

EVALUATION REPORT
Programme of Technical Assistance
To Countries of Eastern Europe and Central Asia
In the Field of Prevention, Control and Surveillance of
HIV/AIDS and other Communicable Diseases
(2013 – 2015)
Phase I

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ABSTRACT

THE EVALUATION REPORT for Phase I of the Programme of Technical Assistance To Countries of Eastern Europe and Central Asia In the Field of Prevention, Control and Surveillance of HIV/AIDS and other Communicable Diseases (2013-2015) contains detailed considerations of the achievements and shortcomings of the Programme implementation within three announced components in three recipient countries: Armenia, Kyrgyzstan and Tajikistan. Expert evaluation of the Programme's strong and weak points has been conducted taking into account the national specifics for the organized activities; the lessons to be learned from the work on Phase I of the Programme have been defined. Conclusions and recommendations to all recipient countries have been submitted, which will allow the partners to fix the detected problems and fill in the determined gaps. As part of the evaluation report it is possible to highlight the package proposals on strengthening the Programme in its second Phase (2016-2018) and beyond that period.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CDC	Centers for Disease Control and Prevention
CPR	Calibrated Population Resistance Tool
CSTO	Collective Security Treaty Organization
CSW	Commercial Sex Workers
EAEU	Eurasian Economic Union
EECAAC	International Eastern Europe and Central Asia AIDS Conference
GDP	Gross Domestic Product
GF	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HAI	Healthcare-Associated Infections
HCOY	Health Counseling Office for Youth
HIV	Human Immunodeficiency Virus
HL	Healthy Lifestyle
IOM	International Organization for Migration
MC	Mobile Clinic
MDT	Multidisciplinary Teams
MSM	Men Who Have Sex with Men
NASA	National AIDS Spending Assessment
NCC	National Coordination Committee
NCEA	National Cost-Effectiveness Analysis for HIV/AIDS
NGO	Non-Government Organization
NPO	Non-Profit Organization
NSCE	Organization for Security and Cooperation in Europe
NSH/A	National HIV/AIDS Strategy
OECD/DAC	Organization for Economic Cooperation and Development / Development Assistance Committee
PID	Persons Who Inject Drugs
PCR	Polymerase Chain Reaction
PHC	Primary Healthcare
PLWHA	Persons Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PSI	Population Services International
RA	Republic of Armenia
RC	Republican Center
REC	Regional Education Center

RF	Russian Federation
RK	Republic of Kyrgyzstan
RNGO	Regional Non-Government Organization
RT	Republic of Tajikistan
SOP	Standard Operating Procedures
SSS	Sentinel Surveillance System
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
UNDP	United Nations Development Programme
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
VH	Viral Hepatitis
WHO	World Health Organization
YFHS	Youth-Friendly Health Services

SUMMARY

The Regional Cooperation Programme involving Armenia, Kyrgyzstan, Tajikistan and Uzbekistan is aimed at strengthening the systems of response to the HIV/AIDS epidemic in those countries, developing national HIV response programmes, as well as technical assistance in reinforcing the systems of HIV/AIDS surveillance, prevention and treatment.

The Programme was being implemented in three main areas:

Component A: “Improvement of the epidemiological surveillance system for HIV, STI and viral hepatitis.”

Component B: “Development of communicable diseases prevention and control, including HIV, STI and hepatitis among women and children.”

Component C: “Improvement of the prevention system for HIV/AIDS, STI and hepatitis among key populations, including prevention among migrants.”

External evaluation of the Programme was aimed at conducting an independent analysis of the completed Phase I of the Programme, its achievements and ‘lessons learned’ that would help formulate recommendations for improving the next phase of the project and overcome the difficulties that arose in Phase I (2013-2015). Over the course of the research, two methods have been used: the individual and group interviews, as well as analysis of the submitted documentation.

Most of the activities within the Programme components of Phase One have been implemented successfully. The Programme allowed to “fix” some of the key problematic areas in the response to HIV/AIDS that had been overlooked by the international community and other international donors in the recipient countries, including problems related to control and prevention of communicable diseases among pregnant women, PMTCT, as well as improving the prevention system among labor migrants. With the support of the Programme, UNAIDS had provided assistance to national healthcare authorities of the three countries in the development of regulatory standards for the epidemiological surveillance on HIV, STI and viral hepatitis, professional training and conducting research leading to the improvement of the national epidemiological surveillance system.

The implementation of the Component A has enabled, inter alia, to improve comprehensive HIV/AIDS epidemiological surveillance, particularly among the hard-to-reach key populations such as migrants.

As part of the Component B, systems for control and prevention of HIV and concurrent communicable diseases among women and children have been strengthened, including assistance in the development of national guidelines for prevention of vertical (mother to child) HIV transmission, compiling educational materials and training specialists. Comprehensive studies on infection control in maternity institutions have been conducted, evaluation of HAI prevention measures and of the infection control system has been carried out; necessary technical and logistical assistance has been provided.

As part of Component C, activities have been focused on the training of outreach specialists, organization and support of HIV, VH and STI diagnostics in remote and hard-to-access areas, as well as staging educational events involving usage of materials published in the national languages of the recent countries.

Deliveries of Russian mobile clinic-and-diagnostics complexes have become an important factor facilitating progress, along with supplies of testing systems and disposable materials, which allowed to significantly expand the coverage of the population provided with diagnostic and counselling services in the three countries.

A substantial factor contributing to the success of the Programme Phase One have been the coherence and consistency of the joint effort of the RF Government, UNAIDS, and the Foundation for Prevention and Control of AIDS and Other Infectious Diseases “AIDS Infoshare” with national partners at the Health Ministries of the Republics and Regional AIDS Centres, since the above-mentioned cooperation and engagement of the key stakeholders has allowed to implement the defined

tasks efficiently and in a timely and comprehensive manner. It should also be noted, however, that cooperation in the recipient countries is probably worth developing further in order to bring the Programme to an even higher level and to make it more relevant and efficient. Educational and awareness-raising work with all population strata remains an important work vector, yet a heavier emphasis should be placed on the work with children and youth.

Over the course of the evaluation certain non-programmatic strategic factors have been detected to be at work in the region, influencing the Programme implementation both directly and indirectly.

Main conclusions:

- Currently, the Programme is one of the pivotal factors in the efforts to contain the HIV/AIDS epidemic in the Republics of Armenia, Kyrgyzstan and Tajikistan.
- The main areas of the Programme have demonstrated their relevance and usefulness within the context of the implementation of national programmes of response to HIV/AIDS. The Programme is an excellent example of an innovative mechanism of technical assistance carried out via the collaboration of stakeholders at various levels. New modes of targeted financial aid from the RF with participation and support of UNAIDS and “AIDS Infoshare”, Russia, have proved to be efficient and promising.
- Mobile clinics have become a successful and relevant component of the Programme. The participant countries have displayed a high level of interest in its further advancement and development. Considering the fact that this line of work has been recognized as successful, relevant, useful and efficient in all three countries, and in order to ensure its further sustainability, an article on mandatory state participation in co-financing and maintaining the given component should be introduced as part of the agreement at the next stages of the Programme.
- As part of the regional project implementation, the recipient countries need to design a number of activities aimed at coordination, time consistency and effective teamwork of international, state (public) and non-governmental partner organizations working towards response to HIV/AIDS at the national level.
- A unified system of project planning and technical reports of the Programme partner organizations ought to be implemented, the system of tracking beneficiaries ought to be standardized for those who have been examined within the project’s framework, following a unified methodological approach in organizing and conducting comprehensive research in the recipient countries in order to ensure better comparability of the results.
- Educational and awareness-raising work component ought to be strengthened, aiming at increasing HIV/AIDS awareness and reducing the stigma, with a particular emphasis on young populations.

Main recommendations:

1. To work on developing a recommended protocol for the coordination and approval of planned and conducted activities by partner organizations, including international, state and non-government organizations in order to increase the cost-effectiveness of HIV/AIDS response at the country level.
2. To conduct detailed process mapping of the main programmes and projects carried out by international and national donor-organizations and foundations working in the countries of the region.
3. In order to ensure Programme sustainability and considering the current situation in the region, where international partner-programmes also working on scaling-up of the response to HIV/AIDS epidemic are decreasing their financial contributions, subsequent agreements with the Programme recipients ought to introduce articles on mandatory state co-financing of the Programme components, including co-financing of purchases of diagnostic testing systems.
4. Possibilities of optimizing the lengthy and complicated UNAIDS’ procedure of contract evaluation and signing should be seriously considered, along with feasibility of switching to longer contract terms (three years) in order to minimize the negative influence of that factor on the efficiency of season-based activities targeting migrants in particular.

5. The scientific and research component of the Programme ought to be reinforced, joint researches in HIV/AIDS response ought to be designed and conducted.
6. To recommend the Programme recipient countries to develop a standard approach to the operational tasks and workload of the mobile clinic personnel and the outreach activities (to standardize education and professional training, create relevant protocols for each of the areas, including a list of professional responsibilities, work conditions and other regulated aspects), or implement the Programme's previously developed regulation package elaborating on organization of the mobile clinic personnel work (Appendix III).
7. To implement a standardized system of encoding the individual data for mobile clinic clients, including the currently existing and successfully employed methods and technologies.
8. To conduct cost-effective regional meetings on the implementation of the Programme in various cities of the participant countries in order to share experiences on a wider scale, deepen cooperation between the participating countries, draw public attention to the key issues, as well as to highlight the role of the Russian aid in the region.
9. To develop mechanisms of state support at the level of local administrations with a number of issues in mind, including ensuring provision of stable electricity supply to the parked mobile diagnostic complexes along their planned or usual routes of operations in distant locations as an element of state co-financing of the Programme.

1. INTRODUCTION

At present it is clear that response to infections including HIV/AIDS is an issue without which it is not possible to ensure sustainable social and economic development, both globally and at the regional level.

In view of this, in accordance with the approved Concept of the Russian Federation's participation in International Development Assistance in order to decrease the risk of dangerous communicable diseases, the Russian Federation is consistently stepping up its efforts in the area of improving national health care and social welfare systems within the framework of such structures as the CIS, SCO, BRICS, etc. Significant attention is devoted to issues regarding provision of assistance to Russia's partner countries in their own capacity building in respect of response to communicable diseases and ensuring sanitary and epidemiological safety for the population.

Owing to a number of projects and programs aimed at assistance to foreign countries that have been implemented by the Russian Federation during the recent 10 years in the CIS countries, in South-Eastern Asia and Africa on a bilateral basis and with the participation of UN organizations, the Russian Federation has become one of the key partners in dealing with health care related problems internationally. This is particularly relevant under conditions of decreasing financing on behalf of international organizations and foundations, as well as limited resources allocated towards health care in these countries.

The Programme of Technical Assistance to Countries of Eastern Europe and Central Asia in the Field of Prevention, Control and Surveillance of HIV/AIDS and other communicable diseases, implemented by the Russian Federation together with the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Russian NGO "AIDS Infoshare", has become one of the successful and effective examples of Russian assistance programmes.

It should be noted that the comprehensive nature of the Programme provides an example of efficient multilateral collaboration between the Government of the Russian Federation, an international organization (UNAIDS) and a Russian nonprofit organization (the Russian NGO "AIDS Infoshare"),

which enabled to utilize the advantages and competencies of each of the participating members to a maximum extent.

Overall, the Programme has clearly demonstrated the consistency of response to the HIV epidemic on behalf of the Russian Federation at the international level, increased the role of Russia in regional and global efforts aimed at the control of communicable diseases, facilitated the strengthening of scientific and community relations with the countries of Eastern Europe and Central Asia.

In compliance with the Concept of Russia's Participation in International Development Assistance, 12 priority areas of Russia's assistance are defined with consideration of the regional specifics. One of these priorities is "Strengthening national healthcare and social protection systems focusing, among other things, on preventing the spread of communicable diseases." In 2013, the Programme of Regional Assistance was launched with participation of Armenia, Kyrgyzstan, Tajikistan and Uzbekistan (the budget for the first phase being US \$16.5 million), aiming at strengthening the systems of preventing the spread of HIV/AIDS in these countries, development of national programmes and provision of technical assistance in strengthening the systems of HIV/AIDS surveillance, prevention and treatment.

The Programme has covered three major components:

Component A: "Improving the epidemiological surveillance system for HIV, STI and viral hepatitis."

Component B: "Development of communicable diseases prevention and control, including HIV, STI and hepatitis among women and children."

Component C: "Improving the prevention systems for HIV/AIDS, STI and hepatitis among key populations, including prevention of these infections among migrants."

2. DESCRIPTION OF EVALUATION SCOPE

Evaluation purpose and questions

The purpose of external evaluation is to conduct an independent analysis of the results of Phase One of the Programme, to describe its general achievements, to determine its ‘lessons learned’ that may help offer recommendations on increasing relevance, effectiveness and usefulness of the upcoming Phase of the project and to fix the problems detected over the course of Phase One in 2013-2015.

The evaluation was designed to address the following questions:

- Have the expected results of the Programme been achieved?
- What are the strong and weak points of the Programme?
- What factors (both external and internal) have affected the successes of the Programme?
- What are the lessons to be learned to apply to Phase Two of the Programme?

Evaluation methodology

The evaluation research employed two methods: the individual and group interviews and analysis of the submitted documentation.

Interviews have been conducted both in the participant countries and in the Russian Federation. The respondents were representatives and employees of the organizations responsible for carrying out certain components of the Programme. Whenever it was possible, the population representatives were interviewed selectively (migrants, mobile clinics clients, medical professionals of various specializations, outreach workers) as immediate beneficiaries of the Programme.

Work plans, execution reports, reports of partner organizations and national and international regulatory documents have also been analyzed, including National HIV Strategies, financial reports, research findings, presented statistical data, topical informational materials and other documents reflecting the results and achievements of the Programme. The complete list of documents used in the course of evaluation is to be found in Appendix I.

Analysis and evaluation have been conducted in the following aspects:

- Relevance, effectiveness and usefulness of the Programme in general at the state level and within the context of the national programmes of response to HIV;
- Role of the Foundation for Prevention and Control of AIDS and Other Infectious Diseases “AIDS Infoshare” in collaboration/coordination with national partners in response to HIV/AIDS in participant countries.

The analysis and evaluation have employed standard criteria recommended by OECD/DAC and adopted by multiple partners in international development: effectiveness, impact, relevance, sustainability and usefulness.

The analysis has concerned the application and results of the Programme over the period from January 2013 to December 2015 within three regional cooperation programmes that have also become partner-countries for Phase II of the project, namely Armenia, Kyrgyzstan and Tajikistan.

Evaluation organization and process

The evaluation has been conducted in several stages, both in participant countries and in the RF. At the first stage, analysis of the submitted documentation of the Programme was carried out. The obtained results helped define focuses and prepare question lists for conducting interviews. At the second stage, visits to recipient countries were made in order to collect additional data and provide counselling at the local level.

During the visits, the evaluation executives attended organizations responsible for the Programme implementation as well as international, state, and non-government partner organizations in the RA (Yerevan and Shirak regions), the RK (Bishkek, Osh) and the RT (Dushanbe, Kurgan-Tyube).

The evaluation executives worked in constant cooperation, exchanged obtained information and coordinated their actions.

At the third stage, the obtained data was compared and analyzed; the documentation submitted upon request at the interviews conducted in participant countries was evaluated. On December 2nd 2016, the preliminary results were submitted at the meeting in the Ministry of Finance of the RF and the final report was prepared following a detailed analysis.

3. EVALUATION RESULTS

3.1 Armenia

General information on Armenia

Armenia is the key country ensuring stability and sustainable development of the South Caucasus and the most important partner of the RF in the region. Russia is the most significant investor into the Armenian economy, the commodity flow between the RA and the RF constitute approximately 25% of the total commodity traffic for the country. The population of Armenia is about 3 million people. Russia also ‘holds’ the largest Armenian Diaspora (about 2 million people). Seasonal labor migration from Armenia to Russia is another significant factor. Armenia is a member of EAEU and CSTO. It hosts a Russian military base and Russian border troops control its borders with Turkey and Iran. Also Russia together with the USA and France is a Co-Chair of the OSCE Minsk Group aimed at advancing the solution of Nagorno-Karabakh conflict.

According to the Armenian Prime Minister Karen Karapetyan’s statement, over the past two years the country’s economy has experienced negative trends due to economic recession of its closest partner – Russia, as well as cuts in external transfers. The current GDP of Armenia is about US\$11.8 billion while healthcare expenditures for 2016 amount to 1.6% of the GDP (equivalent of approximately \$179 million).

Armenia has launched registration of HIV positive people in 1988 (while it was still a part of the Soviet Union) and as of October 31st 2016, 2 482 cases of HIV-infection have been registered. Males constitute the majority (69%); 45 cases (1.8%) have been detected among children. With that said, according to the authorities, 70% of newly detected HIV cases are related to labor migrants (57% are the actual migrants, 13% are their partners). The predominant transmission mode is heterosexual contacts (66%), followed by drug injection (25%). As a positive trend in response to HIV/AIDS in Armenia, complete elimination of vertical HIV transmission (MTCT) confirmed by the WHO should be noted.

The national Programme of Response to HIV is financed by the state budget along with additional sources: the GF and the Government of the RF, with operational participation of UNAIDS, and, in to a lesser extent, by the various UN agencies, namely UNICEF and UNFPA.

The GF remains the major donor in Armenia and in the recipient countries of the RCP. At the same time, the RF, acknowledging its global responsibility for improving the system of international relations, stability and prosperity within the space of EAEU in particular, also pays special attention to the social and healthcare issues in Armenia. The RF provides assistance by financing programmes of response to HIV/AIDS in a number of CIS countries including Armenia, as part of the Regional Programme of Technical Assistance to Countries of Eastern Europe and Central Asia in the Field of Prevention, Control and Surveillance of HIV/AIDS and Other Communicable Diseases. Phase One of the Programme has been already completed. Phase Two was launched in 2016, yet it is already possible to note a number of achievements and to draw conclusions for improvements and increasing effectiveness of Phase Two of the Programme. As part of Phase II the Federal Service for Supervision of Consumer Rights Protection and Human Well-Being (Rospotrebnadzor) will provide assistance to Armenia for a sum of over 295 million roubles. In September 2016, a Cooperation Agreement was signed by the RF and the UN as part of the First Programme of Improving neonatal services in Armenia (with the budget of approximately US \$600,000 for the period of 2017-2019).

It should be emphasized that owing to a high degree of commitment in the field of HIV-screening, prenatal followup and HIV treatment, no cases of MTCT have been detected in Armenia since 2008. At the UN General Assembly meeting on HIV/AIDS held in New York in 2016, the Armenian Minister of Healthcare received a Certificate confirming complete elimination of vertical HIV transmission in Armenia.

The evaluation in Armenia sought to obtain answers to the main evaluation questions listed above. To that end, the Programme reports and project documentation have been studied: regulatory documents (strategy, laws, instructions, executive orders etc.), statistical data and scientific publications. Individual and group interviews have been conducted with representatives of executive organizations and co-executives of the project as well as representatives of international, state and non-government partner-organizations involved in the prevention efforts of HIV/AIDS, VH and STIs.

Analysis of the obtained data has shown that within the framework of **Component A of the Programme: “Improvement of the epidemiological surveillance system for HIV, STI and viral hepatitis”**, UNAIDS has provided assistance to national healthcare organizations of Armenia in the areas of epidemiological surveillance for HIV, STI and VH, personnel specialized training and in research to improve the national system of epidemiological surveillance. Implementation of the Component A has allowed to improve comprehensive epidemiological surveillance for HIV/AIDS, in particular among hard-to-access populations such as migrants.

Achieved results for Component A:

1. Comprehensive behavioural and biological surveillance examinations have been conducted to assess the prevalence of HIV, STI and VH in 2014 (and 2016), in order to improve monitoring of behavioural patterns related to heightened risk of HIV among migrants. The first research among migrants was conducted in 2014 as part of an isolated behavioural-biological component of the research conducted in cooperation with the GF. The segment of the research studying behavioural patterns related to matters of migration, HIV, VH B and C and syphilis, was financed by the Program. For the given research component, a tool kit (protocol and questionnaire) has been developed, testing systems have been purchased. The results of the surveillance research were presented in regular reports on epidemiological surveillance (2014 and 2016) and at the meeting of the Country Coordination Committee. In particular, it has been determined that the migration factor plays an exceptionally important part in HIV spreading in the Republic of Armenia. In over a half (more than 50%) of HIV cases registered in 2009-2015, the viral transmission has occurred outside of Armenia, over 90% of them in Russia (91% in Russia, 5% in Ukraine, 0.8% in Poland, 0.7% in Kazakhstan, 2.6% in other countries). In total, 57% of HIV cases in adults registered in 2011-2015 have been transmitted abroad, and another 13% have contracted HIV from sex partners who had been infected abroad. Thus, approximately 70% of HIV cases registered within the said period are directly linked to migration¹. The obtained data has been used to make improvements in the National Programme of Response to HIV/AIDS up to 2016. Currently an updated National Programme of Response to HIV/AIDS has been developed for the five-year period of 2017-2021, incorporating, inter alia, data obtained in the course of research on migrants²).

2. As part of the Programme, a research on HIV incidence in major populations was conducted in 2014 in order to determine the areas of highest prevalence and develop the most effective preventive interventions. Behavioural biological research has been conducted among migrants, CSWs, MSMs, PIDs as well as among young people and criminal inmates. The research has been conducted in compliance with international recommendations. Work with key populations and target groups has been done by NGOs, and subsequent data processing and analysis has been run by the specialists of the Republican Centre for AIDS Prevention. The current research has been carried out in cooperation with GF and UNAIDS. The results of the research have been presented in routine reports on epidemiological surveillance, as well as in the reports presented by partner organizations.

¹ HIV EPIDEMIOLOGICAL SURVEILLANCE IN THE REPUBLIC OF ARMENIA, 2015

² NATIONAL PROGRAMME ON THE RESPONSE TO THE HIV EPIDEMIC IN THE REPUBLIC OF ARMENIA, 2017-2021

Activities in surveillance on HIV resistance to ART drugs have been prepared and carried out. A method of analyzing HIV drug resistance mutations based on genotyping has been implemented in the laboratory of Armenian AIDS Centre with direct participation of Russian specialists. The technical and HR potential of laboratories has been strengthened, standard operational procedures have been developed and implemented in laboratory work, a strategy of HIV drug resistance monitoring has also been developed. The engaged experts provided assistance to laboratory and clinical specialists in implementing HIV genotyping methodology, conducted a preliminary assessment of prevalence of HIV drug resistance mutations in Armenia and run an analysis of local factors and situations responsible for HIV drug resistance. During preparation and implementation of surveillance on HIV drug resistance, the engaged specialists have assessed the epidemiological situation in Armenia and evaluated HIV treatment programmes; analyzed the possibilities for monitoring research conducted in compliance with WHO recommendations; developed a plan of implementation of monitoring regarding HIV resistance to ART drugs, including an epidemiological monitoring protocol; assessed the laboratory potential and provided recommendations as to its optimization, including development of standard operational procedures; conducted counselling on issues of technical provisions for analysis of HIV drug resistance mutations; interpreted the collected data using the CPR online resource; assessed the prevalence level of HIV drug resistance mutations and prepared recommendations regarding further implementation of the Programme of HIV drug resistance monitoring. External evaluation of HIV drug resistance surveillance was conducted with the participation of the Russian specialist M.R.Bobkova from the D.I.Ivanovsky Institute for Virology. The evaluation results were presented in the corresponding report³. The data obtained in the course of research have been integrated into the Global HIV drug resistance network. In addition, the results of the HIV drug resistance research have been published in the form of articles and theses and presented in 2016 at the Fifth International Eastern Europe and Central Asia AIDS Conference (EECAC-2016) in Moscow. Participating in the implementation of the component related to HIV drug resistance, along with the Russian specialists, was GF, sponsoring purchases of a DNA sequencer and testing systems. It should be noted that in order to improve and develop the laboratory infrastructure as part of the Programme, the following equipment has been delivered and installed: 15 categories of equipment for viral load determination and 34 categories for genotyping. The appropriate laboratory personnel have gone through thematic training on operating the equipment. In 2013 and 2016, 4 specialists in HIV drug resistance underwent this training.

Apart from this, educational materials have been elaborated for specialists and laboratory personnel continuing their education and professional training . A training course on operating Viroseq genotyping system has also been carried out.

3. According to the interviewed personnel, a list of standard operational procedures (SOPs) was compiled as part of the Programme for laboratory service of the Republican Center for AIDS Prevention, including such standard operational procedures as “External quality control” and “Intra-laboratory quality control” where protocols of running external and internal quality control, activities held at the laboratory, professional responsibilities of laboratory personnel and management, and the control system have been detailed; the supervisors in charge of the respective items have been named. Quality control of the conducted laboratory research is ensured in compliance with the above SOPs.

4. In 2014, sanitary and epidemiological guidelines and regulations were developed towards strengthening HIV surveillance system in medical facilities⁴ with the cooperation of Russian experts (Professor S.L.Mukomolov, Chair of the Department of Epidemiology and the Laboratory of Viral

³ Final Report on the results of the Programme of HIV drug resistance monitoring in Armenia.

⁴ “HIV Epidemiological Surveillance” #3.1.1-029-2014. Sanitary and Epidemiological Rules and Norms/Standards, approved by Ministry of Health of Armenia, order # 3175-A, December 29 2014.

Hepatitis at the Louis Pasteur Science and Research Institute of Epidemiology and Microbiology in Saint-Petersburg, et al). At the same time, methodological guidelines were elaborated for the development of a system of VH epidemiological surveillance along with a project for national sanitary and epidemiological norms/standards and rules. A working group at the Ministry of Health of Armenia in cooperation with a Russian expert has made amendments to the National Programme of Response to VH which will allow to conduct epidemiology and prevention activities effectively and in a timely manner, in compliance with global requirements for VH epidemiological surveillance. In February-March 2016, corresponding sanitary regulations for VH were approved by a Decree issued by the Ministry of Health of the Republic of Armenia. During the development of the new sanitary regulations Russian sanitary standards and rules along with WHO guidelines (including WHO AIDS and HIV Case Definitions) have been used. In addition, 18 standard operational procedures (SOPs) for laboratory researches have been developed. On December 9-19, 2013, a joint effort was run in collaboration with A.B.Semyonov, Head of Laboratory of HIV Immunology and Virology at the Louis Pasteur Science and Research Institute of Epidemiology and Microbiology in Saint-Petersburg, aimed at mastering methods of developing SOPs for laboratory services. Over the course of the joint effort, the following protocols have been developed: operating the equipment, working conditions, technical specifications of testing systems and laboratory materials, collecting biological samples, rejecting biological samples, keeping logbooks and registration journals, intra-laboratory quality control, external quality control, conducting laboratory researches, issuing responses and research results, disinfection and sterilization, disposal of biological waste, biological safety, keeping and processing documentation, organizing personnel work, rapid HIV-1 and HIV-2 tests, manual system of enzyme-linked immunosorbent assay (ELISA) and differentiated detection of antibody responses to HIV proteins. The developed SOPs have been approved by the Republican Centre for AIDS Prevention and submitted to the National Centre for Disease Control and Prevention whereupon they were used by other medical institutions for the development of their own SOPs.

5. In 2014, as part of the Regional Programme of Technical Assistance To Countries of Eastern Europe and Central Asia in the Field of Prevention, Control and Surveillance of HIV/AIDS and Other Communicable Diseases, Senior Researcher N.N.Ladnaya (a specialist of the Federal Scientific-Methodological Center for AIDS control and prevention of the Federal Budget Scientific Institution ‘Central Science and Research Institute for Epidemiology at the Russian Federal Service for Surveillance on Consumer Rights Protection and Human Wellbeing’) conducted an external assessment of the HIV epidemiological surveillance system in RA. The assessment results have been presented in a report and recommendations have been issued. Owing to the expert’s work, potentially vulnerable elements of the epidemiological surveillance system have been detected for the first time (detectability, monitoring and control of HIV prevalence), further measures for strengthening the system have been suggested. According to the expert’s conclusions, the main problem related to sustainability and consistency of all the components of the HIV epidemiological surveillance system may consist in international donors being the prevailing source of its financing. This creates a risk that in the foreseeable future financing of certain areas of HIV epidemiological surveillance will be cut off, hence the recommendations for a gradual transition to national financing.

