

Approved



Central Asia Region

Country Operational Plan

FY 2014

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

Regional Overview

Epidemiology and Context

Central Asia is one of only two regions in the world where the number of people newly infected with HIV is on the rise. All CAR countries have concentrated HIV/AIDS epidemics primarily driven by people who inject drugs (PWID) located in urban centers and along drug transportation corridors from Afghanistan through Tajikistan (TJ), Turkmenistan (TK), Uzbekistan (UZ), the Kyrgyz Republic (KG) and Kazakhstan (KZ). HIV prevalence among PWID is high and growing throughout the region, ranging from 3.8-18% in KZ, 14.6% in KG and 16.3% TJ. There is evidence to suggest that the incidence of sexual transmission is on the rise. The risk of acquiring HIV among key populations (KP) is increased by unsafe sexual practices: less than 50% of PWID in TJ report using a condom with sex workers (SW), while in KG, the syphilis prevalence is 32% among SW, 16% among prisoners and 13% among men who have sex with men (MSM). In 2011, the proportion of registered HIV cases acquired through sexual transmission (50.7%) exceeded, for the first time, the proportion of cases acquired through injection drug use (43.7%). HIV in CAR is also particularly high amongst prisoners and detainees (many of whom are also PWID), MSM and SW. Though recent surveillance data indicates a potential decline in HIV incidence in KZ and KG, further analysis suggests that in reality, the trend might simply reflect a disproportionate trend of increased testing among low-risk groups and decreased testing among KP.

Substantial evidence indicates that a combination of structural, biological and behavioral interventions, linked with a supportive social and political environment and with high population coverage, can decrease HIV risk and vulnerability among KP. In Central Asia the proportion of persons who access and receive these core interventions (the coverage rate), particularly among PWID, is generally very low. Political will, the policy environment, financial resources and human capacity will remain major constraints for ROP 14-15 programming. The lack of adherence support for pre-antiretroviral therapy (ART) and ART and low retention rates among people living with HIV/AIDS (PLWH) remain key gaps to be addressed to ensure the delivery of effective services and reduction of high PLWH mortality rates. Linking sufficient numbers of KP with diagnostic and treatment services is challenging due to the limited availability and accessibility of safe, stigma-free service points. Medication assisted treatment (MAT) is limited and there are, in some countries, policy and political constraints to implementing or scaling up MAT. Access to rapid HIV tests for KP is limited by regulations preventing non-governmental organizations (NGOs) from providing HIV screening and confirmation tests, resulting in lack of confirmatory results and delays in enrollment in care. Finally, as indicated in the ROP Technical Area Narratives (TANs), gender based violence (GBV) remains a major issue, as it is not only widespread but also accepted among KP. While the HIV epidemic in CAR is concentrated primarily among male PWID, infections among women, due to sexual transmission, are on the



rise.

Regional partners

The number of other donors supporting HIV/AIDS programming in CAR is limited. The Global Fund (GF) is the major donor in CAR, providing HIV/AIDS grants to KZ, KG, TJ, and UZ totaling over US\$125 million. The UN system (particularly UNAIDS, UNDP, UNODC and WHO) provides technical guidance to national HIV/AIDS programs, but does not provide major funding support. In the past several years, UNDP has taken on a key implementation role as the Principal Recipient (PR) for GF HIV/AIDS grants in TJ, KG and UZ, with the intent of transferring this role to the Ministry of Health (MOH) at a later date. The USG funds UNODC, to support capacity building for work with prison populations, and UNAIDS, to support countries to rationalize and strengthen national investments for addressing the HIV epidemic to ensure maximum impact and cost-effectiveness. In 2013, the USG consolidated a strong relationship with the GF Portfolio Managers and PR representatives in CAR countries. USG representatives meet regularly with GF PRs to share work plans and identify potential barriers and priorities for technical assistance (TA) provision. For example, in the last year the USG has supported the development of a forecasting model for ART that will minimize stock outs of GF-provided treatment drugs at government sites. In 2013, the USG also continued critical support to build Country Coordinating Mechanism (CCM) capacity and leadership in governing and overseeing GF grants through TA and training. USG representatives are voting members on the CCMs in KZ, KG and TJ. While the USG is not a voting member of the CCM in UZ, it does actively participate in the national technical working groups (TWGs), providing targeted technical assistance (TTA) on both HIV and TB programming, and is awaiting formal membership.

