will be disaggregation of data by sex and assessment of opportunities to reach populations currently lacking access to treatment components, including female SW and female PWID. These pilots will seek to improve patients' retention and adherence to ART, cotrimoxazole prophylaxis, and TB screening. Adherence obstacles will be addressed using gender-based approaches and will be closely linked with the GFATM and PEPFAR-supported PLWHA support groups. Couples-based counseling and involvement of "treatment supporters" (volunteers who provide direct observation of TB treatment and coach patients to stay on their medicines) will be introduced to improve patients' adherence and retention.

Strategic Information

The lack of a medical record data system to track services across different clinical facilities has hampered the ability of clinicians to closely monitor and manage patients in the continuum of care. The potential for duplicate enrollment of HIV patients also poses a challenge for the countries to estimate coverage accurately, and loss to follow-up rates for individuals on ART are not tracked. In FY12, the USG will help host governments respond strategically to these challenges by expanding the UIC into HIV information systems to track individuals across community and clinical services while maintaining confidentiality; supporting ongoing quality improvement/quality assurance efforts; expanding the EHCMS in HIV clinical facilities in order to track the quality of services and identify gaps in clinical service at the patient level; improving the use of data for decision-making at the facility level through supportive supervision and on-site M&E TA; strengthen M&E systems by assisting provinces and oblasts to create and maintain databases with the capacity to produce routine reports on key national, oblast, and district level indicators; building capacity to analyze and act based upon routine program data for more effective programming and resource allocation; and training national and local partners on data collection, analysis, and dissemination.

Capacity Building

Given the disparate social and economic conditions across Central Asia, including the role of civil society in the post-Soviet era, local governments differ in capacity building priorities. The diversity across Central Asia makes a single regional approach to providing quality HIV prevention, care, and treatment, services challenging. While trying to address increasingly divergent capacity building needs, the CAR PEPFAR program's primary approach has been the provision of targeted TA both to local Ministries of Health and to recipients working through the

GFATM, the largest funder for HIV/AIDS activities in CAR. The USG CAR PEPFAR program does not provide direct treatment services or drugs but prioritizes TA to improve the quality of services. The USG has focused TA on building quality improvement systems and refining treatment protocols to achieve better health outcomes for PLWHA. The USG has provided TA on issues such as ARV forecasting and treatment standards at the facility level as well as at the Republican (national) AIDS Centers. PEPFAR CAR has provided a subject matter expert in HIV treatment to the Kazakh Ministry of Health and will provide the same to the Ministries of Health in Kyrgyzstan and Tajikistan. The rigid vertical nature of the post-Soviet health care systems in Central Asia present significant challenges to integration of services; for example, HIV and TB services are not integrated within primary health care services and cross-referrals across services are inconsistent. The USG has worked with MOH partners to promote better integration of treatment and care services for PLWHA.

The primary institutions involved in the provision of treatment services in Central Asia are the local Ministries of Health and the GFATM. The USG, through its implementing partners, has worked with local governments to improve warehousing of ARV drugs and is increasingly engaged with GFATM to prevent stock outs of key items related to the prevention and treatment of HIV, including methadone, condoms, and lubricants for MARPs, as well as ARVs.

USG assistance also focuses on institutionalizing and standardizing proven treatment practices and building the knowledge base of local providers. One significant challenge to advancing uptake and adherence to ART in Central Asia is the lack of information on ARVs and, in some instances, clear misinformation on ART targeted at PLWHA and health care providers. Because scientific literature is often not available in the local languages in CAR, health care providers do not have access to changing standards of HIV treatment and care. Thus, PEPFAR implementing partners have focused on working with both regional and central representatives of the Ministries of Health to change service protocols and build providers' knowledge on the importance of adhering to these standards of treatment and care.

The PEPFAR CAR team took its first major step toward a strategic framework in FY11, setting a key objective to strengthen the capacity of the health care system to deliver improved, expanded, equitable and sustainable HIV services for MARPs, PLWHA, and their families. In FY11, the USG conducted capacity building trainings targeting Ministry of Health laboratory staff from all oblast (regional) AIDS Centers in Kazakhstan to increase knowledge on CD4 and VL testing. In FY12, sustainability of care services for PLWHA will require much greater attention to building a policy reform and environment that supports the delivery of services to MARPs as well as to significantly broadening collaboration between governmental agencies and NGOs. Improving access to care will require wide-ranging efforts to reduce stigma and discrimination at all levels. Better data collection, aggregation, and analysis for decision-making are pressing needs that cut across all interventions and objectives. While the metrics of evaluating capacity building are varied, the PEPFAR CAR team has developed a strategic framework for the next five years that drives the development and implementation of its activities. One of the three key objectives within the framework is to strengthen the capacity of the health care system to deliver improved, expanded, equitable, and sustainable HIV services for MARPs, PLWHA and their families. Four key goals support capacity building and sustainability: improving public health technical expertise and program management; integration of HIV/AIDS services with other health services and sectors; improving governance and laboratory infrastructure; and implementing existing national ARV treatment policies.

MARPs

In Central Asia, the predominant mode of HIV transmission is unsafe injecting drug use due to the region's geographical location on key drug trafficking routes from Afghanistan to Russia and Europe. In 2010, it was estimated that approximately 263,000 PWID, 66,380 SWs and 71,200 MSM reside in Central Asia. The majority of PLWHA in CAR are PWID. As of January 2011, PWID accounted for 50% of all newly registered HIV cases in Kazakhstan, 56% in Tajikistan and 64% in Kyrgyzstan. Sexual transmission is on the rise, and there are still a significant proportion of HIV cases with unknown transmission. Of particular concern is the high proportion of HIV-infected children who are believed to have acquired HIV infection nosocomially.

According to national strategies, all countries provide a minimum package of HIV prevention services to MARPs. There are networks of Trust Points for PWID in Kazakhstan, Kyrgyzstan and Tajikistan offering sterile syringes and needles, condoms, educational materials and referrals to HIV counseling, testing and medical care, if needed. There are 168 TPs in Kazakhstan, 46 in Kyrgyzstan and 47 in Tajikistan. However, the majority of HIV prevention services are provided not at the TP sites but by outreach workers who directly contact PWID. Over 80% of contacts with

PWID in CAR are done through outreach activities. Medication-assisted therapy has just recently been introduced in Kazakhstan and Tajikistan on a pilot level. In Kyrgyzstan, MAT has been available since 2001, although coverage of PWID remains very low (less that 5%). HIV prevention services for SW and MSM, including provision of condoms and educational materials, are available throughout the region. So-called "friendly clinics" have been identified for referral of sex workers for HIV diagnosis and treatment.

Critical issues to address with regard to provision of high quality HIV prevention and treatment services to MARPs include lack of identity papers hindering access to health care services including ART; high levels of stigma and discrimination among health care providers who generally perceive that MARPs cannot or will not adhere to ART; lack of social support which limits the effectiveness of clinical services, particularly ART; providers' lack of clinical experience, knowledge, and resources to manage hepatitis C and HIV co-infection; and lack of coordination and collaboration between NGOs and government health care facilities needed for effective implementation of ART.

To address these issues, the USG will continue to support the MDT model, which provides social support as well as training to health care providers to improve their perception and understanding of MARPs, and reduce stigma and discrimination issues. It is hoped that the success of this model, currently supported in pilots, will lead to increased use of MDTs by additional AIDS Centers in CAR.

Human Resources for Health

To address issues of human resources in health, the USG focuses on improving the systemic weaknesses and capacity deficits that prevent MARPs from accessing high-quality HIV prevention, care, and treatment services. USG activities in FY12 will continue to strengthen the technical knowledge of providers through targeted training and mentoring. The USG will help institutionalize improved practices through the development and dissemination of enhanced standards of practice and continue to build the capacity of national-level providers (e.g. RAC staff) and managers (e.g. NGO directors) to expand the range and quality of services being provided through public and NGO settings. The USG will work to ensure that a range of social support services are introduced and continually improved to meet the needs of the populations they serve. We will pilot approaches such as using trained social workers for MARPs, services delivered by NGOs and Community Based Organizations (CBOs), and self-help groups, and working with stakeholders to institutionalize these approaches.

The USG will continue its support to MDTs in CAR through training on adherence to ARV and TB treatment, communication skills, use of IEC materials and social support for PLWHA and their families. ARV forecasting technology will be scaled-up nationally in partnership with the Republican AIDS Center, and Oblast and City AIDS centers will be networked to assure that forecasting is comprehensive and accurate. The USG will continue to support community-based treatment, and will introduce several new options for PWID support services, such as MAT patient organizations which provide peer-to-peer treatment support for MAT patients.

Technical Area Summary Indicators and Targets

Kazakhstan

Future fiscal year targets are redacted.

Indicator Number	Label	2013	Justification
P8.3.D	P8.3.D Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	3,822	
	By MARP Type: CSW	600	
	By MARP Type: IDU	1,407	
	By MARP Type: MSM	500	
	Other Vulnerable Populations	1,315	
	Sum of MARP types	3,822	
C1.1.D	Number of adults and children provided with a minimum of one care service	1,900	Redacted

	By Age/Sex: <18 Male	0	
	By Age/Sex: 18+ Male	0	
	By Age/Sex: <18 Female	0	
	By Age/Sex: 18+ Female	0	
	By Sex: Female	0	
	By Sex: Male	0	
	By Age: <18	0	
	By Age: 18+	1,900	
	Sum of age/sex disaggregates	0	
	Sum of sex disaggregates	0	
	Sum of age disaggregates	1,900	
C2.1.D	Number of HIV-positive individuals receiving a minimum of one clinical service	1,500	Redacted
	By Age/Sex: <15 Male	0	
	By Age/Sex: 15+ Male	800	
	By Age/Sex: <15 Female	0	
	By Age/Sex: 15+ Female	700	
	By Sex: Female	700	
	By Sex: Male	800	
	By Age: <15	0	
	By Age: 15+	1,500	
	Sum of age/sex disaggregates	1,500	
	Sum of sex	1,500	

	disaggregates		
	Sum of age disaggregates	1,500	
H1.1.D	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	5	Redacted
H2.3.D	The number of health care workers who successfully completed an in-service training program	851	Redacted
	By Type of Training: Male Circumcision	0	
	By Type of Training: Pediatric Treatment	0	

Technical Area Summary Indicators and Targets

Kyrgyzstan

Future fiscal year targets are redacted.

Indicator Number	Label	2013	Justification
P8.3.D	P8.3.D Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	8,997	
	By MARP Type: CSW	1,817	
	By MARP Type: IDU	4,670	
	By MARP Type: MSM	900	
	Other Vulnerable Populations	1,610	
	Sum of MARP types	8,997	
P8.1.D	P8.1.D Number of the targeted population reached with individual and/or small	n/a	Redacted

	group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required		
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	2,750	
C1.1.D	Number of adults and children provided with a minimum of one care service	730	Redacted
	By Age/Sex: <18 Male	0	
	By Age/Sex: 18+ Male	0	
	By Age/Sex: <18 Female	0	
	By Age/Sex: 18+ Female	0	
	By Sex: Female	0	
	By Sex: Male	0	
	By Age: <18	0	
	By Age: 18+	730	
	Sum of age/sex disaggregates	0	
	Sum of sex disaggregates	0	

	Sum of age disaggregates	730	
C2.1.D	Number of HIV-positive individuals receiving a minimum of one clinical service	300	Redacted
	By Age/Sex: <15 Male	0	
	By Age/Sex: 15+ Male	200	
	By Age/Sex: <15 Female	0	
	By Age/Sex: 15+ Female	100	
	By Sex: Female	100	
	By Sex: Male	200	
	By Age: <15	0	
	By Age: 15+	300	
	Sum of age/sex disaggregates	300	
	Sum of sex disaggregates	300	
	Sum of age disaggregates	300	
H1.1.D	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	2	Redacted
H2.3.D	The number of health care workers who successfully completed an in-service training program	741	Redacted
	By Type of Training:	0	

	Male Circumcision		
	By Type of Training: Pediatric Treatment	0	

Technical Area Summary Indicators and Targets

Tajikistan

Future fiscal year targets are redacted.

Indicator Number	Label	2013	Justification
P8.3.D	P8.3.D Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	9,983	
	By MARP Type: CSW	2,380	
	By MARP Type: IDU	4,950	
	By MARP Type: MSM	1,050	
	Other Vulnerable Populations	1,503	
	Sum of MARP types	9,883	
P12.2.D	Number of adults and children reached by an individual, small group, or	2,300	Redacted

	community-level intervention or service that explicitly addresses gender-based violence and coercion related to HIV/AIDS		
	By Age: <15	0	
	By Age: 15-24	0	
	By Age: 25+	0	
	By Sex: Female	1,800	
	By Sex: Male	500	
C1.1.D	Number of adults and children provided with a minimum of one care service	955	Redacted
	By Age/Sex: <18 Male	0	
	By Age/Sex: 18+ Male	0	
	By Age/Sex: <18 Female	0	
	By Age/Sex: 18+ Female	0	
	By Sex: Female	0	
	By Sex: Male	0	
	By Age: <18	0	
	By Age: 18+	955	
	Sum of age/sex disaggregates	0	
	Sum of sex disaggregates	0	
	Sum of age disaggregates	955	
C2.1.D	Number of HIV-positive	500	Redacted

	individuals receiving a minimum of one clinical service		
	By Age/Sex: <15 Male	0	
	By Age/Sex: 15+ Male	300	
	By Age/Sex: <15 Female	0	
	By Age/Sex: 15+ Female	200	
	By Sex: Female	200	
	By Sex: Male	300	
	By Age: <15	0	
	By Age: 15+	500	
	Sum of age/sex disaggregates	500	
	Sum of sex disaggregates	500	
	Sum of age disaggregates	500	
H1.1.D	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	1	Redacted
H2.3.D	The number of health care workers who successfully completed an in-service training program	1,216	Redacted
	By Type of Training: Male Circumcision	0	
	By Type of Training: Pediatric Treatment	0	

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Technical Area Summary Indicators and Targets

Turkmenistan

Future fiscal year targets are redacted.

Indicator Number	Label	2013	Justification
P8.3.D	P8.3.D Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	994	
	By MARP Type: CSW	0	
	By MARP Type: IDU	994	
	By MARP Type: MSM	0	
	Other Vulnerable Populations	0	
	Sum of MARP types	994	
H2.3.D	The number of health care workers who successfully completed an	15	Redacted

	in-service training program		
	By Type of Training: Male Circumcision	0	
	By Type of Training: Pediatric Treatment	0	

Technical Area Summary Indicators and Targets

Uzbekistan

Future fiscal year targets are redacted.

Indicator Number	Label	2013	Justification
P8.3.D	P8.3.D Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	1,021	
	By MARP Type: CSW	0	
	By MARP Type: IDU	1,021	
	By MARP Type: MSM	0	
	Other Vulnerable Populations	0	
	Sum of MARP types	1,021	
C1.1.D	Number of adults and children provided with a minimum of one care service	118	Redacted

	By Age/Sex: <18 Male	0	
	By Age/Sex: 18+ Male	0	
	By Age/Sex: <18 Female	0	
	By Age/Sex: 18+ Female	0	
	By Sex: Female	0	
	By Sex: Male	0	
	By Age: <18	0	
	By Age: 18+	118	
	Sum of age/sex disaggregates	0	
	Sum of sex disaggregates	0	
	Sum of age disaggregates	118	
H2.3.D	The number of health care workers who successfully completed an in-service training program	150	Redacted
	By Type of Training: Male Circumcision	0	
	By Type of Training: Pediatric Treatment	0	

Technical Area Summary Indicators and Targets

Central Asia Region

Future fiscal year targets are redacted.