Also in January 2015, upon the request of Armenian Government, the WHO Regional Office for Europe provided technical assistance in conducting evaluation of the HIV Programme and the National Strategic Plan. The Programme evaluation has been conducted in five key areas: (i) Epidemiological analysis; (ii) Analysis of the HIV epidemiological surveillance system; (iii) HIV treatment cascade and care continuum; (iv) HIV-related services for key population groups; (v) Analysis of service models for populations affected by the HIV epidemic from the healthcare system standpoint. One of the surveillance priority areas has been defined by the WHO experts as intensifying diagnostics among key populations, particularly among labor migrants in rural areas, since currently

diagnostic services are over-concentrated in the country's capital and hard-to-access in remote Regions⁵.

The recommendations given by the experts (from Russia and WHO) have led to a review and subsequent improvements of epidemiological surveillance in RA. In addition to external evaluation, the Republican AIDS Prevention Centre conducts an annual internal analysis of the HIV epidemiological surveillance system.

6. The national data regarding the Programme in RA, as well as an analysis of the implementation of the project's components have been presented both at the national and global levels. The project data are annually presented in the Government reports (2013, 2014, 2015), the Ministry of Finance report (November 2015) and at local and national conferences. The project implementation data were presented at the EECAAC Conferences in 2014 and 2016 in Moscow, where theses have been sent and 5 presentations were delivered.

7. In order to strengthen the national HIV surveillance system and as part of the Programme, a 10-day training course on "Improving HIV epidemiological surveillance" was conducted on the grounds of the Central Science and Research Institute for Epidemiology of the Russian Federal Service for Surveillance on Consumer Rights Protection and Human Wellbeing (Rosпотребнадзор). 4 specialists have been trained.

8. In order to develop the laboratory infrastructure of the Republican AIDS Prevention Center, the Russian Federal Service for Surveillance on Consumer Rights Protection and Human Wellbeing (Rosпотребнадзор) has purchased and delivered to Armenia laboratory equipment and 70 000 testing systems for HIV and VH, the recipients of which were pregnant women, inter alia. According to the Republican AIDS Prevention Center, this supply of testing systems has covered 70% of the annual demand in RA and made a significant impact on the work related to HIV diagnostics and prevention. In addition to equipping the Republican AIDS Prevention Center, laboratory equipment has been provided to 4 regional laboratories: in the Ashtarak Medical Center (Aragatsotn Region), Martunin Medical Center (Gegharkunik Region), Noyemberyan Medical Centre (Tavush Region) and Stepanavan Medical Centre (Lori Region). In addition, laboratory specialists have been trained; laboratory tools and disposable laboratory materials have been provided.

Strong and weak points of Component A of the Programme:

The following can be attributed to the *strong points* of the Programme:

- The HIV and VH surveillance system has been strengthened owing to elaboration and revision of the existing sanitary and epidemiological rules and standards.
- The National Programme of Response to HIV/AIDS in RA (2017-2021) has been updated with consideration of the research findings.
- HIV drug resistance surveillance is being conducted; the obtained data are being integrated into the Global HIV drug resistance network.
- Sanitary and epidemiological regulations, guidelines and standards have been adopted, along with methodological guidelines and standard operational procedures developed in cooperation with the Programme, which allowed not only to strengthen the existing system of HIV surveillance, but also to improve healthcare system in general, since the developed SOPs were later adopted as models by other medical organizations as well.
- External evaluation of the HIV epidemiological surveillance system has for the first time allowed to detect the system's vulnerable points and take measures aimed at strengthening HIV detectability, monitoring and control.

⁵ «HIV Programme Review in Armenia», March 2015

- The laboratory potential has been strengthened at the republican and regional (oblast) levels, including supplies of necessary equipment and qualified specialists.

The following can be attributed to the *weak points* of the Programme:

- Despite a significant contribution of the Programme to the development of the laboratory system in RA, research on patients with HIV seroconversion hasn't been conducted owing to inconsistencies in the supply of laboratory equipment and disposable materials and related changes in specialists' training schedule. At the present moment the existing obstacles have been removed and the research in question is scheduled for 2017 by the Republican Center for AIDS Prevention.
- Technical maintenance and repair of the laboratory equipment is being financed by the Russian Programme which weakens the sustainability of the given component.

Factors (external and internal) which impact the Programme:

- As a negative factor weakening future sustainability and performance stability in the field of HIV drug resistance, the Republican AIDS Prevention Centre specialists point out high costs of disposable materials used with testing systems. Thus, the further work on HIV drug resistance surveillance in Armenia seems quite problematic without the involvement of external financing. The matter deserves the closest attention from the authorities, especially considering the scope of the effective joint work already done by Armenian and Russian specialists along with HR trained over the course of the Programme.
- The following positive factor has influenced the given component of the Programme: political commitment in RA and effective organization of activities by domestic partners. In addition, the Russian Programme of Assistance to Response to HIV/AIDS in Armenia has made a significant contribution to scientific cooperation, promoting communication between Armenian medical professionals and scientists and their Russian peers and experts, which is highly appreciated by the partners as a promising area of cooperation⁶.

Lessons applicable to Phase II:

- Attention should be paid to time-synchronization for deliveries of necessary laboratory equipment and disposable materials with scheduling of personnel training courses, in order to avoid further complications in conducting researches, including those on seroconversion patients.
- It has been pointed out in the interviews that if necessary, a designated Republican AIDS Prevention Centre specialist can consult and cooperate with their Russian peers in matters related to quality control of laboratory researches. Support of such cooperation will allow for further strengthening of inter-country communication and increase the effectiveness and quality of laboratory services.
- In the interviews, the Republican AIDS Prevention Centre staff express their desire and willingness to undergo training on laboratory research quality control, provided such an opportunity would be presented as part of the Project.

As part of the Component B of UNAIDS Programme: **“Development of communicable disease prevention and control, including HIV, STI and hepatitis among women and children”** assistance in developing national guidelines on MTCT and paediatric care of HIV positive children has been provided, training materials have been developed and MTCT specialists have been trained,

⁶ Petrosyan, A.R. *Prevalence of genetic variations and mutations of HIV-1 drug resistance among patients not receiving ART in Armenia.*

comprehensive research in infection control in maternity hospitals and children's medical facilities has been conducted, appropriate technical and material assistance has been granted. Strengthening of the control and prevention system for HIV and concurrent communicable diseases among women and children has been designated as the major goal of Component B of the Program.

Achieved results for the Component B:

1 MTCT prevention services and the paediatric ART programme have been improved, including the following:

1.1 Healthcare professionals in charge of HIV prevention and treatment among women and children have received advanced professional training. Training classes involving Russian experts have been held. In 2013 a practical seminar on "Paediatric aspects of ART and MTCT prevention" was held in Yerevan, designed as a continued education course for 21 specialists (with the participation of a Russian expert from the Centre for Assistance to HIV positive pregnant women and children, Saint-Petersburg). In 2013, a 5-days educational course on "MTCT Prevention" was conducted in Moscow at the premises of I.M. Sechenov First Moscow State Medical University with the participation of Russian experts and a WHO expert. 10 specialists have undergone education in current MTCT guidelines and approaches in compliance with global recommendations.

1.2 Over the course of the Programme, national protocols on ART among children and MTCT have been revised and updated in compliance with WHO recommendations of June 2013 formulated in the "Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection." The revisions concerned expanding the range of indications of ART for adults, including pregnant and breastfeeding women, treatment indications in children and adolescents, choice and prescription of treatment regimens, evaluation of therapy effectiveness, scheduling laboratory monitoring, as well as patterns of medical care for HIV patients with concurrent diseases (TB, VH). The revisions were approved by the Order of the Ministry of Health of Armenia #1991-A (issued on August 21st 2014). In addition, a national consultation on revised national protocols has been held, where matters regarding implementation of the protocols and expansion of free public access to HIV treatment after 2015 have been discussed. According to the Republican AIDS Prevention Centre specialists, the next revision aimed at improving the protocols is scheduled for 2017.

1.3 In order to improve the quality of testing and counselling services, a training seminar for 23 specialists was held in Yerevan in 2013. Appropriate recommendations for counselling and testing approaches have been developed and adopted. In particular, an information kit in a flip poster format has been developed and tested in focus groups, where one part featured visual materials for a woman in counselling and the other contained brief description of main points to be elaborated during the counselling session. Such flip posters have been distributed in "Schools for future mothers" which facilitates systematic counselling of women on HIV/AIDS-related matters. A total of 500 flip posters have been printed and distributed in medical facilities, which enables to cover healthcare facilities in all the parts of the country. With the support of UNICEF and in order to improve the quality of counselling services, seminars for medical personnel have been conducted in 19 residential centres in 4 regions of Armenia, using the flip poster aid. In addition, a technical support team for counselling and testing services has been formed out of the Republican AIDS Prevention Centre employees.

2. Access to HIV-related services has been expanded to cover migrants' sex partners, children and adolescents in 25 districts and communities, to promote HIV and STI prevention and lower the risk of HIV exposure among migrants' sex partners. The following activities have been held in order to expand access to such services:

2.1 In order to expand the professional capabilities of the medical personnel at the local level, a training workshop on working with the migrant population was conducted in 2013 for 100 healthcare providers at rural outpatient facilities. The main topics of the workshop were devoted to general issues

related to HIV, VH and STI, including transmission, prevention and diagnostics with a special emphasis on communication with, and correct motivation for the beneficiaries.

2.2 A “training of trainers” on a “peer-to-peer” basis was conducted at the Republican AIDS Prevention Centre premises for 77 counselling trainers preparing them to work in Regions and rural areas. The workshop has been undergone by representatives of 25 communities where a number of activities in HIV prevention, testing and counselling for migrants and their sex partners were scheduled. Such training workshops were conducted in 2013 and 2015 and are scheduled for 2017. Upon completion of the training, graduation certificates were issued. The training curriculum was prepared in compliance with the recommendations contained in “Training of Trainers: Manual.” (2001) published by Y-PEER and developed by UNFPA, UNAIDS, WHO and Family Health International.

3. Over the period of 2013-2015, a total of 755 outreach specialists from 25 localities took part in training activities devoted to the “peer-to-peer” counselling method. The curriculum was based on the “Practical Manual. Peer-to-peer program criteria” developed and published by Y-PEER in cooperation with UNFPA and UNAIDS. Upon completion of the training, the students have been tested to ensure program quality control. The main goal of the training was to increase HIV awareness with a special emphasis on practical communication with beneficiaries, establishing a diagnostics culture (including commitment to regular prophylactic check-ups) and developing the skills of motivating populations to HIV testing and counselling. In order to control the quality of peer-to-peer counselling, monitoring visits to participating localities have been organized. During these visits, evaluation of information and client counselling quality has been conducted along with an analysis of primary monitoring and assessment forms. Based on the results of the monitoring visits, recommendations have been developed and presented, methodological and organizational assistance has been provided.

2.4 In 2014, the Republican AIDS Prevention Center conducted a training seminar on creating and leading mutual support groups for 12 representatives of regional NGOs. 6 mutual support groups took part in the training, 2 persons per group. The training was mainly focused on developing skills of leading mutual support groups for women and also on lowering the risks of HIV exposure in women and boosting their motivation for HIV testing. Upon completion of the training, the students have been tested to ensure program quality control. All the specialists who have received training in mutual support groups are in constant contact with the Republican AIDS Prevention Centre representatives and use telecommunication technologies to seek advice, improve their skills or consult in cases of situations calling for special interventions.

2.5 Based on the results of training activities conducted in 2014 (see item 2.4), 6 mutual support groups for persons living with HIV (PLWH) have been formed, 2 specialists per group. Mutual support groups function in 6 respective regions of the country on the regular basis, once a month. The mutual support groups work in cooperation with and at the premises of regional NGOs mainly engaged in providing legal, social and organizational support to women living with HIV towards their effective integration into the society. Over the course of Phase I of the Programme, 1 446 women have participated in the work of mutual support groups.

2.6 As part of the Programme, medical organizations in 25 regions have been selected where resource centres have been created in order to implement up-to-date informational technologies in HIV/AIDS prevention among local youth and adolescents. The resource centres of 7 regions have been supplied with computer equipment for webinars, financed by the Programme. In 2013-2014, the Republican AIDS Prevention Centre conducted a number of special trainings where 25 medical professionals have been prepared for subsequent work at the resource centres. As a special effort to target youth, a computer game devoted to HIV prevention has been developed on the grounds of the resource centres with participation of World Vision Armenia and local adolescents. The resource centres also provide informational support in matters related to HIV prevention to local youth using

both their websites and social networks. Over the course of Phase I of the Programme, 1 172 adolescents have visited the resource centres.

2.7 Special training activities for community representatives have not been conducted. However, trained community representatives have been efficiently replaced by the graduates of the “training for trainers” courses as well as counsellors trained in accordance with the peer-to-peer system. Thus, the scheduled information and educational activities have been held, engaging 44 582 labor migrants, their sex partners and community representatives (as of December 31, 2015).

2.8 Mobile medical units, formed as part of the Programme, have provided specialized help and informational support to approximately 6 000 women on the grounds of rural outpatient facilities. During more than 150 visits to participating localities, the mobile units have conducted counselling on prevention of HIV, hepatitis B and C and syphilis, and provided an opportunity for testing for these infections. Starting from September 2014, mobile medical services involve the use of a multifunctional mobile medico-diagnostic complex of therapeutic profile provided to the Republican AIDS Prevention Centre. In September 2016, another such complex was delivered and launched. In order to ensure administrative support of the mobile medical units, a training workshop has been conducted targeting Directors of healthcare and social welfare Departments and heads of regional healthcare offices. The event has allowed to increase official involvement in the Programme in general, and to boost the officials’ motivation and potential in providing mobile medical services to regional populations.

2.9 Expanding the range of testing and counselling services for pregnant women has been initiated by health care providers in 25 selected areas and was carried out in the form of distribution of informational materials among pregnant women and provision of counselling services, including those involving the aforementioned flip poster (see item 1.3). Counselling services have been provided in 80 medical facilities for prenatal care, thus covering the whole territory of RA.

2.10 Activities have been held aimed at Information, Education and Communication (IEC) and Behaviour change communication (BCC). 363 persons underwent testing in Yerevan during the European HIV-Hepatitis Testing Week in 2014 and on World AIDS Day in 2014. During similar events held next year in Yerevan and the Basen village in the Shirak Region, a total of 713 persons have been tested. In addition, 283 persons were tested in 2015 during the events in Yerevan and Gyumri, commemorating AIDS victims. 4 new HIV cases have been detected during these activities. It should be noted that the Russian mobile medico-diagnostic complex of therapeutic profile has been used for organization of the said events. As part of the events, informational and educational work has been done and thematic informational materials have been distributed.

Moreover, a TV production has been made in order to promote public awareness of the HIV epidemic in RA with a special emphasis on the migration factor, highlighting HIV prevention and the nature of HIV transmission among migrants. Attention has also been paid to the difficulties in HIV testing, and solutions to the problems have been suggested. Apart from that, detailed information about the role of RF and UNAIDS in the Programme has been presented. The TV production has been aired in CIS countries via satellite television and posted on the internet.

2.11 In order to raise awareness and lower the risk of HIV exposure among women and adolescents, topical webinars are conducted monthly at the premises of the resource centres (see item 2.6). A video blog devoted to HIV prevention is being updated in three languages (Armenian, Russian and English). Accounts of the Republican AIDS Prevention Centre in social networks are actively used in engagement of key populations. In addition, the official website of the Republican AIDS Prevention Centre has been brought up to date to increase its effectiveness and functionality.

2.12 In order to develop networking and cooperation at the community level, informational campaigns are regularly conducted in urban and rural localities, engaging outreach workers and mutual support groups.

2.13 The Programme has provided material and technical assistance towards the implementation of the given Component, including the following computer equipment: 43 computer sets, 7 laptops and 2 copiers, as well as office furniture. In addition, a security system of the Republican AIDS Prevention Centre has been installed to ensure safety of laboratory equipment, technical inventory and the mobile medico-diagnostic complex.

3 As part of the Programme, an initial assessment of the HIV awareness level among young people and the accessibility of HIV/VH/STI services for youth has been conducted. The Institute for Children's and Adolescent's Health, one of the key branches of the largest Republican medical centre in Armenia "Arabkir", has been among the partners in Phase I of the Programme. In 2003 the Institute became a successor to the Republican Organizational-Methodological Centre of Children's and Adolescent's Health Preservation, and it is the leading medical organization in Armenia in the area of children's and adolescent's healthcare. The Institute works toward developing national policies, procedures and control mechanisms, concepts, strategy and investments programmes, professional education opportunities for health care professionals, innovative approaches and promoting experience sharing among various specialists, local and foreign experts to achieve sustainable development of children and adolescent healthcare. The Institute is an active participant in defining youth policies. It is being financed by the state as well as by non-government funds from Switzerland and Belgium.

The Institute conducts the cross-national survey of school students: Health Behaviour in School-aged Children (HBSC) on a regular basis (once every 4 years). The survey is conducted with consideration of national peculiarities (behavioural and ethical). In addition to standardized elements included in the questionnaire and parallel to the main survey, once in 4 years the Institute employees evaluate the adolescents' awareness on issues related to HIV and migration. Over the period from 2008 through 2011, the Institute employees have conducted seminars for youth on reproductive health issues (a 14 hour training course), incorporated in the curriculum on healthy living. In addition, the Institute is engaged in preparing future HIV educators, financed by UNFPA. The Institute, within the framework of the UNAIDS project, initiated the revision and updating of thematic manuals for teachers, including HIV components, developed by a working group of the National Institute of Education of the Republic of Armenia, involving specialists from the National AIDS Center, with the support of UNFPA and UNICEF. These updates of the HIV sections of the manual were also carried out by specialists of the National AIDS Center. With the support of UNFPA and partial sponsorship of UNICEF, 20 youth-friendly clinical centres have been opened and are functioning now.

As part of the Programme, in 2015 the Institute employees in cooperation with the Russian specialist A.M.Kulikov (Chair of Paediatrics Department, Mechnikov's North-West State Medical University) have revised the existing educational materials and developed new methodological recommendations for teachers of "Healthy Living" courses. In addition, adolescent-friendly services in Armenia have been evaluated. The survey was geared towards studying the experience in implementing youth-friendly clinical centres opened in cooperation with UNFPA in Armenia and the work of these centres, as well as detecting their main achievements and problems in order to define the course of further strategic development. Based on the evaluation results, certain problems have been detected, such as lack of cooperation between various services of adolescent healthcare specialists and other "highly specialized" medical professionals in the regions in developing a working system of referrals for adolescents; absence of a functioning system of quality control for the existing services and lack of financing for adolescent screening required by the government contract. There is no legally registered authority to regulate volunteering activities, and no stable system of cooperation exists between medical organizations and the NGOs. A gender bias in services for adolescents has been detected; in particular, adolescent girls' problems frequently remain unsolved. Among the most promising areas of work, the Institute specialists have listed the following: (i) support of the "Adolescents' Service" engaged in raising awareness among children and adolescents, most importantly in preparing competent educators; (ii) development of the website for parents and children; (iii) work with parents –

trainings, informational support, webinars; (iv) assistance in professional trainings and financing of regional centers.

At the present moment, only 35% of the rural population is covered by the work carried out by the Institute, versus 65% of the urban population. In view of the problems related to HIV, VH and STI, intensifying work among rural youth is highly relevant, especially considering the prospects of rural youth becoming migrants.

The collaboration with the Institute was terminated in 2015 upon the completion of Phase I of the Programme. It is worth mentioning that in view of further implementation of the Programme the given Component is highly underrated, considering its extraordinary importance and long-term benefits. Youth-oriented work will not only facilitate promoting safe behaviour patterns among potential labor migrants, but will also shape a positive image of, and attitude towards, the assistance provided by RF among young Armenian citizens.

Strong and weak points of Component B of the Programme:

The following can be attributed to the strong points of the Component:

- Expanding the professional potential of healthcare providers engaged in communicable diseases control and prevention including HIV, STI and VH among women and children.
- Revision and updating of national protocols on MTCT and ART for children, in compliance with WHO recommendations.
- Multidirectional work in professional education (healthcare providers, trainers, outreach specialists) aimed at expanding access to HIV-related services and lowering the risks of HIV exposure among children, adolescents and migrants' sex partners.
- Organization of mutual support groups for persons living with HIV (PLHIV), including women with HIV. Providing diversified assistance towards effective integration of PLWH into the society. Cooperating with and support of the Republican AIDS Prevention Centre.
- Opening, equipping and support of resource centres for HIV/AIDS prevention among local community youth and adolescents.
- Forming and maintenance of mobile medical units for working with key populations, involving the Russian mobile diagnostic complex. Administrative and organizational work carried out within the Component has allowed to increase general involvement of the officials in the project and to strengthen their potential and motivation in the implementation of the Programme and in providing mobile medical services to the population in the regions.
- Providing counselling services to pregnant women (80 medical antenatal organizations), thus covering the whole territory of RA.
- Providing up-to-date equipment and implementing contemporary technologies (Internet, social networks, thematic webinars, mass-media) towards raising public awareness about HIV, VH and STI.
- Assessing the level of youth awareness about HIV, VH and STI, as well as studying the experience of youth-friendly clinical centres, which has allowed to determine the main achievements and problems and influenced further strategic planning in the given area.
- Indirect but significant contribution to elimination of MTCT in RA has been pointed out during the interviews. Additional factors which made an impact have been the following: (i) diagnostic and prevention work of mobile clinics among pregnant wives of labor migrants; (ii) media-campaigns and distribution of informational materials; (iii) outreach work promoting "diagnostics culture" and timely seeking diagnostic services and medical help; (iv) professional trainings for healthcare providers, including paediatricians, in MTCT and HIV treatment, in cooperation with Russian specialists; (v) counselling for pregnant women at antenatal medical facilities. In addition, the Federal Service for Supervision of Consumer Rights Protection and Human Well-Being (Rosпотребнадзор) had purchased 70,000 testing systems that were used, inter alia, in testing pregnant women (according to interview

respondents, this satisfies approximately 70% of the demand for testing systems in Armenia). Also as part of the Programme, equipment and disposable materials have been provided and personnel prepared for 4 regional laboratories (three at the district level and one at the Regional/Region level) that allow to conduct researches at the local level, which has definitely contributed to complete elimination of MTCT.

The following can be attributed to the weak points of the Programme:

- Lack of cooperation and centralized coordination between the Institute for Child and Adolescent Health and the Republican AIDS Prevention Center in conducting youth-related activities.

Factors (external and internal) which impact the Programme:

- One of the leading factors influencing the given Component is the elimination of HIV MTCT in Armenia. According to the Republican AIDS Prevention Centre Management, the key factors in MTCT elimination are: coordination between perinatal care services and AIDS services, as well as strict adherence to WHO recommendations on MTCT prevention.
- Financing of existing areas of work remains a key factor, especially considering the completion of parallel projects by certain partner organizations and the lack of additional resources in the state budget to support further activities. It should also be noted that the proposed draft of the state budget for 2017-2021, as it appears on the National Plan of Armenia, does not allocate funds for HIV prevention and promotion of healthy living among youth.
- As has been shown in the interviews, the level of the population's commitment to regular diagnostic and prophylactic activities is quite low, which is linked to the lack of growth of general "diagnostic culture" and popularity of healthy lifestyle principles.

Lessons applicable to Phase II of the Programme:

- Initiated by medical professionals, extensive coverage by testing and counselling services at women's clinics and facilities for pregnant women requires attention and resources in order to maintain the quality of such services, including both regular consultations with the technical support group of the Republican AIDS Prevention Centre and organized quality control of counselling for pregnant women.
- Conducting educational work in peer-to-peer format within the population, in particular labor migrants and their sex partners, requires attention and thorough control over the quality of educational work as well as regular support for the professional qualification level of the outreach specialists. Evaluations of the educational work quality have to be conducted towards this purpose.
- Continuing work on prevention of HIV and other communicable diseases among children, adolescents and youth requires diversified approaches, including direct involvement of various partner organizations in RA, professionally engaged in children and youth healthcare and education (as of today the connections remain non-formal and unstructured). Active engagement of such partners can be instrumental in effective de-centralization of activities related to HIV, VH and STI prevention, allowing the major partners to concentrate their resources and efforts on certain areas and avoid doubling and overlapping.

As part of Component C: **"Improvement of the prevention system for HIV/AIDS, STI and hepatitis among key populations, including prevention among migrants"**, the Foundation for Prevention and Control of AIDS and Other Infectious Diseases "AIDS Infoshare" has conducted work on developing and implementing training programmes, seminars/workshops and activities in order to ensure sustainable functioning of the system of outreach services, provision of diagnostic and counselling aid, organization of informational campaigns using mass media and up-to-date technologies, conducting educational work on HIV prevention among migrants, their families and other key populations subject to a risk of infection. Apart from educational and prevention-oriented work,

direct material and technical assistance has been provided for specialized professional trainings and strengthening the work on HIV/AIDS, VH and STI prevention.

Achieved results of the Component:

1. Using the Programme's funds, a prevention outreach service has been organized targeting migrants and their sex partners. Out of medical personnel of rural obstetric stations, 60 outreach specialists have been prepared and trained to work in 60 localities. The functional responsibilities of the outreach specialists include the following: they identify households with migrants and their family members, establish contact with the beneficiaries, conduct prophylactic informational sessions with individuals on safety issues and HIV, VH and STI counselling, motivate migrants and their family members to take tests, compile lists of persons invited to diagnostic activities (to correspond to the schedule of the mobile diagnostics complex), as well as provide appropriate information support related to the Programme and its specific services. During scheduled testing visits of the mobile medical unit and mobile diagnostics complex, outreach specialists provide informational and motivational support to migrants and their family members. A representative of the Republican AIDS Prevention Centre coordinating the outreach service conducts regular monitoring visits to provide additional coaching to outreach specialists and evaluate their work, and help find solutions to complicated issues. It is important to note that availability of free diagnostics for STI and VH B and C in rural areas is vital, especially considering logistical difficulties due to remoteness from large medical facilities providing opportunities for testing at significant costs (thus, according to an outreach specialist, VH C screening costs about \$28). The average population in any of the 60 localities covered by outreach specialists is 6 000 people (from 2 000 to 10 000). In average, mobile diagnostics (by mobile medical units and the mobile clinical-diagnostic complex) is conducted once every two months in a given locality, where an average of 25-30 beneficiaries receive diagnostic and counselling services. It should be noted that those communities where organization of engaging and motivating the population for diagnostic and educational activities does not conform to requirements or is not efficient, are replaced with communities with more potential and administrative leverage to motivate population and conduct prevention activities. In addition to the 60 localities covered by the Programme, up to the end of 2015 similar work was conducted in another 40 localities, financed by the GF. Over the period of outreach activities, 18 278 persons have been covered by testing and counselling services. Among the obvious successes owing to well-coordinated and effective work of outreach services, total absence of the so called "vanished after testing" migrants can be noted.

The National Health Institute is engaged to participate in Phase II of the Programme. Its main recommendations are as follows: (a) expanding research activities (targeting not only labor migrants, but also youth (students) etc.); (b) significant strengthening of the range of partners involved in programmes of response to HIV/AIDS; (c) strengthening of the educational component (launching a permanent cycle of courses, for family physicians, nursing personnel etc).

2. Financed by the Programme, two mobile medical units have been formed to conduct prevention and diagnostic work among migrants and their family members. Each mobile unit (team) includes a specialist in infectious diseases (MD), a psychologist and a laboratory nurse. In cooperation with outreach specialists, the mobile units visit the 60 localities covered by the Programme and conduct HIV, VH and syphilis testing and counselling (including rapid tests purchased and delivered by "AIDS Infoshare") on the grounds of first-aid-obstetric stations and rural outpatient facilities.

During Phase I of the Programme, the total test-related purchases are as follows: HIV testing systems – 8 680; VH B testing systems – 5 700; VH C testing systems – 5 700 and syphilis testing systems – 4 000 testing systems. The personnel have already had sufficient skills in using rapid tests and did not require additional training.