The GF's shift toward prioritization of high burden HIV countries adds to the urgency for maximizing impacts with country owned and funded interventions. Last year, a GF reclassification of KZ's eligibility, based on its economic status, resulted in a decision to transition out of HIV/AIDS programs by the beginning of 2016. This could jeopardize the sustainability of NGOs currently supported by the GF, which are essential for targeting KP not reached through the public system. However, \$38 million of transition funding in KZ for TB is currently pending GF final approval. The recent roll-out of the GF New Funding Model (NFM) will require TJ, KG and UZ to submit new applications for HIV/AIDS funding in 2014 based on costed National Strategic Plans and/or UNAIDS IFs. The USG will provide TTA, including support for the development of IFs for TJ and KG, to help countries meet GF requirements and ensure the approval of technically sound proposals. Engaging with the GF to ensure that maximum impact can be obtained from final rounds of funding in the region and institutionalizing evidence based interventions into national systems will remain a priority for the USG in FY15-16.

Other multilateral and bilateral partners include GIZ and the Eurasian Harm Reduction Network (EHRN). USG collaborates closely with the EHRN, particularly on health policy issues, work with PWID, and joint support of the Central Asian Association of PLHIV. Since 2013, Russia has committed \$16.5 million over



three years to fund primarily UNAIDS to work with MOHs and other UN organizations in Armenia, KG, TJ and UZ, with a primary focus on surveillance and reducing mother-to-child infections. [REDACTED]

PEPFAR Approach in CAR

PEPFAR goals in Central Asia are to: (1) increase the coverage and quality of prevention and treatment programs; (2) reduce the number of new infections; (3) reduce the number of HIV-related deaths; and (4) reduce the overall costs and increasing the sustainability of the regional and national HIV response to concentrated HIV epidemics. In ROP 14, PEPFAR will accelerate the use of a Targeted Technical Assistance (TTA) model. This model pivots USG/CAR programming to provide more technical assistance to MOH and NGOs to roll out successful HIV pilot interventions and bring them to scale nationwide. The USG/CAR TTA model also helps build country capacity to adopt and implement programs that provide quality prevention, care and treatment services to KP. Rolling out training and assistance across the region will have a cascade or multiplier effect in increasing the number of skilled HCWs, outreach workers and facilities for responding to the needs of KP.

The TTA framework guides the planning, implementation, monitoring and evaluation of the CAR program through a systematic, science-based, demand-driven and phased approach that provides sustained strategic assistance in identified areas. It uses evidence to prioritize investments through a rigorous cycle of: 1) programmatic assessments/situational analyses; 2) data analysis and recommendations; 3) implementation of pilots and TA interventions; 4) analysis of results; and 5) dissemination of results and advocacy for wider adoption at the country level. The strategy aims to ensure the greatest potential impact of USG interventions and the long-term sustainability of national programs. It requires a combination of results-oriented pilot prevention, care and treatment programs at facility and community levels, capacity-building for improved service delivery, and the development and use of data for evidence based advocacy, planning and policy making.

Achievements

In FY 12-13, the USG carried out a number of regional comprehensive assessments that provide strong evidence for the ROP 2014-2015, including a participatory assessment of HIV policy barriers related to access to services, an assessment of CCMs, a gender assessment, and an NGO capacity building assessment.

USG provided direct grants to 26 NGOs to successfully create demand and strengthen HIV prevention through outreach workers throughout the focus countries. Using peer to peer approaches drop in centers and client friendly sites, trusted NGOs provided critical behavior change communication information to increase HIV awareness and knowledge of risk behaviors. As a result, they conducted outreach and prevention to 26,284 KP, and provided care services for 3,127 PLHIV. In addition, 5,684 individuals were tested and counseled on HIV at PEPFAR supported sites. In elevating the role of NGOs as valued partners in combating HIV in CAR, USG worked with 45 NGOs to strengthen their capacity to provide community



based approaches with reaching KP where they live and congregate and trained 3,679 health workers on improved case management and referrals to services for KP.

After two years of protocol preparation and assessments, the USG established 14 Care and Treatment and 18 comprehensive service sites, and is supporting the TJ Republican AIDS Center (RAC) at five MOH Centers for Provision of Services for PWID and one to SW. The USG has also prepared standard operating procedures (SOPs) for MOH approval and national roll-out in strategic information (SI) and lab procedures; and, in KZ, provided TA for national lab accreditation. The USG helped to establish or strengthen over 20 supportive policies or guidelines, for example the development of nationally accepted guidelines for comprehensive services for MSM and PWID in KZ, the National Adherence Plan in KG and the Supply Management Quality Assurance Plan in TJ.