Indicator Number	Label	2013	Justification
P8.3.D	P8.3.D Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	24,817	
	By MARP Type: CSW	4,797	
	By MARP Type: IDU	13,042	
	By MARP Type: MSM	2,450	
	Other Vulnerable Populations	4,528	
	Sum of MARP types	24,817	
P8.1.D	P8.1.D Number of the targeted population reached with individual and/or small	n/a	Redacted

	group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required		
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	2,750	
AC.426	Number of pilot or demonstration sites at which public and NGO sector collaborate to improve access to services by key populations		Redacted
AC.425	Number of individuals who received HIV testing and Counseling (HTC) at USG pilot sites implementing improved HIV testing and Counseling (HTC)		Redacted
AC.423	Number of individuals who had a complete referral to a facility for		Redacted

	HIV testing		
P12.2.D	Number of adults and children reached by an individual, small group, or community-level intervention or service that explicitly addresses gender-based violence and coercion related to HIV/AIDS	2,300	Redacted
	By Age: <15	0	
	By Age: 15-24	0	
	By Age: 25+	0	
	By Sex: Female	1,800	
	By Sex: Male	500	
AC.421	Number of people living with HIV that received HIV-related care and treatment services from treatment sites that participated in USG-funded care and treatment strengthening program		Redacted
C1.1.D	Number of adults and children provided with a minimum of one care service	3,703	Redacted
	By Age/Sex: <18 Male	0	
	By Age/Sex: 18+ Male	0	
	By Age/Sex: <18	0	

	Female		
	By Age/Sex: 18+ Female	0	
	By Sex: Female	0	
	By Sex: Male	0	
	By Age: <18	0	
	By Age: 18+	3,703	
	Sum of age/sex disaggregates	0	
	Sum of sex disaggregates	0	
	Sum of age disaggregates	3,703	
C2.1.D	Number of HIV-positive individuals receiving a minimum of one clinical service	2,300	Redacted
	By Age/Sex: <15 Male	0	
	By Age/Sex: 15+ Male	1,300	
	By Age/Sex: <15 Female	0	
	By Age/Sex: 15+ Female	1,000	
	By Sex: Female	1,000	
	By Sex: Male	1,300	
	By Age: <15	0	
	By Age: 15+	2,300	
	Sum of age/sex disaggregates	2,300	
	Sum of sex disaggregates	2,300	
	Sum of age disaggregates	2,300	

AC.424	Number of PLHIV who had a complete referral to a clinical facility for TB screening		Redacted
AC.422	Number of laboratory facilities that participated in USG-funded laboratory mentorship program		Redacted
H1.1.D	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	8	Redacted
H2.3.D	The number of health care workers who successfully completed an in-service training program	2,998	Redacted
	By Type of Training: Male Circumcision	0	
	By Type of Training: Pediatric Treatment	0	

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
12026	American Society of Clinical Pathology	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	336,000
12027	International Center for AIDS Care and Treatment Programs, Columbia University	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	750,000
12746	Abt Associates	Private Contractor	U.S. Agency for International Development	GHP-State	0
12772	United Nations Office on Drugs and Crime	Multi-lateral Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	320,000
12799	Ministry of Health/Republican AIDS Center	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and	GHP-State	1

			Prevention		
12812	Ministry of Health/Republican Narcology Center	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	50,000
12859	Population Services International	NGO	U.S. Agency for International Development	GHP-State, GHP-USAID	0
12872	Columbia University Mailman School of Public Health	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State, GAP	1,624,000
12889	Ministry of Health/Republican AIDS Center	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	80,000
13501	U.S. Peace Corps	Other USG Agency	U.S. Peace Corps	GHP-State	123,000
13970	Clinical and Laboratory Standards Institute	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	399,999
13971	Republican Blood Center of the	Host Country Government	U.S. Department of Health and	GHP-State	30,000

	Ministry of Health of the Republic of Kazakhstan	Agency	Human Services/Centers for Disease Control and Prevention		
13972	Republican Blood Center of the Ministry of Health of the Kyrgyz Republic	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	50,000
13973	Health Policy Project	Private Contractor	U.S. Agency for International Development	GHP-State	0
13974	Management Sciences for Health	NGO	U.S. Agency for International Development	GHP-State	0
13976	John Snow, Inc.	Private Contractor	U.S. Agency for International Development	GHP-State	0
13978	Republican Blood Center of the Ministry of Health of the Republic of Tajikistan	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	60,000
17050	UNAIDS - Joint United Nations Programme on HIV/AIDS	Multi-lateral Agency	U.S. Agency for International Development	GHP-USAID, GHP-USAID, GHP-USAID	600,000
17051	TBD	TBD	Redacted	Redacted	Redacted
17067	TBD	TBD	Redacted	Redacted	Redacted

Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 12026	**Mechanism Name: ASCP**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: American Society of Clinical Pathology	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Benefiting Country	Benefiting Country Planned Amount
Kazakhstan	112,000
Kyrgyzstan	112,000
Tajikistan	112,000

Total Funding: 336,000		
Managing Country	**Funding Source**	**Funding Amount**
Kazakhstan	GHP-State	336,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This mechanism supports CAR's PEPFAR Strategy Objective 2. Restructuring and strengthening laboratory infrastructure is a high priority for the Ministries of Health (MOH) in Kazakhstan (KZ), Kyrgyzstan (KG) and Tajikistan (TJ). The goal is to increase the KZ, KG and TJ MOH's capacity on laboratory issues in relation to HIV/AIDS and related co-infections. The American Society for Clinical Pathology (ASCP) will work with different vertical healthcare structures of CAR MOHs (HIV/AIDS services, blood transfusion services, tuberculosis control services and others) to ensure integration and broad capacity building. The target population is the MOH and laboratory staff in KZ, KG, and TJ. ASCP will provide TA (TA) to the MOHs for the development and monitoring of

laboratory strategic plans; strengthening the technical capacity within MOH laboratories through trainings on internationally-recognized policies; implementing laboratory quality management systems and encouraging the accreditation of laboratories. ASCP will provide direct TA to national reference (and oblast level) laboratories in preparing laboratories for accreditation through the Strengthening Laboratory Management towards Accreditation (SLMTA) program; this activity will be monitored and evaluated under the PEPFAR policy reform area on the development of national policies on laboratory accreditation. The requested funding will target ASCP activities aimed at building the capacity of KZ blood transfusion laboratory services at the national and oblast level and the establishment of the National Reference Laboratory (NRL) for KZ blood transfusion services.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	200,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12026**		
Mechanism Name:	**ASCP**		
Prime Partner Name:	**American Society of Clinical Pathology**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	336,000	0
Narrative:			
This mechanism supports CAR's PEPFAR Strategy Objective 2 & linked to HLAB/CLSI, IM#13970 & Columbia Univ IM#12872. Reliable diagnosis and effective treatment of HIV infection would be impossible without quality			

laboratory services. Currently, no CAR country has a strategic plan for improving laboratory quality, a functioning national body overseeing laboratory performance standards, nor any system for laboratory accreditation or licensure for specific levels of competence. There is no culture of service quality, or conception that clinicians who collect samples, order tests, and receive results are the laboratory's clients. This lack of quality management and accountability to other components of the public health system creates barriers for people at risk for HIV infection to get tested, to receive and understand the results, and to have confidence in the accuracy of the testing. It is also detrimental to the success of ART programs. The goal of this project with the American Society for Clinical Pathology (ASCP) is to improve and strengthen laboratory capacity of the MOH in KZ, KG, and TJ in the area of HIV/AIDS and co-infection laboratory testing. *ASCP will offer assistance to the CAR MOHs' national core groups leading the efforts to strengthen laboratory systems by supporting the development of comprehensive national laboratory strategic plans. ASCP will be supporting selected HIV/AIDS, TB, and blood transfusion services national reference and regional (oblast) level laboratories by using the Strengthening of Laboratory Management Towards Accreditation (SLMTA) scheme which is designed to strengthen laboratory quality management, achieve immediate laboratory improvement and accelerate the process toward accreditation. The SLMTA process will include baseline assessments, followed by a series of training workshops and implementation of specific improvement projects in selected laboratories. As a monitoring and evaluation tool, follow-up assessments will be conducted to measure the level of improvement completed by each laboratory in specific focus areas. Upon completion of the training cycle, each laboratory will be visited for a final time by an ASCP assessment team to use the accreditation checklist and compare the scores from the baseline assessment to measure the progress made during the program. The number of SLMTA supported national reference (and oblast) level laboratories will be 4-5 laboratories per country with further expansion of additional laboratories as agreed with the MOHs and as the capacity of the national teams of laboratory managers and assessors are advanced. The SLMTA progress will regularly be documented and reported at national stakeholders' meetings to increase awareness of the strengths and challenges of laboratory operations and facilitate continuous quality improvement. In collaboration with the MOHs, ASCP will determine the types of training most appropriate to each country. Depending on the infrastructure level in each country, basic laboratory operations training, or other content-rich material resources to build capacity and sustainability of personnel will be provided.* *The activities listed above will be funded through previous PEPFAR funds. Requested funding for FY12 will target ASCP activities aimed at building the capacity of KZ blood transfusion laboratory services at the national and oblast level and the establishment of the National Reference Laboratory (NRL) for KZ blood transfusion services*

Implementing Mechanism Details

Mechanism ID: 12027	**Mechanism Name: Strategic Information**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and	Procurement Type: Cooperative Agreement

Prevention	
Prime Partner Name: International Center for AIDS Care and Treatment Programs, Columbia University	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Benefiting Country	Benefiting Country Planned Amount
Kazakhstan	250,000
Kyrgyzstan	250,000
Tajikistan	250,000
Uzbekistan	0

Total Funding: 750,000		
Managing Country	**Funding Source**	**Funding Amount**
Kazakhstan	GHP-State	750,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This ongoing cooperative agreement supports the CAR's PEPFAR Strategy Objective 3. The goal is to provide TA to the MOH staff in Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan to strengthen and build local capacity on HIV strategic information, including surveillance, surveys, M&E, and health information systems. Based on assessments conducted in FY11, SOPs will be developed to allow strategic information systems in the targeted CAR countries operate more efficiently. The project will become more cost-efficient over time as most of the cost intensive activities will take place early in the project. As SOPs are written and incorporated into government "prikaz" (orders), and trainings completed, more local MOH staff will be responsible for on-going implementation and trainings.

Activities funded through this cooperative agreement will primarily target MOH staff (epidemiologists, data management specialists, policy makers, and clinicians) and through the provision of TA, knowledge and skills will be transferred to the host MOHs.

Monitoring and evaluation plans will be developed for all project activities, which will be monitored by USG staff during regular site visits, meetings, and review of monthly activity reports.

Cross-Cutting Budget Attribution(s)

Gender: GBV	128,000
Human Resources for Health	270,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: **Mechanism Name:** **Prime Partner Name:**	**12027** **Strategic Information** **International Center for AIDS Care and Treatment Programs, Columbia University**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	750,000	0

Narrative:

This activity is linked to (1) HVSI BCN/IM # 12746; (2) HVSI BCN/IM 13975; (3)HVSI BCN/IM 12889; (4) HVSI BCN/IM 12799; (5) HVSI BCN/IM 12889. This mechanism supports the CAR PEPFAR Strategy Objective 3. The aim is to strengthen MOH capacity in CAR to collect, manage, analyze, and use HIV data effectively to inform programming and, in turn, impact the epidemic.
Surveillance & Surveys: From 2003-2007, USG helped launch IBBS among MARPs, which has been regularly conducted in Kazakhstan, Kyrgyzstan, Tajikistan, and Uzbekistan. Before the MOHs in these countries could develop adequate capacity to fully conduct IBBS without TA, funding constraints between 2008 and 2010 forced USG to withdraw support for this activity. Results of USG-supported IBBS assessments in TJ (in 2010) and in KZ

and KG (in 2011) revealed the need to improve IBBS practices (sampling, data quality assurance, analysis, and data use) in CAR and to develop SOPs to ensure reliability of results. A similar assessment was conducted in November - December 2011 by the SUPPORT project, in collaboration with a GFATM-funded UNDP project in UZ. In FY12, based on these assessments, the SUPPORT Project, in collaboration with the MOH in the four CAR countries, will develop and introduce detailed SOPs, including pre-surveillance, formative assessment activities; integrate MARPs size estimation into the IBBS; improve data analysis, interpretation, dissemination and use; and pilot electronic data entry and automated data analysis algorithms to reduce data entry errors and improve timeliness. *In addition, the SUPPORT project will provide TA in IBBS expansion, particularly training of staff in sub-regional levels, as well as support piloting IBBS surveys among non-injecting sex partners of PWID in KZ, KG, and TJ. This will be done as a matching activity to the successful Gender Challenge fund proposal. Accurate and timely IBBS are critical to supporting the national strategic plans for HIV response in CAR, as they are an important source of data on the HIV epidemic and allow for informed program planning.* *Health Information Systems: In FY10-11, an electronic HIV cased-based surveillance management system (EHCMS) was piloted in CAR, and the SUPPORT project provided TA to the national EHCMS rollout in KZ.* *In FY12, the SUPPORT project will help with the national rollout of EHCMS in KG and TJ, further improve security and safety of EHCMS data, and develop data quality assurance and data analysis algorithms. Expansion of EHCMS will help countries establish standard data collection methods related to HIV surveillance, care & treatment and will improve quality of data used to construct national indicators.* *Monitoring and Evaluation: In FY11, the SUPPORT Project conducted a national M&E System Strengthening Workshops in KG. Workshop participants from different ministries (MOH; Labor; Social Protection; Justice; Youth; Education) and NGOs assessed components of the national M&E system and developed a joint M&E strengthening plan. In October 2011, the project conducted similar workshops in KZ. The same workshop will be conducted it in TJ. In FY12, USG will support implementation of the national M&E system strengthening plan in CAR.* *The SUPPORT project will closely collaborate with other PEPFAR-funded programs as well as with GFATM and other development partners to leverage resources and avoid duplication of efforts.*

Implementing Mechanism Details

Mechanism ID: 12746	**Mechanism Name: Quality Health Care Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Abt Associates	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	

G2G: No	Managing Agency:

Benefiting Country	Benefiting Country Planned Amount
Kazakhstan	0
Kyrgyzstan	0
Tajikistan	0

Total Funding: 0		
Managing Country	**Funding Source**	**Funding Amount**
Kazakhstan	GHP-State	0

Sub Partner Name(s)

AIDS Project Management Group (APMG)		

Overview Narrative

This mechanism supports CAR's PEPFAR Strategy Objectives 1, 2 and 3.