Starting from September 2014, a mobile medico-diagnostic complex (mobile clinic) has been in operation. It was transferred to the Ministry of Health of Armenia in compliance with the Agreement between the Foundation for Prevention and Control of AIDS and Other Infectious Diseases “AIDS Infoshare” and the Ministry of Health of Armenia. The official presentation ceremony for the first mobile clinic took place on July 15th, 2014 in the presence of Armen Muradyan, the Minister of Health, I.K.Volynkin, the Russian Ambassador to Armenia, and UNAIDS and “AIDS Infoshare” representatives. On September 24th 2014, a request for two more medical and diagnostic complexes was sent to the Russian Ambassador Extraordinary and Plenipotentiary I.K.Volynkin on behalf of A.A.Muradyan (repeated request – June 3rd 2015). According to the Armenian officials, the mobile clinics have allowed to strengthen routine epidemiological surveillance and second generation epidemiological surveillance on HIV, STI and VH among migrants and their sex partners and the rural population of Armenia in general.

It should be noted that the Ministry of Health of Armenia has created dedicated staff positions for medical personnel of mobile clinics, thus co-financing the work of the mobile complex. The rest of the expenditures of the mobile clinic, such as: remuneration of non-medical staff, additional payments to medical personnel, disposable materials and petroleum, supplies, oil and lubricants’ costs, medical supplies, disinfecting agents, personal protection equipment for staff, and pharmaceutical drugs, are currently being financed by the Foundation for Prevention and Control of AIDS and Other Infectious Diseases “AIDS Infoshare”. The mobile clinic staff consists of employees of the Regional AIDS Prevention Centre. Each team includes a specialist in infectious diseases (MD), a functional diagnostics specialist, and a physician or medical laboratory nurse. Upon request from a first-aid-obstetric station, an obstetrician or a sexual health specialist/dermatologist can join the team.

In order to enhance the efficiency of the work of the mobile diagnostic complex, the mobile team travels to a scheduled testing and counselling locality separately, then the mobile clinic moves on to the next scheduled locality to be followed by the medical personnel the next day. During the field missions the mobile complex operates for two weeks with one day-off which is required to return to the Republican AIDS Prevention Centre for technical maintenance, thus conducting 9 shifts in two weeks. Considering the relatively small territory of RA, the given mode of work appears to be the most reasonable of all available options.

Medical personnel use personal protection equipment. All stages of bio-waste disposal are conducted at the Republican AIDS Prevention Centre. Disinfection is carried out in compliance with regulatory documents. The supply of disinfection agents is sufficient, partially financed by the state, according to personnel. All employees have received specialized training at the Republican AIDS Prevention Centre and taken continuing education courses and additional trainings on HIV/AIDS.

Standard testing and counselling work of the mobile clinic starts with the infectious diseases specialist talking with the beneficiary during the pre-testing counselling. The beneficiary then takes a blood test and receives post-testing counselling. In addition, the beneficiary is offered an option of being consulted and examined by other specialists.

The patients are registered by key populations using a special encoding system. The testing results are recorded in a log-book. Upon the return of the mobile team to the Republican AIDS Prevention Centre, the data are converted into electronic format and added to an Excel database.

Testing systems used by the mobile clinics are kept in the Republican AIDS Prevention Centre storage and delivered to the mobile clinic on the day of a scheduled visit. At the end of the day the testing systems are returned to storage. Special portable coolers are used for transporting the testing systems.

Over the period from 2013 to 2015, the mobile clinic has covered all the 60 localities. The mobile clinic and the mobile teams have provided HIV and VH B and testing and counselling services to 6 139 people. In total, 33 186 labor migrants, their sex partners and community members have been

engaged in prevention activities. 11 809 people have been tested for HIV and VH B and C; 25 cases of HIV have been detected. An average of 25 persons is tested for HIV, VH B and C and syphilis per visit of the mobile complex. Technical maintenance of the mobile clinic is conducted in compliance with the recommendations of “AIDS Infoshare” and with the technical documentation.

Russian mobile medico-diagnostic complexes have also been used in community activities for the promotion of HIV awareness and motivation for testing. During the events and activities conducted in 2014 and 2015 as part of the European HIV-Hepatitis Testing Week and the World AIDS Day, 1 359 people took an HIV-test in the mobile clinic; 4 HIV cases have been detected.

Overall, a total of 44 582 labor migrants, their sex partners and community members have been engaged in prevention activities over the course of the Programme. 18 278 people have been tested for HIV and VH B and C; 28 new HIV cases have been detected, including one pregnant woman who then received timely medical treatment.

3. As part of the Programme, activities aimed at promoting awareness in issues related to HIV/AIDS, VH and STI among the population have been conducted; with the support of UNAIDS and “AIDS Infoshare” and in cooperation with Armenian specialists, informational materials have been developed and adapted for migrants and their family members, other key populations and all the residents of RA, in total, approximately 40 000 of informational materials (booklets, posters etc).

4. At the Republican AIDS Prevention Centre an educational research centre has been launched as part of material and technical assistance to healthcare institutions of RA for HIV, VH and STI prevention. In 2013 the educational resource centre of the Republican AIDS Prevention Centre has been equipped with office furniture and projection equipment, as part of the Russian Programme of assistance to RA in response to HIV/AIDS. The centre hall has seating capacity for 140 people and can be divided into two separate premises, thus making it possible to conduct simultaneous seminars, trainings and group work. The following installed technical equipment allows organizers to conduct up-to-date meetings, conferences, seminars and trainings: projectors/monitors for double-screen and wide-screen presentations, a sound-system, speakers, a microphone, video conference equipment for multiple participant video and audio-communication, an analogue conference system with 2-language simultaneous interpretation equipment, with microphones and receivers for 48 participants, two portable interactive boards, and a document-camera (visual presenter) that allows to capture documents and display them on monitors. In addition, meals for 25-30 persons can be served in the Centre hall. Since opening of the education resource centre 30 seminars, trainings and consultations and 3 international seminars and meetings have been conducted.

Strong and weak points of Component C of the Programme:

The following can be attributed to the strong points of the Component C:

- Organization of an effective outreach prevention service targeting migrants and their sex partners, which has a special relevance for RA since, according to the Republican AIDS Prevention Centre, almost 70% of new HIV cases among adults (2011-2015) are linked to the migration factor.
- Services related to communicable disease prevention including HIV, VH and STI provided by the mobile clinics in rural areas are popular and considered more attractive than the services of local family physicians. This is due primarily to free access to diagnostics and counselling and anonymity thereof.
- Migrant coverage by HIV and VH counselling and testing outreach services. The fact of zero “vanished-after-testing” migrants having been registered should be seen as an obvious success achieved by well-coordinated and effective work of the outreach services.
- Strengthening of routine HIV, VH and STI epidemiological surveillance and second generation surveillance among migrants and their sex partners, and among the general rural population of RA, which Armenian officials attribute to the work of the mobile clinics.

- The availability of an electronic patient registration system, encoded by key populations.
- Equipment of the education and resource Centre of the Republican AIDS Prevention Centre ensures an up-to-date technological level of specialized training workshops and various activities aimed at response to HIV.

The following can be attributed to the weak points of the Component:

- Due to the fact that continuing work of the mobile clinic (as well as free HIV, VH and STI diagnostics) in rural areas after the completion of the project looks doubtful, this may impact the overall sustainability of the existing model. Foreign partners point out that all previous projects financed by international donors have been interrupted in a similar way. Considering the effectiveness and relevance of the mobile clinics and the popularity of their services among the population, negotiations should be started already now and by 2018 a detailed plan of gradual transition to state budget financing of the Programme should be developed for the period of 2018-2024. At the present moment the “AIDS Infoshare” Foundation is covering the remuneration of non-medical staff, additional payments to medical personnel, disposable materials, petroleum, oil and lubricants, medical supplies, disinfecting agents, personal protection equipment for staff, as well as pharmaceutical drugs.

Factors (external and internal which impact the Programme:

- Close cooperation and practical coordination with state authorities, primarily the Ministry of Health, is one of the factors ensuring success of the Programme of regional cooperation in response to HIV and other communicable diseases.
- Success of the mobile clinics and testing activities depends not only on awareness-raising work conducted by outreach specialists, but also on the comprehensiveness of services provided. In particular, beneficiaries are further motivated by the availability of additional types of diagnostics and free consultations with specialists. Such an approach is quite effective, considering that a high level of stigmatization regarding people with HIV is preserved in the traditional societies despite all the information and awareness-raising work being done.
- Uninterrupted consistency of the Programme’s work ought to be ensured in the periods of financial year termination, annual renewal of contracts, as well as during incoming payments for continuing financing of the Programme. Lack of guarantees regarding uninterrupted financing of the Programme exerts a negative influence over the given component in view of seasonal migration fluctuations. Considering the existing operators’ procedures regarding processing of the financial resources – UNAIDS and the “AIDS Infoshare” Foundation – it appears reasonable to switch from yearly contracts to three-year contracts to cover the whole term of the Programme and ensure uninterrupted consistency of its implementation.
- Continuing instability in the Middle East and the military conflict in Syria in particular have increased the flow of ethnic refugees thus requiring more assistance related to HIV, VH and STI.
- Armenia and Azerbaijan’s ‘frozen’ conflict over Nagorno-Karabakh prevents the Programme’s potential total coverage of the region’s population, in particular it imposes limitations on mobile clinics’ visits to the above-mentioned region due to political and diplomatic restrictions.
- Armenian membership in integration groups initiated and supported by Russia, increasing economic (inter-)dependence and the importance of the factor of labor migrants determine the permanent vector in developing and implementing of programmes of assistance in socially significant areas and require a comprehensive approach to the implementation of this and other projects.

Lessons applicable to Phase II of the Programme

- The success of the outreach work in Armenia is due to the effectiveness of the National AIDS Centre protocols, which calls for a conclusion that the given component ought to be preserved in Armenia.

- In view of the fact that testing systems used by the mobile clinics are delivered from the storage area on the day of a scheduled visit and special portable coolers are used for their transportation, a particular attention should be paid to ensuring an uninterrupted “cold chain” at all stages of the testing systems’ storage and transportation.

- In September 2016, the second mobile medico-diagnostic complex started operating in RA. Thus the mobile teams have fully covered the northern and central parts of the country. According to the estimation of the Armenian Republican AIDS Centre, an additional mobile clinic is required to effectively cover the entire territory of RA. The third mobile medical van will permit to provide diagnostic and counselling services for the southern part of the country. The Republican AIDS Prevention Centre management has developed a plan of HR distribution to enhance the mobile clinics’ cost-effectiveness. Use of a balanced approach to service coverage would enable to cover over 1 000 rural communities by similar work without engagement of an additional team.

- In addition to the Russian Government grant, the Global Fund is involved in response to HIV/AIDS in RA, carrying out programmes, inter alia, via local NGOs. Formerly 11 NGOs have been engaged in response to HIV/AIDS, while at the present time only four major players can be named due to a cut in the grant volumes. GF’s key partner is Mission East (financed by the Government of Denmark). The Austrian Government is another donor, operating via Caritas Armenia (joining in the activities of the Republican AIDS Prevention Centre). Each NGO covers one of the key populations:

- PID – AIDS prevention, education, care (APEC), works in Yerevan and three regions;
- MSM – New Generation; works nation-wide;
- CSW – AIDS Prevention Union, works nation-wide;
- PLWH – Positive People Armenian Network (PPAN).

The following key players are designated as parts of the regional (South Caucasus) partnership for response to HIV/AIDS: The “Real World, Real People” (RWPR); the Scientific Association of Medical Students of Armenia (SAMSA); the “Public Information and Need of Knowledge” NGO (PINK Armenia), the “New Generation” and the Positive People Armenian Network (PPAN).

Former projects have been carried out as an addition to the Russian joint Programme with GF. The main areas included: human rights training – access to services for key populations; school work (in rural areas in particular), work with youth, cooperation in development of school courses devoted to a healthy lifestyle, work with influential community members and religious ministers.

USAID also operates in the healthcare area of RA, continuing its work on programmes of response to TB and sponsoring programmes at the Department of Public Health at the American University.

The Armenian Branch of the Soros Foundation OSIAFA (“Open Society Institute Assistance Foundation Armenia”) used to focus its activities mostly on human rights issues, including the key populations (PID, MSM), but its projects lacked the specifics of response to HIV/AIDS. According to the interviews conducted at the Republican AIDS Prevention Centre before 2009, the Global Initiative HIV Mental Health project, financed by NGOs of Netherlands, used to operate in all the three republics of the South Caucasus. At the present day, the project is still being implemented only in Georgia and Azerbaijan (the regional centre is located in Tbilisi), while in Armenia the donor stopped its work after the launching of Russian projects (the link between the two cannot be confirmed and has been mentioned by only one interviewee).

General conclusions on Armenia:

1. All the goals declared for Phase I of the Programme have been achieved. New strategic information and innovative approaches to lowering HIV prevalence have been effectively implemented. Second generation comprehensive epidemiological surveillance on HIV/AIDS, VH and STI among migrants has been implemented. The declared goal “Zero new HIV cases among children and saving the lives of mothers” has been reached. At least 60% of migrants’ sex partners in selected communities have access to educational programmes on HIV/AIDS and

testing services, which is timely and relevant considering the HIV epidemiological situation in Armenia.

2. The only active players in healthcare area, in particular in response to HIV/AIDS, are the Global Fund and the Russian Government (RCP).
3. VH B and C and STI (with the exception of HIV) diagnostics is available only on a fee basis and is not easily affordable for the rural population.
4. A lack of coordinated cooperation has been noted between the national partners of the Programme involved in HIV-response in Armenia, along with a lack of regular coordination of their plans and activities and unified synchronized policies in specific matters. Thus, considering that the Republican AIDS Prevention Centre and the Institute for Childrens' and Adolescents' Health pursue similar goals in youth-related work, a lack of coordinated cooperation between the two partners is worth noting. The Institute employees turn to the Republican AIDS Prevention Centre for consultations on a regular basis. However, no official cooperation agreement has been signed and there have been no attempts to create a unified system of activities' coordination. The Institute employees have also noted that up to a certain extent such format of partner cooperation (à l'occasion) is perhaps the most effective since it permits to avoid formalities and red tape routine and helps solve questions in direct communication. The lack of coordination and division of work areas targeting youth has led to a situation where the uncoordinated activities of the Republican AIDS Prevention Centre and of the Institute is clearly overlapping in such areas as awareness and education, training classes and webinars, social networks and specialized training for specialists working with youth and adolescents. In the absence of a formalized alignment or delimitation of the areas of work with the youth of National AIDS Center and the Institute, there is a parallel coverage of these activities by these organizations such as: informing and educating, conducting training classes and webinars, working in social networks, training specialists in working with young people and adolescents.
5. Uninterrupted continuity of the Programme activities ought to be ensured. The pauses between the Programme "phases" required for contract signing and renewal between UNAIDS and the contractors ("AIDS Infoshare", etc.) lead to temporary but unnecessary suspensions of the project, which in turn can be detrimental to the motivation and subsequently lead to the drain of highly skilled personnel with specialized training and education. Decision-making, development and registration of regulatory and financial documents for extension of the project and transition to Phase II (due to the existing procedures of financial approval at UN), was carried out over the period from January till March, when engaging migrants in diagnostic and prevention activities can be done in the most effective way. Because of the lengthy terms of bureaucratic procedures at the headquarters of the partner organizations and due to the lack of a well-coordinated procedural protocol for transition to the next stage of the project, the seasonal factor hasn't been used to a full extent. In order to avoid such situations in the future it is worth considering the options of transition from yearly contracts to three-year agreements so as to ensure uninterrupted continuity of implementation of the current and future Programmes.
6. One of the remaining external factors influencing the Programme's areas of activities are restrictive regulations concerning entry of HIV-positive migrants to Russia and the lack of inter-state cooperation regarding provision of ART to the migrants leaving for Russia.
7. Another external factor is the current urgent need to provide aid to refugees. At the present moment the largest such group is that consisting of refugees from Syria.

Recommendations on Armenia:

1. To discuss at the level of the key stakeholders and organizations in RF an option of conducting prevention activities among labor migrants from Armenia at the territory of RF.
2. To strengthen youth-targeting work by conducting topical awareness-raising and educational activities in recipient countries and in the RF in order to promote commitment to the “culture of diagnostics” and healthy living, including matters related to HIV, VH and STI prevention.
3. To strengthen the comprehensiveness of the Programme with consideration of the humanitarian and socially significant components defining not only youth-targeted work on healthy living but also expansion of main and additional educational programmes for children, youth and adult populations, including study of the Russian language and culture, economic and legal realities and cooperation between the two states, which will help labor migrants increase their opportunities to be included in integration processes within the European Union.
4. To strengthen cooperation between the national partners involved in HIV response; to conduct regular coordination on programmes and activities; to develop a unified synchronized policy for coordination by a single operator.
5. To ensure uninterrupted consistency of transition between the Phases of the Programme, including financing, in order to avoid work interruptions during the migration season by making activity schedules more flexible.
6. To consider the question of acquiring a third mobile medico-diagnostic complex as part of the Programme, in order to ensure total coverage in RA and further develop the processes of decentralization for routine laboratory functions of the Republican AIDS Prevention Centre, on condition of sustainability of the given component in terms of state financing or an alternative financial contribution to the project.
7. To explore the issue of increasing sustainability of the Programme by considering a possibility of Armenia’s participation in co-financing of the mobile medico-diagnostic complexes (disposable materials, petroleum, oil and lubricants, technical maintenance and repairs).

3.2 Kyrgyz Republic

General information on Kyrgyzstan

Kyrgyzstan is a state in Central Asia with a population of 6 million people. Bordered by Kazakhstan, Tajikistan, Uzbekistan and China, Kyrgyzstan is an important partner of the Russian Federation in Central Asia. In terms of economic development of the country, the most important sectors today remain to be gold extracting and agriculture (up to 50% of the total workforce, therefore, there are considerable numbers of rural population). Other important income sources are remittances from labor migrants working abroad, tax collection and custom duties. Regarding cooperation with Russia, the year of 2012 can be provisionally pointed out as a turning point in recognizing the interdependence between security and development in the region of Central Asia. In September and October 2012, V.V.Putin made visits to Bishkek (Kyrgyzstan) and Dushanbe (Tajikistan), respectively. Military and political cooperation (creation of a military base) is strengthened by cooperation in the power industry, writing off state debts, overcoming crisis situations in social, economic (education, healthcare) and environment areas.

According to experts, Kyrgyzstan holds the first place among the CIS countries in volumes of the received Russian aid (over the 5 recent years, state budget aid and private initiative contributions made up over US \$3.5 billion). Under the UN aegis, the Russian contribution represents more than one quarter of the total UN aid, leaving behind such donors as the USA, China, the EU and Turkey. Considerable amount of aid (on a bilateral basis and via UN organizations) is being transferred towards healthcare solutions (approximately 2.1% of the GDP in Kyrgyzstan is allotted to healthcare). Despite that, the country still has one of the highest maternal mortality rates (approximately 47 per 100 000). As far as the HIV/AIDS situation is concerned, the first case was registered in 1996. As of today, the number of registered HIV cases is approximately 6.500; over the last five years the number of HIV cases has doubled. Kyrgyzstan has one of the highest levels of HIV/AIDS prevalence.

As has been noted previously, Russia leaves behind other foreign donors; nevertheless up until recently, the key player in response to HIV was the Global Fund that is now cutting its involvement in Kyrgyzstan (and Tajikistan). Among the other prominent international donor organizations in Kyrgyzstan are PSI (Population Services International) implementing projects in response to HIV/AIDS in countries of Central Asia since 2002; USAID Dialogue on HIV and TB Project (conducts trainings on monitoring and evaluation tools, emphasizing democracy building and human rights) and the US CDC (Center for Disease Control and Prevention) in Central Asia (IBBS implementation, electronic HIV monitoring system etc).

The evaluation in Kyrgyzstan has been designed to address the most relevant issues. For this purpose, the Programme's reports and project documentation have been studied: regulatory documents (strategy, laws, decrees, orders etc.), statistical data and scientific publications. Individual and group interviews have been conducted with representatives of executive organizations and co-executives of the project, as well as representatives of international, state and non-government partner organizations involved in HIV/AIDS, VH and STI prevention.

The analysis of the obtained information has evaluated the Component A of the Programme: **“Improvement of the epidemiological surveillance system for HIV, STI and viral hepatitis.”** As part of the given Component, UNAIDS has assisted national healthcare organizations of Kyrgyzstan in improving epidemiological surveillance on HIV/AIDS, training specialists for the Kyrgyz AIDS service in innovative research on HIV surveillance, and implementing systemic sustainable monitoring on HIV in medical organizations.

Achieved results of the Component A:

1. Educational programmes on epidemiological HIV surveillance have been integrated into the system of continuing medical education in RK, more specifically:

1. As part of the Programme, an educational methodological package on “Epidemiological surveillance on HIV and parenteral VH B, C and D” has been developed. The package has been designed both for medical doctors and nursing personnel. By the order of the Academic Board of the Kyrgyz State Medical Institute for career development and continued education issued on January 27th 2016, the package was recommended for publication (the package development was conducted during Phase I of the Programme). The package has been developed with the support on behalf of Russian experts from the Louis Pasteur Science and Research Institute of Epidemiology and Microbiology in Saint-Petersburg. The package has for the first time synthesized exploration of epidemiological surveillance on HIV and parenteral VH. The package consists of 6 modules:

- a). HIV and parenteral VH B, C and D (ethology, pathogenesis, epidemiology, clinical specifics);
- b). Laboratory diagnostics of HIV and parenteral VH B, C and D;

- c). Epidemiological surveillance on communicable diseases;
- d). Routine epidemiological surveillance on HIV and parenteral VH;
- e). Integrated bio-behavioural surveillance on HIV and parenteral VH as part of the national monitoring and evaluation system;
- f). Prevention and epidemiological activities for HIV and parenteral VH.

In addition, a separate unit of the package is devoted to prevention of the aforementioned infections as part of epidemiological surveillance.

The educational and methodological package has been implemented in medical education, career development and continued education for healthcare providers, in particular epidemiologists, infection control specialists and medical doctors of other specializations.

1.2 Two online remote education courses have been developed and launched for epidemiology specialists of the Centre to Fight and Prevent AIDS and the Centre of Disease Prevention and State Sanitary and Epidemiological Surveillance, Regional AIDS Centres and infection control specialists of healthcare organizations. Each course is 2.5 months long, including introductory and concluding seminars and online sessions. 5 trainers and 57 students have taken the remote education courses. According to reports, 30 people have successfully completed the full cycle of online courses.

1.3 Epidemiological surveillance specialists have received advanced training on international grounds, including participation in global seminars and conferences. Specialists of both medical and non-medical organizations involved in various stages of HIV epidemiological surveillance have received training as well. As part of the Programme, the total number of specialists who received advanced training in HIV and parenteral VH epidemiological surveillance is 94, including epidemiology specialists, assistant epidemiologists of the Centre to Fight and Prevent AIDS and the Centre of Disease Prevention and State Sanitary and Epidemiological Surveillance, infection control specialists, AIDS Centres employees, medical doctors of various specializations and teaching staff of secondary and higher medical education institutions. It ought to be noted that advanced training workshops in HIV epidemiological surveillance count as credit hours required for a specialist certificate.

2 According to the interviews, specialists of the Kyrgyz AIDS Service have not conducted the researches on HIV surveillance as declared in the Programme.

2.1 Specialized research on HIV among the key populations to determine characteristics and tendencies of the epidemic (Incidence study) has not been conducted.

2.2 According to the interviews, researches on modes of HIV transmission have not been conducted either. However, the new State Programme to Stabilize the HIV Infection in RK presents a plan for such research to be carried out.

3. Activities related to the theory and practice of systemic monitoring for HIV epidemiological surveillance in medical organizations have been conducted at both national and local levels:

3.1 As part of Phase I of the Programme, a tool kit for monitoring of HIV epidemiological surveillance in medical organizations has been developed, approved and implemented. The “Manual for monitoring and evaluation of HIV infection control in healthcare organizations” and the “Evaluation check-list for infection control” have been developed and approved by administrative order #482 of the Ministry of Health of RK on 29.10.12, along with the “Questionnaire for evaluation of epidemiological surveillance for nosocomial HIV cases, for medical personnel of healthcare organizations” and the “Questionnaire for evaluation of epidemiological surveillance for nosocomial HIV cases, for epidemiology specialists of the Centre for State Sanitary and Epidemiological Surveillance and the Regional Centre for Response to AIDS”.

3.2 Key specialists of the Department of State Sanitary and Epidemiological Surveillance and the AIDS Centres have received training in application of the tool-kit for monitoring of epidemiological surveillance.

3.3 Three-stage monitoring of national epidemiological surveillance in key medical organizations has been conducted in children's hospitals, maternity hospitals and other inpatient facilities in all the regions of the country. Thus, initial monitoring of epidemiological surveillance on blood-borne infections has been conducted in 7 regions of RK.

The developed tool-kit covering 95 criteria of infection control has also been used for conducting baseline monitoring and organizational evaluation of epidemiological surveillance system in 51 healthcare organizations in several regions of RK (namely in the cities of Bishkek and Osh, as well as the Osh, Batken, Naryn and Talas Regions), including 13 maternity hospitals and paediatric hospitals in the cities of Bishkek and Osh. As part of the monitoring, a multi-centre survey has been conducted among the medical personnel of healthcare organizations, epidemiology specialists of the Centre for State Sanitary and Epidemiological Surveillance and AIDS Centres. Two-stage sampling has been used in the research: at the first stage, priority regions have been selected (the cities of Bishkek and Osh, and the Jalal-Abad, Osh, Batken, Chui and Talas Regions). At the second stage, random sampling has been applied to select healthcare organizations (n=51). In total, 669 respondents have participated in the survey: 364 medical doctors, 251 medical nurses and 54 epidemiology specialists from the Centre for State Sanitary and Epidemiological Surveillance and AIDS Centres. The conducted survey and evaluation of the epidemiological surveillance system and infection control regarding HIV transmission in medical organizations have determined that the existing system of epidemiological surveillance is not effective, partly due to insufficient education of the medical personnel and to weak organization of epidemiological surveillance on blood-borne infections in healthcare organizations⁷. On October 25 2013, the data obtained in the course of basic infection control monitoring in maternity hospitals and children's inpatient facilities in Bishkek and Osh, has been presented at the offsite meeting of the Board of the Ministry of Health of RK devoted to infection control on medical and prophylactic organizations. In addition, the research results have been discussed at the meeting of the Emergency Epidemiology Commission of the Government of RK which took place in November 2013 and were used in the revision of the Ministry of Health administrative order #202⁸.

In 2016, the final stage of the monitoring and evaluation of epidemiological surveillance on blood-borne infections was conducted in 7 regions of RK. The final evaluation has been conducted in 41 organizations and employed the tool-kit used at the basic stage. Final evaluation has also included a multi-centre survey conducted among medical personnel, epidemiology specialists of the Centre for State Sanitary and Epidemiological Surveillance and AIDS Centres selected by two-stage sampling. A total of 605 respondents have participated: 308 medical doctors, 257 medical nurses and 40 epidemiology specialists of the Centre for State Sanitary and Epidemiological Surveillance and AIDS Centres. The results of the survey have demonstrated certain progress in improving the system, however, remaining problems with epidemiological surveillance on blood-borne infections have also been detected. Thus, the systems of epidemiological surveillance on nosocomial cases of blood-borne infections are not sufficiently effective at the level of healthcare organizations. Approaches to sharp waste disposal remain unsafe; direct blood transfusion is occasionally performed in emergency situations. Only in one out of four cases of puncture or cut wound, post-exposure prophylaxis (PEP) is performed. The monitoring and evaluation of epidemiological surveillance on healthcare-associated HIV in healthcare organizations has determined that at the present stage the existing system is not effective. Thus, 78.2% of the criteria of organizing the system of epidemiological surveillance for nosocomial HIV infections are met, which is 7.4% more than has been demonstrated at the baseline monitoring stage. At both stages, insufficient correspondence to the criteria was mainly due to the

⁷ "Report on the basic evaluation of organization of HIV epidemiological surveillance in healthcare organizations of RK."

⁸ Ministry of Health of RK order #202 issued on 12.05.2008 "On conducting HIV laboratory diagnostics, epidemiology activities and monitoring in medical and prophylactic organization of RK."

absence or ineffective organization of the system of detection, registration and accounting of nosocomial HIV infection and other blood-borne infections, both among patients and medical personnel⁹.

3.4 Based on the findings of the baseline monitoring and evaluation, guidelines have been developed on “Epidemiological surveillance on blood-borne infections in healthcare organizations.” On March 13th 2015, the guidelines have been approved by the administrative order of the Ministry of Health of RK #114.