The CAR PEPFAR team has consolidated programs to strengthen the overall health system and to increase KP programming. The USG established referral systems for KP at 107 sites ; established demonstration programs at 14 sites; strengthened blood safety, laboratory and facility-based health systems; established and strengthened high quality surveillance, monitoring and evaluation (M&E) procedures and health information systems (HIS); established facilities that link to community advisory boards (CABs) at 17 sites; and helped countries to develop enabling policies to support the introduction and scale up of services. These high-level interventions, described in detail in the ROP TANs, have reinforced the USG's role in the region as a trusted partner and source of evidence-based TA. Other successful interventions have included gaining national stakeholder consensus on internationally accepted comprehensive packages of services (CPS) for PWID, MSM, and SW; promoting greater community engagement in the health system through CABs; and demonstrating the effectiveness of multidisciplinary teams (MDTs) of professionals to improve adherence of PLWH to ART (1,374 PLWH new to ART were reached in FY13)..

Priorities in FY15

In FY15, the USG team will build upon past successes and provide TTA to enhance country ownership and sustain interventions that impact the epidemic and address key gaps. Specifically, since USG is not the major donor in HIV in CAR, intense efforts will leverage GF and host government resources. USG TTA will support successful implementation of final rounds of GF grants under the New Funding Model in KZ, KG and TJ. In addition, USG will more strategically leverage non PEPFAR TB, Democracy & Governance, and other funding to maximize USG resources and impact the HIV epidemic. In FY15, the USG will support progress in core policy initiatives and re-focus pilot activities to generate evidence through evaluations, so that results are used to advocate for scale up of effective interventions. The impact of comprehensive, cross-agency, coordinated initiatives on rapid testing will help to establish policies, standard lab algorithms and HCT protocols, and a delivery system targeted at KPs. USG will continue to support improved access to and quality of MAT services, links to care and treatment, and retention and adherence to ART to impact mortality. Current strategies will increase referral uptake, improve training and monitoring of outreach staff, expand use of peer to peer outreach to KP and support trusted organizations and the NGOs best positioned



to reach KP.

The USG will build on achievements in modernizing the lab and blood supply systems in CAR and upgrading central laboratories to meet international accreditation in each country. Other priorities include strengthening TJ's and KZ's capacity to use the electronic HIV case management system (EHCMS) and MAT system for program improvement, generating evidence about the effectiveness of the delivery of services, and building a community and facility linked unique identifier code (UIC) for program monitoring, improved coverage measurement, and evidence generation.

Regional Priorities in the FY 2014 PEPFAR Funding Letter

Staffing: In order to achieve the TTA model and priority interventions for FY15 and 16, the USG PEPFAR team will streamline coordination across agencies to ensure strong collaboration and complementarity across all interventions. Several essential positions (a permanent PEPFAR Coordinator and a GF Liaison) have been filled. USAID CAR is currently undertaking a staffing to budget realignment and recruitment of a USAID Senior Advisor for Prevention is being revisited and may be filled internally as a result.

Portfolio Review: Following a rigorous set of meetings in KG, KZ and TJ with government, multilateral agencies, and CSOs at the end of 2013, USG CAR held its first ever intra-agency, regional portfolio review in January 2014 to assess country programs and the regional programs implemented by partners. Moving forward, the USG remains committed to supporting an interagency approach that fully engages all CAR country staff and to holding annual portfolio reviews and comprehensive stakeholder meetings.

New Multi-country Procurements

Both CDC and USAID are planning new procurements. USAID is currently finalizing procurement of its new Regional TB Flagship Project and initiating the design of a new regional HIV Flagship Project, given that two current programs, Dialogue and QHCP, end in FY 2014. The TB and HIV Flagships will coordinate closely to reach KP infected with both diseases. The new HIV project will build upon successful pilot interventions to expand outreach, referrals and retention of HIV/AIDS services for KP. Activities will focus on: TTA for institutionalized training of trainer (TOT) models; rolling out adopted evidence-based tools, guidelines and norms; scale-up of CPS for KP, demand generation and effective referrals by outreach workers; and the active participation of NGOs and CSOs in HIV activities. A second new regional activity (currently in procurement) will focus on reducing HIV transmission and improving the quality of services for PWID and PLWH in detention and post-detention settings. Building on the UNAIDS IF activity, a new Health Financing and Governance activity will provide TA to countries in national budgeting for HIV services to ensure a maximum return on investments.