The Quality Health Care Project's overall goal is to support increased use of effective HIV and TB public health services, by vulnerable groups in CAR. The project focuses on improving the continuum of care for MARPs by strengthening the enabling environment, with a focus on building policy environments that support the delivery of care to MARPs and addressing policy and legal barriers that constrain MARP access to health services; governance of GFATM grants and governance of national HIV programs; and capacity of health providers and NGOs to plan, deliver and manage improved services for MARPs.

The project will work closely with the Health Policy Improvement Project in conducting a rapid review of policy assessments and developing and implementing a policy advocacy strategy and interventions. Quality will build on the work of GMS in implementing capacity strengthening activities for country CCMs and regional coordinating bodies. Quality will work with AIDSTAR II to conduct diagnostic assessments of NGOs and develop and implement capacity building strategies to strengthen the role and capacity of NGOs in supporting national AIDS responses.

FY12 activities will be focused in KZ, KG and TJ. Previous year funds will be used in TK and UZ. Target populations are MARPs, health providers, MOHs, NGOs, civil society, and policymakers. All activities will be closely coordinated with the GFATM, MOHs and other USG partners to leverage resources and build ownership

and sustainability of project interventions. Baseline assessments are conducted for each intervention, tracking progress during and after the completed intervention. The project provides on-going mentoring and support

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

Budget Code Information

Mechanism ID:	12746		
Mechanism Name:	Quality Health Care Project		
Prime Partner Name:	Abt Associates		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	0	0
Narrative:			
This mechanism will support the CAR PEPFAR Strategic Objective 3: Strengthen the capacity of public and private sectors to collect, analyze, manage and utilize data for evidence-based planning and policy making at all levels particularly sub-objective 3.1 health information systems. This activity is linked to HVSI BCN of Columbia University-ICAP SUPPORT Project, IM # 12027 and HVSI BCN of the Regional Technical Support project IM #13975. Multiple partners are currently collecting data on MARP populations in KZ, TJ and KG. NGOs collect information on MARP outreach, coverage and behaviors. Republican AIDS Centers conduct MARP size estimation studies, annual sentinel surveillance surveys, among other studies. Health facilities collect data for patients. Donors			

and development partners conduct surveys and assessment. In order to support one M&E system for Central Asian countries, NGO and AIDS Center data need to be consolidated and standardized. By determining ways to share and use data from the community, facility and national level, countries will have a better understanding of the HIV epidemic and will be more effective in programming limited resources.

The Quality Project will leverage broad project resources and experience and use limited funds to improve the use of data for decision making. Specifically, the project will support streamlining data on MARPs services from the community/NGO level to feed into the national M&E system.
In Kyrgyzstan, the Quality Project will build on recent commitment from the government sector, within the scope of the national health sector strategy (Den Sooluk) to create a system by which NGOs report MARPs data to the Republican AIDS Center. This merging of information systems between governmental and non-governmental groups will contribute significantly to clarifying currently unreliable coverage statistics, and should ultimately feed into more accurate population size estimations; it is expected that the dynamic between the governmental and non-governmental sectors will also allow the two groups to hold each other more accountable for accuracy of data. When this system is successfully implemented in Kyrgyzstan, the Quality Project will explore opportunities to introduce a similar system in Tajikistan. The project will work very closely with USG partners, MOHs, development partners, and GFATM Principal Recipients to ensure that these activities support one monitoring and evaluation system for Kyrgyzstan and Tajikistan.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0

Narrative:

This mechanism supports CAR PEPFAR Strategy Objective 1 and 2 & is linked to OHSS BCN/IM #13974& IM#13977. The HIV epidemic in CAR is affected by many health systems challenges such as stigma, discrimination, legal and policy barriers to accessing services, lack of coordination between NGOs and the health care system, weak program oversight, limited human resource capacity, and vertical, non-patient-friendly systems of care. These challenges need to be addressed as a coordinated approach with other stakeholders at the national and service delivery levels. In previous ROPs, the Quality Project focused its activities on service delivery and supporting NGO capacity building. In FY12, the project will re-focus on broader policy and governance issues to build sustainability of national HIV programs. The Quality Health Care Project will focus on Health System Strengthening activities to improve four sub-objectives: Policy Environment: the project will support development and implementation of national health and HIV strategies in KZ, KG, TJ to include more equitable and gender-sensitive services for MARPs. Using results from the barrier analysis, the project will provide TA to support country partners to improve the legal and policy framework, such as improved documentation services for released prisoners. It will also support approaches such as the strengthening of local coordinating councils and the formation of community

advisory boards at the National AIDS and Narcology Centers and local levels to strengthen the role of MARPs in shaping health services. Governance: The project will build management capacity of the CCMs and of regional coordinating bodies in KZ, KG and TJ. The project will strengthen national systems that affect efficiency of GFATM grant implementation such as TA to improve procurement and supply management in TJ and KG. It will assist CCMs in KZ, KG, and TJ to use the dashboard data for decision-making. The project will also provide targeted TA and support as identified by the GMS led diagnostic and CCM capacity development framework. The project will continue to support CCM mechanisms (i.e. technical working groups, oversight teams) that bring together NGOs and health providers to strengthen their partnership. Capacity: In collaboration with CDC partners, the project will support USG efforts to strengthen capacity of health providers in primary health care facilities. Activities may include reviewing and updating in-service curricula, rollout of in-service HIV communication skills training (i.e stigma reduction), and applying new training and mentoring models. The project will strengthen counseling and social work skills for in-service professionals. Integration, collaboration and sustainability: The project will provide targeted technical and management TA to address needs identified by the NGO capacity assessment. The project will also support the essential role of NGOs by advocating for introducing a government financing mechanism for NGOs i.e. social contracting in KG and TJ and for expanding KZ's current government NGO financing program, as well as provide TA to develop key aspects of social contracting. Many project activities will be shaped by the results from the reviews of CCM capacity, NGO capacity and stigma and discrimination. The project will work very closely with USG partners, MOHs, development partners and GFATM PRs to ensure that recommended activities from these reviews are implemented and coordinated.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVCT	0	0
Narrative:			
This mechanism supports CAR PEPFAR Strategy Objective 1 and is linked to (1) HVCT BCN/IM #12859; (2) IM #12872; (3)IM #12889; (4) IM #13217; and (5) IM #12812. The numerous policy and legal barriers for expanded rapid testing for MARPs contribute to very low levels of MARPs who know their HIV status. Most counseling and testing is only available at national AIDS centers, which are difficult for MARPs to access due to fear, stigma and lack of legal documents or registration. The quality of counseling and loss to follow up also limits MARP access to quality counseling and testing services. One solution is to expand access to rapid testing for MARPs in a variety of settings and to accompany these tests with high quality pre- and post-test counseling. *The Quality Health Care Project will support two PEPFAR sub-objectives of improving access to rapid HTC in KZ, KG and TJ, and improving the policy and legislative environment for HTC. To improve access, the project will coordinate closely with CDC implementing partners and GFATM to expand access to HTC for MARPs, by instituting the pilot use of rapid tests in six target primary health care facilities in KZ, KG and TJ, and expanding use to outreach workers in the field. In close collaboration with CDC implementing partners, the project will*			

establish appropriate rapid testing protocols, including follow-up testing links for those with positive rapid tests in a non-medical setting. The project will continue to train primary health care workers and facility providers in interpersonal communications skills necessary for accurate risk assessment and provider-initiated counseling and testing. Ongoing mentoring will enable health providers to continually increase their responsiveness to both MARPs referred for HTC and MARPs presenting for other health needs. Continuous Quality Improvement processes as well as on-going monitoring and evaluation will measure HTC quality as well will be used to assess the success of these models.

Using data from the secondary review of policy issues related to MARPs as well as experience from successful models of rapid testing, the project will work with USG, government and development partner stakeholders to further policy changes that promote implementation and institutionalization of rapid testing in different settings. The Quality Project will also work with host country partners to update relevant policies and laws to ensure sustainability of the new testing algorithms.

In KZ, the project will work closely with other USG partners and the Almaty City AIDS Center to examine appropriate rapid testing protocols. The project will also explore funding mechanisms within the state budget to assure that purchase of rapid tests is scaled-up in future years. In KG and TJ, the project will work closely with other USG, outreach partners and GFATM PRs to assure that a strategic plan is in place for rolling out rapid testing to reach more MARPs, and appropriate protocols exist for both rapid testing and follow-up for those who test positive.

The project will coordinate closely with MOHs, other USG partners, GFATM and other donors on policy activities, on efforts to expand coverage of HTC services as well as on identifying models and best practices that can be scaled up and sustained.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	0	0

Narrative:

This mechanism supports CAR Regional PEPFAR Strategy Objectives 1 and 2 and is linked to: (1) IDUP BCN/IM #12859; (2) IM#12872;(3) IM #12889; (4) IM #13217; (5) IM# 12812; (6) IM #13969; (7) IM# 12772; and (8) IM#13973. The HIV epidemic in Central Asia continues to be primarily driven by injection drug use, with most HIV cases registered among young, unemployed males. The proportion of HIV infection attributed to PWID was around 53% in KZ, 55% in TJ, and 64% in KG. Of CAR's estimated 263,000 PWID, only 1,225 (in KZ, KG, and TJ) are receiving MAT. High levels of stigma and discrimination, a restrictive policy environment, and vertical systems of care for most at risk populations are among the many barriers that prevent access to HIV prevention, treatment and care services.

The primary focus of Quality's work will be in the areas of policy advocacy and capacity strengthening of HIV/AIDS national and regional governance structures, NGOs implementing HIV/AIDS and health providers in targeted primary health care facilities. *Taking recommendations from the Health Policy Project-led rapid review of policy assessments conducted to date, including harm reduction and stigma and discrimination policy reviews, the Quality Project will implement policy change advocacy activities to increase access to PWID services (i.e. expand MAT) and reduce stigma and discrimination at the national and service delivery levels. Among other areas of policy focus, the project will work with other development partners to develop and implement recommended actions to improve the legal and political framework for the expansion of MAT, including assisting in preparation of key policies and protocols, and prikazes and algorithms to implement and expand these services. The project will develop and advocate for adoption of drug treatment legislation that assures right to MAT for treatment of opioid dependence.* *In close collaboration with CDC implementing partners, the project will help build the capacity of providers within targeted primary health care facilities to improve and scale-up HIV programs related to drug dependency, including, as available, MAT for PWID. The project will work to improve the capacity of health care workers to address the needs of PWID and improve interpersonal communications skills; follow-up mentoring will be provided and quality of care for PWID will be measured through patient satisfaction surveys and focus groups.* *The project will work closely with targeted primary health care facilities to develop and implement service referral systems to promote models of integrated care for MARPs. Attention will be paid to increasing access to these services for women. Quality will also conduct trainings for NGOs and health care workers on family centered approaches for treating females who use injecting drugs.* *The project will continue to coordinate with MOHs, other USG and development partners and GFATM grants to ensure coordinated approaches to policy and advocacy and capacity building for health providers can be scaled up and sustained.*

Implementing Mechanism Details

Mechanism ID: 12772	**Mechanism Name: UNODC**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: United Nations Office on Drugs and Crime	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Benefiting Country	Benefiting Country Planned Amount
Kazakhstan	80,000
Kyrgyzstan	80,000
Tajikistan	160,000

Total Funding: 320,000		
Managing Country	**Funding Source**	**Funding Amount**
Kazakhstan	GHP-State	320,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This ongoing cooperative agreement supports the Central Asia Region (CAR)'s PEPFAR Strategy Objectives 1, 2 and 3. The goal of the project is to increase access to a full range of essential and quality HIV and TB prevention and treatment services among MARPs, primarily persons who inject drugs (PWID) and incarcerated populations. The United Nations Office on Drug and Crime (UNODC) will provide technical assistance, training and professional development, along with multi-sectoral advocacy and policy development. The target populations are PWID, incarcerated people, providers of services to these populations, and government policymakers in KZ, KG, TJ and UZ. The project will engage local experts when possible to help reduce costs, and will assist the governments in developing effective and cost efficient prevention programs to prevent the spread of HIV among PWID and prisoners. Activities are designed to build capacity of local entities (national or regional governments, prisons, and HIV service providers) and develop policies, protocols and laws that will be left behind for local governments after the project ends. All activities will be integrated with those of other USG partners as well as international donors including the EU, DFID, and GFATM to ensure that regulatory documents, models of care and capacity building activities are coordinated and complementary to other programs. To leverage resources and build ownership and sustainability of project interventions, a clear transition strategy will be developed to transfer activities at the conclusion of the project. A comprehensive M&E plan will be developed, using the UN and PEPFAR guidelines for integrating specific indicators of access to HIV-related services into the state monitoring and evaluation systems.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	12772		
Mechanism Name:	UNODC		
Prime Partner Name:	United Nations Office on Drugs and Crime		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	IDUP	320,000	0

Narrative:

This mechanism supports the CAR Regional PEPFAR Strategy Objectives 1, 2 and 3. This activity is linked to: (1) IDUP BCN/PSI IM #12859; (2) Columbia University/IM #12872; (3) RAC-KZ/ IM #12889; (4) RAC-KG/IM #13217; (4) RNC-KG/IM #12812; (5) TBD Harm Reduction Center/IM #13969; (6) Abt Associates/ IM # 12746; and (7)Health Policy Project/IM#13973. UNODC will provide technical assistance (TA) to the host governments of Kazakhstan, Tajikistan, Kyrgyzstan, Turkmenistan and Uzbekistan to improve the availability, coverage and quality of HIV services for drug users and incarcerated populations by: 1) updating regulatory documents (national guidelines, operational plans, management standards, etc.) to ensure that the scale and quality of services conforms to the WHO/UNODC/UNAIDS comprehensive package for the prevention, treatment and care of HIV among PWID; and 2) developing a model for integrated delivery of a comprehensive set of interventions addressing the health needs of people who inject drugs (PWID), including an effective referral mechanism that would ensure continuity of community- and prison-based care. The project contributes to institutional capacity building by updating standards of professional education for those working with PWID in health care, social work and criminal

justice, with 120 people as the target number of faculty and national master trainers trained over 2012-2013. This will be paired with in-service trainings for prison health care personnel and community providers on the provision of a comprehensive package of HIV prevention services (target 130 people trained over 2012-2013). TA and capacity building will be based on 2009 WHO/UNODC/UNAIDS guidelines and input from CAR PEPFAR program as frameworks for planning, monitoring and evaluating services for prisoners, PWID and their sex partners, including: MAT and other drug treatment modalities; HTC; prevention and treatment of STIs, viral hepatitis and TB; and ART. All activities will be integrated with those of other USG partners as well as international donors including the EU, DFID, and GFATM to ensure that regulatory documents, models of care and capacity building activities are coordinated and complementary to other programs. Indicators based on the UN and PEPFAR guidelines will be integrated into the state monitoring and evaluation systems to track uptake of HIV-related services by prisoners and PWID. USG will monitor this project through regular joint field visits with regional and country-based UNODC staff and through periodic joint work plan reviews.