In compliance with the guidelines, a training course on epidemiological surveillance has been developed along with a DVD-course for remote education on “Infection control in dental care organizations.” The course has been distributed in medical schools and regional dental clinics.

The developed tool-kit for monitoring of HIV epidemiological surveillance in healthcare organizations “Epidemiological surveillance guidelines” and the “Manual of epidemiological surveillance” (order of the RK Ministry of Health #461 dated 07.08.2015) enabled to implement systemic monitoring and to create an electronic database on execution of epidemiological surveillance on blood-borne infections within 12 organizations in 3 regions. In total, 270 epidemiology specialists have been trained in 2014-2015 as part of the implementation of the epidemiological surveillance system of blood-borne infections in healthcare organizations.

3.5 Based on the monitoring and conducted research, a recommendation package for improving HIV epidemiological surveillance in RK has been prepared. Concerning Phase I of the Programme, it should be noted that systemic monitoring of HIV epidemiological surveillance in medical facilities has been implemented in 12 pilot healthcare organizations, in compliance with administrative order #461 from 07.08.2015. Three one-day orientation meetings have been conducted, where 12 chief managers of the “pilot” organizations have received basic training. Also 6 three-day training activities devoted to epidemiological surveillance regarding blood-borne infections for the pilot organization personnel have taken place. As a result of the education key managers of the pilot organizations have improved their skills and competencies for the implementation of the system of epidemiological surveillance on blood-borne infections. An electronic database (in Excel format) for collecting and processing data has been developed. Specialists in data collection and electronic databases of epidemiological surveillance on blood-borne infections have been trained in 3 pilot regions.

In addition, the required computer equipment for an electronic system of epidemiological surveillance on blood-borne infections in healthcare organizations has been delivered (9 computers and 9 printers for territorial hospitals, district Family Medicine Centres and Centres for State Sanitary and Epidemiological Surveillance, 3 units of each equipment article for the following regions: the city of Bishkek, the Chui and Osh Regions).

3.6 Standard operating procedures (SOPs) have been developed for the improvement of HIV and VH screening researches. In 2015, standard operational procedures have been implemented in all the AIDS diagnostic laboratories and healthcare organizations at the regional level. In compliance with the Ministry of Health administrative order #637 from 26.11.2014, further implementation of the SOPs in all healthcare organization is conducted by specialists prepared in accordance with the cascade training model as part of the Programme. Over the course of the Programme a total of 203 specialists of healthcare organizations have received training, including healthcare and nursing managers, as well as 50 laboratory personnel.

4. According to the interviews, specialists of the AIDS Service possess basic knowledge and skills to perform monitoring and evaluation of HIV drugs resistance. In 2015 they received thematic training

⁹ “Evaluation report on the organization of epidemiological surveillance for HIV and parenteral VH in healthcare organizations of RK”, by NGO “Prevention medicine” of the Republican Applied Scientific Center for Infection Control, 2016.

(no data available as to their number, affiliation, topic or location of the trainings). The interviews point out that regional monitoring hasn't been conducted, however the Republican AIDS Centre is developing a control system for HIV drugs resistance in RK. Thus, during Phase I of the Programme it was planned to develop cooperation at the level of Russian expert involvement in conducting HIV drug resistance research and sample analysis in RK. Also, through cooperation with the Federal Service for Supervision of Consumer Rights Protection and Human Well-Being (Rospotrebnadzor), a DNA sequencer for detecting HIV drug resistance mutations has been purchased and delivered to RK. The work on HIV drug resistance, however, hasn't been launched due to the lack of expendable material supply (according to the interviews).

According to the interviews, the DNA sequencer is stationed at the Republican AIDS Centre, and the issue of HIV drug resistance research is to be solved in the near future. Bilateral consultation with Russian specialists has been conducted and a plan of cooperation in research on HIV drug resistance has been designed, which envisages use of the equipment. Thus it can be concluded that over Phase I of the Programme, the HIV drug resistance control system has not been implemented.

Strong and weak points of Component A of the Programme:

The following can be attributed to the strong points of Component A:

- Strengthening of HR potential in matters of HIV epidemiological surveillance; integration of HIV epidemiological surveillance into the system of continued education in RK.
- Development and implementation of a tool-kit for systemic monitoring of HIV epidemiological surveillance in medical organizations; appropriation of innovative technological approaches, such as the development of an electronic database for epidemiological surveillance on blood-borne infections.

The following can be attributed to the weak points of the Component:

- Lack of specialized research on HIV cases among the key populations examining characteristics and tendencies of the HIV epidemic (Incidence study); lack of research on modes of HIV transmission; both being due to organizational shortcomings. According to the interviews, the new State Programme aimed to stabilize the HIV Infection in RK includes research on MTCT, HIV drug resistance and epidemiological surveillance, and active preparations are being made. According to the plan, specialists required for such research are to receive the required training at the end of 2016.
- Regional monitoring of HIV drug resistance has not been conducted. The DNA sequencer for detecting mutations (which had been purchased and delivered) has not been used. According to the interviews, the work on HIV drug resistance hasn't been launched due to the lack of expendable materials and sufficient organization of the process. At the present moment, according to the interviews, the Republican AIDS Centre is actively working on developing a HIV drug resistance control system in RK.

Factors (external and internal) which impact the Programme

- According to "Prevention medicine" NGO of the Republican Applied Scientific Centre for Infection Control, the criteria for system of epidemiological surveillance on healthcare-associated HIV have not been met due to the following main factor: lack of organization or insufficient organization of the system of detection, registration and accounting of nosocomial cases of HIV and other blood-borne infections, both among patients and medical personnel.
- Changes in the management of the Republican AIDS Center upon the completion of Phase I of the Programme have influenced the work in the given area. Thus, interviews have shown commitment to further development of activities related to HIV drug resistance.

Lessons applicable to Phase II of the Programme:

- In view of low effectiveness of the currently existing system of epidemiological surveillance in prevention and treatment of HIV, the issue of strengthening the given area in the future should be considered.
- The issue of conducting the declared HIV Incidence Study among the key populations as well as research on modes of HIV transmission should be considered.
- Attention should be devoted to conducting activities related to HIV drug resistance monitoring in RK and to further employment of the DNA sequencer provided by RF.

The analysis of the collected data has determined that as part of the Component B **“Development of communicable disease prevention and control, including HIV, STI and hepatitis among women and children”**, UNAIDS has provided assistance in designing and conducting activities in infection control of HAI in maternity hospitals and children’s inpatient facilities. Evaluation of HAI prevention activities and infection control system has been conducted; the system of early HIV diagnostics in children born to HIV positive mothers has been established.

Achieved results for Component B of the Programme:

1. The data on healthcare-associated HIV cases in children’s inpatient facilities have been requested but not submitted. Thus, no information on this article of the Programme is available.
2. As part of the Programme, a systemic approach to designing and conducting activities in HIA control in maternity hospitals and children’s inpatient facilities of RK has been established.

2.1 According to the interviews, as part of the Programme, evaluation of compliance of the training courses on healthcare-associated infection control for medical professionals with current requirements has been conducted; based on its results recommendations for improvements have been issued. However, no documents on the conducted evaluation have been presented. In 2014, evaluation of HAI prevention activities and the infection control system was conducted at a pilot medical organization. The evaluation was aimed at improving medical services in maternity hospitals and children’s hospitals in order to lower the risks of healthcare-associated infections and mortality in the healthcare organization of RK. The main goals of the evaluation have been to assess the system of HAI prevention in maternity hospitals and children’s inpatient facilities in the city of Bishkek; to present the results at a round table meeting; to develop appropriate recommendations; to analyze the corresponding regulatory documents in RK and to suggest steps for their improvement; to evaluate the HAI control system and to suggest improvements, as well as to assess the demands and resources regarding organization of personnel trainings in HAI prevention.

In order to evaluate the main components of infection control, the experts have been provided with the “Tool-kit for evaluating HAI prevention system in inpatient facilities”, presented by the Institute for Family Health (Russia) at UNICEF.

The evaluation report (2014) presents the evaluation results and recommendations, including priority approaches to HAI prevention for budget development, required resources, practical changes and suggestions for personnel trainings.

2.2 In order to continue the work in HAI prevention in compliance with recommendations of WHO and the Ministry of Health of RK, the “Collection of standard operational procedures, approved by the Ministry of Health order #379 from 04.07.2014 and recommended for clinical practices in healthcare organizations of RK” (500 copies) has been developed and published in cooperation with UNICEF, including 9 SOPs presented as a flip-poster and 21 SOPs in a book format also issued in the amount of 500 copies for practical use by medical personnel in obstetric and children healthcare organizations.

With the financial support from the UNAIDS and as part of the Programme and the Community Health Project financed by the Swiss Government and carried out by the Swiss Red Cross in RK, in 2015 the educational and methodological package “Infection control in healthcare organizations” was developed

for students of secondary and higher medical schools, continued education students, epidemiologists, infection control specialists, medical personnel of various specializations and healthcare managers in charge of infection control activities. The given training course has been developed on the basis of the adapted HAICATT education course on prevention of infections related to medical equipment, based on infection control guidelines and standards. In addition, a DVD course on “Infection control in healthcare organizations” has been recorded for use in remote education, including courses for specialists in remote areas of RK.

Thus, it can be stated that training programs for health care providers devoted to infection control in medical procedures have been improved.

3. With the support of the Programme, an early HIV diagnostics system for children born to HIV positive mothers has been implemented. Thus, activities aiming at shaping main elements of the early HIV diagnostics system for children born to HIV positive mothers, as well as provision of expendable materials supply for the period up to 2016, have been conducted. At the regional seminar on implementation of early HIV diagnostics held in Almaty, Kazakhstan, the following specialists have received training: 3 specialists from the Republican AIDS Center, 1 specialist from the Department of Disease Prevention and State Sanitary and Epidemiological Surveillance, 1 specialist from the Ministry of Health and the Kyrgyz State Medical Institute for Continued education. 60 specialists from Bishkek and the Osh Region have also received training in laboratory diagnostics including polymerase chain reaction (PCR) and dry blood spots (DBS) techniques. The training has been conducted with the participation of a laboratory specialist from the Scientific Centre for Obstetrics, Gynaecology and Perinatology in Almaty, Kazakhstan. On the grounds of the Federal Budget Scientific Institution ‘Central Science and Research Institute for Epidemiology of the Russian Federal Service for Surveillance on Consumer Rights Protection and Human Wellbeing’ (Moscow) and with direct participation of Russian experts, 2 specialists (from the Republican AIDS Centre and the Department of Disease Prevention and State Sanitary and Epidemiological Surveillance) have received training as part of continued education certification cycle named “Molecular methods of early HIV diagnostics in children born to HIV positive mothers.”

As part of the Programme and with the support of UNICEF, activities have been conducted towards implementation of early HIV diagnostics; in particular, the Ministry of Health issued the administrative order #618 from 22.10.2013 “On conducting HIV screening of children born to HIV positive mothers by PCR using DBS.” Guidelines for early HIV diagnostics in children born to HIV positive mothers have also been developed in compliance with international recommendations. 200 tests and all the expendable materials required for HIV diagnostics using DBS have been purchased. According to the Republican AIDS Centre, over the period from 2012 to 2015 early diagnostics coverage has increased by 75% (from 14% to 89%). In total, 67% (37 out of 55 children born to HIV positive mothers) have been tested using the DBS method over the last year of Phase I of the Programme.

In addition, in the Osh, Jalal-Abad and Chui Regions quality monitoring of medical services performing early HIV diagnostics of children born to HIV positive mothers has been conducted in 27 Centres for Family Medicine, 16 maternity hospitals and 2 Regional AIDS Centres. An evaluation report presented based on the results of the conducted evaluation, and recommendations have been given for system improvements; 239 medical professionals have received training in infection control.

4 Systemic approach to work with PLWH and their sex partners has been developed and implemented in order to lower risks of sexual HIV transmission. In 2013, a trilateral agreement on cooperation in support of multidisciplinary teams (MDTs) has been signed by the Republican AIDS Centre, Centres for Family Medicine and NGO “Araket Plus”, aiming at providing assistance (including medical, counselling, informational, supportive, legal, social and adaptive) to PLWH. With the support on behalf of the Centres for Family Medicine, premises have been provided to MDTs. In addition, functional responsibilities for the staff have been elaborated and approved by an administrative order.

A total of 6 MDTs have been formed over Phase I of the Programme: 2 in the Chui Region, 3 in the city of Osh and the Osh Region, and 1 in the Batken region. In 2016, another 3 MDTs were formed and added to the project: 2 in Jalal-Abad and 1 in the Osh Region. Based on the assessment of PLWH needs that had been carried out in 2013 and included studying 100 respondents in Bishkek and the Chui Region, a conceptual framework has been developed to expand access for PLHIV to services related to HIV treatment, care and support.

In total over the period of 2014-2015 the partner organization NG Fund “Araket Plus” has organized and conducted training courses for MDTs aiming at continued education and strengthening the potential of the specialists. In 2014, five workshops were conducted: “Basic issues of sexual and reproductive health, including HIV and STI prevention for MDT members” (27 specialists trained), a three-day seminar “Basics of psychological and social counselling” (22 specialists trained), “Follow-Up seminar on psychosocial counselling” (18 specialists trained), and “Organizational development of MDTs with elements of strategic planning” (25 specialists trained). The latter training course has been conducted in order to assist in the development of vision, mission, values and strategic plans for 2014-2016. In addition, the second part of the workshop on “Organizational development of MDTs with elements of strategic planning” has been conducted in order to assist revisions of the strategic plans for 2014-2016.

In 2015, the following training courses were conducted: “Basic standards for mutual aid groups on MDT grounds” (22 people trained, including 18 MDT members, the Republican AIDS Centre employees and Osh Region AIDS Center employees); “Introduction to monitoring and evaluation of MDT” (26 people trained, including a healthcare specialist from Osh, 4 managers of Centres for Family Medicine, 18 MDT members, staff of the Republican and Osh Regional AIDS Centres), and “Institutionalization of MDT work. Project exit strategy” (35 participants, including 4 managers of Centres for Family Medicine, 18 MDT members, an ICAP/USAID project manager, staff from the Republican and Osh Region AIDS Centres).

4.1 In 2014, evaluation of PLWH satisfaction with MDT services was conducted as part of the Programme of NGO “Izildoo Plus.” The evaluation goals were: (a) to determine the level of PLHIV satisfaction with psychological and social support, counseling, follow-up, peer-to-peer counselling skills, treatment process and results, and other services provided by MDTs; (b) to detect problems in work with PLWH and their family members as well as those in MDT work organization. Data collection has been conducted through semi-structured interviews with PLHIV, their family members, and MDT specialists (medical doctor, nurse, peer counselor). The research has been based on adapted methods recommended in the recommendation collection manual “Evaluation methods for voluntary HIV testing and counselling”, UNAIDS, 2000. The respondents have included 96 PLHIV and their family members, as well as 17 MDT specialists (medical doctors, medical nurses, peer counsellors). In addition, evaluation of 6 medical offices at the Centres for Family Medicine has been conducted for MDTs. Interviews and the evaluation have been conducted in three regions: the Chui Region (2 medical offices), the Osh Region and the city of Osh (3 offices), and the Batken Region (1 office). The evaluation conclusions and recommendations have been presented. Thus, the research has shown that clients use the whole range of MDT services; the demand depends on the clients’ category, their degree of social integration as well as their previous experience. The recommendations suggested that a more flexible or individual approach to the clients should be used in the future. In general, the evaluation has shown a high level of PLHIV satisfaction with MDT work and services.

In their interviews, MDT members have pointed out the usefulness and effectiveness of the information received during trainings and assure that there exists a need for regular trainings and constant informational support. Despite a high level of the specialists’ knowledge, it has been recommended to conduct testing of their HIV counselling skills using USAID tools (most likely the given recommendation is linked to some interviewees’ responses regarding their satisfaction with the quality of pre-testing and post-testing counselling). It has also been pointed out that the client-related problems

indicated by MDT members are contingent upon the key population the client belongs to. At the same time, it has been recommended to exclude some parameters from accounting journals, e.g. clients' personal information (name, address).

The research data and recommendations have been used for making corresponding revisions to the system of work with PLWH and their sex partners.

4.2 In cooperation with the Republican AIDS Centre and Regional AIDS Centres, a system of social and psychological support to PLHIV has been developed, using previous experience and best practices (including guidelines also developed in cooperation) used by partner organizations (the Global Fund and ICAP) that had worked in the area since 2009 and subsequently stopped financing for the given Component. In addition, organized work was launched in cooperation with PSI for locating previously registered HIV clients who had since "disappeared." The partner organizations in the given area are UNFPA (leading partner), GF, ICAP and Kyrgyz State Medical Institute for Continued education.

Within the existing support system, PLHIV are provided with social and medical services. Centres for Family Medicine provide assistance in receiving diagnostic and laboratory services, specialized treatment and obtaining documents from the state organizations. PLWH mutual aid groups are functioning. Active work is conducted with PLWH family members, including people who suffered from HIV.

Accounting of the provided assistance is conducted by unified identification codes (UIC) registered in a database that can be accessed by all AIDS Centres nationwide and GF. It is further planned to grant access to Centres for Family Medicine as well. At the present moment all specialists have their own accounting journals.

A training programme on PLHIV sexual and reproductive health has been developed in cooperation with the Kyrgyz State Medical Institute for Continued education and UNFPA, using study materials and recommendations issued by WHO and UNFPA. The curriculum covers topics of birth control, planned parenthood, sexual and reproductive rights, other legal matters and questions of HIV, VH B and C, and STI prevention. 18 MDT members, 6 managers of Centres for Family Medicine and 2 managers of Regional and Republican AIDS Centres have been trained in accordance with the programme. GF and ICAP have conducted similar training courses through their websites and on their grounds.

Education quality control is conducted using baseline and final testing. Internal monitoring of education quality and collecting feedback of beneficiaries are carried out as well. According to the interviews, over the course of Phase I of the Programme, 26 specialists have been trained in sexual and reproductive health regarding PLHIV.

During Phase I of the Programme, 350 persons have been covered by the system of PLHIV social and psychological support. An estimated figure for Phase II of the Programme is 500 persons.

4.3 As part of Phase I of the Programme, an advocacy campaign for the "Treatment as Prophylaxis" approach has been conducted. Thus, specialized training courses on HIV prevention against the background of ART been held for serodiscordant couples. Among active participants in promotion of the "Treatment as Prophylaxis" approach have been both state (the Republican AIDS Centre) and international (UNAIDS, WHO) organizations. The coverage of the "Treatment as Prophylaxis" programme is reflected in the Republican AIDS Centre report. According to the interviews, the Republican AIDS Center, GF and UNAIDS have cooperated in development of the programme for promoting commitment to early treatment among PLHIV and healthcare providers. The programme contains general information about ART, drug side effects, drugs compatibility, concomitant diseases, as well as about awareness and commitment to therapy. The programme is based on WHO recommendations and clinical protocols. Specialized training according to this programme has been

conducted for specialists with the participation of the Kyrgyz State Medical Institution for Continued education, the Republican AIDS Centre, the GF and the WHO.

4.4 Advocacy campaigns aimed at de-stigmatizing and de-criminalizing HIV at the community level have been conducted in 6 MDTs within 3 regions (starting from 2016 – 9 MDTs within 4 regions). As recently as 4 years ago HIV was taboo for women in labour, and there is still no law regulating HIV screening (the Kyrgyz Parliament is recommended to direct their attention to development of proper regulatory standards). PLHIV receive assistance in obtaining state social security payments; assistance in providing formula supplements for HIV positive mothers is granted; children are assisted with entering educational organizations without disclosing their status, owing to work conducted with the Department of Education. Schools in general and school teachers in particular have not been engaged so far, but such work has been planned in the future.

Work aimed at de-stigmatizing and de-criminalizing of HIV is conducted at Centres for Family Medicine, where MDT specialists educate medical personnel covering the issues of assistance, care and treatment of PLHIV.

It has been suggested that mandatory HIV screening and confidentiality of HIV status should be removed from the law, which will help to combat the stigma (that is, by creating a new framework for HIV perception, we move away from an “isolated” status of HIV diagnosis and shift HIV nosology to the category of common diseases).

In addition, MDT medical personnel have conversed with local religious leaders, engaging them in prevention work among migrants. According to a Kyrgyz custom, people seek a minister’s blessing before departure for a long trip, including labor migration. Thus, the ministers can influence them in terms of moral, ethical and religious principles, reminding them of behavioural patterns of HIV, VH B and C and STI prevention.

In active cooperation with UNAIDS and WHO, components of overcoming HIV stigma and criminalization have been developed and used in the training activities. These components have been developed in compliance with WHO and UNAIDS recommendations, international declarations and documents and concerned issues of human rights and various legal aspects. Separate training courses in this area have not been developed and conducted, however 26 MDT specialists have appropriated the above components for their work. According to the interviews, seminars and training workshops for medical personnel have also been conducted by foreign donors, such as GIZ and USAID. Particularly, representatives of RK are interested in conducting mapping of GIZ, USAID and GF activities, since partner organizations often conduct identical or economically unfeasible activities. Thus, USAID has financed a maternity hospital construction at the Issyk-Kul lake, but approximately 30% of the grant money has been spent on fees for specialists not familiar with the local specifics. Back in 2008, Germany allotted money for a clinic construction, but the construction hasn’t been completed yet. Japan has delivered technical equipment to the Kyrgyz Scientific Centre for Human Reproduction but the equipment wasn’t set up to operate and there were no specialists trained to operate it. Saudi Arabia has built three first-aid obstetrics stations, but but with a precondition for also building a number of mosques). China and Qatar are also involved in financing, but the donors’ distribution of the funds is not effective. The most active donors are the USA, the GF and the UN Development Programme (UNDP), but they have strict requirements and conditions for receiving their grants, which causes certain discontent on the part of recipient countries.

By implementing the given component, the Programme has significantly improved the results of the work previously launched by the other partner parties. An important part has been played by the management of Centres for Family Medicine and AIDS Centres and their commitment to the implementation of the component. They fully support activities of the programme’s “teams”, which contributed greatly towards the success of the work. An example of successful project institutionalization can be the fact that peer counsellors have been accepted for permanent positions at

the Centres for Family Medicine, financed by the Centres themselves. Implementation of a multi-disciplinary approach has significantly increased the number of HIV-related services, which has in turn helped expand the coverage for PLWH counselling, diagnostics, treatment and medical, social and psychological support.

Strong and weak points of Component B of the Programme:

The following can be attributed to the strong points of Component B:

- Improvements of the systemic approach to planning and conducting activities and control on HIA in maternity hospitals and children's inpatient facilities of RK, in particular, evaluation of compliance with contemporary requirements of educational programmes for medical personnel on infection control in medical procedures and recommendations for further improvements issued based on the evaluation results. Improvements of educational programmes for medical personnel on infection control in medical procedures, including publication of a collection of standard operational procedures in HAI prevention, developed in compliance with WHO recommendations, for practical use by medical personnel in maternity hospitals and children's healthcare organizations.
- Development and implementation of a remote education course on infection control in healthcare organizations. The course has been acknowledged as relevant and useful, especially for specialists in the remote areas of RK.
- Improvements in the early HIV diagnostics system for children born to HIV positive mothers, including development of main elements of early diagnostics and provision of expendable diagnostic materials. Also worth noting is the work on legal support of practical implementation of the early HIV diagnostics system in compliance with global recommendations, including organization of quality monitoring of medical services for early HIV diagnostics in children born to HIV positive mothers, recommendations for further improvements based on the monitoring results and trainings on infection control for medical personnel.
- The most effective part of the Component was focused on the development and implementation of a systemic approach to work with PLHIV and their sex partners. This part of the Component has relied on the best international practices, such as the MDT implementation system, expanding access for PLHIV to quality medical services, promoting client-oriented services, sustainability of commitment to treatment and lowering the level of HIV stigma and discrimination. It is important to note that RK is conducting active work on HIV prevention via treatment among serodiscordant couples. Mutual support groups have been organized, helping PLWH disclose their status, attract their close contacts and employ peer counsellors for engaging previously unapproachable people.

The following can be attributed to the weak points of Component B:

- Lack of specialized informational materials for lowering the levels of HIV stigma and discrimination.
- Despite active cooperation on behalf of UNAIDS and WHO in developing training components for overcoming HIV stigma and discrimination, specialized training courses have not been developed, which should be reconsidered in the future in view of the problem's relevance.

Factors (external and internal) influencing the Programme

- Due to insufficient amount of state financing for required activities in RK, the needs of the national programmes of response to HIV cannot be met.
- According to the respondents, current mechanisms of integration and cross-sector coordination between organizations involved in response to HIV do not function effectively enough.
- The factor of turnover among top managers and key stakeholders in state structures poses a certain threat to the sustainability of HIV prevention programmes.

- Starting from 2015, the “Treatment as Prophylaxis” approach has been implemented in RK. Medication purchases, including those required for the implementation of this approach, have been financed by GF. In 2017 GF stops financing ART and TB drugs purchases for RK. At the present moment, GF has already stopped purchases of drugs for opportunistic infections (OI), with the exception of vulnerable group representatives), and now the financing is fully the responsibility of the state.
- Withdrawal of the GF (in particular, financing of testing systems for pregnant women has been cut off) will have a pronounced negative impact on response to HIV, including potential redistribution of state financing.
- Levels of HIV stigma and discrimination are quite high not only in the society in general, but also among medical personnel, which has led to staff replacements in MDTs. Stigma and discrimination towards PLHIV have also been noted among health providers. School teachers have so far also played a negative role by and large being generally rather unhelpful on the issue of overcoming HIV stigma and discrimination.
- A positive factor certainly worth noting, is the high level of awareness and professional qualifications demonstrated by the specialists engaged in MDT work. It is largely due to their efforts that level of PLHIV stigma and discrimination has been reduced at the Centres for Family Medicine, inpatient facilities and social development organizations.
- A factor of low motivation and limited opportunities for medical personnel has also been noted: primarily, it’s the problem of low salaries (5-8 thousand soms), along with a heavy workload and shortening of time slots per counselling session. Lack of sustainability of the programmes has also been pointed out: many programmes close down after donors’ withdrawal. Staff turnover is yet another problem, many medical doctors move abroad (to Russia in particular).

Lessons applicable to Phase II of the Programme

- There is a shortage of diagnostic materials in RK, even considering the HIV testing systems for pregnant women purchased over the course of the Programme, so HIV testing is run only once during pregnancy, despite the recent international recommendations and guidelines. Up to 2016, testing systems have been delivered as planned, but in view of the lack of external financing the situation will deteriorate. Increasing assistance in this area of the Programme requires consideration.
- 89% of HIV-positive children receive treatment; 11% remained uncovered by ART due to low commitment not least generated by the lack of psychological assistance services. Strengthening of informational and educational work on commitment to treatment is required not only among children and adolescents, but also among parents.
- There’s a need for publication of a broad range of informational materials on all areas of work with PLHIV.
- Issues of HIV stigma and discrimination require proper attention and improvements of approaches to the problem, especially among health care professionals. The given problem requires elaboration of measures for overcoming HIV stigmatizing, including specialized training courses in the areas of ethics and deontology in work with PLHIV in particular, for medical specialists continuing their education. In addition, according to the interviews, thematic work among school teachers hasn’t yet been conducted; it is planned for the future which may require support and assistance. Attention should be paid to the development and publication of informational materials aimed at overcoming HIV stigma and discrimination among target groups.
- Coordination of work on overcoming HIV stigma and discrimination between partner organizations, including NGOs, is run by the Ministry of Health. However, according to the interviews, the conducted work is not sufficiently effective and it is carried out in a rather formal manner. A desire

has been expressed to revive cooperation between organizations in the given area by engaging the Country Coordinating Committee.

- Educational activities for PLHIV on sexual and reproductive health have been conducted as part of the Programme. However, during the same period GF and ICAP have been conducting similar trainings on their grounds and sites. In view of that, the issue of coordinating such activities and synchronizing partner efforts should be elaborated.

The analysis of the collected data has determined that as part of the Component C **“Improvement of the prevention system for HIV/AIDS, STI and hepatitis among key populations, including prevention among migrants”** the “AIDS Infoshare” Foundation has conducted work on strengthening the system of outreach services, diagnostic and counselling assistance, conducting awareness-raising activities on HIV prevention among migrants, their family members and other key populations subject to the risk of infection. Inter alia, 3 Russian mobile medico-diagnostic complexes have been provided to ensure work on HIV/AIDS, VH and STI prevention among the population of the remote and hard-to-reach locations of the country.