In ROP13, 93% of the CDC program budget went to international organizations with the remaining 7% for MOH partners. Under ROP 14 CDC will transition the program budget: only 22% will go to international organizations, 51% will go to local partners, and 27% to MOH partners. In FY 15, two five-year agreements



with an international university, ICAP/Columbia, will end. ICAP activities will be continued and expanded through a procurement for a local partner (as defined by PEPFAR), who will, based on the recommendations of earlier assessments, focus on building the capacity of the MOHs in KZ, KG and TJ to provide care, treatment, laboratory, SI, and prevention services at international standards. In addition the new partner will further successful interventions with PWID, carried out through PEPFAR's Key Populations Challenge Fund (KPCF) in all three countries, and will continue implementation science activities started with PEPFAR's Key Populations Implementation Science (KPIIS) grant. In FY15, CDC will also renew government-to-government (G2G) agreements with the Republican Blood Centers in KG and TJ, the Republican Narcology Center in KG and the AIDS Center in TJ, as current five-year agreements will end in March 2015. The new cooperative agreements will build on successful interventions to expand MAT (KG) and KP Centers (TJ) for PWID and SW. CDC CAR offices and the local partner will continue to provide TTA for all G2G cooperative agreements.

Central Initiatives

In addition to programs described in the ROP, the USG PEPFAR team will manage four additional Central Initiative awards. These programs include: 1) An award for \$820,860 through PEPFAR's Local Capacity Initiative (LCI) to strengthen and enhance country ownership by building the capacity of the CAR Regional Association for PLWH over a three-year period; 2) an award for \$1 million through PEPFAR's Country Collaboration Initiative to strengthen CCM oversight of grants and grant monitoring visits in Tajikistan; 3) An award for \$979,781 through the KPCF with the objective of building health care provider capacity to provide integrated HIV, MAT and TB services and improve the entry, retention and adherence of PWID in MAT programs in KZ, KG and TJ; and 4) an award for \$500,409 through KPIIS for an 18-month evaluation in KG to assess the effectiveness of different models on needle and syringe program (NSP) delivery. (Please see the ROP TANs for more information).

Trajectory in FY 2015 and Beyond

In 2015, the USG will remain focused on provision of the TTA model discussed above. PEPFAR CAR activities will provide TTA to MOHs and NGOs to improve HIV prevention, care and treatment services for PWID and other KP. The USG will continue to collaborate closely with, and leverage resources from, the GF, other USG funding, to provide evidence and support to assist governments to align programs to address drivers of the concentrated epidemic, and continue to increase direct funding to local entities.

Country Summaries (see Annexes for individual country maps with locations of USG project sites)

Kazakhstan

Overall HIV prevalence in the KZ general population of 17.7 million is 0.2%, but prevalence among KP, where the epidemic is concentrated, is much higher. HIV prevalence among PWID ranges greatly within the



country - from 4.6% in Almaty to 18% in Pavlodar (IBBS, 2011). High rates of HIV also affect SW (5% - 9.2%), and MSM (1.0% - 3.3%). Government data indicates that sexual transmission now accounts for 61% of new HIV infections, though this data requires further review. Despite having a highly concentrated epidemic, testing does not focus on those most at risk: approximately 13% of the population is tested, of which only 1.6% are KP. In 2012, 54% of the 13,119 registered HIV cases were enrolled in care, of which 4,024 cases were eligible for ART, and an even smaller number of those cases (42%) were actually on ART. According to EHCMS data, co-infection of TB/HIV is a major problem, with TB accounting for the leading cause of death (31%, N=720) among PLWH. Approximately 17% of HIV-infected PWID are co-infected with TB, but as of January 2013, only 56% of all PLWH had been screened for TB in the last 12 months. AIDS-related mortality is high, reflecting late initiation of treatment and high drop-out rates at each stage of the cascade continuum of services.

The GOK, unlike other countries in the region, is the primary funder of the national HIV program, supporting 53% of the budget last year, with the rest coming from the GF (27%), USG (12%), and other international organizations (8%). KZ has not created an HIV/AIDS National Plan, but rather allocates funding for HIV prevention, ART, laboratory equipment and test kits, annual integrated bi-behavioral surveillance (IBBS) and MAT pilots under the general State Program of Health Care Development Plan for 2011-2015. The GF Round 7 grant, which funded all major outreach efforts, recently ended in December 2013. With the phasing out of this grant, KZ currently lacks sufficient funding to support outreach activities. Round 10 funding, worth an estimated \$12.5 million, focuses on PWID and PLWH in five geographical regions but is on hold, contingent upon resolution of political issues between the GF and RAC. As GF support comes to an end, the USG's role as the primary provider of TA to the GOK is of particular importance.