Implementing Mechanism Details

Mechanism ID: 12799	**Mechanism Name: Support to Ministry of Health/Republican AIDS Center of the Republic of Tajikistan**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Ministry of Health/Republican AIDS Center	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 1		
Managing Country	**Funding Source**	**Funding Amount**
Tajikistan	GHP-State	1

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This ongoing cooperative agreement supports the Central Asia Region (CAR)'s PEPFAR Strategy Objective 1, 2

and 3. The goal is to provide TA to the Republican AIDS Center of the Ministry of Health (MOH) in Tajikistan to strengthen: their capacity to implement high quality HIV prevention services for MARP and their ability to measure, monitor, and evaluate HIV morbidity and prevention programs. Six HIV prevention demonstration sites will be established to offer MARPs friendly services in underserved areas and deliver comprehensive packages of quality HIV prevention services. Activities funded through this cooperative agreement will primarily target Ministry of Health staff (clinicians, epidemiologists, data management specialists, policy makers) and MARPs, primarily persons who inject drugs (PWID) and sex workers. Sustainability of the program will be fostered through systems strengthening, trainings, and capacity building of the MOH staff at the national, regional, and health care facility level. USG will work with the TJ MOH and GFATM to ensure sustainability of the demonstration sites at the conclusion of the project period. Train the trainer approaches will allow local staff to assume responsibility of activities later in the project, thus increasing cost efficieny. The project will closely coordinate with other PEPFAR-funded programs, GFATM and international partners to leverage funding and avoid duplication of efforts. The program will monitor indicators using electronic databases and internal registration forms and will be evaluated by the MOH and USG on a regular basis.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

Budget Code Information

Mechanism ID:	**12799**
Mechanism Name:	**Support to Ministry of Health/Republican AIDS Center of the Republic of Tajikistan**
Prime Partner Name:	**Ministry of Health/Republican AIDS Center**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	0	0

Narrative:

This activity supports CAR PEPFAR Strategy Objective 3: Strengthen the capacity of public and private sectors to collect, analyze, manage and utilize data for evidence-based planning and policymaking at all levels. This activity is linked to (1) HVSI BCN Columbia University-ICAP SUPPORT Project/ IM # 12027; (2) Abt Associates Quality Health Care Project/ IM # 12746; and (3) TBD Regional Technical Support project/ IM 13975. Since 2003, the USG helped to launch regular Integrated Biological and Behavioral Surveillance (IBBS) among MARPs that became a routine practice implemented nationwide in Tajikistan. In FY10, the USG team conducted an assessment of IBBS. The results of the assessment revealed the need to improve IBBS practices to ensure more effective implementation. No FY12 funds are being requested to fund strategic information activities through the Republican AIDS Center. Funds from previous fiscal years will be used in FY12 to support a nationwide IBBS conference to present and discuss the HIV epidemiologic situation in Tajikistan. These funds will also be used to support the Republican AIDS Center to conduct size estimation of MSM, PWID, and SW, which will include data entry, data analyses, report writing, and results distribution. The Project will also closely coordinate its efforts with other PEPFAR-funded programs, GFATM, and donors to leverage funding and avoid duplication of efforts.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	1	0

Narrative:

This mechanism supports CAR PEPFAR Strategy Objective 1. This activity is linked to: (1) HVOP BCN Columbia University (Treatment and Care) Project/IM#12872; and (2) PSI/ IM #12859. No ROP FY12 funds are being requested for these activities. In Tajikistan (TJ), HIV is the most commonly transmitted through injecting drug use. The proportion of annual HIV cases reporting injection use as the method of transmission decreased from 64% in 2006 to 56% in 2010. Over the last few years, sexual transmission of HIV has been increasing, accounting for 27% of all HIV cases in the country (2010). The estimated number of sex workers (SW) in Tajikistan has increased from approximately 1,071 in 2006 to over 12,500 in 2010. HIV prevalence among SW has shown no consistent trend from 2006-2010, with HIV prevalence at 3% in 2010, while the percentage of SW tested for HIV who knew their HIV status increased from approximately 27% in 2006 to 44% in 2010. Under this cooperative agreement, using previous year funds, the USG will provide TA to the Republican AIDS Center to improve access and quality of HIV prevention services for SW. This project will support the TJ MOH to establish a Drop-in-Center for SW, which will offer a comprehensive package of HIV prevention services. The services include distribution of free condoms; informational materials on HIV, harm reduction, and sexually transmitted diseases; referral to medical assistance and social services at local public health facilities, such as STI diagnosis and treatment. The location of these

facilities will be determined by examining available data and mapping the location of sex workers to existing HIV prevention services. The project will be implemented in collaboration with other USG funded organizations. USG will work with the TJ MOH and GFATM to support community centers and scale up other HIV prevention sites for MARPs to increase coverage of vulnerable groups with HIV prevention services and to improve the quality of services. The program will monitor indicators, including number of people served; number of referrals made; number of people tested and who received results; and the number of people trained, using electronic databases and internal registration forms. The Project will also closely coordinate its efforts with other PEPFAR-funded programs, GFATM and other international partners to ensure leverage of funding to avoid duplication of efforts.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	0	0

Narrative:

This ongoing cooperative agreement supports the CAR PEPFAR Strategy Objectives 1 and 2. This activity is linked to: (1) IDUP BCN PSI's/IM #12859; (2) Columbia University/IM#12872; (3) UNODC/IM #12772; and (4) Health Policy Project/IM #13973. Unsafe injecting practices among PWID accounted for 55% of all HIV cases in Tajikistan (TJ) registered in 2009. High levels of stigma and discrimination, and low levels of HIV knowledge, make the estimated 25,000 PWID in TJ difficult to reach. There are 43 Trust Points (TP) throughout the country, which provide HIV prevention services to PWID. However, only 56% of PWID in TJ have been reached with HIV prevention services. HIV prevalence among PWID averaged 18% across all HIV Sentinel Surveillance sites, with the highest prevalence in Kulyab (34%). Overall, 45% of PWID shared needles the last time they injected drugs, with rates of 91% in Kulyab and 86% in Vahdat. This project has two objectives. The first is to increase access to and coverage of HIV prevention services in areas with underserved PWID. The vast majority of the country is mountainous and without paved roads, which prevent PWID from reaching services. In addition, some geographical areas offer no basic HIV prevention services for PWID. This project will support the TJ MOH to scale-up HIV prevention services to PWID, with the establishment of four TPs and a DIC for PWID. The location of these facilities will be determined by examining available data and mapping the location of PWID to existing HIV prevention services. These new facilities will provide access to individual protection items; free condoms; informational materials on HIV, harm reduction, sexually transmitted diseases, and overdose prevention; referral to medical assistance and social services at local public health facilities, and HIV testing and counseling. These activities will be included into the national HIV plan of TJ to avoid duplication of effort and complement existing services for MARPs. The main project will set up models that can be replicated in the future with support of other donors. A vigorous M&E system will be established to evaluate project implementation and results. The program will monitor indicators, including number of people served; number of referrals made; number of people tested and who received results; and the number of people trained.

The second objective is to increase the capacity of MOH personnel providing HIV prevention services to MARPs, at the local and national level, experience monitoring the impact of HIV prevention services with biomedical

outcomes. MOH personnel will be able to link HIV prevention activities to outcomes such as HIV testing, STI treatment, HIV treatment, and other health services. The project will also closely coordinate with other PEPFAR-funded programs, GFATM and international partners. These activities will be included into the national HIV plan of TJ to avoid duplication of effort and complement existing services for MARPs. *In light of recent Congressional directives on NSPs, PEPFAR CAR will eliminate direct USG support for NSPs and instead leverage GFATM resources and networks for NSP procurement and distribution with USG-funded MARP outreach and peer education efforts.*

Implementing Mechanism Details

Mechanism ID: 12812	**Mechanism Name: Support to Ministry of Health/Republican Narcology Center of the Kyrgyz Republic**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Ministry of Health/Republican Narcology Center	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: Yes	Managing Agency: HHS/CDC

Benefiting Country	Benefiting Country Planned Amount
Kyrgyzstan	50,000

Total Funding: 50,000		
Managing Country	**Funding Source**	**Funding Amount**
Kazakhstan	GHP-State	50,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This ongoing cooperative agreement supports CAR PEPFAR Strategy Objectives 2 and 3. The goal is to provide TA

to the Kyrgyzstan Republican Narcology Center (RNC) of the Ministry of Health (MOH) to strengthen it's capacity and expand access to high quality HIV prevention services. This project will support the establishment of two demonstration sites to provide high quality, MARPs- friendly Medication Assisted Treatment (MAT). Activities funded through this project will primarily target KG MOH staff and people who inject drugs (PWID). The Republican Narcology Center will establish protocols for MAT provision, using effective and cost efficient programs and processes, and a M&E system to allow tracking of indicators, such as retention rates, and monitoring of progress. Sustainability of the program will be fostered through systems strengthening, training and capacity building of the RNC and MAT site staff, allowing them to monitor and improve the quality and efficiency, including costs, of their program. A vehicle will be purchased to support this activity with the purpose to deliver methadone to MAT sites, and to deliver program tracking materials from the demonstration sites to the RNC. Currently, there is only one functioning vehicle (purchased by GFATM) serving 20 MAT sites across this mountainous, difficult-to-traverse country. RNC possesses two old vehicles which are essentially non functional.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	20,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: Mechanism Name: Prime Partner Name:	12812 Support to Ministry of Health/Republican Narcology Center of the Kyrgyz Republic Ministry of Health/Republican Narcology Center		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Prevention	HVCT	50,000	0
Narrative:			

This supports the CAR PEPFAR Strategy Objectives 1 and 2. This activity is linked to: (1) HVCT BCN Columbia University/IM #12872; (2) PSI/IM #12859; (3) RAC-KG /IM #13217; (3) TBD Harm Reduction Center/IM #13969; and (4) UNODC IM #12772. No FY12 ROP funding is being requested. Similar to the other countries in CAR, the predominant mode of HIV transmission in KG is unsafe injecting practices. Injection drug use has become more prevalent in recent years due to the country's geographical location on key drug trafficking routes from Afghanistan to Russia and Europe. In 2010, it was estimated that approximately 26,000 PWID reside in KG. In 2009, HIV infection rates among PWID were 14% nationally, with the highest rate of 30% reported in Osh Oblast. As of January 2011, PWID accounted for 64% of all registered HIV cases, and only 61% were covered by HIV prevention services. PWID comprise almost 20% of the prison population. Data from 2009 show that 3% of KG prisoners are HIV infected; including 10% of prisoners from the Bishkek area. The goal of this cooperative agreement is to provide TA to the Republican Narcology Center to increase access and quality of HIV prevention services for PWID in underserved areas of KG. The project will give the KG MOH experience providing high quality, MARP friendly HIV prevention services via establishment of "demonstration" MAT sites both in community and prison settings. In addition, rapid HIV testing will be piloted at the MAT demonstration sites. KG currently does not use rapid HIV tests in their national testing algorithm and there is no data on how many PWID, who are on MAT, have been tested for HIV and know their HIV status. Through this program, USG will provide TA to pilot the use of rapid HIV testing as part of the HTC at the MAT demonstration sites. Rapid testing will be used for screening, and in the event of a positive screening result, venous blood will be collected and sent for confirmatory Western Blot testing at the National Reference Laboratory. People will receive appropriate post-test counseling and instructions for returning to receive their confirmatory result. For persons tested HIV positive, appropriate medical and social service referrals will be made. To insure quality assurance of counseling, intensive training will be conducted for counselors and laboratory specialists on use of the rapid HIV test kits, and QA/QC. The Project will closely work with other PEPFAR-funded partners, to leverage the resources and avoid duplication. The project indicators will include the number of PWID who are tested for HIV at MAT sites, the number of PWID referred for additional testing, counseling, and treatment services, and the number of persons trained in both the laboratory and counseling aspects of rapid HIV testing. Only FDA approved rapid HIV tests will be purchased. PEPFAR funds will be used to purchase rapid HIV tests to be implemented at the two demonstration MAT sites. Approximately 160-180 PWID will be tested. Random sample verification will monitor the quality of the rapid test results. These activities will be included into KG's National HIV Strategic Plan to eliminate duplication and complement existing services for MARPs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	0	0
Narrative:			

This supports the CAR PEPFAR Strategy Objectives 1 and 2. This activity is linked to: (1) IDUP BCN Columbia University/IM #12872; (2) PSI/IM #12859; (3) UNODC/ IM #12772; (4) and Health Policy Project/IM#13973. Similar to the other countries in CAR, the predominant mode of HIV transmission in KG is unsafe injecting practices. Injection drug use has become more prevalent in recent years due to the country's geographical location on key drug trafficking routes from Afghanistan to Russia and Europe. In 2010, it was estimated that approximately 26,000 PWID reside in KG. In 2009, HIV infection rates among PWID were 14% nationally, with the highest rate of 30% reported in Osh Oblast. As of January 2011, PWID accounted for 64% of all registered HIV cases, and only 61% were covered by HIV prevention services. PWID comprise almost 20% of the prison population. Data from 2009 show that 3% of KG prisoners are HIV infected. The goal of this cooperative agreement is to provide TA to the Republican Narcology Center to increase access and quality of HIV prevention services for PWID in underserved areas of KG. The project will give the KG MOH experience with providing high quality, MARP friendly HIV prevention services via establishment of "demonstration" MAT sites in both community and prison settings. KG was the first country in Central Asia to introduce MAT in 2002, however, less than 5% of PWID receive MAT services. This project will support the KG MOH established two new MAT sites, with enhanced services, such as expanded hours and more accurate methadone dosing, to encourage retention and improve the quality of the program. One MAT site will be established in Osh Oblast and one in a prison setting near Bishkek. These sites were chosen due to the high prevalence of drug users, high HIV infection rates in the target populations, and the clear need to expand access to MAT. The GFATM will purchase methadone for CDC – supported MAT pilots.The program will monitor indicators using electronic databases and internal registration forms. Indicators will include coverage and reach of the services, including the number of people served, number of referrals made and provided, the number enrolling in MAT, retention rates at 3, 6, 9, and 12 months, and the number of people trained. Supervision will be provided by the MOH. Log sheets will be sent to the national MOH on a monthly basis, and shared with USG, for M&E purposes. The Republican Narcology Center works closely with GFATM and other international donors to leverage resources and avoid duplicative efforts. Since this will be a MoH implemented project, USG will work with both GFATM and the KG MOH to support the sites after successful implementation of these demonstration sites.

Implementing Mechanism Details

Mechanism ID: 12859	**Mechanism Name: Dialogue on HIV and TB (formerly Health Outreach Project)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	

G2G: No	Managing Agency:

Benefiting Country	Benefiting Country Planned Amount
Kazakhstan	0
Kyrgyzstan	0
Tajikistan	0
Turkmenistan	0
Uzbekistan	0

Total Funding: 0		
Managing Country	**Funding Source**	**Funding Amount**
Kazakhstan	GHP-State	0
Kazakhstan	GHP-USAID	0

Sub Partner Name(s)

AIDS Foundation East, West (AFEW)	Kazakh Association of People Living with HIV	

Overview Narrative

This project supports CAR PEPFAR strategy objectives 1 and 2.
The goal of the USAID Dialogue on HIV and TB Project is to increase access to HIV and TB prevention and treatment services among most at risk populations (MARPs) through outreach, TA, and training. The project implements outreach programs in 16 sites in Kazakhstan, Kyrgyzstan, and Tajikistan focusing mainly on people who inject drugs and sex workers, people living with HIV/AIDS, men who have sex with men and migrants. Dialogue consortium member, AIDS Foundation East-West, will target prisoners in eight sites in the three countries. The project will fill the gap between services through direct outreach to MARPs, providing referrals to services throughout the HIV continuum of care, and escorting clients to needed services.

