

## I. INTRODUCTION

Tajikistan is a land-locked country bordering with Xinjiang Province, China to its East, Afghanistan to its South, Kyrgyzstan to its north and Uzbekistan to its West and North-West (refer to the map below). Drugs spill over to Tajikistan due to an increase in opium production in Afghanistan and trafficking of drugs to Europe spill over to Tajikistan. An unfortunate consequence is that Tajikistan, like Kyrgyzstan and Xinjiang Province of China, is witnessing a growing injecting drug use population.



Tajikistan gained independence in 1991 and recently emerged from the 1992-1997 civil war. Consequently its education, economic, health and social systems have been weakened. With international assistance, Tajikistan has been gradually stabilizing and reconstructs these systems.

The Tajikistan National Development Strategy (NDS) sets as a priority for the period leading to 2015<sup>1</sup> the achievement of the Millennium Development Goals (MDG). The NDS focused on sustainable economic growth, expanding public access to basic social services and reducing poverty. The country's economic situation has shown signs of recovery. Its GDP grew at 9.3% between 2000 and 2005<sup>2</sup>. Due to the collapse of cotton production

and economy in general post-Soviet system, there is a growing unemployed population, particularly in rural farming communities. Labour migration becomes an ever increasing way for income generation for a large number of households in Tajikistan. With the large remittances labour migrants generated to support rural families, labour migration has been identified as one of the key national development issues to be managed.

The Social block, one of the three blocks of NDS, covered the development of the health care system and of the education system, improvement of the social welfare and the promotion of gender equality. This block has direct relevance to Tajikistan's national HIV responses.

The first Poverty Reduction Strategy Paper (PRSP) was developed with World Bank support. It provided a three-year action plan for the NDS<sup>3</sup>. The PRSP identified four strategies for reducing poverty: Efficient governance, targeted support to the poorest; efficient and fair provision of basic social services, and equitable, fast-track growth. Within the PRSP, the strategies for agriculture, education, health care, infrastructure,

<sup>1</sup> National Development Strategy of Republic of Tajikistan, 2006 to 2015, Government of Tajikistan, Dushanbe, August 2006, Draft.

<sup>2</sup> Ibid foot note 1, p4.

<sup>3</sup> Poverty Reduction Strategy Paper, June 2002, Dushanbe, The Government of the Republic of Tajikistan. This was the version of PRSP received from UNDP GIU.

labour and private sector development, and social protection could together, contribute to HIV vulnerability reduction in Tajikistan. The evaluation team was provided the 2002 PRSP, Tajikistan by GIU/UNDP.

Based on a search of UNDP, Tajikistan website, there is a first draft of PRSP-2 for the period of 2007-2009. However, the English version of the draft is not accessible. The evaluator reviewed and analyzed the indicators proposed for the goals set under the second PRSP-2 draft.<sup>4</sup> The first to the fifth goals are relevant to support the achievement of the sixth goal, which is to reduce HIV incidence. The first goal is to halving extreme poverty, starvation and number of malnourished people. The second goal is to guarantee universal access to secondary education for both girls and boys. The third goal relates to gender equity between women and men by expanding education and employment opportunities and rights of women. The fourth and fifth goals relate to reduce child mortality, under five mortality and maternal mortality. The tasks proposed for achieving these goals if accomplished, can contribute to building HIV resilience in Tajikistan.

The Priority Areas and Outcomes of the United Nations Development Assistance Framework (UNDAF) for Tajikistan<sup>5</sup> are shown in the table below. In the UNDAF, three of the four priority areas and seven of the eight outcome areas are relevant to HIV vulnerability reduction in Tajikistan. The three priority areas are transforming livelihood, redistributing responsibilities and reversing decline. The seven outcome areas are basic education, infectious diseases prevention, improved health and nutritional status of women and children, agricultural productivity and economic opportunities, clean drinking water, accountable and responsive decision-making, and strengthened regional partnership. Implementing these priorities to reach the desired outcomes would require joint implementation between health, education, agriculture, planning, and financing sectors. These multi-sectoral collaboration will have synergistic impact on HIV vulnerability reduction in Tajikistan.

Three out of the four thematic areas of the Country Programme Action Plan (CPAP)<sup>6</sup>, reflected these three UNDAF priorities. These actions are

- development of community business advisory services and employable skills;
- community micro-financing and utilization of remittance-based economy;
- strengthened local governance to support local capacity building;
- improved service delivery including health and education services;
- building local civil society organization capacities;
- improved accountability and transparency in policies and budget;
- coordination and monitoring drug use and abuse; education on human rights;
- curbing HIV growth through strengthening capacity to treat AIDS with improved leadership and inter-sectoral planning and coordination;
- national political and financial commitments; and

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<sup>4</sup> Indicator matrix for Poverty reduction strategic paper -2, first draft, Tajikistan, 2007-2009.