Beyond sustainability planning, other barriers to an effective response in KZ include: high levels of stigma and discrimination among health care providers; KP 'self-stigma' resulting in lower demand for services;; low coverage of MAT;; weak data collection and monitoring systems; and a weak link between the number of KP reached by outreach workers and those who get HIV tested and know their results.

The USG will provide TA to develop strong lab and blood supply systems; and strengthen practices that will increase the access of KP to HIV testing, care and treatment services. This includes ramping up rapid testing through community/peer initiated counseling and testing (CPICT); antiretroviral (ARV) forecasting; and introducing new approaches for tracking and following up KP. USG will continue to provide TA to enhance the quality of care, treatment and MAT services, and will start development of an electronic MAT Management System to improve MAT services and monitoring. The USG will scale up and expand upon the development of MDTs, which have been shown to improve treatment adherence to ART among PLWH, develop SOPs for the laboratory systems and forecasting module within EHCMS to assess national and oblast needs for ART and other HIV-related pharmaceuticals. The USG will also continue to provide critical



support to local NGOs for the national grant application process to ensure a smooth transition of GF support. USG will assist the CCM in KZ to strengthen the Secretariat and build advocacy-kills of NGOs working with to address stigma and discrimination. In FY 2015 the USG will monitor the effectiveness of implementing recommendations to improve services and impact the epidemic. This data will provide evidence for advocacy with the government and other donors to leverage their support for scaling up efforts.

The Kyrgyz Republic

According to UNAIDS, 8,727 people are living with HIV in KG. Of those, 1104 are currently receiving ART. HIV prevalence among the general population remains low, with infection concentrated in KP (predominantly PWID). Based on a recent assessment from WHO/UNAIDS, KG is one of 25 countries with the highest rates of HIV infection - the number of officially registered HIV cases in the past eight years has risen from 826 cases in 2005 to 5,087 in 2013 (AIDS Center). Routes of transmission are largely parenteral (66.96%) and sexual (29.75%). Nosocomial infection is also an issue in pediatric hospitals and other medical facilities. HIV/TB co-infection is of particular concern; it increases mortality for PLWH and is a driver of multi-drug resistant TB. Official AIDS center data states that 1044 people in KG are co-infected with HIV and TB, and 955 patients out of 1044 are on ART treatment, but actual co-infection numbers are likely much higher. KP in KG face hostility because they tend to be or are perceived to be drug users. Stigma and discrimination toward KP is demonstrated by both police officers and HCW.

The Government of KG (GOKG) operates under a National AIDS Program for 2012-2017 that increases the government's share of total financing for the HIV response. Due to lack of financing and weak staff capacity, the national program has not played a significant coordinating role in the country. The donor community has established an effective partnership with the GOKG, NGOs, local communities, law enforcement entities, human rights organizations, research institutions, and other stakeholders. The goal of this multi-sectoral partnership is to improve the effectiveness of the national response and address social and economic issues caused by the epidemic. The GF is the main funding source for the State HIV/AIDS program and covers almost 85% of its activities in-country. At present, KG is entirely dependent on external support for ART, laboratory supplies and other commodities. WHO and UNAIDS provide substantial technical inputs to HIV national policy, guidelines, assessments and operational procedures. USG-funded programs are closely planned and implemented with the GF and other donor programs to enhance the effectiveness and non-duplication of HIV programming in KG. PEPFAR has closely collaborated with international donors and organizations, including GF, UNAIDS, WHO, UNICEF and Soros Fund. The GF has been particularly critical to the execution of PEPFAR activities in KG.

KG was the first CAR country to initiate a pilot of HTC among KP through NGO Rapid testing. To date 4480 KP representatives have been tested in non-clinical settings, with 210 testing positive. However, only 64 of those 210 followed up with the confirmatory test at AIDS centers. There is lack of continuity of services and



social support for PLWH and the drop-out from timely and continuous use of services along the cascade is highly problematic.

Progressive policies in KG allow for expanding HIV prevention interventions for PWID, including MAT, naloxone for responding to heroin overdose, and NSPs in prisons and community settings. There are currently 30 MAT sites operating in KG (4 supported by PEPFAR and 26 by GF), including 7 in the penitentiary system. The KG national MAT program has the highest number of people on MAT in the region (1,086) and the government would like to expand this program with GF grants. Despite this enabling environment, prisoners still lack access to treatment – an estimated 350 prisoners in KG are living with HIV, while only 67 are currently receiving ART – and post-release services.