Gender will be addressed through targeted outreach activities, increasing equity in HIV activities, and addressing male norms and behaviors. Since this program is co-funded with TB funds, it will also address TB prevention, treatment and adherence.

During the last two years of the project, the project will reduce the number of sub-partners and key staff in the

consortium to reduce program costs. The project will provide organizational capacity building to NGOs by training outreach workers and peer educators and through grants. By building organizational and financial management skills of NGOs, it is expected that they will be able to receive grants from other donors in the future. The project will advocate for innovative models such as multi-disciplinary teams (MDTs) to be institutionalized into the national level program.
The project uses a rigorous monitoring and evaluation system which consists of on-going oversight and monitoring including financial audits and behavior change surveys.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Mobile Population

Budget Code Information

Mechanism ID:	**12859**		
Mechanism Name:	**Dialogue on HIV and TB (formerly Health Outreach Project)**		
Prime Partner Name:	**Population Services International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	0	0
Narrative:			
Same BC as ROP 2012; no narrative required. ROP 2012 narrative should have carried over.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Prevention	HVCT	0	0
Narrative:			
Same BC as ROP 2012; no narrative required. ROP 2012 narrative should have carried over.			

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0
Narrative:			
Same BC as ROP 2012; no narrative required. ROP 2012 narrative should have carried over.			

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	0	0
Narrative:			
Same BC as ROP 2012; no narrative required. ROP 2012 narrative should have carried over.			

Implementing Mechanism Details

Mechanism ID: 12872	**Mechanism Name: Columbia University (Columbia Treatment and Care)**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Columbia University Mailman School of Public Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Benefiting Country	Benefiting Country Planned Amount
Kazakhstan	541,334
Kyrgyzstan	541,333
Tajikistan	541,333

Total Funding: 1,624,000		
Managing Country	**Funding Source**	**Funding Amount**
Kazakhstan	GAP	150,090
Kazakhstan	GHP-State	1,473,910

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This ongoing cooperative agreement supports the CAR PEPFAR Strategy Objectives 1, 2 and 3. The overarching goal is to provide TA to and build the capacity of the Ministries of Health in CAR so that care, treatment, laboratory, and MARPs prevention services for people at risk for, and living with, HIV/AIDS in CAR will be provided according to accepted international standards, and adapted to the local context. These activities will take place primarily in Kazakhstan, Kyrgyzstan, Tajikistan, and to a lesser extent, Uzbekistan.

The TA is primarily targeted to most-at-risk-populations, people living with HIV/AIDS, their health care and other service providers, and Ministry of Health staff. This mechanism's strategy to become more efficient over time is by developing standard operating procedures, guidelines, and quality management systems, in partnership with CAR Ministries of Health, which will be institutionalized and incorporated into CAR governmental "prikaz" (orders of the MOHs) to be implemented nationwide, after appropriate USG-supported training of relevant staff. The SUPPORT Project will closely coordinate its efforts with other PEPFAR-supported programs and the GFATM and other development partners to leverage limited resources and avoid duplication of efforts.

USG will monitor the activities funded through this cooperative agreement through regular, ongoing site visits, meetings, and monthly reports. In addition, the implementing indicators included in the monitoring and evaluation plan will be regularly monitored by USG.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	600,000
Key Populations: MSM and TG	200,000

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

Budget Code Information

Mechanism ID:	12872		
Mechanism Name:	Columbia University (Columbia Treatment and Care)		
Prime Partner Name:	Columbia University Mailman School of Public Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	399,000	0

Narrative:

This mechanism supports CAR PEPFAR Strategy Objective 1. This activity is linked to HBHC BCN PSI/IM #12859. The goal is to build individual, institutional and organizational capacity in Kazakhstan, Kyrgyzstan, and Tajikistan to provide high-quality facility-based and home/community-based care activities for HIV-infected adults and their families.

In FY 11, The Columbia University's SUPPORT Project completed comprehensive assessments of C&T services in KZ and KG and TJ. In FY12, the project will complete a similar assessment in Uzbekistan, and will then develop recommendations based on the results. The SUPPORT Project will assist the MOHs to develop clinical guidelines on palliative care for PLWHA and organize a CAR Conference on Palliative Care for PLWHA. The project will also provide in-service trainings for AIDS-center's staff (physicians, nurses, physiologists, gynecologists and epidemiologists) on HIV-related care as part of a pilot C&T model that will be implemented by six selected AIDS Centers (two each in KZ, KG, and TJ). As part of the model, the SUPPORT Project will facilitate bi-directional referral systems with other USG partner's programs, including those implemented through NGOs and will work with the AIDS centers to integrate provision of clinical care, nutrition assessment, counseling, support and palliative care (pain and symptom relief) and positive prevention services into their routine medical HIV care. Most of the services will be facility-based, but if needed, home-based care will be provided through the existing Visiting Nurse program of the AIDS Centers. Couples-based counseling and gender-based approaches will be introduced to ensure effective positive prevention. It is expected that model implementation will result in higher retention rates, improved quality of life and treatment outcomes among PLWHA. All models will include rigorous M&E, including a standard set of indicators, a client data management system (client contact forms and an electronic database), supervisory visits, mid-term and end-line evaluation of results, patient exit interviews and

focus group discussions with PLWHA groups (NGO-based and independent). The results of performance measurement data will be used to refine model activities. Upon completion, successful models will be recommended for national rollout using GFATM funds in Kyrgyzstan and Tajikistan and state/local health care funds in Kazakhstan. If accepted, the revised procedures and the extended package of care services will be included into the SOPs to be developed for the HIV clinical departments of the AIDS Centers during FY13.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	335,000	0

Narrative:

This mechanism supports the CAR Regional PEPFAR Strategy Objective 1. This activity is linked to: (1) HLAB ASCP/ IM #12026 and (2) CLSI,/IM#13970. The primary goal is to support the MOHs in Kazakhstan, Kyrgyzstan, Tajikistan, and Uzbekistan, to enhance laboratory capacity to provide HIV-related diagnostic and monitoring tests according to international laboratory competency standards. The current HIV testing algorithms in CAR require an excessive number of tests for confirmation of results; existing procedures contribute to delays and difficulties for individuals to obtain their results of laboratory examinations. The SUPPORT Project will provide TA to help MOHs strengthen referral and communication links between laboratories and medical providers, and provide TA to MOHs to examine different HIV screening and diagnostic algorithms, including the incorporation of rapid testing, and the addition of quality assurance procedures.

The lack of effective and accessible laboratory monitoring for PLWHA seriously hinders effective clinical management of patients. The SUPPORT Project will provide training on proper use of laboratory equipment needed for monitoring of people on ART. Currently, CD4 and viral load testing is being performed primarily at the national level, and in a few regional (oblast) level laboratories. Due to this centralized laboratory structure, high cost and irregular delivery of kits and necessary supplies, and lack of trained personnel, only a fraction of people on ART are being properly monitored. The SUPPORT Project will work closely with all Republican (national) AIDS Centers in KZ, KG, TJ and UZ, as well as with selected regional AIDS Center laboratories, to develop and implement laboratory Quality Management System (QMS), QA/QC procedures, protocols, and SOPs for HIV testing and laboratory monitoring of PLWHA. The project will continue supporting MOH TWGs in CAR to develop and implement SOPs for viral load and CD4 testing, including on-site training and mentoring as well as national workshops for laboratory technicians on a variety of topics. Technical assistance will also be provided for strengthening referral linkages and networking between clinical and regional and national reference laboratories. The SUPPORT Project will work with the MOH in KZ, KG and TJ to plan and implement validation of test-kits adapted to dry-blood spot (DBS) elutes and saliva-based and blood-based rapid tests officially registered in each of the countries. Results of validation will allow improving QA/QC procedures and improve implementation of IBBS and rapid HIV testing. The SUPPORT Project will work with the Laboratory Coalition partners to address remaining gaps and issues on HIV quality testing. The SUPPORT Project TA will include assisting the MOHs

develop and implement an effective system of forecasting and planning for laboratory supplies, including training of laboratorians and related staff on how to use the newly developed systems.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVCT	50,000	0
Narrative:			
This mechanism supports the CAR Regional PEPFAR Strategy Objective 1. This activity is linked to: (1) HVCT BCN RAC-KZ/ IM #12889; (2) RNC-KG/ IM #12812; (3) RAC-KG/ IM #13217; (4) PSI /IM #12859; and (5) Abt Associates/IM # 12746. The primary goal is to support the MOHs in Kazakhstan, Kyrgyzstan, Tajikistan to scale up counseling and testing activities to ensure that PWID, their sex partners and other MARPs receive access to high-quality and accurate HTC services. According to IBBS data, HIV prevalence among female SW in 2010 was 1.5% in Kazakhstan, 2.7% in Tajikistan and 1.6% in Kyrgyzstan. The percentage of SW who were tested for HIV and knew their results ranged from 44% in Tajikistan to 80% in Kazakhstan. The prevalence of HIV among PWID was 2.8% in Kazakhstan, 14% in Kyrgyzstan and 17.6% in Tajikistan, while HIV testing knowledge was 61% in Kazakhstan, 38% in Kyrgyzstan and 27% in Tajikistan. The percentage of MSM tested for HIV who knew the results of their test was 60% in 2010. Based on IBBS assessments results we know that IBBS prevalence data is most likely underestimated, while HIV testing indicators are overestimated, and the actual level of HIV testing among MARPs is very low. Official HIV testing statistics shows that HIV tests among MARPs represent less than 2% of the overall number of tests performed in the region In FY12, the SUPPORT Project's TA will include activities in which both HTC are provided through provider-initiated and client-initiated approaches in government-run health-facilities, including MAT distribution sites, stationary and mobile Trust points (sites offering specialized prevention services for PWID) and outpatient departments of the AIDS centers (friendly clinics) in KZ, KG, and TJ. At least 30 medical specialists, counselors, outreach workers, and social workers will be trained on motivational interviewing techniques to increase utilization of HTC by MARPs, including couples-based counseling and gender-based counseling. The SUPPORT Project will also support strengthening of peer-driven interventions to motivate PWID, their sex partners, and SW to increase HIV testing rates. Quality assurance systems for both testing and counseling will be developed and piloted in USG-funded HIV prevention sites. Activities to track enrollment of HIV-positive people into care will be ensured, including voucher-based referral and monitoring systems and case management activities. The SUPPORT project will closely collaborate with other PEPFAR-funded programs as well as with GFATM and other development partners to leverage resources and avoid duplication of efforts. The project will support the MOHs in CAR to evaluate the existing HIV rapid test systems and make recommendations that would allow integration of rapid HIV testing into the national HVCT algorithm.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Prevention	HVOP	200,000	0

Narrative:

This project supports CAR's PEPFAR Strategy Objective 1. This activity is linked to HVOP BCN PSI /IM #12859. In Central Asia, HIV is most commonly transmitted through injecting drug use. However, heterosexual transmission has been increasing, with the proportion of newly registered cases reporting this mode of transmission rising between 2006 and 2010 from 20% to 43% in Kazakhstan, 17% to 27% in Tajikistan and from 30% to 33% in Kyrgyzstan. HIV transmission from PWID to their sex partners is believed to be the key factor for the increasing number of heterosexually transmitted HIV infections.

Rates of male-to-male sexual transmission are largely unknown. According to the KZ RAC the estimated number of MSM in 2010 was 37,500 in Kazakhstan, however other yet unpublished study indicates that the estimated number of MSM in 4 major cities is 60,000. According to the RAC (2010), the estimated number of MSM is 3,700 in KG: and is 30,000 in TJ. There are currently no good estimates for the size of MSM population in Tajikistan, Kyrgyzstan and Uzbekistan.

In Kazakhstan, the percent of officially registered HIV cases with male-to-male sexual transmission increased from 0.5% of all registered cases in 2006 to 1% in 2010. In Tajikistan 0.03% (4 cases) of registered HIV cases were among MSM. In Kyrgyzstan, official statistics do not separate sexual transmission by heterosexual and male-to-male. Annual IBBS among MSM conducted in 8 sites in Kazakhstan estimated 1% HIV prevalence among MSM, however these figures are underestimated. Results of one study conducted in Almaty showed that HIV prevalence among MSM in Almaty can be as high as 20.2%. According to the IBBS data, 60% of MSM were tested for HIV and know their results.

With funds available from previous years, the SUPPORT project will work with the Ministries of Health of Kyrgyzstan and Tajikistan and local MSM NGOs to develop a protocol and conduct a survey to estimate the size of the MSM population and identify key barriers and opportunities for HIV prevention among this group. Based on existing evidence, the SUPPORT Project will provide TA to the MOH in Kazakhstan to pilot MSM-friendly HIV services in four sites based at GFATM/Government –supported friendly clinics. Technical assistance will include formulation of approaches and implementation, on-site training and mentorship, including technical competence to initiate and provide quality counseling related to sexual practices and ability to monitor and evaluate services provided. Technical assistance will focus on incorporating evidence-based behavioral and combination strategies to daily work, including motivational counseling and couple-counseling.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	200,000	0

Narrative:

This activity is linked to: (1) IM #12889; (2) IM #13217; (3) IM #12812; (4) IM #13969; (5) IM #12799; (6) IM #12772; (7) IM#13973, (8) IM #12859; and (9) IM #12746. This Project supports CAR Strategy Objectives 1 and 2.