Achieved results for Component C:

1. Work has been conducted on strengthening the outreach-system in the Kyrgyz Republic aimed at expanding access to diagnostic and counselling services for HIV/AIDS, VH and STI prevention for labor migrants and their family members residing in rural areas. Towards that goal of the Programme and in cooperation with the National Red Crescent Society, a training course for promoters has been conducted, in order to further coordinate the activities of the outreach volunteers in all the regions of RK: Osh, Chui, Batken, Jalal-Abad, Naryn, Issyk-Kul and Talass. In total, 12 promotion specialists have been trained to become managers of outreach teams. The specialized training has covered issues of organization and management of the outreach activities, community mobilization, as well as HIV, TB and STI prevention. The promoters’ responsibilities include work with the local population, including conducting specialized promo-trainings, where active community members are offered to volunteer in HIV prevention work. Selected volunteers then receive further thematic education. Promoters work in contact with outreach volunteers, encourage their motivation, conduct work on organization, coordination, monitoring and supervision of their activities and provide counselling assistance.

Promoters are responsible for the division of the covered territory among volunteers and for giving them the necessary information on HIV, TB and STI prevention (including printed materials) for further distribution among the local population.

Volunteers establish initial contact with community representatives, conduct risk assessment of every potential client, perform prophylactic interviews on “What do you know about HIV, VH, TB and STI?” Informational and educational work is conducted both verbally and through distribution of printed materials. In addition, outreach specialists invite clients to participate in thematic group sessions on HIV, VH, TB and STI prevention and actively engage the local population to take respective tests, informing local community about the time and place of a mobile clinic visit.

In total, over the course of Phase I of the Programme, a network of 4 promoters and 60 outreach volunteers has been formed and financed, covering all regions of RK. In addition, 48 800 people have been covered by door-to-door rounds over the period from 2013 to 2015. 20 197 people have participated in topical information sessions on HIV, VH, TB and STI prevention.

A lack of a commonly accepted and unified understanding of the concept that accurately identifies the category “migrants’ family members” in RK and substantial variations in accounting methodology for door-to-door visiting rounds have created difficulties in interpreting the data on the coverage of key

populations by the outreach services. In view of that situation, a decision has been made to cancel further work on the outreach component in RK starting from 2016.

2. In order to increase the population coverage for HIV/AIDS, VH, TB and STI testing and counselling services, especially among the target groups, such as labor migrants and their family members, the Programme has financed purchases and launching of three mobile medico-diagnostic complexes, including salaries for the staff, maintenance expenses and purchase of medical and diagnostic materials required for proper work of mobile clinics.

Due to operations of the mobile medico-diagnostic complexes, access to medical and diagnostic services for the population has been expanded in rural areas. Particularly, mountainous and hard-to-access locations of RK have been covered, where access to such services used to be very limited due to insufficiently developed local network of medical services and facilities, logistical problems and the low income of the local population. It should also be noted that provision of medical and diagnostic assistance as part of the given Component of the Programme is conducted free of charge, with priority attention given to underprivileged and socially vulnerable population groups.

Initially, activities related to mobile clinics have been conducted by the National Red Crescent Society of RK (in capacity of “AIDS Infoshare” Foundation’s subcontractor). However, starting from 2016, in agreement with the Ministry of Health and in order to improve coordination work and itinerary planning, including cooperation with regional activities (“health caravans”) and improving organizational work in general, mobile clinics have been transferred under the management of regional clinical hospitals, participating in partnership for current clinical and diagnostic activities. Specialist teams, previously prepared for work in mobile clinics, have been preserved and continue their work in the same format.

The operations of the first mobile clinic were launched in September 2014 in the Chui Region. Reports point out that the work of mobile complex in the Chui Region has been conducted on territories poorly provided with medical services, in districts populated with national migrants, including socially vulnerable low-income individuals. The second mobile clinic was presented to RK in 2015 for operations largely in the Osh Region, where a fact-finding visit has been conducted as part of the given evaluation, studying the work of the mobile complex. As of 2016, all the 8 districts of the Osh Region have been fully covered by the work of the mobile complex. The itinerary and schedule of the mobile clinic are planned in advance in cooperation with district coordinators. First-aid and obstetric stations are notified in advance, according to the schedule; local residents are mobilized with a particular emphasis on representatives of risk groups. According to the estimate made by the medical personnel themselves, about 70-90% of the mobile clinic’s clients in the Osh Region are women.

A multiple-destination route can take 4 to 10 days. Normally, the work of the mobile clinic is conducted on the grounds of first-aid and obstetrics stations (FOS) and in cooperation with the local specialists.

All the information related to mobile clinic testing is registered in an accounting journal. It should be noted that accounting is kept in paper format, there’s no electronic database at this stage. The list of the tested clients is submitted to the FOSs, and the accounting journal is stored at the Osh Inter-Region United Clinical Hospital. Testing results data are then converted into electronic format and submitted to the Osh Regional AIDS Prevention and Control Centre on a monthly basis.

The mobile clinics offer testing services for HIV, VH B and C, and STIs. Over the course of Phase I of the Programme, the following materials have been purchased and delivered to RK to be used by the mobile clinics: HIV rapid tests – 13 000 units; VH B and C – 5 000 units respectively (10 000 in total), TB – 9 500; and syphilis – 6 000 testing systems.

TB screening was conducted before the end of 2015, but since 2016 testing systems are not purchased, even though according to the staff at the clinics, the population regularly expresses interest in taking such tests. As far as STIs are concerned, only syphilis testing systems have been purchased, other

nosology categories are not covered, despite the population's interest. According to the interviews, about 10% of women seeking gynaecological help in a mobile clinic may have clinical indications for screening for other STI (gonorrhoea and trichomoniasis).

Considering that the majority of diagnostic services in RK are offered on a paid basis (including gynaecological services, according to the interviews), diagnostic activities conducted by the mobile clinics are well-received and widely-appreciated by the local population.

The stock of testing systems is refilled regularly from the local storage supplies, in the given case they come from the storage area of the Osh Inter-Region United Clinical Hospital. Before starting on a route, the mobile clinic is provided with testing systems, 200 to 500 units, depending on the itinerary length. In case of shortage of diagnostic materials, a special transport delivers extra supply from the storage.

As it has been observed during the visit, testing systems are kept in a laboratory not equipped with a thermometer. Even though the mobile clinic is equipped with a central system of temperature regulation and the fridges have several temperature modes, considerations should be made about equipping the premises where testing systems are stored with thermometers to ensure proper temperature control.

As part of the Programme, personal protective equipment for the mobile clinics' staff (masks, gloves) and disinfecting materials have been purchased. The supplies are refilled on a regular basis. According to medical personnel of the clinic, disinfecting materials are purchased, inter alia, by the Inter-Region Clinical Hospital. Waste disposal is conducted at the site of the mobile clinic's work in the FOSs, in compliance with the agreement with state healthcare organizations.

Specialized training for the mobile clinic team was conducted in 2015 at the premises of the Osh Regional AIDS Prevention and Control Centre. Baseline and final testing was conducted to evaluate the quality of the programme. The clinics' specialists have mentioned workshops on counselling and lab diagnostics as strong component of the training. Medical personnel have also expressed their willingness to take such courses on a regular basis in order to ensure up-to-date qualifications and knowledge of the topic. According to the staff, they apply the mastered skills in practice, conducting pre-testing and post-testing counselling. In their practical work, medical specialists follow current protocols, updated in compliance with global recommendations. In 2015, the "Clinical protocol on HIV for healthcare organizations of levels 1-3" was approved and published. Consideration should also be given to the lack of a separate protocol for "emergency situations." However, according to the personnel, in their practical work they follow the Ministry of Health administrative order #114 from March 13th 2015 "On measures of blood-borne infections prevention in healthcare organizations of RK."

The mobile clinic team consists of staff from state medical organizations who receive payment from the Programme's funds in addition to their regular salary. However, they do not receive reimbursement for their expenses during mobile clinics' visits from the state funds (these expenses are compensated by the "AIDS Infoshare" Foundation).

The third mobile clinic was presented to the Ministry of Health of RK at the end of 2015 and started operating in the Issyk-Kul Region in the spring of 2016. Previously the given mobile clinic was scheduled to be presented to the Uzbek Republic, but later Uzbekistan's participation was cancelled by a joint decision on behalf of RF and UNAIDS.

In total, 76 localities of two Regions have been covered by the mobile clinics' services. 34 454 people have been engaged.

Maintenance and service of the mobile clinics are financed by the Programme, including such expenses as fuel, expendable materials, spare parts for repairs and expendable materials for regular technical maintenance.

Strong and weak points of Component C of the Programme:

The following can be attributed to the strong points of the Component:

- Purchases, deliveries, organization and support of the work of three mobile medico-diagnostic complexes and as a consequence, expanded access of rural residents constituting the majority of the population to medical services, particularly in the mountainous and hard-to-reach districts where access to such services used to be very limited.
- Medical and diagnostic assistance is provided on a free-of-charge basis, with special attention given to underprivileged and socially vulnerable groups of population. Considering that the majority of diagnostic services in KR are offered on a fee basis, diagnostic activities conducted by the mobile clinics are widely popular among the local population.
- HIV cases detected via mobile clinic diagnostics have been referred to the Regional AIDS Centre for registration and further diagnostic and clinical services.

The following can be attributed to the weak points of the Component:

- The support of outreach projects by the Programme has been cut off due to a lack of a commonly accepted and unified understanding of the concept “migrants’ family members” in door-to-door rounds, and difficulties in interpreting the data on coverage of key populations by outreach services.
- Virtually all expenses related to mobile clinics’ operation are financed by the Programme, including technical maintenance, purchases of expendable materials and medical and diagnostic materials required for full-range operation of the diagnostic complex. Such an approach in combination with a total lack of co-financing by the state, poses risks for the sustainability of the given Component of the Programme.
- A lack of standard approach to the system of individual encoding of clients’ data.

Factors (external and internal) which impact the Programme

- According to the medical personnel, approximately 70-90% of the mobile clinics’ clients are women (according to the data obtained in the Osh Region), including the target group’s (migrants’) sex partners.
- As employees of state healthcare organizations, medical personnel of the mobile clinics do not receive reimbursement for travel expenses related to the mobile clinics’ visits from the state budget. These expenses are compensated by a donor (the “AIDS Infoshare” Foundation).
- There are no state preferences, subsidies or discounts for technical maintenance of the mobile clinics; no state co-financing for purchases of petroleum, oil and lubricants. The same terms are applied to medical equipment carried by the clinics. Spare parts and expendable materials are available, however, according to the interviews, repairs and replacement of certain elements of medical equipment can be performed only in Russia.
- It has been pointed out that a lack of access to water creates difficulties in some areas of the mobile clinics’ healthcare services (including the programme “Health caravan” and its sub-project “Safe maternity”).
- The medical personnel working at the mobile clinics have not received VH B vaccination, which poses significant risks to their health and safety, considering their interactions with key populations.

Lessons applicable to Phase II of the Programme

- TB screening had been conducted before the end of 2015, but starting from 2016 there were no purchases of TB testing systems (due to a lack of a WHO protocol), even though, according to medical personnel, the population regularly expresses interest in such services.

- As to STIs, testing systems for syphilis diagnostics have been purchased. Other nosology categories are not covered, even though the population expresses interest in such diagnostics. According to the interviews, about 10% of the women seeking gynaecological help at the mobile clinics may have clinical indications for screening related to other STI (gonorrhoea and trichomoniasis). It appears reasonable to consider expanding the range of nosology categories, since in rural areas, referrals of patients to inpatient medical facilities to receive diagnostic services will highly likely result in a loss of the patients in view of logistic and financial inaccessibility of such services.
- Testing systems storage conditions at mobile clinics requires further evaluation, since the lab premises are not equipped with thermometers. Even though the mobile clinic is equipped with a central system of temperature regulation and the refrigerators have several temperature modes, considerations should be made about equipping the premises where testing systems are stored with thermometers.
- Health care providers have also expressed their willingness to take thematic educational courses on the regular basis to ensure up-to-date qualifications and knowledge of the topics of HIV, VH and STI. According to the personnel, they apply the mastered skills in practice, including pre-testing and post-testing counselling.
- According to the interviews, a mobile clinic specialist can serve up to 90 patients per day (the highest figure declared), in case of intensive patient flow. According to the reports, the average number of patients served does not exceed 45 patients per day. It should be noted that all employees point out the intensity of work and occasionally heavy workload. It has also been noted that during the winter period the number of patients seen at the mobile clinics decreases owing to the amounts of time required for preparing the clinics for a workday in low-temperature conditions. Considering that winter period is a season when migrants return home, the decrease in number of patients examined leads to a decrease in the effectiveness of the given Component.
- Considering the load and specifics of work at the mobile clinics, the lack of reimbursement for the personnel's travel expenses by the state can have a negative impact on HR sustainability of the Programme in the future. It appears reasonable to elaborate the issue of state co-financing for the travel expenses for the staff of healthcare organizations, in addition to the existing extra-payments financed by the Programme.

Conclusions on Kyrgyzstan:

1. The main goals declared for Components B and C have been fully achieved. Systems of prevention and control of HIV/AIDS, VH and STI among women and children have been strengthened. The system of prevention for HIV/AIDS, VH and STI among key populations has also been improved, including the migrant population.
The goals of Component A – improving HIV/AIDS, VH and STI epidemiological surveillance – have been achieved only in part, due to unwillingness of the Kyrgyz party to work on their full implementation, and they require additional elaboration of the declared researches on HIV surveillance at the level of healthcare system top management. It is also necessary to conduct activities for practical implementation of regional monitoring of HIV resistance to ART in the Republic.
2. Monitoring research has shown not only certain achievements in improving the system of epidemiological surveillance on HAI cases, but also detected remaining problems in the organization of epidemiological surveillance on blood-borne infections. The systems of epidemiological surveillance on healthcare-associated blood-borne infections are not sufficiently effective at the level of healthcare organizations. Particularly, observation and evaluation of the system of epidemiological surveillance on HIV transmission in inpatient medical facilities have shown that the existing system is not effective at the present stage.

3. Implementation of MDTs, improving accessibility of quality medical services for PLHIV, promotion of commitment to treatment and lowering the level of HIV stigma and discrimination have proved to be effective, useful and sustainable, including work with serodiscordant couples on “Treatment as Prophylaxis” approach, organization of mutual aid groups and employing peer counsellors from among PLWH in order to engage previously inaccessible patients.
4. There are no specialized training courses or specialized informational materials on overcoming HIV stigma and discrimination in RK.
5. The mobile clinics have proved their usefulness, effectiveness and relevance, considering the geographical specifics of hard-to-access rural areas of KR.
6. There’s a lack of general standard approach to tracking the coverage of key populations with outreach services and to developing a system of encoding of mobile clinic clients’ individual data.
7. Expenses related to the mobile clinics’ maintenance are covered by the Programme, without co-financing from the state budget, which presents risks for the sustainability of the given Component.
8. It has been emphatically pointed out that efforts in work with adolescents ought to be intensified, including children suffered from HIV during the 2007 outbreak. Socializing such children and HIV positive adolescents is critically important, including their adaptation and integration into the society at large. Also requiring special consideration is work with parents of such children and their education, including engagement of psychologists (the GF works with parents on raising commitment to their children’s treatment, in coordination with the Republican AIDS Centre; the UNICEF works with psychologists). A summer camp for HIV status disclosure is held in RK annually, and about 100 children have already disclosed their status (300 children, in total).
9. The GF has cut off financing of purchases of HIV testing systems for pregnant women. In view of the existing shortage of diagnostic systems it presents serious risks to the work on annihilation of vertical HIV transmission (MTCT) in general.
10. There are difficulties in working with CSWs, linked to the legal ban on commercial sex services and ongoing war with this industry. The approval and implementation of such a state policy has led to significant problems in working with the given risk group.

Recommendations on Kyrgyzstan:

1. To consider the ways of completing the declared activities and conducting an incidence study among target population groups in order to determine the characteristics and trends of the HIV epidemic, as well as research on the HIV modes of transmission.
2. To conduct the declared activities in organization of HIV drug resistance monitoring in RK.
3. To consider the ways of designing and conducting activities aimed at strengthening the effectiveness of the existing system of epidemiological surveillance on HIV in inpatient healthcare facilities.
4. To consider ways of continuing and increasing assistance in the provision of HIV diagnostic systems for pregnant women.
5. To develop a plan of activities for increasing commitment to treatment among HIV positive children, including activities involving work with parents of such children.
6. To consider ways for supporting such relevant area as the “Treatment as Prophylaxis” approach, drawing on previous experience of KR and other countries participating in the Programme.
7. To consider ways of publishing a broad range of thematic informational materials on all the elements of work with PLHIV, drawing on the work conducted by GF.

8. To improve approaches to lowering the level of HIV stigma and discrimination, including development and implementation of specialized training courses, thematic work in schools, and development and publication of informational materials on overcoming HIV stigma and discrimination among the target groups and in the society at large.
9. To conduct work on the development of a protocol for coordination of designed and conducted activities between partner organizations, including global, state and non-government organizations, in order to improve the economic effectiveness of the efforts towards response to HIV (particularly related to HIV stigma and discrimination, and to matters of sexual and reproductive health for PLHIV).
10. To incorporate into future agreements an article on state co-financing of the mobile clinics, including reimbursing state employees' travel expenses and/or incorporating part of the Programme's expenditures into the state budget (including expenses related to purchases of petroleum, oil and lubricants, certain kinds of medical drugs, disinfection materials, personal protective equipment for medical personnel, and testing systems).
11. To conduct an evaluation on the accessibility of water resources in hard-to-reach rural settlements and suggest measures aimed at solving existing problems.

3.3 Tajikistan

General information of Tajikistan

Tajikistan is a country in Central Asia with \$8 billion GDP and an 8.5 million population. Over the period of the last few years the country's economy has been sluggish and not demonstrating the signs of the sustainable economic growth. Tajikistan maintains a considerable level of cooperation with Russia on many issues (the renewed agreement regarding a Russian military base 201 in Tajikistan, assistance in fighting drug trafficking, easing legal registration for labor migrants, discounts on Russian supplies of petroleum, oil and lubricants).

According to the interviews, the economy of RT is currently in a "transitional" stage, and budget funds allotted for socially significant areas are not sufficient. 2.2% of GDP are currently spent on healthcare (the required minimum is 3%), where approximately 92% of the budget funds are spent on salaries for medical personnel (it has been pointed out that the salaries remain low and non-official or 'under-the-table' payments continue constitute a large part of personnel revenue). A dangerously small amount of budget funds is allotted for the purchases of basic medical drugs, medical materials and equipment. Meanwhile, Tajikistan is presently in a concentrated HIV epidemic phase. At the beginning of 2016 the number of HIV patients was 6 117, but as of October 1st 2016, it was 6 621 (in total, 8,824 HIV-cases have been registered over the period from January 1991 till July 2016). However, according to the PEPFAR estimates (with reference to UNAIDS) the number of HIV-patients in Tajikistan is at least 16,000. Since a significant part of the population's income is constituted by remittances of labor migrants working abroad, a particularly disturbing fact in the context of HIV epidemic is that in 2016 14.3% of new HIV cases were migrants (and more than a half of HIV positive women reported that their sex partners were migrants).

As in other cases, the key donor of the programmes of response to HIV is the Global Fund (\$35 million have been allocated in 2015). However, the GF is decreasing financing of the programmes. At the present moment, it has completely stopped financing related to HIV screening of pregnant women and MTCT prevention. The key populations still receiving GF financing are so-called 'vulnerable' groups: CSWs, MSMs and PIDs. In addition to GF and the Russian Programme funds, the Islamic Development Bank works directly with the Government of RT (financing the training component on HIV MTCT). According to the interviews, insufficient transparency and lack of coordination with state

authorities present problems for the US-based donors working with certain NGOs. The core activities of international donors in HIV-response continue to focus on the key populations. The major players in this field are USAID and PEPFAR (the global initiative of the US Government for response to HIV/AIDS with a \$70 million budget having been allocated over the last decade and a special emphasis on key population groups). The German Development Bank emphasizes infrastructural projects; GIZ focuses on trainings. Presently, two projects in the healthcare system are financed by the World Bank (\$33 million for 5 years).

The evaluation of the Phase I of RCP in Tajikistan has been designed to address the most important issues. For this purpose, the Programme's reports and project documentation have been studied: regulatory documents (strategy, laws, decrees, orders etc.), statistical data and scientific publications. Individual and group interviews have been conducted with representatives of executive organizations and co-executives of the project, as well as representatives of global, state and non-government partner organizations involved in HIV/AIDS, VH and STI prevention.

The analysis of the collected data has determined that as part of the Component A **“Improving the epidemiological surveillance system for HIV, STI and viral hepatitis”**, UNAIDS has provided assistance to the national healthcare system of RT in specialized HR trainings in key aspects of HIV surveillance, implementation of innovative approaches into the HIV monitoring system, and conducting bio-behavioural studies among the risk groups towards improving the national system of epidemiological surveillance and development of legal regulatory standards for HIV, VH and STI epidemiological surveillance.

Achieved results of the Component A of the Programme

1 A significant amount of effort has been allocated towards the development of professional potential for specialists in key aspects of HIV surveillance. As a part of the Programme, trainings on HIV epidemiological surveillance for epidemiology specialists have been conducted (including epidemiological research issues which are particularly relevant, considering that the mode of transmission is not identified in 12% of HIV cases). Thus, in December 2013, a five-day training course on “HIV epidemiological surveillance” was conducted within the framework of ‘continuing education’ for epidemiology specialists from the regional AIDS Prevention and Control Centres. The training course has facilitated not only the development of HR potential in key aspects of HIV surveillance, but also the implementation of innovative approaches to HIV monitoring. The training has been conducted with the help and participation of Russian experts: S.R.Saukhat, the Head of the Southern Federal District Center to Fight and Prevent AIDS and Communicable Diseases of the Federal Budget Scientific Institution (RF), and A.B.Shemshura¹⁰, the Head of the Laboratory and Clinical Department of the same institution. National-level “training of trainers” (ToT) on HIV epidemiological surveillance has helped prepare specialists for further cascade training of regional and district specialists.

Training activities for practicing doctors of various specializations have also been conducted, including such topics as voluntary testing and counselling, and commitment to ART treatment. In addition, training courses for specialists on database building and security (“electronic surveillance” system) have been conducted. It should be noted that according to the Republican AIDS Centre, starting from 2015 training courses on HAI for medical personnel have been conducted as part of the Programme. However, according to the interviews with personnel of the Infectious Diseases Hospital, medical staff receives HAI-related training from the specialists of the Infectious Diseases Department of the Abu Ali Ibn Sina Tajik State Medical University. It should also be noted that health care providers of various

¹⁰ <http://www.nc-aids.tj/>

specializations who participated in national and regional trainings suggest that accessibility of educational materials should be improved, HIV-related issues should be adapted to specific medical specialization, and the range of visual and interactive educational materials used in the process of education should be expanded.

As part of continuing education for medical staff, regular training courses for epidemiology specialists are conducted on the grounds of the Republican AIDS Centre. The programme is particularly characterized by the fact that upon its completion medical specialists can receive free certificates which are required for epidemiologists to receive a so-called 'category'. This adds to the students' motivation and contributes to the solution of the staff turnover problem.

While developing training courses for doctors (including continued education programmes), the Republican AIDS Centre relies on previously conducted trainings, makes revisions in educational materials in compliance with global recommendations and best practices, and engages previously trained specialists. Internal control of the programme quality is conducted through baseline and final testing performed by the Republican AIDS Centre staff. Whenever other partner organizations participate in the training courses, their representatives are engaged in conducting external control of the programme quality.

Over the course of the Programme a total of 238 specialists in epidemiological control have received training from the Republican AIDS Centre, namely: 67 epidemiologists, 118 specialists in infectious diseases, 20 paediatricians, and 33 managers of control laboratories from all the regions of RT.

According to the interviews conducted at the National Centre for Reproductive Health, the respondents mentioned that over the course of Phase I of the Programme in 2013-2015, 6 training courses have been conducted for 431 national specialists (expected to further educate medical personnel). Each of the graduates then monitors the work aimed at response to HIV in 2-3 districts of RT, making at least 2 visits per year. In addition, the following training activities have been conducted: 6 training courses for primary medical care specialists, 6 training courses for obstetricians and 3 training courses for youth (15-24 years old) at the Youth Counselling Centre, with a special emphasis on safe behavioural patterns. The relevance and timeliness of the Russian Programme has been pointed out, along with the fact that its implementation has started at the time when GF has started cutting its contributions to the areas in question. GF has been providing national specialists with testing systems, without providing any educational training on their operation. By contrast, the Programme first conducts educational activities and only then provides the actual testing systems. 300 health care providers from maternity hospitals have been covered by educational activities since 2015, including midwives.

2 Innovative approaches to HIV monitoring have been partly implemented, including conducting and analyzing research among high risk groups. Approximately 50% of the activities in the given area declared have been implemented in the Programme. Only half of the goals in this area of response to HIV have been achieved, issuing from the priority list of the declared activities.

2.1 An electronic system of HIV surveillance (electronic database of HIV cases) has been developed and launched. The system allows regional AIDS Centres to update HIV case databases remotely in online mode and to conduct data analysis, including risk groups. In order to ensure uninterrupted functioning of the database a team of specialists in HIV electronic surveillance has been trained. At the present moment the electronic system of HIV surveillance covers about 90% of AIDS Centres in RT, which has significantly improved the process and quality of data collection and ensured timely projection of the demand for medical drugs and diagnostic materials. As part of the Programme, the electronic surveillance system has received material and technical resources, software, equipment (10 computers, 4 printers and systems of uninterruptible power supply have been purchased for District AIDS Centres), and well as technical and informational support have been provided. Thus, the regional

potential has been strengthened; the coverage of the electronic system of HIV surveillance has been improved at the national level.

2.2 According to the Republican AIDS Centre, no focused Incidence Study of new HIV cases has been conducted among key populations, owing to an insufficient level of organization and planning. It turned out that the amount of required preparations for such research substantially exceeds initial estimations. Thus the question of conducting an Incidence Study by the Tajik specialists and in compliance with scientific requirements and global standards is still relevant for Phase II of the Programme. At the same time it should be noted that the Republican AIDS Centre conducts routine work on collecting data for new HIV cases, including the mode of transmission and specific risk groups. According to data provided by the Republican AIDS Centre, in 2015 the mode of transmission for new HIV cases was as follows: sexual transmission – 61.7%; drug injection – 21.2%, and MTCT – 4.9%. Special consideration should be given to the fact that for 12.2% of HIV cases the mode of transmission remains unknown. The respondents have also noted that in the recent years the distribution of specific modes of HIV transmission among key populations has changed significantly, in particular, a transition from prevalence of injection drug use transmission to sexual mode of transmission took place.

2.3 According to the Republican AIDS Centre, in 2014 an assessment of national expenses on response to HIV/AIDS in 2012-2013 was conducted in cooperation with the Ministry of Finance of RT. According to the assessment, approximately 37% of the expenses (which are highly insufficient to begin with) on response to the HIV epidemic is financed by the state budget. It should also be noted that over the period from 2010 to 2013 international financing of the National Programme of Response to HIV in RT has decreased by 14%, while the expenses have increased threefold (since 2011)¹¹. According to the assessment, the key organizations financing the National Programme of Response to HIV/AIDS in RT are GF (73%), USAID (13%), UNFPA (3.2%) and other partner organizations such as UN agencies, bilateral donors, international foundations and NGOs. A positive trend has been noted in an increase of the state financing for basic categories of expenses: expenses on HIV prevention have increased by 32% by the end of 2013; treatment and care expenses – by 42%. In addition, the state has for the first time provided assistance for activities related to social security and social services¹².

Another such assessment of expenses for 2014-2015 has been scheduled for 2016. In addition, similar further assessments are planned to be conducted on a bi-annual basis. The results of previous assessments of national expenses on HIV response are further used for advocacy aiming at increasing the ratio of internal resources allotted to programmes of response to HIV/AIDS and development of the next cycle of strategic planning. Thus, previously at least 5% of the expenses for the salaries of medical and other staff, as well as the maintenance of premises, were covered by the state budget; however, currently the figure is at least 20%, including additional expenses on purchases of medical drugs and testing systems for pregnant women.