The GF provides enough ARVs for approximately 10% of PLWH in KG, but even this minimal supply is underutilized as HCW lack the knowledge to effectively prescribe them. Responsibility for ARV prescription and provision of HIV care was shifted to the primary health care sector as part of recent health sector reform, but the shift was not accompanied by necessary capacity building. In general, KG primary health care providers have been unable or unwilling to manage ARVs, and patients tend to go without ARVs (especially those who lack geographic access to Bishkek or regional AIDS Centers).

Over the last two years, USG priorities in KG have focused on strengthening HIV policy, service delivery and access to care by KP. USG activities have contributed directly to the national program on HIV, which names improved access to treatment, care and support for PLWH and strategic coordination and management of HIV programs among its top five priorities. The USG supports activities to improve access to care by KP and has provided TA to the MOH and the RAC to strengthen facility-based HIV prevention, care, support and treatment services, and to the Republican Narcology Center to increase coverage and improve quality of MAT sites in community and prison centers. At the community level, the USG provides technical assistance to NGOs (which are integral partners, actively engaged in providing outreach and prevention services to KP), with the goal of reducing risk behavior and increasing their access to quality health care services, reducing stigma and discrimination, and strengthening the primary health care systems' capacity to plan, deliver and monitor enhanced services. The USG also provides TA to support sustainable, evidence-based systems, including for national strategic information system – including surveillance, monitoring and evaluation (M&E) and informatics – to improve blood safety through stronger management of nationally-coordinated blood transfusion services, and to achieve sustainable laboratory capacity through the development of comprehensive national lab strategic plans.

Programs funded in KG over the next two years will prioritize the institutionalization of evidence-based procedures and systems, and the rationalization of budgeting for the HIV response, through TA in order to increase sustainability and country ownership. For example, the USG budget-making decisions with regard



to the HIV response and ensuring a maximum return on national and donor HIV investments.

TA for collaborative work with the national program, e.g. pilot sites for MAT programs and Rapid Testing activities, will be supported through a system of regular M&E for quality assurance. The USG will also build upon successful pilot interventions to expand outreach, referrals and retention of HIV/AIDS services for KP and to strengthen the role of NGOs working on HIV prevention. The USG will also work closely with the Global Fund (GF) and the UN system to harmonize support for the national government and minimize duplication.

Tajikistan

TJ faces considerable challenges in providing high volume, low threshold and high quality comprehensive HIV prevention, care and treatment services in urban and rural areas. TJ is a mountainous country with an estimated 7.5 million population, of which over 73% live in rural areas and 40% are under 18. A 1,300 km shared border with Afghanistan places TJ in the middle of one of the main transit routes for heroin, opium and other drugs leaving the region. As a result of these hardships and resource needs in other sectors, less than 7% of the national budget was allocated towards health in 2012. Tajikistan has the least financial resources for HIV/AIDS epidemic response in the region.

The number of officially registered HIV cases in TJ has increased from 1,422 in 2008 to 5,550 in 2013. Current estimates suggest that in reality, approximately 12,000 PLWH are infected. Approximately 72.2% of HIV cases are registered among men and 27.8% among women. Injecting drug use is the primary driver of the HIV epidemic, with over 52% of total transmission occurring from unsafe drug injection. In more than 39% cases, HIV is transmitted sexually, though the sources of these infections are far from clear. The majority of sexually transmitted cases are from male PWID to their sexual partners but female SW who inject drugs are also potential transmitters. According to recent estimates, there are about 12,500 female SW in TJ. While only 1.5% of the MSM population is estimated to be HIV positive, better estimates are needed to fully understand the burden in this population group.

HIV/AIDS program actions are mandated as part of the National Program on the Response to the Epidemic of HIV/AIDS, 2011-2015. The current National Strategic Plan focuses on prevention for KP and other vulnerable groups, preventing mother-to-child transmission (PMTCT) and blood safety programs, and the provision of ART, care and social support for PLWH. Most HIV services for KP are implemented through a network of 38 AIDS Centers at the national, provincial and district levels with the RAC as the national coordinator for HIV surveillance, prevention, and care and treatment activities. Additionally, there are 47 Trust Points (TP) and 25 Friendly Cabinets (FCs) that provide free outpatient HIV-related services to PWID and SW (31 located at the AIDS centers and the rest NGO-based). Activities at TPs and FCs reached 8,914 PWID and 5,663 SW in 2012. A limited number of NGOs provide HIV prevention services to MSM but it is



difficult to estimate the number reached.