HIV in CAR is mainly transmitted through unsafe injecting practices. In 2010, the proportion of PWID among officially registered HIV cases was 53% in KZ, 55% in TJ, and 64% in KG. There are about 263,000 PWID in CAR; HIV infection rates range from 3% in KZ to 17% in TJ. The majority of PWID are young, unemployed males. IBBS results for PWID show high frequency of sharing injecting equipment and low levels of condom use. Transmission of HIV from PWID to their sex partners is believed to be a key factor for increasing sexual transmission of HIV in CAR. *In FY12, the project will disseminate results of geographical mapping of HIV services for PWID in KZ, KG and TJ to increase service provider and PWID awareness of service availability and also provide evidence-based recommendations for improving HIV prevention programs. The project will continue to build MOHs capacity to routinely update maps of HIV/AIDS health services. The project will work with local partners to develop a system to collect program data from all partners working with PWID.* *The project will provide TA to the MOHs of KZ, KG and TJ to implement HIV prevention services for PWID and their sex partners through mobile Trust Points & a client-friendly drop in center. The project will support the introduction of evidence-based and effective approaches, promotion of peer-driven interventions, development of guidelines, counseling training & mentoring of staff (including gender-based counseling and couples-counseling); motivational counseling for HIV testing; introduction of rapid tests; positive prevention; ART support for PWID/PLWHA; case management and referral to TB diagnoses and treatment; referral for other medical services, peer support and psychosocial care. TA for M&E will include elaboration of indicators, data collection forms and reporting tools, training of staff and supervisory monitoring visits and establishment of quality assurance systems at the central and service delivery levels.* *In close collaboration with USG, GFATM and other partners, this project will organize a Regional Harm Reduction Conference to share best practices and lessons learned in Harm Reduction, including MAT and other evidence-based interventions across Central Asia and the rest of the world.* *In FY12, the project will disseminate results of comprehensive assessments of the GFATM-funded MAT programs in KZ, KG, and TJ and work with the MOHs and international partners to improve the quality of MAT implementation by training MAT staff and improving M&E of MAT programs. To further improve understanding of MAT among existing and potential clients, SUPPORT will help MAT sites to develop information education materials for clients and their family members. By disseminating lessons learned and organization of regional meetings, the project will support regional exchange fostering collaboration and knowledge transfer among service providers working on HIV prevention for PWID.*			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HTXS	440,000	0
Narrative:			
This cooperative agreement (CoAg) supports the CAR's PEPFAR Strategy Objective 1. The goal is to build individual, institutional and organizational capacity in Kazakhstan, Kyrgyzstan, and Tajikistan to provide			

high-quality comprehensive C&T packages, including ARV, cotrimoxazole prophylaxis and TB screening. The MOHs in these countries have identified a great need in improving their capacity in ARV treatment, and The SUPPORT Project will be the primary provider of rigorous TA to the AIDS Centers in HIV treatment. In FY11-12, the project completed a comprehensive baseline evaluation of the HIV C&T Services in KZ, KG, and TJ. The key results show poor levels of knowledge and understanding among clinicians of existing ARV recommendations, low prescription of preventive cotrimoxazole treatment and TB screening, poor efforts to implement positive prevention, absence of a multi-disciplinary approach to patient management, low patient retention, low adherence to treatment, and lack of comprehensive treatment services at the ARV treatment sites. The project will conduct in-service trainings for medical staff on ARVs, treatment schemes, and adherence. On-site supervisory visits will follow to ensure proper use of skills and knowledge obtained during trainings. The project will support national ARV conferences to inform clinicians about new ARVs, results of the latest studies and recommendations for ARV usage, and assist the MOHs develop ARV forecasts for 2012-2015. In order to make the ARV forecasting and planning process data driven, transparent, and sustainable, the SUPPORT Project will incorporate an ARV forecasting module into the Electronic HIV Case Management System (EHCMS) that is now being rolled out to the local AIDS Centers in CAR. This will allow automated calculation of ARV needs, based on the current ARV demand and predicted enrollment of new clients. Furthermore, the project will provide TA to the MOHs in implementing the EHCMS entry of clinical data, and will support two AIDS Centers each in KZ, KG and TJ (six total) to pilot comprehensive patient-centered C&T service-delivery models. These pilots will seek to improve patient retention and adherence to ARVs, cotrimoxazole prophylaxis, and TB screening by working closely with other PEPFAR-funded programs. Implementation of the models will involve in-service trainings, task shifting, and development of standard operating procedures. The SUPPORT Project will conduct on-site supervisory visits, and develop M&E systems to track evaluation of outcomes using data from the EHCMS and client interviews. Adherence obstacles will be addressed using gender-based approaches, and will be closely linked with PLWHA support groups. Couples-based counseling and involvement of treatment supporters will be introduced to improve patient retention. Performance measurement data from the EHCMS will be closely monitored and used to refine model activities. Project activities will primarily target MOH medical clinic staff (clinicians, epidemiologist, and data management specialists). Through the provision of TA, in-service trainings, and development, dissemination and implementation of standard operating procedures and other documents, knowledge and skills will be transferred to the host MOHs to assure sustainability of ARV service delivery.

Implementing Mechanism Details

Mechanism ID: 12889	**Mechanism Name: Support to Ministry of Health/Republican AIDS Center of the Republic of Kazakhstan**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and	Procurement Type: Cooperative Agreement

Prevention	
Prime Partner Name: Ministry of Health/Republican AIDS Center	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: Yes	Managing Agency: HHS/CDC

Benefiting Country	Benefiting Country Planned Amount
Kazakhstan	80,000

Total Funding: 80,000		
Managing Country	**Funding Source**	**Funding Amount**
Kazakhstan	GHP-State	80,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This ongoing cooperative agreement supports the Central Asia Region (CAR)'s PEPFAR Strategy Objectives 1, 2 and 3. The goal is to provide TA to the Republican AIDS Center, Ministry of Health (MOH), of Kazakhstan to provide an expanded and high quality minimum package of essential HIV prevention services for MARPS, particularly people who inject drugs (PWID). The target population is the MOH in KZ, MARPS, especially PWID, and their service providers. Through this project, TA and support will be provided to enhance access to and increase the quality of HIV prevention services to PWID, through rapid HIV testing in mobile units, and additional activities to foster a friendly environment for PWID. These programs will be developed to maximize efficiency and cost effectiveness. Activities are designed to work with the MOH to develop policies and protocols that will be adopted by the KZ government when the project ends. All activities are coordinated with the GFATM, and other USG partners to leverage resources and build ownership and sustainability of project interventions. Monitoring and evaluation plans will be developed for all project activities, which will allow MOH staff to monitor and improve the quality and efficiency of their HIV prevention services. These reports will be monitored by USG staff during regular site visits, meetings, and review of monthly activity reports.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	40,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: Mechanism Name: Prime Partner Name:	12889 Support to Ministry of Health/Republican AIDS Center of the Republic of Kazakhstan Ministry of Health/Republican AIDS Center		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	50,000	0
Narrative:			
This activity supports CAR's PEPFAR Strategy Objective 3: Strengthen the capacity of public and private sectors to collect, analyze, manage and utilize data for evidence-based planning and policymaking at all levels. This activity is linked to: (1) HVSI BCN Columbia /IM # 12027; (2)the Abt Associates /IM # 12746; and (3) the Regional Technical Support project/ IM #13975. Since 2003, USG helped to launch regular Integrated Biological and Behavioral Surveillance (IBBS) among MARPs that became a routine practice implemented nationwide in Kazakhstan. In FY 11, the USG team conducted an assessment of IBBS. The results of the assessment revealed the need to improve IBBS practices to ensure its effective implementation. ROP12 funds will be used in FY12 to support a nationwide IBBS conference to present and discuss the HIV epidemiologic situation in Kazakhstan. The Project will also closely coordinate its efforts with other PEPFAR-funded programs, GFATM and other international partners to ensure leverage of efforts and avoid duplication.			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Prevention	HVCT	30,000	0
Narrative:			
This supports Central Asia Region (CAR)'s Strategy Objective 1 and 2. This activity is linked to HVCT BCNs (1)Columbia/IM #12872; and (2) Abt Associates/IM # 12746. The predominant mode of HIV transmission in Kazakhstan (KZ) is unsafe injecting practices. As of January 2011, there were an estimated 119,000 PWID in Kazakhstan, of which approximately 17,000 reside in Almaty. Sentinel Surveillance indicates an HIV prevalence among PWID of 3%, accounting for 53% of all registered HIV cases in Kazakhstan in 2010. Only 23% of PWID have been reached by existing, fixed-location HIV prevention services (Trust Points or TP), which are primarily located in medical facilities. Poor coverage of PWID by these Trust Points is attributed to lack of transportation, fear of medical institutions and legal authorities, and a perceived hostile or unfriendly environment. It is expected that a mobile outreach program would significantly expand services to PWID in underserved areas of Almaty. Kazakhstan does not use rapid HIV tests in their national testing algorithm. Through this program, USG will provide TA to the Kazakh Ministry of Health (MOH) to pilot the use of rapid HIV testing as part of the HIV testing and counseling in the mobile outreach station proposed for Almaty. Rapid testing will be used for screening, and in the event of a positive screening result, venous blood will be collected and sent for confirmatory Western Blot testing at the National Reference Laboratory. In these instances, persons will receive appropriate post-test counseling, and will receive instructions for returning to receive their confirmatory result. For persons testing HIV positive, appropriate medical and social service referrals will be made. To insure quality assurance of counseling, intensive training will be conducted for counselors and laboratory specialists on use of the rapid HIV test kits, and QA/QC. The target for the number of PWID who undergo rapid HIV testing in the mobile unit setting is 950 for this budget period. The project indicators will the number of PWID, their sex partners, and other MARPs who are tested at the mobile unit, the number who were informed of their HIV test result, the number referred for additional testing, counseling, and treatment services, and the number of persons trained in both the laboratory and counseling aspects of rapid HIV testing. Only FDA approved rapid HIV tests will be purchased. PEPFAR funds will be used to purchase rapid HIV tests for the pilot project. Once the use of rapid tests is incorporated into the national algorithm, Government of Kazakhstan will support the use of rapid tests in the country. Random sample verification will monitor the quality of the rapid test results. The Project will also closely coordinate its efforts with other PEPFAR-funded programs, GFATM and other international partners to leverage funds. These activities will be included into Kazakhstan's National HIV Strategic Plan to eliminate duplication and complement existing services for MARPs. NGOs working with PWID and other MARPs in Almaty will be involved to disseminate information about the availability of the mobile unit and rapid HIV testing for PWID.			

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	0	0
Narrative:			
This project supports the Central Asia Region (CAR)'s PEPFAR Strategy Objective 1. This activity is linked to			

IDUP BCNs of: (1) PSI/ IM #12859; (2) Columbia/IM #12872; (3) UNODC IM #12772; and (4) Health Policy Project, IM #13973. The predominant mode of HIV transmission in Kazakhstan is unsafe injecting practices. However, the proportion of registered cases reporting injecting drug use as the method of transmission decreased from 66% in 2006 to 52%% in 2010. As of January 2011, there were an estimated 119,000 people who inject drugs (PWID) in Kazakhstan, of which approximately 17,000 reside in Almaty. In 2010, Almaty city had the largest number of HIV registered cases (3,204). Almaty city also has the highest HIV prevalence rates with 203.4 HIV cases per 100,000 people. HIV prevention services for PWID are implemented through a network of government and donor supported sites called Trust Points (TP). There are 168 TP in the country, but only 23% of PWID have been reached by existing, fixed-location TPs, which are primarily located in medical facilities. Poor coverage of PWID by these TP is attributed to lack of transportation, fear of medical institutions and legal authorities, and a perceived hostile or unfriendly environment at the TPs themselves. Under this cooperative agreement, USG will provide TA to the Republican AIDS Center (RAC) to establish a Drop-in-Center (DIC) in the city of Almaty, in an area with a high prevalence of drug users and high HIV prevalence. The DIC will provide a comprehensive package of HIV prevention services, including dissemination of individual protection items, educational materials, social support, and referrals to medical services (HIV counseling and testing, narcologist, TB and STI clinics and surgeon). The project will be implemented in collaboration with other USG funded organizations. Data shows the coverage of PWID with mobile teams remains low. USG will also provide TA to RAC on how best to operate mobile units (bringing best practices, developing guidelines, developing messages to PWID, creating schedules, provide trainings for mobile teams). It is expected that establishment of a DIC for PWID and enhancing mobile outreach would significantly expand services to PWID in underserved areas of Almaty. The main purpose of these activities is to set up models that can be demonstrated and replicated in the future with support of the Government of Kazakhstan. A vigorous M&E system will be set up to evaluate implementation and results of the models. The program will monitor indicators, including number of people served; number of referrals made; number of people tested and who received results; and the number of people trained, using electronic databases and internal registration forms. After the 12 month implementation phase, if successful, these models will be included into the KZ national plan and activities will be supported by the local government budget (it may take another 12 months to approve the support from local budgets. The Project will also closely coordinate its efforts with other PEPFAR-funded programs, GFATM and international partners to ensure leverage funds and avoid duplication of activities. In light of recent Congressional directives on NSPs, PEPFAR CAR will eliminate direct USG support for NSPs and instead leverage GFATM resources and networks for NSP procurement and distribution with USG-funded MARP outreach and peer education efforts.

Implementing Mechanism Details

Mechanism ID: 13501	**Mechanism Name: Peace Corps**
Funding Agency: U.S. Peace Corps	Procurement Type: USG Core
Prime Partner Name: U.S. Peace Corps	

Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Benefiting Country	Benefiting Country Planned Amount
Kyrgyzstan	123,000

Total Funding: 123,000		
Managing Country	**Funding Source**	**Funding Amount**
Kyrgyzstan	GHP-State	123,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This mechanism supports the CAR Regional PEPFAR Strategy Objective 1.The overall goal of the Peace Corps PEPFAR program in Kyrgyzstan is to provide education on HIV/AIDS prevention, behavior change, stigma reduction, responsible behavior and consequences of drug use, and promotion of healthy lifestyles among youth. Technical assistance is also provided to local organizations to reduce stigma and discrimination in the community and among service providers. Populations targeted by Peace Corps Volunteers and their counterparts will include at-risk youth, trans-migrant population and others at risk for engaging in injecting drug use and commercial sex. The project will be conducted in Chui, Talas, Issyk-Kul and Naryn oblasts. Peace Corps continues to strengthen its approach to development which advances country ownership of PEPFAR program efforts through placement of volunteers in requesting local governmental and non-governmental organizations for specific assignments that are time-limited and designed from the onset to build community capacity to sustain projects. In every instance, this involves day-to-day collaboration with host country national partners and counterparts. Volunteers and their counterparts receive training in monitoring and evaluation and PEPFAR reporting. Peace Corps compiles data on Volunteers' PEPFAR-funded activities on a semi-annual basis and conducts periodic site visits to monitor the implementation of activities.

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	20,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	13501		
Mechanism Name:	**Peace Corps**		
Prime Partner Name:	**U.S. Peace Corps**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVOP	123,000	0
Narrative:			
Funds will be used for training and support of volunteers and counterparts to work with communities to design and implement context-appropriate and evidence-based prevention interventions addressing the keys drivers of the epidemic, including sexual and behavioral risk and harmful gender/cultural norms. Programs also include a cross-cutting focus on reduction of stigma and discrimination. Trained volunteers and their counterparts will work with at-risk youth and trans-migrant populations on HIV education, safer behaviors reducing the risk of HIV acquisition and transmission, drug use and alcohol abuse prevention, as well as stigma and discrimination reduction. Activities may include trainings of local service providers, camps for at-risk youth, and stigma reduction campaigns. Volunteers and their counterparts will have access to small grants for community-initiated projects that address HIV prevention through the PEPFAR funded Volunteer Activity Support and Training (VAST) program. They will carry out effective and culturally appropriate HIV/AIDS interventions in their communities.			

Implementing Mechanism Details

Mechanism ID: 13970	Mechanism Name: CLSI (under the former Lab Coalition mechanism)

Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Clinical and Laboratory Standards Institute	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Benefiting Country	Benefiting Country Planned Amount
Kazakhstan	121,333
Kyrgyzstan	121,333
Tajikistan	121,333

Total Funding: 399,999		
Managing Country	**Funding Source**	**Funding Amount**
Kazakhstan	GHP-State	399,999

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This ongoing cooperative agreement supports CAR's PEPFAR Strategy Objective 2. The goal of the cooperative agreement with the Clinical and Laboratory Standards Institute (CLSI) is to strengthen the HIV/AIDS and related co-infection laboratory capacity and implement laboratory quality improvement strategies in Kazakhstan, Kyrgyzstan and Tajikistan. CLSI is an international standards-developing and educational organization whose which mission is to develop and promote the use of best practices in clinical and laboratory testing. CLSI will facilitate the development and implementation in CAR laboratories of effective quality management systems (QMS) – a set of key quality elements that must be in place for laboratory operations to deliver consistent, high quality and cost-effective laboratory services.