2.4 National control research on HIV seroconversion has not been conducted. The research has been scheduled to be conducted before the end of 2016; a working group has been created; the Ministry of Health has issued the required order; the protocol on seroconversion is currently under consideration. In addition, 2 workshops on studying seroconversion patients for the medical network have been scheduled, with participation of medical staff from central and district clinics (1 representative par clinic). However, owing to the lack of cooperation on approving the list of the specialists, the plan has been altered and the seminars have been replaced by two similar seminars on infection control.

3 In order to improve epidemiological monitoring and prognostication, bio-behavioural studies have been conducted among high risk groups.

¹¹ According to the “National strategy for Response to the HIV/AIDS epidemic in RT in 2015-2017”, 2014

¹² According to the “National strategy for Response to the HIV/AIDS epidemic in RT in 2015-2017”, 2014.

3.1 Over the course of the Programme, thematic epidemiological surveillance has been conducted among risk groups, covering PIDs, CSWs and MSMs. The research has been designed to assess HIV, VH C and syphilis prevalence among the above populations, to study behavioural patterns and risk factors in the above populations, to determine the share of increased infection vulnerability individuals within the populations and to assess the level of the populations' awareness about HIV in general and HIV prevention methods in particular. In addition, the purposes of the study included assessing the level of accessibility of prophylactic means for the risk groups, coverage of HIV prevention and testing activities, and assessing the share of patients seeking medical help. The data obtained by the control epidemiological surveillance have permitted to improve the existing prevention programmes and increase their effectiveness. According to the 2014 assessment of the number of PIDs and CSWs, an average of 23 000 PIDs (ranging between 18 200 and 28 000) and 14 100 CSWs (ranging between 10 800 and 17 400) are currently residing in RT. As part of the research on MSMs, an assessment of the number of the given risk group has been conducted. According to the preliminary estimation, the number of MSM currently residing in RT is 13 400 in average (ranging between 12 900 and 13 900).

Despite the problems with targeting MSMs in RT, coverage with voluntary testing and counselling has increased more than tenfold (89 cases in 2010 versus 942 in 2013). It has been determined that the level of HIV, VH C and syphilis prevalence among MSMs depends directly on their level of awareness about HIV modes of transmission and HIV prevention. A low level of HIV/AIDS awareness has been detected among HIV positive MSMs (0.1%), while for the HIV negative MSMs the figure is 54.6%. MSMs infected with VH C and syphilis displayed a similar lack of knowledge. It should also be noted that owing to an existing unspoken taboo, MSMs seek medical help rather rarely.

Expanding the scope of HIV prevention assistance over the period of 2009 to 2013 has had positive impact on the PID population, however it is noted that some problems remain unsolved. The National Strategy focuses on the sexual mode of transmission from PIDs to their partners, including the ones who do not belong to the PID population, declares the importance of the given area of work and highlights the existing problems in accessibility of HIV prevention activities for PIDs. The opioid replacement therapy (ORT) programme in RT operates in 4 residential centres of the country and covers approximately 1.5 of alleged PIDs. The main obstacles complicating accessibility to treatment are restrictive state policies, geographical remoteness of ORT Centres and lack of psychosocial support. In addition, services for the users of narcotics and other banned substances are not available on a free-of-charge basis, which poses yet another problem.

Since the beginning of the Programme, coverage by HIV testing and counselling services among CSWs has increased more than threefold, however despite high coverage rates the given area requires further improvements.

In June 2014, the Republican AIDS Centre and the "Assistance" project conducted a selective anonymous survey among 1 300 women providing sexual services for a fee (further to be referred to as commercial sex workers or CSWs) in 12 localities.

Based on the results of the survey, recommendations have been issued for improving HIV prevention among key populations.

Currently monitoring of the key populations is conducted by the Republican AIDS Centre in cooperation with NGO. Thus, needle and syringe exchange programmes (NSPs) are successfully used for tracking PIDs. An accounting system for PIDs has been implemented, including assignment of an individual code to each PID, which permits to avoid data duplication and repetitive services. Thus the system allows to receive quarterly reports from NGOs to keep track of the dynamic changes and updates of the number of the risk groups.

4 As part of the Programme, activities aimed at the development of a regulatory and legal framework for HIV epidemiological surveillance have been conducted in compliance with WHO and UNAIDS recommendations.

4.1 In order to ensure sustainability of the educational activities preparing skilled personnel, the existing educational programme for epidemiologists has been adapted for the Continued Education Institute; now it also covers issues of HIV epidemiological surveillance. Over the course of the project, 20 epidemiology specialists from district AIDS Centres have been trained according to the updated programme.

4.2 In 2014 the protocol on HIV testing was updated, including changes and additions concerning the Procedure of medical evaluation for HIV, in compliance with recommendations of WHO and UNAIDS. In 2014 the following legal documents were issued: the Law of RT “On Response to HIV/AIDS” (#1078, approved on March 14th, 2014), the Resolution of the Government of RT (#528, 06.08.2014) “On Changes to the Resolution of the Government of RT #171, approved on April 1st 2008” “On Approval of the Procedure of Medical Evaluation for HIV, Accounting and Prophylactic Monitoring of the HIV positive and the List of Persons Liable to Mandatory Medical Evaluation for HIV by Epidemiological Indications”. The changes have concerned recommendations for persons belonging to high risk population groups to receive regular medical evaluation for early HIV detection, counselling and timely beginning of ART.

In order to increase the level of safety, integrity and effectiveness of healthcare-related manipulations, a decision has been made at the legislation level that any manipulations with children, performed by medical personnel (except surgical interventions) ought to be performed in the presence of parents (or any other legally entitled party) and strictly after consultations about the essence and potential consequences of each procedure. Thus, one of the revisions in the Government Resolution prescribes to conduct HIV counselling for persons taking care of HIV positive children.

The articles about mandatory medical evaluation for HIV for migrants and foreign citizens coming to RT for a period over three months, as well as refugees, have been excluded from the Law on “Mandatory Medical Evaluation.” The part concerning deportation of foreign citizens from RT in case of HIV infection had been excluded from the Law earlier, in 2008. These important changes lifting the limitations on the mobility of HIV positive persons significantly contribute to lowering the level of HIV stigma and discrimination of PLHIV in RT. However, at the practical level it is complicated by traditional ethics in rural areas and prevailing authority of local elders, parents-in-law and religious ministers.

4.3 Over the course of the Programme the Ministry of Health and Social Protection of RT has approved updated clinical protocols on medical evaluation for HIV and ART for adults and adolescents, as well as the tactics of treating patients with concomitant HIV/VH B and HIV/TB.

4.4 As part of the Programme a working group (specially formed for the task) has developed a draft of Regulations on the National Foundation for Response to HIV/AIDS. This project was widely discussed by all stakeholders nationwide (Ministries, State Departments, civil society organizations, PLWH community, international organizations etc)., after which the final version of the document was submitted to the Government of RT. The Regulations on the National Foundation for Response to HIV/AIDS have been approved, nevertheless no practical work is being conducted due to lack of Foundation funds.

4.5 According to the Republican AIDS Centre, analysis and elaboration of recommendations for increasing state subsidies for the National Programme’s priority tasks to ensure a sustainable mode of financing have not been conducted, owing to the fact that similar studies have been conducted as part of the assessments of national expenses on HIV response.

4.6 The National Coordination Committee (NCC) to Fight HIV, TB and Malaria headed by the Tajik Prime-Minister has been established. The Vice-Director of the Committee is the Minister of Health of RT. The Committee contains 5 working groups that include all partner organizations, including NGOs and organizations representing PLWH. At the NCC sessions issues of HIV prevention and treatment, including programmes of harm reduction, are discussed. The organization of NCC work and inter-

department cooperation permit to develop common, coordinated policies on epidemiological surveillance and elaborate on legal issues in compliance with global standards and recommendations.

In general, over the course of Phase I of the Programme in TR the legal framework for response to HIV has been improved and updated. The National Strategy for Response to HIV (2015-2017) has been developed and approved. Updates have also been made to the following: the Law on Response to HIV; the Procedure of HIV Testing and Counselling; clinical protocols on HIV positive pregnant women and MTCT prevention, in compliance with recommendations from WHO and UNAIDS. In 2013, the Protocol on HIV treatment which includes 13 independent protocols has been revised and approved. In 2013, the Protocol on sentinel epidemiological surveillance of HIV has been approved, and the protocol on HIV testing has been updated in compliance with recommendations from WHO and UNAIDS. Upon request from healthcare facilities the following documents have been presented: “Practice of implementation of the country programme for elimination of MTCT” (WHO, Ministry of Health of RT), a treatment module “HIV in paediatrics” (UNESCO) and the “Clinical protocol on HIV treatment and assistance to HIV detection” (WHO, Ministry of Health of RT; consists of 13 sections).

Over the course of the Programme the following inter-sectoral regulatory documents have been approved and implemented into practice: the New National Programme (currently under consideration), a joint strategic plan for response to HIV and TB, developed in cooperation with the Republican TB Center (2015-2017), as well as a plan for integration of activities carried out in the area of TB/HIV/STI prevention and in the area of Reproductive health.

5 As part of the Programme and in cooperation with the Federal Service for Supervision of Consumer Rights Protection and Human Well-Being (Rospotrebnadzor), laboratory equipment and tools have been purchased in order to develop cooperation and strengthen the lab infrastructure of the Republican AIDS Centre and in order to build and support a network for surveillance on HIV drug resistance. 5 pieces of diagnostic equipment have been purchased and installed in laboratories of a number of treatment and prophylactic organizations (ELISA enzyme-linked immunosorbent assay, Western Blot, polymerase chain reaction (PCR)).

As part of the Programme, in April 2014 two specialists from the National Control Laboratory and the Laboratory of the AIDS Centre have received training with support and participation from leading specialists from the Central Science and Research Institute for Epidemiology, Moscow. The ten-day education course has incorporated dry blood spot method in PCR laboratory.

In addition to other pieces of equipment, a DNA sequencer for detecting mutations in HIV drug resistance has been purchased and delivered to RT. However no work on HIV drug resistance has been launched, due to a lack of expendable materials and skilled specialists. As part of Phase I of the Programme, cooperation has been conducted at the level of the expertise of RF in research and analysis of samples from RT for detection of HIV drug resistance forms and transferring the collected blood samples to the Russian laboratory for further DNA analysis to be performed. At the present moment, the DNA sequencer is kept at the National Genetics Centre, and research on HIV drug resistance has been postponed till the problems with financing, expendable materials and training skilled personnel are resolved. According to a representative of the Republican AIDS Centre, activities for a joint research with RF on HIV drug resistance have been scheduled for 2017 and involve the employment of the purchased equipment.

Thus it can be stated that as part of Phase I of the Programme the development process for a system of control on HIV drug resistance has been launched. However, no full-range autonomous complex of such activities in RT is being conducted at the moment.

Strong and weak points of Component A of the Programme:

The following can be attributed to the strong points of the Programme Component:

- Work on strengthening the professional potential of the specialists in key areas of HIV surveillance, including trainings of specialists in operation and security of the HIV electronic surveillance system
- Organization and preliminary training of personnel for technical and practical aspects of rapid testing, conducted prior to the deliveries of diagnostic testing systems to RT.
- Effective work on development and implementation of the system of electronic surveillance on HIV and provision of technical equipment required for the system to operate effectively. At the present moment, the electronic system of HIV surveillance covers about 90% of the AIDS Centres in RT, which has significantly improved the process and quality of data collection and ensured timely projection of demand for medical drugs and diagnostic materials, which proves relevance of this activity.
- Assessment of national expenses on HIV/AIDS conducted in cooperation with the Ministry of Finance of RT. According to the assessment, about 37% of the expenses are covered by the state budget. The assessment results are used for advocacy purposes, including increasing the share of internal resources allocated for programmes of response to HIV/AIDS and development of the next cycle of strategic planning.
- Conducting of bio-behavioural studies among key populations aimed at improving epidemiological monitoring and projections. The obtained data have permitted to revise the existing prevention programmes with consideration for current needs and towards further development and improvement of their effectiveness. Considering cultural and ethical peculiarities of the region, along with denial of the problem at the official level, it should be noted that the research conducted among MSMs is an achievement of its own.
- Conducting activities in the area of development and harmonization of the regulatory and legal framework for HIV epidemiological surveillance in compliance with the current recommendations from WHO and UNAIDS, including adaptation of the existing educational programme for epidemiologists for the Continued Education Institute, updating and approval of clinical protocols and recent updating of the protocol on HIV testing. The parts of the Law on Mandatory Medical Evaluation, concerning mandatory medical evaluation for HIV for refugees and foreign citizens entering RT for a term over 3 months, have been excluded from the Law, which made a significant contribution to lowering the level of stigmatizing and discrimination of PLHIV in RT and can be rated as an undoubtedly useful and effective result in the area of overcoming HIV stigma and discrimination.
- Establishment of the National Coordination Committee to Fight HIV, TB and Malaria, permits to develop common, coordinated policies on epidemiological surveillance and to effectively discuss legal matters in compliance with global standards and recommendations.

The following can be attributed to the weak points of Component A:

- A lack of targeted Incidence Study aimed at obtaining exact data regarding new HIV cases for monitoring of HIV epidemic and improving interventions, due to insufficient level of research organization and organizational shortcomings in the work of the Republican AIDS Centre. However it should be noted that the Republican AIDS Center conducts routine work on tracking and accounting of new HIV cases, including the modes of transmission and risk group identification.
- Lack of a National thematic monitoring system of the behavioural patterns among persons with seroconversion and cancelling of previously scheduled seminars on studying persons with seroconversion for the medical network, due to the problems with approval of the list of invited specialists.

- Despite the conducted work on designing a draft for Regulations on the National Foundation for Response to HIV/AIDS and its implementation, at the present moment, according to the interviews, the Foundation is not effective and virtually no practical work is being conducted due to a lack of funds.
- A lack of analysis and subsequent recommendations for increasing the share of state financing of priority tasks of the National Programme for development of a sustainable financing mechanism. Such research has not been conducted, owing to regular assessments of national expenses on response to HIV/AIDS.
- Lack of work on HIV drug resistance, which is due to a lack of expendable materials and skilled personnel. The DNA sequencer provided by RF is stored at the National Genetics Centre and research on HIV drug resistance is postponed till the issues with financing, expendable materials and training of skilled staff are resolved. An activity plan for joint research with RF on HIV drug resistance has been designed and approved, including employment of the provided equipment.

Factors (external and internal) influencing the Programme

- Low rates of staff retention have a heavy negative impact, among other areas, on the system of HIV epidemiological surveillance both at the national and at the regional level. The current situation with staffing poses risks to investment, including external contributions towards development and strengthening of epidemiological surveillance, monitoring and evaluation, especially considering the conducted work and expenses on trainings for personnel. As a solution to this problem, issues of HIV epidemiological surveillance have been incorporated into the curriculum for continued education which is expected to produce a long-term effect in increasing HR potential.
- It should be particularly noted that the mode of HIV transmission has not been identified in 12.2% of cases, which proves the urgency of conducting a specialized research on new HIV cases, as well as a need for evaluation of the existing methods and quality of HIV epidemiological surveillance.
- A positive trend can be observed in the increasing of state financing for the main categories of expenses on the response to HIV/AIDS: by the end of 2013, expenses on HIV prevention have increased by 32%, on HIV treatment and care – by 42% (an extremely low initial figure, however, should be taken into account).
- At the practical level, the influence of traditional morals of the region and the prevailing authority of local elders and religious ministers remain strong, which complicates the active effort to lower the level of HIV stigma and discrimination in society at large.
- A long border between Tajikistan and Afghanistan and the exploitation of RT territory for drug trafficking, along with trans-border financing of terrorist activities and growth of organized crime, contribute to retention of conservative views in the society, on one hand, and to lack of political stability, on the other.

Lessons applicable to Phase II of the Programme

- It should be noted that medical personnel of various specializations who have taken part in national and regional trainings are interested in improvements in accessibility of educational materials, adaptation of HIV-related issues to specific specializations and expanding of visual and interactive elements of the educational process.
- A demand has also been noted for specialized educational programmes on monitoring and treatment of HIV patients for general physicians with a special emphasis on peculiarities of opportunistic and concurrent diseases. Such programmes will help the physicians to provide autonomous skilled assistance in the care and treatment of HIV patients in a timely manner, without referring them to departments of infectious diseases to seek such assistance.
- A question of improving material and technical provisions for healthcare organizations in order to improve HAI prevention (technical disinfection means, expendable individual protection

equipment such as gloves, masks, disinfection agents, paper towels and hands disinfectants) has become a part of the agenda.

The analysis of the collected data has determined that as part of the Component B **“Development of communicable disease prevention and control, including HIV, STI and hepatitis among women and children”**, UNAIDS has provided considerable assistance in achieving substantial progress in organization of work on elimination of MTCT HIV transmission. Infection control over HIV (and other blood-borne infections) in healthcare organizations has been strengthened. Work has been conducted on ensuring conditions for elimination of cases of AIDS and AIDS mortality among children; accessibility of HIV-related services for women and adolescents has been improved, including activities in lowering the level of HIV stigma and discrimination.

Even before the launching of the Russian Programme in 2006, 18 pilot districts of RT had started working on strengthening MTCT HIV prevention. The chief problem is the level of awareness among the population. HIV testing in the pilot districts has been performed twice: at the time of registration (up to 12 weeks of pregnancy) and at 28-30 weeks of pregnancy. Such measures have resulted in significant growth of HIV detection rate. Over the course of 9 months of 2016, primary testing has been performed on 75% of all pregnant women, secondary testing – on 20-25% of all pregnant women. (Tracking and coverage of the key population is conducted through the network of clinico-diagnostic centres for MTCT HIV prevention). Thus in 2015, 21 HIV-positive women were diagnosed; in 2016, 8 such new HIV cases have been registered; till the present day, new cases are registered, where HIV-positive mothers (not registered previously) have been tracked via tracking their HIV-positive children. Previously new HIV cases among children have not been detected, due to a number of causes, including a lack of financing for the given area from GF. The problem first received attention only as part of the Russian Programme. According to the National Centre for Reproductive Health, in order to ensure full coverage by double-testing among pregnant women, RT needs at least 450 000 testing systems per year.

Achieved results of Component B of the Programme

1 A significant contribution has been made to organizing work on elimination of MTCT HIV transmission, including the following:

1.1. As part of the Programme, activities aimed at increasing the level of awareness about HIV-related services for women, engaging the population in testing and expanding the coverage of pregnant women with HIV testing services have been undertaken. In view of this goal, the Programme has financed purchase and delivery of 40 000 HIV rapid tests. The diagnostic tests have been delivered to the cities of Dushanbe, Khujand, Kulyab and Kurgan-Tyube for further distribution in primary health care organizations and Reproductive Health Centres. In addition, video- and audio- clips have been designed and produced along with 13 articles of informational and educational materials intended for increasing the level of HIV/AIDS awareness and mobilization of the population. The information materials include the following booklets: “Positive motherhood”, “Take care of yourself”, “Health issues”, as well as “Stop HIV” and “HIV and a mother-to-be.” Materials on HIV stigma and discrimination has also been produced and distributed among health care providers. In addition, wall calendars and banners have been placed in large cities (more than 10 000 informational materials).

The following educational sessions have been initiated and conducted for health care providers of the network of primary medical care and reproductive health organizations as well as community representatives who have mastered skills in voluntary HIV counselling and testing, raising the population’s awareness about HIV-related services and engaging pregnant women in HIV testing activities. The NGO “Safe motherhood” has conducted 18 seminars in various regions of the country engaging 230 nurses from rural areas and 274 migrants’ wives or close relatives. Over the course of

Phase I of the Programme (2013-2015) 15 training workshops have been conducted to the purpose of improving the quality of antenatal services and MTCT HIV prevention, aiming at increasing the professional potential of the health care providers at primary healthcare organizations. 6 training workshops have been conducted for family doctors of the primary health care service, 6 training workshops – for obstetricians, gynaecologists and staff of Centres for Reproductive Health services, and 3 training workshops for the specialists of youth counselling organizations. Training activities have been conducted for specialists of Dushanbe (including districts of federal jurisdiction), medical personnel of Khujand (for districts of the Sughd region) and Kulyab (for districts of the Khatlon region).

In total over the course of Phase I of the Programme in RT (2013-2015), 450 000 pregnant women have been tested at an early stage of pre-natal care, which improved early HIV detection among the given population and timely assistance for HIV MTCT prevention.

1.2 Over the course of the Programme, HIV MTCT prevention services coverage of pregnant women has been expanded. As of 2016, 97.8% of pregnant women were covered by HIV MTCT prevention services and about 4 200 women are being monitored. Since 2010 582 children have been born to HIV positive mothers, 12 of them have been HIV positive.

Evaluation of the implementation of HIV MTCT prevention was not conducted as part of the Programme, since such evaluation had been conducted previously in 2015 by GF. However, the Republican AIDS Centre has refused to accept the results, expressing doubts in the quality of the evaluation, in particular the issue of the effectiveness HIV MTCT prevention. Subsequently, the question of monitoring the effectiveness of HIV MTCT prevention is under consideration at the level of the Ministry of Health of RT.

According to the data obtained for 2014, the share of HIV positive pregnant women receiving ART for reducing the risk of MTCT varies between 51.6% (national statistics) and 82% (spectrum analysis), depending on the source¹³.

Coverage by HIV testing among pregnant women has increased from 92% in 2011 to 98% in 2015 (the figure for 2016 is 100%, according to the Republican AIDS Centre), which is partly due to performance of HIV testing during labor and delivery. However according to the data presented in the National Strategy for Response to HIV, every year retrospectively detected HIV cases are registered among women (i.e. detected after epidemiological investigation issuing from detection of HIV in their children). Taking into account that annually over 200 000 pregnancies are registered in RT, and home births are still widespread (according to different sources, from 9% to 40%, and up to 80% in some areas), especially in rural areas and hard-to-access districts, the given fact requires detailed consideration.

HIV testing among pregnant women remains to be an area requiring careful attention. Expanding HIV testing coverage has significantly influenced detection, and subsequently, growth of the number of new HIV cases. Thus, over the course of 6 months of 2014, the Republican AIDS Centre has reported 106 HIV cases detected in pregnant women, where about 70% of the cases have been detected by performing HIV testing during labor and delivery. Such a growth can be partly explained by a 1.4 times increase in HIV testing among pregnant women. It is also necessary to take into account the ongoing changes in the distribution structure of new HIV cases, namely the growing share of heterosexual and vertical modes of transmission (according to the data for 2014, 44% and 54% respectively). In 2013, 80% of new HIV cases among women were registered as having had the sexual mode of transmission, with about 40% of women being in the age group between 21 and 29 years old.

Notwithstanding the diagnostic tests provided by the Programme, the system of HIV MTCT prevention continues to have periodical shortages of the materials. Owing to this, testing of pregnant women is

¹³ “The National Strategy for Response to HIV/AIDS in RT in 2015-2017”, 2014

frequently conducted by the rapid testing method only once, thus not following the recommendations on double testing. Double testing is performed based on epidemiological indications, for instance, if a pregnant woman's husband belongs to a risk group.

1.3 During Phase I of the Programme, no work has been conducted on creating a national team of teaching staff regarding implementation of the national protocols on MTCT in compliance with the updated WHO protocols, including the B+ Strategy. No educational programmes have been conducted for specialists regarding implementation of the national protocols on MTCT at the national and Region levels, owing to the fact that the protocol was updated in compliance with the declared criteria in 2016.

2 Work has been conducted on strengthening of infection control on HIV and other blood-borne infections in medical organizations.

2.1 As part of the Programme, the clinical protocol on MTCT has been updated and distributed. Upon request, healthcare organizations have been presented with a document on "Practical implementation of a national programme of elimination of HIV MTCT" (WHO, Ministry of Health of RT), 2013. The protocol was most recently reviewed and updated in 2016. Based on the updates, a document has been developed on the "National policies and clinical protocol on elimination of HIV MTCT in RT" (3rd country/national inspection, in compliance with WHO recommendations). The inspection has been conducted in connection to improving distribution of the country's limited resources in order to achieve more effective and sustainable results in the work aimed towards elimination of HIV MTCT. The revised protocol contains a chapter on "Clinical scenarios: pregnancy, birth, post-birth period" presenting the B+ option recommended by WHO for countries and regions with high birth rates and high HIV prevalence as the most effective strategy. The updated manual highlights that life-long prescription of ART to pregnant and breastfeeding women can help decrease HIV prevalence and prevent HIV transmission both during the current and future pregnancies. Publication and implementation of the latest edition of the protocol is scheduled for 2017.

According to the Republican AIDS Centre, the RT does not have a protocol on HIV infection control, standard procedures and observing universal safety measures. However, cooperation and joint efforts of specialists representing the Ministry of Health and Social Protection of RT, the State Service for Sanitary and Epidemiological Control and the Republican AIDS Centre have resulted in the development and publication of practical guidelines on "Control and universal safety measures in prevention of communicable diseases." In addition, there exists the administrative order of the Ministry of Health of RT #667 (2014) on measures of prevention of healthcare-associated HIV infections, as well as the aforementioned Regulations of the State Sanitary and Epidemiological Control Department of RT, defining measures of prevention of healthcare-associated HIV infections (2014). The given Regulations and the order of the Ministry of Health have been presented to managers and staff of the health care organizations.

2.2 As part of the Programme of professional education in HAI prevention, training activities on infection control in medical organizations have been conducted for medical personnel. The training workshop "HAI Prevention in Healthcare Organizations" has been conducted by the staff of the Republican AIDS Center for specialists in charge of infection control at the health care organizations. In May through June 2014, the training was conducted in the cities of Dushanbe, Kurgan-Tyube and Khujand. The training workshops have engaged medical personnel from healthcare organization of Dushanbe, the Sughd region, the Khatlon region, as well as districts of federal jurisdiction. The participants have received practical manuals on "Control and universal safety measures in prevention of communicable diseases" for further use in routine educational programmes for medical personnel at their healthcare organizations.

2.3 In addition, an inter-departmental working group has developed methodological recommendations on "Methods of assessment of HAI in medical organizations of RT (except TB organizations)." The recommendations were approved by the order of the Ministry of Health #667 (August 16, 2014).

According to the interviews, the Order and the recommendations have been presented to the top managers of medical organizations of RT.

3 Work has been conducted on creating conditions which would guarantee eliminating AIDS cases and AIDS mortality among children, including the following:

3.1 A system of referrals for accurate and timely neonatal diagnostics of HIV has been developed and implemented. A system of early HIV diagnostics in neonates has been developed along with optimized approaches to HIV care, when within the first 48 hours after birth all babies born to HIV positive mothers have their blood samples taken for PCR. Additional tests are conducted at 12 weeks, 6 months and 18 months of age. All these blood samples are then transferred to the laboratory of the Republican AIDS Centre.

3.2 The national protocol on paediatric treatment and care, as well as early neonatal HIV diagnostics, was revised in 2013 in compliance with the updated WHO recommendations. The revisions of the protocol on HIV treatment has permitted to start treatment immediately after a child has been diagnosed with HIV, regardless of their disease stage and immune status.

3.3 In order to increase the professional potential of health care providers in HIV treatment for children, a thematic workshop “HIV MTCT Prevention” was conducted in Dushanbe in November 2014. The training was conducted by specialists from the Republican AIDS Centre for obstetricians and gynaecologists from regional AIDS Centres, in order to teach them contemporary approaches to HIV MTCT prevention in compliance with the latest recommendations of global organizations. The training has employed interactive methods. 25 specialists from AIDS Centres of all regions of RT have been trained.

At the present time, over 96% of HIV-positive children are receiving ART, however ensuring compliance and adherence to treatment remains a top priority task. In view of this goal, it is necessary to maintain a high level of effort on increasing adherence to ART in all activities targeting HIV-positive children and their parents. As HIV-positive children grow up, medical professionals face new challenges, such as assisting the clients in psychological acceptance of their positive HIV-status. The given area requires specialized training and highly skilled personnel.

4 Work has been conducted on improving accessibility of services related to HIV prevention for women, including activities in lowering the level of HIV stigma and discrimination.

4.1 Activities aimed at lowering the level of HIV stigma and discrimination have been implemented, including training workshops for specialists from YFHS, primary healthcare network and family medicine. In particular, 3 training workshops have been conducted for specialists from the youth organizations specialising on medical counselling. Training workshops have been conducted both for specialists from Dushanbe (including districts of federal jurisdiction) as well as for medical personnel of Khujand (for districts of the Sughd region) and Kulyab (for districts of the Khatlon region).