Core HIV prevention interventions for KP, however, face several challenges – methadone coverage is extremely low and rapid testing is not widely used, limiting the number of those, particularly KP, who return for test results. Although HTC coverage has increased considerably in recent years, HTC coverage of KP remains low (though coverage is high in the low-risk general population). For example, in 2012, of the 447,636 people that accessed HTC only 2.8% were PWID, SW, and/or MSM. A further barrier is the delay in accessing ART: as noted, many of those tested do not return for their results, and many enter treatment at a late stage, with a low CD4 count (51% of those enrolled in ART were at Stage 4). The vertical nature of health services in TJ also makes continuity of care challenging. Services such as TB care, HIV care and treatment, STI treatment and harm reduction are not coordinated, creating challenges for patient access. Support for significant outreach to KP is limited – the dedicated sites (TPs for PWID and FCs for SW) are not institutionalized, and the policy environment for reaching KP needs to be strengthened. TJ also has limited reach under its MAT program. Four pilot sites supported by the GF reach 288 PWID, barely 1% of the estimated PWID population. Two more sites are planned for 2014. For epidemiological significance, expanding MAT interventions is a high priority for FY 14.

The TJ HIV/AIDS program depends heavily on international funding with about 85% of the \$15.4 million spent on HIV/AIDS in 2011 coming from international organizations. The GF is the major contributor. TJ has received four rounds of GF funding, the latest in 2009, and will be applying to the GF under the NFM. Other partners include UNDP, WHO and the Russian Federation. The TJ PEPFAR program works closely with the GF, WHO, the World Bank and UNDP to build MOH capacity to manage GF funds. Coordination with GFATM ensures KP reached with outreach, education and referrals have access to GFATM commodities. Referrals also include services for TB and STI diagnosis and treatment, drug abuse treatment and social support. Multi-disciplinary teams of physicians, nurses and social workers ensure completion of TB treatment and retention on ART. PEPFAR support has enhanced the capacity of the National AIDS Center in M&E, specifically in generating high-quality data on the HIV/AIDS epidemic to ensure an evidence-based national program. PEPFAR has also provided TA to strengthen the national blood safety and laboratory systems and to expand coverage of KP.

In FY 2014 and 2015, USG's top priorities include 1) expansion of coverage through targeted outreach and comprehensive prevention programs to improve linkage and referral to other services; 2) TA to CCMs to meet the requirements of the GFATM and to improve its coordinating role. HTC expansion and promoting screening of KP for viral hepatitis C and B and TB; 3) scaling up low threshold MAT and NSP; 4) piloting integrated management for people with opioid dependence in MAT sites; 4) working with MOH and partners to inform policy changes to support rapid testing in non-governmental TPs; 5) strengthening and establishing MDTs, CABs and coordination councils (CCs) to support adherence to ARV and TB treatment;



and 6) Increasing engagement and strengthening of local NGOs on advocacy, policy change, and engagement in service delivery.

Turkmenistan

TK, a country with a population of 6.2 million, does not track and publish data on its HIV/AIDS epidemic. The country has an unbudgeted National HIV/AIDS strategy, 2011-2015, that acknowledges only the possibility of TK's HIV/AIDS epidemic and the need to harmonize laws and policies with international practices. The strategy mainly focuses on HIV prevention but also addresses treatment, including the provision of drugs. It includes HIV diagnosis among risk groups, including PWID, SW and TB patients, information campaigns for the general population, and states that a patient diagnosed with HIV has the right to free treatment. However, there is no associated budget.

Currently, the only bilateral/multilateral organizations working in HIV in TK are the USG and WHO. The UNAIDS program closed in 2013. Donors provide few resources however, and the USG currently funds limited HIV/AIDS activities in TK. The USG provided initial funding, in 2010, for a public-private partnership with Chevron to support HIV prevention among youth through Youth Centers in Ashgabat and Mary cities. While these two Youth Centers were unexpectedly closed in January of 2014, the project continues to support HIV prevention and diagnostics among drug addicts and SW through a UNODC drop-in center. While no new HIV/AIDS funds are available, USAID/Turkmenistan has limited pipeline funding to continue supporting UNODC's work and hopes to expand support to two additional drop-in centers during FY 14. The USG has also supported HIV/AIDS prevention and training linked to programs to strengthen the overall health system and to address TB. In 2013, the USG supported inputs to update National HIV Guidelines, specifically chapters on co-infection, updates to standards on treatment of pregnant women, and revised indications on use for some ARV drugs. The USG is open to exploring future options for providing TA to address HIV prevention, care and treatment for KP, including programs linked to USG's current work in TB.