The target populations are the Ministries of Health and other laboratorians in KZ, KG, and TJ.

With the requested additional funding this cooperative agreement will primarily target laboratory managers and quality officers in HIV/AIDS laboratories of the national and oblast levels in KZ and KG.

The project will provide short-term targeted TA to implement project activities so there is no need for the project to

become more cost-efficient over the longer term.
CLSI mentors will continue working with laboratory quality officers and other designated individuals to identify gaps in current laboratory operations, and to assist in QMS implementation. QMS implementation will be monitored and evaluated based on the number of laboratories supported, number of mentor visits conducted and on review of documented progress on quality improvement projects in those laboratories.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	200,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	13970		
Mechanism Name:	CLSI (under the former Lab Coalition mechanism)		
Prime Partner Name:	Clinical and Laboratory Standards Institute		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	399,999	0
Narrative:			
This mechanism supports CAR's PEPFAR Strategy Objective 2.This activity is linked to HLAB BCNs of: (1) ASCP/ IM #12026 and (2) Columbia/ IM #12872. Reliable diagnosis and effective treatment of HIV infection would be impossible without quality laboratory services. Currently, no Central Asian country has a strategic plan for improving laboratory quality, nor a functioning national body overseeing laboratory performance standards, nor any system for laboratory accreditation or licensure for specific levels of competence. There is no culture of service			

quality, or any conception that clinicians who collect samples, order tests, and receive results, are the laboratory's clients. This lack of quality management and accountability to other components of the public health system creates barriers for people at risk for HIV infection to get tested, to receive and understand the results, and to have confidence in the accuracy of the testing. It is also very detrimental to the success of ART programs. *Clinical and Laboratory Standards Institute (CLSI) is an international standards-developing and educational organization, which provides TA on standards and guidelines for laboratories to develop internal quality systems. CLSI provides on-going capacity building assistance to the Republican (and oblast level) AIDS Centers and Blood Centers' laboratories in Kazakhstan, Kyrgyzstan and Tajikistan by developing and implementing quality management systems (QMS) as part of strengthening national laboratory services. CLSI will follow up on QMS workshops held in KZ and KG during FY10-FY11 for laboratory leaders from both the central and oblast levels. CLSI mentors work closely with local laboratory quality officers and other designated individuals to identify gaps and begin /continue QMS implementation. Ongoing support includes hands-on assistance as well as facilitation of self-assessments and quality improvement projects in order to give quality managers successful experiences and encourage them to expand their work. To facilitate QMS implementation, laboratories are provided with QMS-related guidelines and companion documents, including the "Key to Quality" reference checklists; additionally, CLSI also offers local institutions CLSI memberships providing full access to all CLSI documents. CLSI's TA on laboratory QMS are linked to other partners' laboratory related activities. For example, Columbia University's capacity-building activities on CD4 and viral load testing will be reinforced by introduction of QMS essentials.* *With the requested additional funding for ROP12, this cooperative agreement will primarily target laboratory managers and quality officers in HIV/AIDS laboratories in KZ and KG. CLSI mentors will continue working with laboratory quality officers and other designated individuals to identify gaps in current laboratory operations, and to assist in the QMS implementation in two additional oblast level HIV/AIDS labs (KZ) and a national level HIV/AIDS lab (KG). The QMS implementation will be evaluated based on the number of laboratories supported, number of mentor visits conducted and on the review of the documented progress on quality improvement projects in those laboratories.*

Implementing Mechanism Details

Mechanism ID: 13971	**Mechanism Name: Republican Blood Center - Kazakhstan**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Republican Blood Center of the Ministry of Health of the Republic of Kazakhstan	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No

Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Benefiting Country	Benefiting Country Planned Amount
Kazakhstan	30,000

Total Funding: 30,000		
Managing Country	**Funding Source**	**Funding Amount**
Kazakhstan	GHP-State	30,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This mechanism supports CAR's PEPFAR Strategy Objectives 2 and 3. The primary goals are to increase the capacity of the Republican Blood Center in Kazakhstan (recently re-organized as the Almaty Oblast Blood Center) to improve their blood safety program, ensure an adequate blood supply, perform accurate and appropriate blood screening for the KZ population, and to sustain these program improvements over time. Challenges in blood safety in KZ include lack of voluntary donors, inappropriate clinical use of blood, lack of capacity and high staff turnover, and insufficient quality management systems (QMS). Under this award, TA will be provided to the KZ RBC to improve these deficiencies and to build a QMS covering all stages of the transfusion process. A key element for the QMS will be supported by integrating the International Standards for Blood Transfusions (ISBT) 128 and the blood centers' Excel-based M&E data into the existing health information management software. These improvements will allow the KZ blood centers to improve their efficiency over time. The project will implement a national M&E system for blood service indicators, which will include number of donors served, number of donors tested, number of donors positive for Transfusion Transmissible Infections, and number of trained people over time. Indicators will be monitored by review with a standardized checklist during regularly scheduled site visits. Sustainability of the program and country ownership will be fostered through training and capacity building of RBC staff, and enhanced quality and utility of the electronic databases for both QMS and M&E, which will allow the RBC to monitor and improve the quality and efficiency of their activities.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	15,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: Mechanism Name: Prime Partner Name:	13971 Republican Blood Center - Kazakhstan Republican Blood Center of the Ministry of Health of the Republic of Kazakhstan		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HMBL	30,000	0

Narrative:

This ongoing Cooperative Agreement supports CAR's PEPFAR Strategy Objectives 2 and 3.
In 2007, CDC re-screened 7500 samples from blood donors in CAR, confirming that contaminated blood is being administered in health facilities. Transfusion of HIV-infected blood is 100 times more efficient for transmitting HIV infection than intravenous injection with a contaminated syringe. An adequate supply of safe blood and the appropriate clinical use of blood are important components of the PEPFAR CAR prevention strategy, as well as a priority for the Government of Kazakhstan.
The goals for this activity are to: (1) improve the KZ national strategy for voluntary blood donorship using international expertise and results from a KAP survey; (2) help establish a quality management system (QMS) for blood banking, with screening for Transfusion Transmitted Infection (TTI), blood compatibility and typing; (3) reduce non-evidence-based clinical use of blood products; (4) establish national norms, standards and organizational structures for a national blood service; (5) improve information systems and standardize databases for tracking blood donors and donated blood units; and (6) strengthen professional development of blood services staff.
The RBC has developed its own Access-based data management software to track blood donors and blood units,

and an Excel-based M&E system for tracking blood service indicators, both of which have limited utility. Technical assistance will be provided to integrate the two databases and improve the software's analytical capacity; assist with the integration of the ISBT 128 standard into existing software; scale up a sustainable electronic database to track blood donations from vein to vein; conduct on-site training workshops on the database; implement and scale up a bar code system and to the Oblast level. These activities address the 1st (Policy), 5th (Training), 6th (Monitoring and Evaluation) and 7th (Sustainability) key elements identified by the Medical Transmission TWG. The KAP surveys will inform a national strategy on voluntary donorship, including IEC campaigns for recruitment of donors. Trainings and recruitment materials will be developed for donor recruiters on republican, oblast and rayon levels, who will also collect basic donor information. These activities are related to the 1st, 2nd and 5th and 7th elements of the TWG. Technical Assistance will be provided to assist with the establishment of facility-based transfusion committees (ongoing activity using prior year funds) as well as a national transfusion committee (new activity using FY12 funds). Technical Assistance activities to assist the committees include guideline development, protocols, SOPs and data collection tools. To improve data quality, on-site trainings will be conducted. These activities are related to the 1st, 3rd-7th elements identified by the TWG. These activities will be conducted in the context of a QMS, currently being developed by the MOH, spanning the entire chain of blood services. They will be integrated with other HIV/AIDS related services, as potential donors who test positive for TTIs will be referred to the KZ AIDS Center for further counseling, testing and treatment. Sustainability of the program and country ownership will be fostered through capacity building (training the Government of Kazakhstan to improve their blood safety program) and technology transfer (the electronic database).

Implementing Mechanism Details

Mechanism ID: 13972	**Mechanism Name: Republican Blood Center - Kyrgyzstan**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Republican Blood Center of the Ministry of Health of the Kyrgyz Republic	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: Yes	Managing Agency: HHS/CDC

Benefiting Country	Benefiting Country Planned Amount
Kyrgyzstan	0

Total Funding: 50,000		
Managing Country	**Funding Source**	**Funding Amount**
Kazakhstan	GHP-State	50,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This mechanism supports CAR's PEPFAR Strategy Objectives 2 and 3. The primary goals of this award are to increase the capacity of the Republican Blood Center (RBC) in Kyrgyzstan to improve their blood safety program, ensure an adequate blood supply, perform accurate and appropriate blood screening for the KG population, and to sustain these program improvements over time. Challenges in blood safety in KG include lack of voluntary donors, inappropriate clinical use of blood, inadequate maintenance of the cold chain, inadequately trained staff, an outdated, unsustainable electronic blood donor database, and lack of a quality assurance management system (QMS), potentially hindering laboratory performance. Technical assistance will be provided to the KG RBC to improve these deficiencies and to develop a QMS covering all stages of the transfusion process. These improvements will allow the KG blood centers to improve their efficiency over time. Included in this project is implementation of a nationwide M&E system for blood services indicators, and training of staff on the system. The indicators will include number of donors served, number of donors tested, number of donors positive for transfusion transmissible infections, and number of trained people over time. Indicators will be monitored by review with the standardized checklist during regularly scheduled site visits. Sustainability of the program and country ownership will be fostered through training and capacity building of RBC staff, and development of effective and useful electronic databases for both QMS and M&E. These activities will allow the RBC monitor and improve quality and efficiency.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	20,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: Mechanism Name: Prime Partner Name:	13972 Republican Blood Center - Kyrgyzstan Republican Blood Center of the Ministry of Health of the Kyrgyz Republic		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HMBL	50,000	0

Narrative:

This ongoing Cooperative Agreement supports CAR's PEPFAR Strategy Objectives 2 and 3.
In 2007, CDC re-screened 7,500 samples from blood donors in CAR, confirming that contaminated blood is being administered in health facilities. Transfusion of HIV-infected blood is 100 times more efficient for transmitting HIV infection than intravenous injection with a contaminated syringe. An adequate supply of safe blood and the appropriate clinical use of blood are important components of the CAR PEPFAR prevention strategy, as well as a priority for the Government of Kyrgyzstan.
Almost 60% of the blood supply in KG is based on the principle of "donor replacement." The goals for this activity are to: (1) improve the KG strategy for voluntary blood donorship using international expertise and results of a KAP survey; (2) help to establish a quality management system (QMS) for blood banking, including screening for transfusion transmitted infections (TTI), blood compatibility and typing; (3) assure cold chain maintenance, including expansion to the rural areas; (4) reduce non-evidence-based clinical use of blood products; (5) establish national norms, standards and organizational structures for a national blood service; (6) improve information systems and standardize databases for tracking blood donors and donated blood units; and (7) strengthen professional development of blood services staff.
Technical assistance (TA) will be provided to assist with the establishment of a sustainable electronic database to track blood donations (ongoing activity using prior year funding) and scale up this activity nation-wide (new activity using FY12 funds). Scale-up will include on-site workshops, implementation of a bar code system at the Oblast level, and trainings on cold chain maintenance for all levels of blood services. These activities address the 1st (Policy), 5th (Training), 6th (Monitoring and Evaluation) and 7th (Sustainability) key elements identified by the Medical Transmission TWG.

The KAP surveys will inform the national strategy on voluntary donorship, including IEC campaigns for donor recruitment. Trainings and recruitment materials will be developed for donor recruiters on republican, oblast and rayon levels, who will also collect basic donor information. These activities are related to the 1st, 2nd and 5th and 7th elements identified by the TWG. TA will be provided to assist with the establishment of a KG National Transfusion Committee using FY12 funds. TA activities to assist the committee include development of guidelines, protocols, SOPs and data collection tools. These activities are related to the 1st, 3rd-7th elements identified by the TWG. These activities will be conducted in the context of a QMS, currently being developed by the MOH, spanning the entire chain of blood services. They will be integrated with other HIV/AIDS related services, as potential donors who test positive for TTIs will be referred to the KG AIDS Center for further counseling and testing and treatment. Sustainability of the program and country ownership will be fostered through capacity building (training the KG government to improve their blood safety program) and technology transfer (the electronic database).

Implementing Mechanism Details

Mechanism ID: 13973	**Mechanism Name: Health Policy Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Health Policy Project	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Benefiting Country	Benefiting Country Planned Amount
Kazakhstan	0
Kyrgyzstan	0
Tajikistan	0

Total Funding: 0		
Managing Country	**Funding Source**	**Funding Amount**
Kazakhstan	GHP-State	0

Sub Partner Name(s)

Partners in Population and Development Africa Regional Office	White Ribbon Alliance for Safe Motherhood	

Overview Narrative

This mechanism supports CAR's PEPFAR Strategy Objective 1.
The goal of the Health Policy Project (HPP) is to improve the enabling environment for MARPs in Central Asia, focusing on identification and reduction of the legal and policy barriers for MARPs to access services. HPP also supports HIV financing as well as capacity development to address gender and stigma-based inequitable access to health services and to improve measurement of policy impacts on health outcomes.

The project will conduct activities in Kazakhstan, Kyrgyzstan and Tajikistan and will work with policymakers, NGOs and most-at-risk populations.
The project will provide short-term targeted TA to implement project activities so there is no need for the project to become more cost-efficient over the longer term.
Most project activities will be assessments and reviews but any materials that are developed will be incorporated into development partner plans or will be shared with other donors including the GFATM.

The project will develop monitoring and evaluation plans for all project activities, which will be reported to and monitored by USG.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

Budget Code Information

Mechanism ID:	13973		
Mechanism Name:	Health Policy Project		
Prime Partner Name:	Health Policy Project		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	IDUP	0	0

Narrative:

This mechanism supports the CAR's PEPFAR Strategy Objective 1, with a focus on Sub-objective 1.1 Enabling Environment: Stigma, discrimination, gender, and legal and policy barriers pose significant challenges for HIV prevention, especially for PWID, SW, and MSM. This activity is linked to IDUP BCNs of: (1) PSI/M #12859;(2) Abt Associates/ IM # 12746;(3) Columbia / IM#12872;(4) RAC-KZ/IM #12889; (5) RAC-KG/IM #13217; (6) RNC-KG/IM #12812; (7) TBD Harm Reduction Center/IM #13969;(8) UNODCIM #12772; and HPP/IM #13973. The Ministries of Health (MOHs), USG and other donors currently employ a range of strategies at all levels to help ensure that services are provided for stigmatized and marginalized populations. Through communities, peer outreach approaches are used to efficiently bring HIV services (condoms, information, and referrals) to MARPs. Through service delivery, the USG, GFATM and other donors use vouchers and social escorts, case management teams, training for health providers and salary incentives to improve the quality of services. At the national level, limited policy and advocacy activities have been conducted to improve the legal framework and sensitize policy makers to improve stigma and discrimination.