4.2 In 2013, in order to improve coordination and unification of work in HIV prevention and protection of reproductive health in women and girls, preparations have been conducted for work on harmonization of activities of the Ministry of Health of RT, Reproductive Health Centres, NGOs and other key partners. Organizational and administrative issues have been resolved; a final round table meeting has been preliminarily scheduled for the adaptation of a standard package of HIV-related services to the needs of women, girls and other vulnerable groups in the area of sexual and reproductive health. In addition, in 2013 informational sessions (6 series of meetings) have been held for representatives of NGOs and various organizations of the Ministry of Health in the cities of Dushanbe, Kurgan-Tyube and Khujand with participation of specialists of Reproductive Health Centres, NGOs

and target group representatives¹⁴. In addition, 3 round table meetings have been held on issues of HIV MTCT prevention with an emphasis on vulnerable population groups and aiming at advocacy and strengthening of inter-sectoral collaboration.

Strong and weak points of Component B of the Programme:

The following can be attributed to the strong points of the Programme:

- Work conducted on raising awareness about HIV services among women, engaging them in testing activities, expanding coverage of HIV testing among pregnant women. Programmes of HIV MTCT prevention have improved coverage, owing to HIV diagnostics having been provided during labor and delivery, including women from vulnerable population groups.
- Strengthening of infection control regarding HIV and other blood-borne infections in health care organizations, including revision of the national protocols on MTCT in compliance with updated WHO protocols, including the B+ strategy. However it should be noted that the given procedure was conducted after the completion of Phase I of the Programme in 2016, and publication and implementation of the latest edition of the protocol are scheduled for 2017. A practical manual on “Control and universal safety measures for prevention of communicable diseases” has been published. Also in 2014 an order of the Ministry of Health #667 on measures of prevention of healthcare-associated HIV was issued. In addition, a toolkit for HAI assessment has been developed and implemented.
- Specialized training workshops on infection control in medical organizations for health care providers, including training workshops for medical personnel for further cascade training at the health care organizations where they are employed.
- Development of the system of referrals for accurate and timely neonatal HIV diagnostics.
- Approval and implementation of the protocol on paediatric treatment and care, and provision of early neonatal HIV diagnostics in compliance with updated data and WHO recommendations.
- Improving the professional potential of health care providers on issues related to in HIV treatment in children, using up-to-date approaches to HIV MTCT prevention in compliance with global recommendations.
- Work on adaptation of the standard package of HIV-related services to the needs of women, girls and other vulnerable population groups in the area of sexual and reproductive health.

The following can be attributed to the weak points of Component B:

- A lack of official approval on behalf of RT authorities on conducting evaluation of the implementation of the MTCT programme as part of the Programme. It is linked to the refusal of the Republican AIDS Centre to accept the results of similar evaluation which had been conducted by GF in 2015. Subsequently the issue is currently under consideration by the Ministry of Health.
- Over the course of Phase I of the Programme, no national team of teaching staff for implementation of the national protocols on MTCT in compliance with updated WHO protocols, including B+ Strategy, has been formed. No educational programmes have been conducted for specialists on topics related to the implementation of the national protocols on MTCT at the national and regional levels, owing to the fact that the protocol was updated in compliance with the declared criteria in 2016.

¹⁴ “1st Technical Report on the Implementation of the Programme of Technical Assistance to Countries of Eastern Europe and Central Asia in the Areas of Prevention, Control and Surveillance of HIV/AIDS and Other Communicable Diseases (2013-2015)”

- Insufficient engagement of health care providers in educational programmes aimed at lowering the level of HIV stigma and discrimination, considering the requests of healthcare personnel for such activities.

Factors (external and internal) influencing the Programme

- Cutting down on GF programmes and donations that currently results in a lack of financing for activities in testing among pregnant women and HIV MTCT prevention.
- Despite the diagnostic tests provided by the Programme, the system of HIV MTCT prevention continues to have periodical shortages of materials. Owing to this, testing of pregnant women is frequently conducted by the rapid testing method only once, thus not following the recommendations on double testing. Double testing is performed based on epidemiological indications, for instance, if a pregnant woman's husband belongs to a risk group.
- Home births are still widespread in RT (according to different sources, from 9% to 40%, and up to 80% in some areas), especially in rural areas and hard-to-access districts. It is linked to a high level of traditionalism as well as to religious factors.

Lessons applicable to Phase II of the Programme:

- It should be noted that the MTCT programme is integrated into routine work of prenatal and obstetrical assistance in RT and special attention should be given to trainings in voluntary HIV counselling and testing for medical personnel of the primary level medical network targeting pregnant women. It is also important to ensure accessibility of respective HIV-related services for HIV positive pregnant women.
- Within the context of MTCT it is very important to ensure sustainability and growth of voluntary counselling coverage and testing activities, as well as providing ART treatment, especially considering the current trends in the epidemiological situation (shift towards sexual mode of transmission).
- Notwithstanding the diagnostic tests provided by the Programme, the system of HIV MTCT prevention continues to have periodical shortages of the materials. Owing to this, testing of pregnant women is frequently conducted by rapid test only once, thus not following the recommendations on double testing. Double testing is performed based on epidemiological indications, for instance, if a pregnant woman's husband belongs to a risk group.
- It should be noted that the respondents express a general wish regarding the need for educational and counselling programmes for health care professionals of various specializations devoted to ethical aspects of work with PLWH in order to lower the level of HIV stigma and discrimination.

The analysis of the collected data has determined that as part of Component C **“Improvement of the prevention system for HIV/AIDS, STI and hepatitis among key populations, including prevention among migrants”** the “AIDS Infoshare” Foundation has conducted work on developing a system of outreach services for diagnostic and counselling aid and offering educational programmes on HIV prevention among migrants, their family members and other population groups experiencing risk of infection. A specialized educational centre for migrants has been provided with equipment and technical assistance in organizing and strengthening work on prevention of HIV/AIDS, VH and STI.

Achieved results of Component C

1. The Russian mobile medico-diagnostic complex which was presented to RT has become the key element of Component C, along with financing and comprehensive support of its work. The mobile

clinic was presented to the Ministry of Health in September 2013 and launched in October 2013. The mobile clinic is stationed at the Regional AIDS Center of Kurgan-Tyube in the Khatlon Region, that is the largest and the most hard-to-access area of R. The mobile clinic visits districts 100-300 kilometers away from the centre of the country in order to provide care to the population in mountainous areas.

The clinic is designed to conduct diagnostics, counselling and prophylactic evaluations and to provide primary medical and sanitary care. The mobile clinic has equipment for conducting laboratory, instrumental, functional and ultrasound diagnostics. The equipment allows the clinic to work autonomously providing services of various medical specialists and can also be used in joint work with rural hospitals or first-aid and obstetrics stations. In the latter case, the portable equipment of the clinic (ECG machine, ENT and eye care equipment etc). can be installed at the premises of the local organization, thus enabling to serve more patients. It should be noted that the level of the technical equipment of the mobile clinic is significantly higher than the one at the local medical organizations in rural and mountainous areas of RT.

The mobile clinic has 3 fully equipped medical offices: a general practice physician's office, a gynaecology office and a laboratory for express rapid diagnostics. During the visit, the medical team of the clinic included a physician, an obstetrician and a laboratory diagnostics specialist.

According to the reports, during visits the mobile clinic serves over 100 clients a day (according to medical personnel, about 90), where about 25 people take tests for HIV, VH, TB and syphilis. This leads to the conclusion that the services are in high demand and there exists a need for detailed analysis of the quality of the services, counselling, evaluation of organizational aspects of the clinic's visits and possible a revision of terms and workload for the mobile clinic's personnel.

The mobile clinic's services are in high demand, since diagnostics is provided on a free basis which is especially relevant because diagnostics in RT in general is provided on a paid basis and in remote areas of the country there exist logistics difficulties providing such services to local population. Only about 50% of remote and hard-to-access localities are covered with HIV, VH and STI prevention services however during the winter period this figure goes down due to climate and geographical specifics. In total, about 4-5 of such mobile clinics are required to ensure full coverage of RT.

Over the course of Phase I of the Programme, in the area of diagnostic work of the mobile clinic, "AIDS Infoshare" has purchased and delivered the following: 28 000 HIV diagnostic test systems; 13 000 VH B and C test systems respectively, 15 500 syphilis test systems and 15 500 TB test systems. Over the period of 2013-2015, 7 449 people have taken HIV tests at the mobile clinic, and 63 512 people have received access to medical services. In total, 67 500 people have been provided with medical services at the mobile clinic. The main clientele of the mobile clinics are rural women, migrants' wives. Thus in some districts, pregnant women for the first time received an opportunity to take an HIV test through the mobile clinic's services.

The mobile clinic has performed clinical and diagnostic services in over 50 localities of the Khatlon Region. Some localities have been visited more than once (3-6 times), due to a high demand among the local population and upon enthusiastic requests from the local authorities.

Work of the mobile clinic is financed by the Programme, including extra payments for medical doctors, reimbursements for a driver and an engineer, and renting an additional motor vehicle for staff transportation. Expendable materials of medical use, medical drugs, individual protective equipment and disinfection material are purchased through the Programme. The Ministry of Health is in part co-financing the mobile clinic's work by paying monthly salaries to medical staff at their main workplace. It should be noted that expenses for the technical maintenance of the mobile clinic – such as fuel, spare parts for repairs, and expendable materials for technical maintenance – are fully financed by the Programme as well. In addition, the legal system does not allow for any preferences, subsidies or privileges to be co-financed by the state for technical maintenance of motor vehicles or purchases of petroleum, oil and lubricants. The same equally applies to maintenance of motor vehicles and medical

equipment. Spare parts and expendable materials are available; however repairs or parts replacement of some elements of the mobile clinic's medical equipment can be conducted only in Russia, which, in turn, can affect the comprehensive approach to providing assistance during periods of the mobile clinic's temporary inactivity due to scheduled repairs or technical maintenance.

It should also be noted that in the Khatlon Region the mobile clinic is used not only for clinical and diagnostic services, but also for parallel awareness and educational outreach engagement with rural population in distant locations. In addition, the mobile clinic is mandatorily engaged in all activities and actions related to healthcare issues.

2. The second area of work covered by the Programme has been the establishment and financing of an educational centre for migrants in the Khatlon Region (the city of Kurgan-Tyube) on the grounds of the National Red Crescent Society. In 2013 work has been conducted on renovating and equipping of the centre's premises, and the required furniture and technical equipment have been purchased (projector, screen, 12 portable computers etc).. Educational and information materials have also been developed in both Tajik and Russian languages; the manual on "Legal framework for providing medical services to foreign citizen in RF" has been developed and published to be used in the educational activities. The Centre was opened in the Spring of 2014, and by the end of Phase I of the Programme, 380 people have undergone training.

The Centre's educational programmes for migrants cover 4 topics: healthcare (HIV, VH, TB, STI), Russian language, computer literacy and legal matters. The mandatory curriculum includes informational sessions on the following subjects: general issues of HIV diagnostics and prevention; TB and STI diagnostics, prevention and treatment; accessibility of medical services for labor migrants (both in their homelands and in the destination countries); and general legal issues regarding labor migration (including the legal framework for seeking medical help in RF). According to the Centre's personnel about 60% of the total education time is devoted to health care issues. Russian language, law and computer literacy are taught to motivate migrants' attendance and boost their commitment to education. The curriculum has been coordinated and developed in cooperation with the Region AIDS Center (the city of Kurgan-Tyube), "Counseling Center for Employment in Saint-Petersburg" (Kurgan-Tyube) and the Healthy Lifestyle Centre and has engaged specialists and informational materials from the International Federation of the Red Cross and Red Crescent Societies. The teaching sessions also use visual and informational materials (booklets, leaflets, posters), including the ones developed independently based on online resources (thematic websites: WHO, UNAIDS, "AIDS Infoshare"). It is emphasized that all the handout materials have been financed by the Programme. The Centre's personnel point out timely updates of the information used in class, in compliance with requirements of global organizations. Within the health care section a particular emphasis is made on HIV, VH, TB and STI prevention and elimination of specific modes of transmission.

Internal evaluation of the quality of education is conducted on a regular basis, using various methods of testing and oral control, a journal of academic progress and practical assignments. At the end of the term, students successfully passing final evaluation (exams) receive certificates which, according to the Center's representatives, significantly improve the prospects of employment in Russia. Thus, the certificate contributes to the students' motivation and commitment. External evaluation of the quality of education is conducted in the form of regular monitoring by representatives from "AIDS Infoshare" and the officials from the Migration Service of RT.

Student accounting is conducted by compiling and keeping lists (including electronic format), attendance journals and storing personal data (copies of students' passports).

Selection and training of teaching staff has been conducted by the International Federation of the Red Cross and Red Crescent Societies, however no professional/specialized training in healthcare has been conducted. Continued education activities are not conducted; there's no plan of education programmes for teachers. Only the Russian language instructor has participated in continued education programmes

(on the grounds of the Republican Institute for Continuing Education of Russian Language Educators, 2015). The Centre's teachers point out that they have received training only at the national level and no foreign experts have been involved. Particularly, the teachers have expressed desire to improve their skills and receive additional training in their respective areas.

The length of the course is 1.5 months (2 hours a day, 5 days a week). Applicants sign up for one-two courses in advance, which testifies to an existing demand for the given services. In addition, cooperation of the Centre with the "Counselling Centre for Employment in Saint-Petersburg" helps establish contact with Russian organizations, in Saint-Petersburg in particular, which is instrumental for individual employment. Specific referrals of migrants to particular employers can potentially permit to control and access risk factors for exposure to infectious diseases (work conditions, quality of life, medical evaluations, food etc).

Over the course of the term, students are offered to take tests for HIV, VH and STI upon completion of the programme and before departure for the destination country. However, regardless of the test results, the medical document issued in RT is not considered valid in RF, and migrants have to be tested again in order to obtain work permits.

Over the course of the programme, an emphasis is placed not only on general educational and prophylactic work, but also on the importance of diagnostics for migrants leaving for Russia to find employment. However, similar work with migrants returning to RT requires at least a similar amount of attention and consideration for further development. Medical evaluation of the returning migrants lacks additional motivation and as a rule is performed by personal choice.

Recent changes in labour migration have been pointed out towards continuous growth of the number of female migrants. According to various expert estimations, the share of women in the total number of labor migrants varies from 7% to 20%. Indirect evidence can be seen in the fact that the students of the Centre are mainly men from rural areas (only 12-15% are women), however, according to a representative of the Centre, the share of women among migrants from urban areas is about 60%. Considering the cultural and civilization-related specifics of the region and specifics of issues related to HIV, VH and STI, it should be emphasized that classes are run for mixed gender audiences. Practical sessions are conducted on a peer-to-peer basis and imply exchange of opinions and collective discussion of relevant matters.

The total number of migrants, according to different estimates, varies from 10-12% to 20% of the population of RT (according to various sources, from 1 million (Migration Service) to 2 million (National Strategy) people out of 8-9 million population). Thus, the efforts focused on that particular group play a significant part in the prevention of infectious diseases such as HIV, VH and STI. It is crucial to note that despite the fact that 14 centres working with migrants in RT possess generally adequate material, technical, information and human resources' capabilities, only 1 of them is actually focused on HIV, VH and STI prevention, due to the of funds for hiring dedicated teachers and personnel to handle HIV, VH and STI prevention issues. As a result, despite the available resources and technical equipment, comprehensive educational and prophylactic work conducted by only 1 centre for migrants in the Khatlon district is clearly insufficient and does not provide a sufficient response to the challenge: only a total of 800 people have participated in the Centre's trainings over the course of its operation (2016), which is roughly estimated to represent approximately 0.08% of the overall number of migrants.

Considering the fact that during the recent years the number of new HIV cases among persons with international labor migration background has been increasing – from 62 people in 2010 to 165 people in 2015 (according to the RT data as of 2015, 23 827 labor migrants have been tested, including 17 534 men and 6 293 women) – further implementation of the given component will not only contribute to lowering the risks of cross-border HIV epidemic in RF, but also will also facilitate the strengthening of control on infectious diseases among migrants by the Russian party.

3. The third area of the Component C is work on the development and support of a system of outreach services. The National Red Crescent Society of RT has trained 16 volunteers to work as outreach workers. Outreach workers are divided into 4 groups to work with key populations in 4 districts of the Khatlon Region. The management and coordination of each group is conducted by trained promoters acting as managers of outreach services in respective districts. Trained volunteers perform door-to-door rounds, conduct informational and educational work, interview the local population in order to determine existing risk factors, and conduct activities in assessing the level of awareness about HIV, VH, TB and STI. Outreach workers distribute informational materials, motivate the population to participate in informational sessions on such topics as “HIV prevention”, “STI”, “TB” and “VH”, as well as conduct activities in engaging population in educational programmes of the Centre for Migrants. An important component of the work of outreach volunteers is coordination of their activities with the services of the mobile medico-diagnostic complex, such as: preliminary informational work with the population, including information on the time of the mobile clinic’s visit and the range of offered services as well as motivation and mobilization of the population for HIV, VH, TB and syphilis counselling and testing. According to the reports, outreach services performed on door-to-door rounds have covered a total of 26 157 people in 4 districts of the Khatlon Region. In addition, the outreach service maintains subsequent follow-up contacts with migrants previously taught at the Centre, providing them with required information and thematic counselling upon request. In order to improve the outreach component and raise the quality of informing the populations about HIV, VH and STI, it appears potentially beneficial to give special attention to revising the existing model of outreach work, particularly considering the implementation of the second mobile clinic and expansion of coverage.

Strong and weak points of the Programme:

The following can be attributed to the strong points of the Programme:

- The main achievement is the work conducted on equipping and presenting the mobile medico-diagnostic complex to RT as well as comprehensive support and organization of its performance.
- Providing free diagnostic services for population, which is particularly relevant considering the practice of paid testing in RT in general and logistical difficulties with accessibility of such services for residents of remote areas.
- All HIV cases detected through diagnostics provided by the mobile clinic have been redirected to the Regional AIDS Centre for further registration, as well as proper diagnostic and clinical management.
- Establishing and financing the educational Centre for Migrants in the Khatlon Region (the city of Kurgan-Tyube), including its technical equipment and development of educational programmes in both Tajik and Russian languages.
- One of the Centre’s achievements is the emphasis on teaching the topics related to healthcare and prevention of HIV, VH and STIs.
- Mixed gender audiences for class meetings, including sessions on HIV, VH and STI prevention. Practical sessions are conducted on a peer-to-peer basis and imply exchange of opinions and group discussion of the matters of interest.

The following can be attributed to the weak points of the Programme:

- The Republic of Tajikistan has not implemented the system of clients’ encoding and accounting, unified and standard for all participant countries of the Programme that allows personnel to enter clients’ data in a convenient format and perform its subsequent analysis and comparison (including the data collected in other participant countries).
- Poor cooperation with local authorities of the localities visited by the mobile medico-diagnostic complex, which has a negative impact on the practical implementation of the Component.

Factors (external and internal) influencing the Programme:

- Speaking of work load and conditions of the mobile clinic's team, it should be noted that there are no centralized or organized locations for rest and relaxation of the mobile clinic's personnel on their routes. They rest or sleep overnight at the premises provided by rural outpatient clinics or hospitals.
- Limited diagnostic and testing opportunities for population due to a lack of required testing systems affect the work of the mobile clinic. Thus, while conducting HIV testing personnel do not offer clients a comprehensive medical evaluation, and additional VH testing is usually performed only in case of clinical indications.
- Owing to the underdevelopment of infrastructure in rural and mountainous areas of RT, the mobile clinic has practical difficulties accessing the power line in respective localities.

Lessons applicable to Phase II of the Programme:

- Periodical and regular training and continued education for specialists in RT are not established, there is no plan for professional education for teachers. Teachers point out that their training has been conducted only at the national level with no foreign specialists engaged. It is emphasized that teachers express interest in continuing education and additional professional training in their respective areas.
- Applicants of the Centre for Migrants sign up for 1-2 courses in advance, which testifies to the existence of a demand for such services.
- According to the reports, during visits the mobile clinic serves over 100 clients a day, which testifies not only to a high demand for the given service, but also to an intense workload of medical personnel and difficulties in organization of proper working conditions for personnel, which inevitably affects the quality of conducted services.
- Variations of intensity of testing strip coloration has been noted, depending on the changes in temperature of the environment (working in high or low temperatures and depending on the season), along with the fact that HIV rapid tests used by the mobile clinic have produced several false positive results and one false negative result (in a patient previously diagnosed as HIV positive). Considering the scope of conducted testing, such figures represent a standard share of false results in rapid testing. In addition, the testing systems have successfully passed quality certification not only in RF but also in partner countries. However, in order to improve the quality of conducted services and to ensure compliance with global requirements related to the quality of purchased medical goods, the testing systems have to be on the list of goods preliminary approved by WHO quality control. In view of the above, it appears advisable to recommend either to accelerate the process of receiving preliminary quality assuredness for the testing systems by the supplier, in compliance with WHO requirements, or to consider an option of choosing the testing systems out of the stocks of goods previously certified by WHO preliminary quality assuredness.
- The mobile clinic's services are in high demand among the population of RT, since they are available on a free-of-charge basis, which is particularly relevant in view of financial and logistical difficulties with accessibility of such services for residents of remote areas.

Conclusions on Tajikistan:

1. The goals declared in Component C of the Programme have been fully achieved. The system of HIV/AIDS, VH and STI prevention among key populations has been strengthened and improved, including prevention of the above infections among migrants.
The goals of improving HIV/AIDS, VH and STI epidemiological surveillance have not been achieved in full and require additional efforts in conducting declared studies on HIV surveillance in RT, as well as organizing activities required for practical implementation of regional monitoring of HIV drug resistance in RT.

The goals of the component devoted to developing HIV, VH and STI prevention and control among women and children have not been achieved in full due to lack of organizational support from RT authorities, and they require additional efforts in conducting evaluation of implementation of the MTCT programme, building a national “team” of teaching specialists in implementation of the national protocols on MTCT and expanding engagement of healthcare personnel in educational programmes on lowering the level of HIV stigma and discrimination.

2. Owing to a large number of diverse training workshops/activities, the HR potential for HIV, VH B and C, STI prevention and response has been strengthened.
3. The problem of retention of medical staff of the RT organisations working on various aspects of the RCP Programme is caused by the low salaries, undermines the effectiveness of investing in the area of specialized HR training and has a negative impact on the sustainability of the Programme in general.
4. Primary and early HIV-diagnostics for children is one of the components calling for more detailed consideration in the future, since children are quite frequently diagnosed only at the stage of clinical manifestations of the disease. A number of cases have been reported when medical personnel performing testing has not detected several cases of HIV infection among children due to insufficient coverage and organization shortcomings.

Among the main causes of HIV vulnerability of labor migrants, as emphasized in the National Strategy, is a broad range of cultural and behavioural factors that intensify in seasonal migration. A low level of awareness about modes of HIV transmission and prevention measures is an integral part of informational and cultural vulnerability of labor migrants, which proves the relevance of the activities conducted as part of Component C of the Programme which are aimed at solving the existing problem, and calls for continuing active work in the given area.

Services of the mobile medico-diagnostic complex are in high demand among the population, since diagnostics is available on a free-of-charge basis which is particularly relevant in view of financial and logistical difficulties with accessibility of such services for residents of remote areas.

5. The legal system does not allow for any preferences, subsidies or privileges for technical maintenance of the mobile clinic’s motor vehicles or purchases of petroleum, oil and lubricants. No assistance from local authorities is offered in accessing power lines. Spare parts and expendable materials are available; however repairs or parts replacement of some elements of the mobile clinic’s medical equipment can be conducted only in Russia, which can complicate comprehensive and timely assistance to the population of RT.

Testing for VH B and C in remote areas is conducted by specialists of territorial AIDS Centres on a selective basis in order not to spend test stock on “package-testing” of clients who have already taken HIV test. Such a ‘cost-effective’ approach is linked to the general shortage of testing systems (compared to current demand) for VH in clients with respective complaints and indications. In view of the above it is recommended to develop standard regulations for testing at the mobile clinic, with consideration of the goals declared by the Programme.

Recommendations on Tajikistan:

1. To consider the question of completing declared activities and conducting a number of researches, including the HIV Incidence Study and the National control assessment of behavioural patterns in persons with seroconversion.
2. To conduct declared activities regarding organization and implementation of monitoring of HIV drug resistance in RT.

3. To complete the declared work on conducting analysis for increasing state financing of priority tasks for the National programme of developing a sustainable financing mechanism, which, in turn, will help to improve the effectiveness and usefulness of the National fund.
4. Considering a high prevalence of unidentified modes of HIV transmission, it appears advisable to conduct assessment of methods and quality of epidemiological investigation of HIV infections and the quality of trainings for respective specialists, and to consider the need of a targeted research on new HIV cases.
5. To conduct work on adapting HIV educational materials for health care providers of various specializations and to expand the range of visual and interactive components used in educational programmes.
6. To consider the possibility of introducing specialized courses on monitoring and treatment of HIV positive patients into the curriculum for general physicians.
7. To consider the possibility of improving the material and technical equipment of healthcare organizations with the purpose of HAI prevention.
8. It is necessary to establish work with children and adolescents as well as their parents on commitment to treatment. The given area requires specialized education and highly skilled personnel.
9. To consider the issue of the need for specialized training for paediatricians and other medical personnel regarding provision of services to HIV-positive children. It may be worth considering establishing such services as a specialised are of medical services requiring extra specialized training.
10. To conduct an evaluation of implemented measures regarding strengthening infection control for HIV and other infections.
11. Considering current positive trends towards increasing the state financing for main categories of expenses, active support should be given to the positive course of RT in strengthening sustainability of the programmes of response to HIV. In view of that goal, future agreements should include an article on mandatory co-financing of certain activities of the Programme.
12. To conduct independent external evaluation of the education quality at the Centre for Migrants.
13. To elaborate the question of cooperation and possible state co-financing of the mobile clinics' work by ensuring their access to power lines at the locations where their work is carried out.
It is necessary to develop a protocol on providing specialized assistance for each specialist of the mobile clinic, including their functional responsibilities and regulations of counselling and assistance to the population.
14. To consider the issue of obtaining additional mobile medico-diagnostic complexes for comprehensive coverage of the territory of RT, under condition of the state co-financing to ensure sustainability of the given component of the Programme.
15. To conduct research on control of the quality of ensuring the "cold chain" at all stages of storing and transporting of diagnostic testing systems, including extreme temperature conditions.
16. It is advisable to consider the issue of developing and implementing a new approach to outreach work, standard for participant countries, possibly with participation of skilled specialists on the grounds of the mobile clinics.
17. To develop and implement a unified encoding standard for clients of the mobile clinics.

3.4 The Republic of Uzbekistan

Initially, the Programme in Uzbekistan included the same 3 components as in Armenia, Kyrgyzstan and Tajikistan. The required understanding has been achieved with th representatives of respective

Ministries and Government Departments of Uzbekistan. In particular, the authorities have officially pledged to create conditions for effective implementation of the Programme.

However, the first several months of the Programme have clearly revealed that the authorities had not delivered on any of the pre-agreed steps for ensuring proper organizational and legal conditions and support for the effective implementation of the Programme. The details are as follows:

- Despite multiple requests by the UNAIDS country-office in the Republic of Uzbekistan and the UNAIDS Regional Director in Eastern Europe and Central Asia, the Ministry of Foreign Affairs hasn't given its 'official approval' of the Programme. As a result, RF and UNAIDS programme activities couldn't be conducted in Uzbekistan directly, officially and in the most effective way.
- For the same reason, due to the specifics of the legal system of Uzbekistan, no legal framework for direct contracts with national medical departments and organizations has existed to allow for their participation in the implementation of the Programme.
- In view of the above circumstances, UNAIDS had to conduct the declared programme activities via other UN agencies, such as UNFPA and UNICEF. However, the Programme in general and its components separately have been initially geared towards direct (and vital to the overall efficiency of the Programme) participation of national partners (the Ministry of Health, the Republican AIDS Center, the Institute of Epidemiology), which would permit to significantly increase their potential in response to HIV epidemic, particularly in HIV testing, prevention and treatment.