Uzbekistan

With its population over 30 million in 2013, UZ is the most populous country in CAR. It is located on major drug trafficking routes from neighboring Afghanistan and has the largest number of PLHIV. While the prevalence of HIV infection among the general population remains low (0.1%), prevalence is higher among some sub-populations: 8.4% among PWID; 2.2% among SW; and 0.7% among MSM. Testing among KP remains low: in 2011, only 29% of PWID reported that they had been tested for HIV in the last twelve months and knew the results. In 2011, nearly one third (31%) of people diagnosed with HIV infection had a CD4 count <350 at the time of diagnosis (i.e. they were diagnosed late). Reported condom use among PWID is low at 31%, and the rate of infection among sexual partners of PWID is rising. The rate of new infection is high, at 12.7 per 100,000 population.



Historically, the national HIV response has faced a number of challenges, including: strong politicization of HIV and a high degree of central control over HIV activities; limited involvement of CSOs due to government regulation and civil society capacity; limited success in promoting HTC among KP; provision of a limited range of prevention services for KP; closure of all MAT sites; and the presence of legislation reinforcing stigma, discrimination and criminalization of KP. However, a number of recent steps by the government of Uzbekistan (GOU), including the 2013 lifting of all restrictions on entry, stay and residence for PLWH and the commitment of US\$1 million for ART annually, has advanced the response.

Last year the GOU also launched the 2013-2017 National Strategic Program on HIV/AIDS with primary goals of 1) ensuring a reduction in the spread of HIV in UZ by 2017 and 2) achieving universal access to comprehensive HIV prevention, treatment, care and support by the same year. The plan outlines several priority actions to address these goals: improvement of the legal framework to ensure universal access; preventing HIV infection among high-risk groups, particularly PWID, SW and MSM; prevention of HIV transmission in healthcare settings; PMTCT; HIV and STI prevention in the general population; and ensuring universal access to diagnosis and treatment of HIV and STIs.

A GF grant currently supports approximately 30% of the program budget for UZ's HIV response. In close alignment with National Strategic Program priorities, the GF's main goal is to prevent the spread of HIV by reducing its impact on KP and to strengthen health systems and national capacity for universal access to HIV prevention, diagnosis, treatment and care in UZ.

Until December 2012, GF was the sole direct funder of ART in UZ, although delivery of treatment has relied heavily on GOU contribution in terms of staff, infrastructure and operations, making it country owned from the start. In March 2013, Medecins sans Frontiers initiated a treatment program for up to 1,000 people annually (US\$1.6-\$1.8 million per year). In June 2013, RussAID announced commitment of US\$1.8 over three years to fund primarily UNAIDS work with the UZ MOH, WHO, UNICEF and UNFPA with a focus on PMTCT and surveillance activities. The UNODC has a long-standing presence in CAR and maintains its regional office in UZ. UNODC helped to initiate trust point programs in the region and has been involved in HIV/AIDS programming since the 1990s.

Historically, the GOU and HIV/AIDS donors have been poorly coordinated. However, in the last three years, an overall positive trend in bilateral U.S.-UZ relations has emerged. In 2010, the Interagency Multi-Expert Committee (MEC) under the Cabinet of Ministers or the equivalent CCM in UZ approved implementation of TA through USAID's Dialogue on HIV and TB Project activities in pilot regions of UZ for the next 5 years. In 2012, the MEC then approved TA by USAID's Quality Health Care Project to work in TB and HIV in UZ. This has resulted in robust cooperation of both projects with Project Hope and WHO, who are long and trusted partners of the GOU. Given USG investment in the GF, USAID projects support CCM capacity building, and



both CDC and USAID participate in CCM TWGs. In recent months, USG agencies have received a number of requests to provide TA to improve GOU's national HIV response and improve governance. Specifically MOH, along with GF/UNDP, requested CDC UZ staff to provide leadership in coordinating the TA around quality assurance of rapid testing roll-out in UZ. Also, MOH continues to request CDC to provide TA on HIV clinical standards of care and treatment by requesting CDC trainers for MOH sponsored trainings. Finally, GF/UNDP requested CDC to provide trainer on data quality management.

In 2013, USAID and GOU finally executed an MOU to expand cooperation in health. This creates a window of opportunity for building on USAID's TB work and providing TTA in HIV prevention, care and governance. In 2012 CDC received official accreditation, which allows CDC to work under the USG bilateral agreement. This allows CDC's division of global health protection to roll out activities on antimicrobial resistance, reducing extremely dangerous pathogens under cooperation with the Defense Threat Reduction Agency, and trainings on clinical standards and data use.