To develop a more strategic and systematic approach to policy development, the Health Policy Project will conduct a rapid review of policy reviews and assessments completed by the USG and other partners during the last several years. The review will identify any gaps and assist in the development of a strategically-focused policy advocacy agenda, including targeted policy interventions, to guide USG inputs in this area. HPP will assist in the development of focused approaches to engage legislature and parliaments to address MAT issues. HPP will look more closely at policy-related stigma and discrimination in Central Asia. To better inform the MOHs, USG and other development partners, a second rapid review will be conducted in Kazakhstan, Kyrgyzstan and Tajikistan to identify key policy and other barriers constraining MARPs. This review will inform a more strategic approach to addressing stigma and discrimination in all three countries. The project will widely disseminate the findings from the review, and use this information as an advocacy tool for policy makers, NGOs, MARPs and development partners. The project will also identify additional activities that should be conducted by other USG partners to address these barriers. As a result of this review, USG and development partners will be able to more strategically focus limited resources to address these legal and policy barriers.

Strengthening financing of HIV activities is critical to helping to ensure sustainability and country ownership of these programs. The project will provide TA to enable national and local HIV/AIDS stakeholders to analyze, interpret, and utilize costing data, to support policy advocacy efforts, and to assess and promote more effective and efficient resource allocation. The project will introduce a strategic planning model that links national program goals and resource levels to program outcomes and provides information on the cost and effect of different approaches on the achievement of national goals. *The project's activities will be closely coordinated with other USG partners, MOHs, policymakers, development partners and the GFATM to ensure that the findings from the review and HIV financing activities are coordinated and used.*

Implementing Mechanism Details

Mechanism ID: 13974	**Mechanism Name: GMS follow-on**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Benefiting Country	Benefiting Country Planned Amount
Kazakhstan	0
Kyrgyzstan	0
Tajikistan	0

Total Funding: 0		
Managing Country	**Funding Source**	**Funding Amount**
Kazakhstan	GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of the GMS Follow-On project is to provide TA to improve the functioning of GFATM grants and thereby increases the effectiveness and efficiency of prevention, care and treatment interventions for HIV/AIDS, TB and malaria in Central Asia. The mission of GMS is to provide urgent, short-term TA to the CCMs and the PRs for the purpose of unblocking bottlenecks and resolving systemic problems that hinder the response to the three diseases.

The project will conduct activities in Kazakhstan, Kyrgyzstan and Tajikistan and will work with all members of the CCMs.

The project will provide short-term targeted TA to implement project activities so there is no need for the project to become more cost-efficient over the longer term.
Most project activities will be assessments and reviews but any materials that are developed will be incorporated into development partner plans or will be shared with other donors including the GFATM.

The project will develop monitoring and evaluation plans for all project activities, which will be reported to and monitored by USG.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

TB

Budget Code Information

Mechanism ID:	13974

Mechanism Name:	GMS follow-on		
Prime Partner Name:	Management Sciences for Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	0	0

Narrative:

This mechanism supports the CAR's PEPFAR Strategy Objective 2 particularly sub-objective 2.3 Governance. This activity is linked to OHSS BCN of Abt Associates/IM # 12746. The GFATM has been the primary and largest source of HIV funding in the Central Asia Region. During the first few years of GFATM grant implementation, all CCMs in the region faced a number of organizational and management challenges including: duplication between CCM and other national coordination bodies; lack of clarity of CCM functions, political mandate, and scope of work; inefficiencies of CCM Secretariats; poor cooperation between government and non-government members; and problems with communication and information sharing. Despite intensive TA to address many of the challenges of CCMs in Kazakhstan, Kyrgyzstan and Tajikistan, more work needs to be done to strengthen the CCMs in Central Asia and incorporate these entities into broader health coordination.

The primary objective of the GMS follow-on will be to provide additional targeted technical support to the CCMs in Kazakhstan, Kyrgyzstan and Tajikistan. A challenge with past TA from GMS is that it only addressed immediate problems of the CCM without creating a more comprehensive framework for capacity development. In FY12, the project will conduct diagnostics, develop a capacity development framework and map out a plan for CCM capacity development for Kyrgyzstan and Tajikistan. The project will conduct some training and TA activities for core CCM functions such as oversight, use of the dashboard, and CCM roles and responsibilities. The project will also identify activities that should be conducted by other USG partners to sustain the limited technical support from the project. In Tajikistan, the project will complement activities that are already planned through current GMS TA and through the GFATM collaboration grant. The project may also help CCMs in Kyrgyzstan and Tajikistan to work with UNDP and jointly develop a phase-out plan for UNDP as Principal Recipient of the GFATM grants.

Another activity of the project will be to suggest strategies and develop a plan to incorporate the CCMs into broader coordination and oversight activities led by the Ministry of Health. This will help to strengthen the functions of the CCM while also focusing on sustainability of this important oversight and management function. In Kazakhstan, for example, GFATM activities may end within the next five years, so including CCM roles within a government structure will be an important way to ensure sustainability of program oversight and management.

The project will also identify and compile best practices on CCM management and oversight, both within the region and throughout the rest of the world. In collaboration with the GFATM, the project will help to convene regional

meetings of CCM members to share best practices and approaches to CCM oversight and implementation from Central Asia and other countries. *Activities from this project will help support the USG PEPFAR GFATM Engagement strategy and will be closely coordinated with other USG partners, the GFATM and its principal recipients and sub-recipients, MOHs and other development partners.*

Implementing Mechanism Details

Mechanism ID: 13976	**Mechanism Name: Youth Centers GDA (Turkmenistan PPP)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: John Snow, Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Benefiting Country	Benefiting Country Planned Amount
Turkmenistan	0

Total Funding: 0		
Managing Country	**Funding Source**	**Funding Amount**
Kazakhstan	GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This mechanism supports CAR's PEPFAR Strategy Objective 1

The Drop-in and Youth Centers Project's goal is to provide HIV outreach and prevention for drug users and a forum for at-risk youth to gain skills and knowledge to promote healthy lifestyles. The Drop in Center, located in Ashgabat,

Turkmenistan, provides HIV outreach services, TA, and training for PWID and SWs who inject drugs. The project also supports two Youth Centers which provide education on HIV/AIDS prevention, stigma reduction, responsible behavior and consequences of drug use.

The program is co-funded through a public-private partnership with Chevron Nebitgaz Company which funds Youth Center activities. PEPFAR funds only support HIV prevention activities.

The project works closely with the National AIDS Center, National Narcology Center and the Youth Organization of Turkmenistan. The program also receives support from international donors such as UNFPA, United Nations Children's Fund (UNICEF), and UNDP which help to share some costs of running these centers. At the end of the project, it is expected that the Government of Turkmenistan will continue to support all Centers.
The project measures use of services at each center using a unique identifier code. Project activities are monitored through client satisfaction surveys as well as through client roundtables.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Increase gender equity in HIV prevention, care, treatment and support

Budget Code Information

Mechanism ID:	13976		
Mechanism Name:	Youth Centers GDA (Turkmenistan PPP)		
Prime Partner Name:	John Snow, Inc.		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Prevention	IDUP	0	0
Narrative:			
This mechanism supports the CAR Regional PEPFAR Strategy Objective 1: Improve access in public and private sectors to quality HIV prevention, care and treatment services to reduce the transmission and impact of the HIV epidemic in Central Asia with a focus on Sub-objective 1.1: Equitable Access to services. UNODC reports that Turkmenistan has an opiate prevalence (% of people who use illicit opiates) rate of 0.3% in 2010, resulting in an estimated 32,000 heroin users. Of this number, the Government of Turkmenistan (GOTk) estimates that 94 percent are male. Unofficially, the total number of heroin users is likely much higher. According to a 2009 UNDP survey, most sex workers in Turkmenistan start engaging in sex work between the ages of 15-17 and drug addiction among youth is also very common. The Drop-In and Youth Centers project will provide outreach activities through peer educators to vulnerable youth and will target HIV/AIDS prevention, condom use and drug demand reduction. Outreach workers will conduct education and information sessions both in the Drop-In and Youth Centers and on the streets. *PEPFAR Funds will be used to support the activities of the Drop-in Center (DIC) component of the project. The DIC located in Ashgabat will provide PWID with a safe place to receive counseling and social support services and referrals. The Drop-In Center will provide outreach services which will include information, education and communication messages that focus on safer injection and safer sexual behaviors and HIV counseling. PWID will be encouraged to bring their partners for couples counseling where partners will receive information on HIV prevention, treatment, drug abuse treatment, condoms, and social support. Drug using sex workers will also be provided with information on blood borne and sexual prevention of HIV, drug prevention and treatment. The project will assist in introducing opioid substitution therapy in Turkmenistan through negotiations with government officials and international donors. If substitution therapy becomes available, it will be offered at the polyclinic where the DIC is located.* *The DIC will use the Unique Identifier Code (UIC) developed previously by the Drug Demand Reduction Project to capture information about individual use of medical consultation services to maintain clients' anonymity and confidentiality. Client data will be entered into a database where data can be aggregated on periodic basis for both reporting and management services.* *The project will coordinate with USAID Dialogue on HIV and TB Project, the Red Crescent Society of Turkmenistan, the USAID Quality Project and UNODC which supports HIV/AIDS prevention among drug users and sex workers in other pilot sites of Turkmenistan. In mid-2011, the GOTk pledged to open DIC and provide opioid substitution therapy in every region in the country. This site will serve as a model for other sites throughout the country.*			

Implementing Mechanism Details

Mechanism ID: 13978	**Mechanism Name: Republican Blood Center - Tajikistan**

Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Republican Blood Center of the Ministry of Health of the Republic of Tajikistan	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Benefiting Country	Benefiting Country Planned Amount
Tajikistan	60,000

Total Funding: 60,000		
Managing Country	**Funding Source**	**Funding Amount**
Tajikistan	GHP-State	60,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This mechanism supports CAR's PEPFAR Strategy Objectives 2 and 3. The primary goals of this award are to increase the capacity of the Republican Blood Center (RBC) in Tajikistan (TJ) to improve their blood safety program, ensure an adequate blood supply, perform accurate and appropriate blood screening for the TJ population, and to sustain these program improvements over time. Challenges in blood safety in TJ include lack of voluntary donors, inappropriate clinical use of blood, inadequate maintenance of the cold chain, inadequately trained staff, an outdated, unsustainable electronic blood donor database, and lack of a quality assurance management system (QMS), potentially hindering laboratory performance. Under this award, TA will be provided to the Republican Blood Center of TJ to improve these deficiencies and to develop a QMS covering all stages of the transfusion process. These activities will allow the TJ blood centers to improve their services and efficiency over time. The project will implement a nationwide M&E system for blood services indicators. The indicators will include number of donors served, number of donors tested, number of donors positive for transfusion transmissible infections (TTI), and number of trained people over time. Indicators will be monitored by review with the standardized checklist during regularly scheduled site visits. Sustainability of the program and country ownership will be fostered through training and capacity building of RBC staff, and development of effective and useful

electronic databases for both QMS and M&E. These activities will allow the RBC monitor and improve the quality and efficiency of their activities.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	20,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID: Mechanism Name: Prime Partner Name:	13978 Republican Blood Center - Tajikistan Republican Blood Center of the Ministry of Health of the Republic of Tajikistan		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HMBL	60,000	0
Narrative:			
This ongoing Cooperative Agreement supports CAR's PEPFAR Strategy Objectives 2 and 3. In 2007, CDC re-screened 7500 samples from blood donors in the Central Asia Region (CAR), confirming that contaminated blood is being administered in health facilities. Transfusion of HIV-infected blood is 100 times more efficient for transmitting HIV infection than intravenous injection with a contaminated syringe. An adequate supply of safe blood and the appropriate clinical use of blood are important components of the CAR PEPFAR prevention strategy, as well as a priority for the Government of Tajikistan (TJ). Almost 98% of the blood supply in TJ is based on the principle of "donor replacement." The goals for this activity are to: (1) improve the TJ strategy for voluntary blood donorship using international expertise and results of a Knowledge Attitude Practices/Behavior (KAP)			

survey; (2) help to establish a quality management system (QMS) for blood banking, including screening for transfusion transmissible infections (TTI), blood compatibility and typing; (3) assure cold chain maintenance, including expansion to the rural areas; (4) reduce non-evidence-based clinical use of blood products; (5) establish national norms, standards and organizational structures for a national blood service; (6) improve information systems and standardize databases for tracking blood donors and donated blood units; and (7) strengthen professional development of blood services staff. Technical assistance (TA) will be provided to assist with implementation of a newly developed electronic database to track blood donations at the oblast-level blood centers; conduct on-site training workshops on the database, including entering and using donation data; implement a bar code system for blood services at the oblast level; conduct trainings on cold chain maintenance for all levels of blood services, including national, oblast and rayon. These activities address the 1st (Policy), 5th (Training), 6th (Monitoring and Evaluation) and 7th (Sustainability) key elements identified by the Medical Transmission technical working group (TWG). *The KAP surveys will inform the national strategy on voluntary donorship, including Information (IEC) campaigns for recruitment of donors. Trainings and recruitment materials will be developed for donor recruiters on republican, oblast and rayon levels, who will also collect basic donor information. These activities are related to the 1st, 2nd and 5th and 7th elements identified by the TWG. Ongoing activities include laboratory strengthening (using prior year funding). All activities will be conducted in the context of a QMS, currently being developed by the TJ MOH, spanning the entire chain of blood services. They will be integrated with other HIV/AIDS related services, as potential donors who test positive for TTIs will be referred to the TJ AIDS Center for further counseling and testing and treatment. Sustainability of the program and country ownership will be fostered through capacity building (training the TJ government to improve their blood safety program) and technology transfer (the electronic database).*

Implementing Mechanism Details

Mechanism ID: 17050	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 17051	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 17067	TBD: Yes
REDACTED	

USG Management and Operations

Assessment of Current and Future Staffing.

Redacted

Interagency M&O Strategy Narrative.

Redacted

USG Office Space and Housing Renovation.

Redacted

Agency Information - Costs of Doing Business

U.S. Agency for International Development

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Computers/IT Services		109,994		109,994
ICASS		566,950		566,950
Non-ICASS Administrative Costs		254,003		254,003
Staff Program Travel		152,865		152,865
USG Staff Salaries and Benefits		1,454,688	0	1,454,688
Total	**0**	**2,538,500**	**0**	**2,538,500**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHP-State		109,994
ICASS		GHP-State		566,950
Non-ICASS Administrative Costs		GHP-State		254,003

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total

Capital Security Cost Sharing	344,400			344,400
ICASS	552,520			552,520
Non-ICASS Administrative Costs	756,696	38,500		795,196
Staff Program Travel	568,100			568,100
USG Staff Salaries and Benefits	413,284	565,000		978,284
Total	**2,635,000**	**603,500**	**0**	**3,238,500**

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention Other Costs Details

Category	Item	Funding Source	Description	Amount
Capital Security Cost Sharing		GAP		344,400
ICASS		GAP		552,520
Non-ICASS Administrative Costs		GAP		756,696
Non-ICASS Administrative Costs		GHP-State		38,500

U.S. Peace Corps

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
USG Staff Salaries and Benefits		0		0
Total	**0**	**0**	**0**	**0**

U.S. Peace Corps Other Costs Details