Despite the repeated multiple requests to the authorities of the Republic of Uzbekistan by the UNAIDS office in Tashkent, the situation remained unchanged. The situation concerning the evident lack of conditions allowing the Programme to proceed in Uzbekistan has been promptly reported to the Coordination Committee of the Programme and the UNAIDS headquarters. In view of this, RF and UNAIDS have made a joint decision to limit the implementation of the Programme in the Republic of Uzbekistan to only selected components of Phase I. By the end of 2015, all the activities and goals of these components of Phase I have been achieved, and their results have been presented in the final report of the Programme. Over the course of implementation of selected components of Phase I, 1 200 health care professional of various specialization areas have received training. 50 000 testing systems have been presented to the Republican AIDS Center. In 2014-2015, 100 000 people have been tested for HIV, VH and STI as part of the Programme in Uzbekistan.

In 2016, it has been decided to close the UNAIDS country-office in the Republic of Uzbekistan. At the same time, RF and UNAIDS made a joint decision to re-distribute the funds of Phase II of the Programme and transfer the implementation of the Programme from Uzbekistan to the Republic of Belarus, where currently there exist both a demand for conducting the Programme and all the required conditions for its effective implementation. Belarus is one of the 6 countries where the Programme is conducted by the Russian Federal Service for Supervision of Consumer Rights Protection and Human Well-Being (Rospotrebnadzor) and where UNAIDS has a country-office, performing coordination of the Programme execution at the national level.

4. THE ROLE OF THE FOUNDATION FOR PREVENTION AND CONTROL OF AIDS AND OTHER INFECTIOUS DISEASES "AIDS INFOSHARE"

The "AIDS Infoshare" Foundation is a co-executive partner of UNAIDS in the implementation of the Programme of Regional Cooperation with Countries of Eastern Europe and Central Asia in Response to HIV/AIDS and Other Infectious Diseases. The "AIDS Infoshare" Foundation is designated as a partner of UNAIDS in the implementation of the above Programme in the Memorandum of Understanding between the Russian Government/Ministry of Finance and UNAIDS. In Armenia, the Russian NGO "AIDS Infoshare" acts in compliance with the Agreements on understanding and cooperation in the implementation of the Component "Improving the systems of HIV/AIDS, VH and

STI among key populations, including migrants” between the Ministry of Health of Armenia, the state NPO “Republican Center for AIDS Prevention”, the Ministry of Health of RA and the Russian NGO “AIDS Infoshare”, signed on December 10th 2013 and March 23rd 2016 for Phase II of the Programme. Cooperation with Tajikistan is regulated by similar agreements with the Ministry of Health of RT dated May 21st 2013 and June 12th 2016. In Kyrgyzstan, Phase I of the Programme has been conducted in the framework of a quadrilateral agreement with the participation of the Minister of Health of RK, the Foundation, as well as the International Federation of the Red Cross and Red Crescent Societies and the National Red Crescent Society of RK, however by the beginning of Phase II a transition has occurred to bilateral agreements without the participation of the International Federation of the Red Cross and Red Crescent Societies.

The Foundation is fully responsible for the implementation of Component C of the Programme and coordinates and monitors areas related to the “HIV and migration” topic. Specialists from the “AIDS Infoshare” Foundation conduct regular working meetings at the Ministries of Health, health care facilities, Russian Embassies and Consulates and offices of the Russian Government ‘Rossotrudnichesvto’ Agency (‘Russian Cooperation’) in order to coordinate its ongoing projects.

In May 2016 the “AIDS Infoshare” Foundation became an organizer (together with the Republican AIDS Centre, Armenia) of the regional consultation “Migration and HIV in the Eurasian Economic Union and Tajikistan”. Participating in the consultation were 46 representatives of Ministries of Health, sanitary departments, migration services and other state and non-government organizations from 6 countries of Eastern Europe and Central Asia (Eurasian economic Union and Tajikistan). Recommendations have been issued to be elaborated in 2017 by the Expert Healthcare Council of The Interparliamentary Assembly of Member Nations of the Commonwealth of Independent States (IPA CIS). In September 2016, the Russian NGO “AIDS Infoshare” became a co-organizer of the International Scientific Conference “Migration in countries of Eastern Europe and Central Asia. Contemporary challenges, experience, innovations” held in Kazan. Representatives from Armenia, Kyrgyzstan and Tajikistan have participated in the work of the conference.

As part of Phase I of the Programme, the “AIDS Infoshare” Foundation has purchased three mobile medico-diagnostic complexes based on multi-sectional insulation van on Kamaz chassis with cross-country power for Kyrgyzstan, as well as mobile clinics for Armenia and Tajikistan.

In Kyrgyzstan and Tajikistan, the Foundation’s projects based on the mobile clinics have been included into national programmes of prophylactic evaluation of population “Health Caravan.” In a number of localities, mobile clinics have tested pregnant women for HIV for the first time.

In March 2014 as part of Component C in Kurgan-Tyube, the Centre for Migrants was open, offering courses on the Russian language, computer literacy and legal matters of RF. In 2016 the Centre has relocated to the new premises, and already in July of the same year, the first group of students graduated (courses take two months, there are 12 people per group, applications are accepted 1-2 months in advance, which testifies to a high demand for the programme among the population).

Over the course of their visits to participant countries (at least 4 times per year), specialists of the “AIDS Infoshare” Foundation conduct working meetings at Ministries of Health, medical organizations, embassies and consulates of RF and offices of the Russian Cooperation, coordinating their ongoing projects. Nevertheless, despite the regular cooperation of the Foundation with Russian organizations, a number of officials have expressed their desire for closer coordination in the development and implementation of policies for receiving assistance in the destination countries.

For over 10 years, the “AIDS Infoshare” Foundation has been functioning as a front-office for the Conference on HIV/AIDS in Eastern Europe and Central Asia.

It should be noted that the experience in the implementation of Phase I of the Programme with participation of the Russian NGO “AIDS Infoshare” as a co-executive has proved the effectiveness of engaging NGOs in the implementation of international projects, including projects in the area of response to HIV/AIDS. The key advantages of the given counteragent are: mitigation of the unstable political conditions in the recipient countries and their immediate neighbours, an opportunity for the project implementation under the specific national conditions of the recipient countries, establishing horizontal networks not only with profile organizations and state authorities, agencies and departments, but also with the key populations of the recipient countries, and developing the culture of prophylaxis and a healthy lifestyle.

Another advantage of the Foundation is full mastery of cultural, historic and civilizational context in cooperation with the recipient countries’ authorities and ability to reach agreements with minimum of bureaucratic procedures and obstacles.

5. EXTERNAL STRATEGIC REGIONAL FACTORS INFLUENCING THE PROGRAMME

- The current situation when partner countries note new cross-border HIV infections brought by migrants returning from Russia and not vice-versa shows that the current restrictive measures of deportation of HIV positive migrants from RF are ineffective and do not have any epidemiological significance. Further adherence to restrictive policies (travel restrictions for PLHIV) different from the other countries of the region, deportation of HIV-positive migrants and refusal to provide ART to migrants in RF have a highly negative impact on Russia’s claim to be a leading country in response to HIV/AIDS in Eastern Europe and Central Asia. However, considering the above, it is necessary to carefully elaborate alternative approaches to working with HIV-positive migrants in order to avoid a situation when migration would happen only for the purposes of receiving treatment in Russia, when treatment in home country has turned out to be unavailable or of inferior quality.

- In view of the above, consideration should be given to the lack of cross-country cooperation in the area of ART for continuing HIV treatment/prevention for citizens of Armenia and Russia stationed in those countries and in synchronizing the legal parameters of participant countries in order to ensure such changes.

- In particular, it is recommended that the Russian stakeholders work at the cross-country level with the respective ministries and departments of stakeholder countries of the Commonwealth of Independent States in order to develop mechanisms for providing accounted temporary treatment to HIV-positive migrants in RF on a nominally free-of-charge basis and annually settling the provided ART costs via the existing intergovernmental trade and transactions systems or via international medical insurance covering ART.

- According to the interview, the “Treatment as Prophylaxis” approach has been used in Kyrgyzstan since 2015. Thus, trainings for serodiscordant couples have been successfully conducted. In view of that, it is advisable to consider the question of supporting this relevant area based on the existing country practices and of further employing the gained experience in other participant countries.

- Documentation on the HIV status of foreign citizens obtained outside of RF is not considered valid in RF, subsequently migrants have to undergo medical evaluation again in order to obtain a work permit.

- The processes linked to geopolitical changes in the region manifest a factor of necessary assistance to refugees.

- In regard of the recipient countries it is necessary to take into the account the intensifying activity of foreign donors, such as Saudi Arabia and USA, in the areas most challenging to national budgets in order to prevent the donors from imposing aid-provision pre-conditions, political manipulations and using in any form the factors contributing to the spread of Islamic fundamentalism. Special consideration should be given to the fact of introduction of “Islamic money-lending” (sukuk) in Kyrgyzstan at the legal level. Another serious factor in Tajikistan and Kyrgyzstan is the financial aid

from Saudi Arabia, Qatar, and Islamic Development Bank providing assistance only under the pre-condition condition of building mosques and spreading radicalised Islamic teachings in the region.

- Decreased disbursements on behalf of the Global Fund in the countries participating in the Programme have a considerable influence on the national programmes of HIV response. In particular, decreased financing allocated for the purchasing of testing systems for HIV diagnostics in pregnant women presents under current conditions of shortage of diagnostic systems a risk to the success of the work aimed at elimination of the vertical HIV transmission (MTCT) in the countries participating in the Programme.

- In Tajikistan, where a partner organization has 14 centres for working with migrants, only 1 of them works in the area of HIV, VH and STI prevention, due to limited funds. Despite an available material and technical capability, comprehensive prophylactic and educational work conducted by the only center for migrants in the Khatlon Region is nowhere near sufficient to effectively respond to the existing challenge: over the time of the center's operation (as of 2016), only about 0.08% of the total number of migrants have received training.

6. GENERAL NOTES AND CONCLUSIONS:

6.1 Notes and observations:

1. The Programme plays a key (and in the mid-term perspective, virtually indispensable) part in supporting the respective efforts of recipient countries in response to HIV epidemic. Already Phase I of the Programme implementation has allowed to fill in many crucial gaps in the area of HIV prevention that have not been covered by national healthcare systems and other partner organizations:

- Testing pregnant women, including rapid testing
- Training of personnel in nosocomial infections (HAI)
- Work with migrants and their sex partners
- Conducting testing in remote and hard-to-access areas using the mobile medico-diagnostic complexes

2. Tentative harmonization of the Programme's work with partner organizations (from among international donors) has been observed only in Armenia, where GF has taken charge of diagnostics and testing in 40 localities (in addition to 60 localities already covered by the Russian mobile clinics). The Russian Programme also filled in the gaps after GF had stopped its activities in a number of areas. Thus, in Tajikistan work in the areas of pregnant women and HIV MTCT is conducted only in the framework of the Russian Programme. Other international donors, including GF, do not express any interest in the given areas. In a similar way, GF has initially started working on establishing MDTs in Kyrgyzstan, and after GF withdrawal the area was supported by the Programme.

3. Human rights issues are, mostly, an area of activity of other programmes and donors. The USAID and European partners (GIZ, Mission East, Caritas Armenia etc) specifically focus on this area. In general, the region reveals multiple social and cultural factors that make behavioural HIV prevention among women an unlikely goal to achieve. The factors are: traditional sexual culture and refusal to use condoms resulting from it; the inferior position of women in families and their economic dependence on their husband and older family members; a low educational level and (as a consequence) lack or low level of awareness about HIV/AIDS, as well as low accessibility of voluntary HIV testing services. These factors testify to the necessity of giving careful consideration to the spread of HIV epidemic outside of traditional risk groups, via heterosexual contacts.

Thus, in the opinion of many women working in, or otherwise related to, NGOs in Tajikistan, the current figures of HIV prevalence among women may substantially underestimate the problem. Based

on the results of the joint assessment conducted in April 2011 – March 2012 by the organizations “UN – Women” and “UN Programme of Response to HIV/AIDS”, it has been recommended to use obtained data and suggestions that can be instrumental in strengthening the importance of gender issues and their incorporation into national strategies of response to HIV/AIDS in Tajikistan¹⁵.

In addition, mixed gender education in schools for migrants includes sessions on sexual health, including group discussions and equal dialogue on HIV and STI prevention, which testifies to possibilities for overcoming certain gender problems and requires further efforts in this area, especially among young people.

In addition, conducting a seminar/training on forming and managing mutual support groups for PLHIV in Armenia should be pointed out. These organizations mainly work with women, providing them with legal, social and organizational assistance towards effective integration of women living with HIV into society at large. Over the course of implementing Phase I of the Programme, 1 446 women have participated in mutual support groups. All the professionals working at the mutual support groups stay in contact and consult with the Republican AIDS Centre.

4. According to the interviews, the Programme has had a certain impact on the situation of people from the key populations, including a lowered level of HIV stigma in all the recipient countries. In addition, the following has been pointed out: (a) convenience of the mobile clinics’ services, due to availability of anonymous and confidential testing (not only HIV testing, but also health monitoring services); (b) In all traditional societies of rural areas, elders of both genders and religious ministers still have prevailing authority and influence. Thus, in 2016 Tajikistan has passed a law on mandatory HIV testing for newlywed couples. The interviewees note that women are becoming more open and aware and more willing to take tests. This contradicts the above theses about fear of testing without guarantees of confidentiality. Nevertheless, the only substantial progress has been shown by the study of the MSM group in Tajikistan.

5. In order to ensure sustainability of the Programme, it is necessary to emphasize independent research activities (to develop a roadmap of problem zones throughout the CIS, including Russia), to continue educational programmes and training workshops, to activate work with young people (engaging Russian trainers, in order to expand and strengthen cross-country cooperation in the areas of education and healthcare), including the work of Russian specialists in partner countries; and to continue active work on the synchronization of national legal systems in matters related to HIV, introducing limited ‘conditionality’.

It is possibly advisable to direct part of the Programme’s resources to developing activities among schoolchildren and students in recipient countries. In particular, the funds can be used to cover travel expenses for bringing schoolchildren to summer and winter camps in Russia, where they take courses on healthy living, the Russian language, culture and tolerance. Development and implementation of practical activities for foreign students of medical, education and sports universities/departments from Russian cities is another such area.

6. According to the interviews conducted in countries participating in the Programme, the Russian Programme does not duplicate other donors’ projects, while among other national and global organizations there is neither coordination of the actual activities nor coordination thereof with authorities of the recipient party (within the Programme, all activities are coordinated with the Government of recipient countries). Poor coordination with subcontractor organizations conducting activities of other donors active in the countries has also been pointed out.

However, it is still impossible to talk about comprehensive coordination between participant countries. The only exception is thematic conferences and activities conducted by RF (regular International Eastern Europe and Central Asia AIDS Conferences held biannually; the next one is scheduled for

¹⁵ “The National Strategy for Response to HIV/AIDS Epidemic in the Republic of Tajikistan in 2015-2017”, 2014.

2018; the regional consultation “Migration and HIV in countries of Eurasian Economic Union and Tajikistan”; the international scientific conference “Migration in countries of Eastern Europe and Central Asia: contemporary challenges, experience, innovations” in Kazan, etc). In other words, despite vertical cooperation and engagement, no horizontal connections are being formed between executives and beneficiaries of the Programme. It is possibly advisable to conduct regular assessment of such cooperation on the grounds of UNAIDS and the “AIDS Infoshare” Foundation, including experience sharing and error correction of all the participant countries with participation of key operators (AIDS Centres), respectively responsible ministries and departments, subcontractor institutions and NGOs. A potentially interesting format of cooperation can be so called “peer reviews” or “peer error correction” including consultations on problematic areas in one or several recipient countries (for instance, studying successful experiences in elimination of HIV MTCT, successful outreach programmes, MDT experience, Centres for Migrants etc).

At the same time, vertical cooperation from donors to recipients is well developed, along with cooperation with organizations working on implementation of the Programme, UNAIDS and the “AIDS Infoshare” Foundation in the first place. A high level of professionalism shown by specialists of organizations has also been noted, which helps the Programme achieve the declared goals. The following could also contribute to consolidation and effectiveness of the Programme: developing a closer partnership between the Programme’s executives; possibly developing and signing long-term and comprehensive agreements and conducting various, but compatible, projects (as opposed to limited collaboration within a single Programme); conducting joint trainings; coordinated representation in national and international activities; engaging representatives of the “AIDS Infoshare” Foundation in continued education programmes and similar activities within the UN format; granting status of 3rd category international NGO of the United Nations Economic and Social Council with the right of participation in meetings, obtaining of informational materials etc.

It is worth noting that despite regular information updates on conducted activities and actions (participation of top representatives in official ceremonies of presentation of mobile clinics, visits of specialists from the “AIDS Infoshare” Foundation to Embassies, current news being posted on websites), official representatives of the Ministry of Foreign Affairs have expressed their doubts concerning sufficiency of information they receive and a wish for more active involvement of their departments in the implementation of the area of nursing personnel in general and the Programme and its components in particular.

7. The interviews conducted in Armenia and Tajikistan point out the need for additional mobile clinics (1 to Armenia, 4 to Tajikistan). However, in order to ensure the sustainability of the Programme it is necessary to consider the question of allocating new mobile clinics, provided approval and practical implementation of state co-financing in participant countries are achieved.

6.2 Promising/uncovered areas:

- A need for work with adolescents and youth has been noted in all 3 countries, including HIV, VH and STI prevention, healthy living, lowering the level of HIV stigma and discrimination and disclosure of HIV status among children and adolescents. According to specialists, Kyrgyzstan and Tajikistan urgently need efforts for socialization, adaptation and integration of HIV positive children and adolescents, including HIV status disclosure. This work is being conducted in “pilot” mode, but requires additional attention and strengthening of all the components.

- The interviews have established that the population of RT is actively interested in diagnostics of haemoglobin level, however no such services are available at the mobile clinics. The given area is relevant, especially considering the prevalence of anaemia in RT. Neither does the mobile clinic provide surgical services (due to specifics of disposal of contaminated tools and expendable materials),

even though minor surgical manipulations (including reproductive health) are relevant and in demand among population of remote areas.

- Specific VH B prevention among health care providers in RK and RT is worth considering, along with offering specific measures for the given area.

6.3 General conclusions and recommendations:

Conclusions:

1. The present project, same as the majority of projects financed by RF, is both significantly more effective in terms of declared goals and substantial results, and unpoliticized if compared to the assistance programmes implemented by European, North American and Middle Eastern countries which are to a large extent geared towards lobbying and advocacy practices as well as often appearing to pursue politically and religiously-motivated goals, in essence, unrelated to HIV-epidemic response or healthcare in general. It should also be noted that the Russian project and the Programme of Response to HIV/AIDS conducted in cooperation with UNAIDS are focused more precisely on improving the quality of life in recipient countries and have social significance. Considering RF's close neighbouring ties to these countries, the benefits of investments into quality of life and support of political stability through population coverage with socially significant services are undeniable not in commercial terms but from the social, humanitarian and sociopolitical point of view, since it permits to prevent negative scenarios for these states. The role of the component will become more important in the future due to additional problems with refugee inflow into the countries of CIS from troubled regions of the Middle East.

Another advantage of the Russian programme is a transparent mechanism of its implementation, a high level of cooperation with local authorities and other partners in recipient countries, priorities of investments into epidemiological surveillance and healthcare systems of the recipient countries, purchasing of material funds (mobile clinics in context of the present programme) that will retain their significance and will continue to be used by recipient parties even after completion of the Programme (long-term material purchases from other grants are less common and frequently a significant part of financial means are spent on salaries of personnel from donor countries).

Finally, worth of special note is the Programme operators' profound knowledge of state management specifics at the state, regional and local levels of recipient countries, which permits to effectively overcome the existing official and informal barriers linked to the national specifics of CIS countries and to manage the allocated funds in the most efficient way.

2. The Programme can indeed serve as an example of the 'best practice' of an innovative mechanism of technical assistance via partnerships between stakeholders of various levels. The new RF model of targeted financial aid with active participation and support of UNAIDS and the "AIDS Infoshare" Foundation has proved its effectiveness, relevance and long-term potential. Such cooperation permits to avoid potentially negative political context and accusations of interference in domestic affairs of other countries on the part of donors, to ensure full transparency regarding the activities and to increase the responsibilities of all the parties, including recipient countries, for the final results. Involvement of an organization belonging to the "UN family" significantly increases the Programme's authority and trustfulness, and NGOs as co-executives, in turn, break bureaucratic barriers in the way of the Programme's implementation, increasing its effectiveness and raising the level of trust not only among official representatives of recipient countries, but also among the population of recipient countries. Based on the above-said, a conclusion can be made that, firstly, consideration of further development of the Programme beyond Phase II should include its expansion with a

special focus on educational and research components, and secondly, further development of a similar mechanism, including strengthening/institutionalizing of networking between executives, is possibly beneficial to use in the implementation of other programmes of assistance to development, establishing a multi-level consortium of stakeholders.

3. The component of the Programme related to mobile clinics should be recognized as successful, since it permits to maximize population coverage of diagnostic and counselling services, considering geographical, cultural, historical, ethical and religious factors.

4. Participant countries express particular interest in further development of Component C of the Programme, related to the mobile clinics. The key feature of the given component is an opportunity to provide medical services to the most hard-to-access and vulnerable population of the republics, which allows the countries to maintain political stability in the regions, avoid economic problems by increasing the population's quality of life and ensures engagement of remote rural areas in the social, political and economic life of the countries despite insufficient state financing in the areas of health care and social security.

This component shows the most active state support and demand for strengthening and expansion of its element on the part of responsible counteragents. At the present moment, recipient countries contribute to the Component by paying salaries (and creating new jobs) to medical personnel engaged in the work of the mobile clinics, outreach services and peer-to-peer services. In order to ensure long-term sustainability of the Programme more active co-financing is required on behalf of the state and more substantial contributions from the recipient countries. At the present stage, considering a lack of sufficient funds at the national level of recipient countries, it appears advisable to elaborate on manner and size of state contributions (ensuring mobile clinics' access to power lines, financing purchases of petroleum, oil and lubricants, covering travel expenses for mobile clinics' personnel, purchasing rapid test systems etc).

5. Despite certain progress in terms of increasing awareness among the population in the area of healthcare and response to HIV/AIDS, and in lowering the level of stigmatizing PLWH, it is necessary to strengthen informational activities towards that goal, with a particular emphasis on young generations.

6. The Programme does not emphasize the role and rights of women in the area of HIV/AIDS prevention, and despite the fact that some aspects involve activities in providing assistance to women (forming and training mutual support groups), a conservative approach to gender-related issues still prevails.

7. It is necessary to develop a unified standard of keeping project-related and technical accounting for partner organizations in recipient countries participating in the Programme.

8. It is also necessary to develop a unified approach and recommendations for conducting comprehensive and comparable studies of key populations in all the recipient countries.

9. It is urgently necessary to synchronize the Component of the Programme with the "seasonal factor" in all the recipient countries, where it concerns organizational work of approving future phases in managing organs of executive organization of the Programme.

Recommendations

1. To conduct work on developing a mechanism of coordination and approval of designed and conducted activities between partner organizations, including global, state and non-government organizations, in order to increase the economic effectiveness of response to HIV and develop horizontal cooperation between participant countries for information sharing and implementation of the existing strong components and effective practices in other countries participating in the Programme.

2. It is advisable to conduct detailed mapping of areas of work and programmes of global and national organizations and foundations active in countries of the region. Such mapping will permit to

avoid duplication activities and help harmonize and increase effectiveness of response to HIV, including analysis of previous experience and with an emphasis on specifics and causes of failed implementation of previous partner projects.

3. GF's withdrawal of funds for financing activities in participant countries is explained, inter alia, by the un-sustainability of further development in the areas receiving assistance, which is linked directly to the lack of co-financing on the part of state budgets of the recipient countries. Thus, considering the need of ensuring sustainability of the Programme and the current situation with decreasing financing for programs of response to HIV in the region, it is necessary to include articles on mandatory co-financing of the Programme's components in all future agreements.

4. Considering the demand for diagnostic services in partner-countries, it is advisable to increase the purchases of testing systems for further expansions of target group coverage. In order to avoid shortages of testing systems for pregnant women and to increase sustainability of the Programme in general, it is recommended to increase the number of purchased diagnostic testing systems through agreements on state co-financing in partner countries.

5. It is necessary to strengthen the scientific research component of the Programme, to conduct on sustainable basis joint (bilateral and multilateral) studies in response to the HIV/AIDS epidemic, and to develop a roadmap on joint research and development (R&D) with the participation of leading Russian science and research institutes and universities in the areas of healthcare and epidemiology.

6. It is necessary to enhance the efficiency of work with migrants with consideration to the seasonal factor and to conduct assessment of the quality of practical consultations on the Programme's areas of responsibility.

7. It is advisable to develop a standard approach to outreach work and HR education and training, to formulate the meaning of such concepts as 'migrants' and 'migrants' family members' in order to develop standard accounting of services, counselling sessions, door-to-door rounds, informational sessions etc. In view of this goal it is recommended to consider the issue of developing a standard protocol including the list of activities and requirements for outreach specialists and other regulating parameters.

8. To elaborate the issues of encoding, accounting and confidentiality of personal data in diagnostics at the mobile clinics during field work. It is possibly advisable to consider the question of developing a standard approach to the system of clients' individual encoding, including existing and successfully applied methods and technologies. The issue of standardization using electronic equipment and a unified accounting/registration database requires detailed consideration and ought to consider technical specifics and difficulties in the implementation of such an approach within the conditions of mobile clinics (such as problems with power lines, limited working space for personnel etc).

9. To conduct cost-effective regional meetings on the Programme in cities of participant countries, which will permit to draw attention to the problem, to tell about the Programme addressing a broad audience in the country and the region, and to highlight the part of Russia.

10. Over the course of next Phase of the Programme it is advisable to conduct control on the implementation of previously unimplemented components.

11. One of accidental findings of the evaluation: health care providers working with key populations, as well as laboratory staff and general practitioners, do not receive any specialized VH B prevention. Thus, medical specialists of elder age groups haven't been re-vaccinated and younger personnel haven't been vaccinated at all, referring to lack of respective information and/or motivation. Therefore, awareness-raising work on issues of specialized HAI prevention among medical personnel requires particular attention and careful consideration. In addition, health care providers have emphasized that educational programmes and training workshops give less attention to VH (VH B in particular) than to coverage of issues related to HIV and STI.

8. CONCLUSION

The results of the implementation of Phase I of the Programme of Technical Assistance To Countries of Eastern Europe and Central Asia In the Field of Prevention, Control and Surveillance of HIV/AIDS and other Communicable Diseases, by three main components:

Component A: “Improving the epidemiological surveillance system for HIV, STI and viral hepatitis.”

Component B: “Development of communicable diseases prevention and control, including HIV, STI and hepatitis among women and children.”

Component C: “Improvement of the prevention system for HIV/AIDS, STI and hepatitis among key populations, including prevention of these infections among migrants.”

The Programme has allowed to find new approaches and solutions to main priority problems in the area of response to HIV/AIDS that have been overlooked by the global community and other donors. Primarily these are the problems of prevention and control of infectious diseases among pregnant women, MTCT and improving prevention among labor migrants.

With the support of the Programme, Russian and international UNAIDS specialists have provided assistance to national healthcare organizations of three countries in developing regulatory documents in the area of HIV, VH and STI epidemiological surveillance, specialized trainings for specialists and conducting studies the results of which helped to improve national epidemiological surveillance systems. Implementation of Component A has permitted to improve comprehensive epidemiological surveillance on HIV/AIDS, particularly among hard-to-access populations, such as migrants.

An important element of the Programme’s success is the presentation and implementation of Russian mobile medico-diagnostic complexes and provision of testing systems and expendable materials, which permitted to substantially increase the coverage of population in three countries with diagnostic and counselling services.

Another important element of the successful implementation of Phase I of the Programme is teamwork and complimentary cooperation of the Russian Government, UNAIDS and the “AIDS Infoshare” Foundation with national counteragents in Ministries of Health and regional AIDS Centres, since it is precisely such a team of stakeholders that has ensured timeliness and comprehensiveness in achieving the declared goals. In addition, it is possibly advisable to further expand the base of contacts and cooperation in recipient countries, which will permit to take the Programme to a new level and further increase its effectiveness. Awareness-raising and educational work with all groups of population remains an important area. However, more emphasis should be placed on working directly with the children and the young people.