<sup>5</sup> The United Nations Framework for Development Assistance to Tajikistan, 2005-2009.

<sup>6</sup> Country Programme Action Plan, 2005-2009, The Government of the Republic of Tajikistan and United Nations Development Programme

improved public understanding of HIV and utilization of services.

The National AIDS Strategic Plan<sup>7</sup> (NASP) focused on the following:

- behavioural change of populations with high-risk behaviours,
- improved access to preventive and sexually transmitted infection (STI) services for vulnerable populations;
- prevention of maternal to child transmission (PMCT);
- ensuring safe blood, organ transplant and medical procedures and post-exposure prophylaxis;
- provision of treatment for people living with HIV (PLHIV) including anti-retroviral therapy (ART), opportunistic infections (OI) and tuberculosis (TB), with care and support.

The NDS, PRS, UNDAF, CPAP and NASP provided UNDP country office with the political and policy basis to effect HIV vulnerability reduction in Tajikistan.

<i>The UN will assist Tajikistan in the following main areas</i> <b>(Priority Areas)</b>	<i>The UN's work will all be aimed at helping to achieve one of these results in Tajikistan</i> <b>(Outcomes)</b>
<i>Reversing Declines</i>	1. Increased access to and completion of <b>basic education</b> , especially for girls
	2. Strengthened capacity to prevent and reduce <b>infectious diseases</b> , especially HIV/AIDS, malaria and tuberculosis
	3. Improved <b>health and nutrition status</b> of women and children
<i>Overcoming Mountains</i>	4. <b>Natural resources</b> sustainably managed, and fewer persons killed or affected by <b>disasters</b>
<i>Transforming Livelihoods</i>	5. Increased <b>agricultural productivity</b> , food security, and <b>economic opportunities</b> , especially for women and vulnerable groups
	6. Better access to clean <b>drinking water</b>
<i>Redistributing Responsibilities</i>	7. Increased responsiveness and accountability of <b>decision-making</b> structures strengthen the rule of law and human rights
	8. Strengthened <b>regional stability</b> and partnerships

Source: *Moving mountains, A United Nations Assessment of Development Challenges in Tajikistan, UNDAF, Tajikistan, 2005-2009.*

<sup>7</sup> Strategic plan of response to the epidemic of HIV in the Republic of Tajikistan, 2006-2010, Dushanbe, 2006, Draft.

## II. EVALUATION METHODS

This UNDP Tajikistan HIV Programme outcome evaluation was commissioned by UNDP, Tajikistan country office. Support to this evaluation was provided by the Global Fund to Fight AIDS, TB and Malaria (GFATM) Grant Implementation Unit (GIU). UNDP has been the designated Principle Recipient (PR) for Tajikistan's GFATM grants. The scope of evaluation covered two major HIV programs of UNDP as follows:

- (1) the United Nations Joint Advocacy Programme, and
- (2) the Phase I of GFATM Round 4 AIDS grant. This was the second of the three GFATM AIDS grants awarded to Tajikistan.

The three AIDS grants were as follows:

### ***Round 1, March 2003 - April 2006, 2.4 million USD***

Round 1 focused on outreach to sex workers (SW), injecting drug users (IDU), men who have sex with men (MSM), and school youth; building a safe-blood control system and HIV surveillance; decentralization of prevention activities; strengthening national capacities on HIV prevention and, sectoral coordination. As of April 2006, the Ministry of Education has made little progress on the school youth and curriculum component of this Grant. The MSM outreach had limited results. The blood safety system needs further strengthening to eliminate transfusion related HIV infections. The proposed substitution therapy and prison harm reduction were not yet implemented. Based on the timely implementation of the other elements of this Round 1 grant, the GFATM Secretariat approved a no-cost extension until end of December 2006. An evaluation of this 3-year performance was conducted in June 2006 and a draft report was available at UNDP<sup>8</sup>.

### ***Round 4, January 2005-December 2009, 8.1 million USD***

#### ***Reducing the burden of HIV/AIDS in Tajikistan***

Round 4 focused on the following areas: outreach to migrant labourers and their families; street children and prisoners; promoting ART, care and support for PLHIV; and building national monitoring and evaluation capacity. The receipt of Round 4 grant resulted in a parallel implementation of both Round 1 and Round 4 grants from January 2005 to December 2006 on surveillance, decentralization of preventive activities, sectoral coordination and capacity building on HIV and AIDS responses. Phase I of Round 4, January 2005-December 2006, was implemented on time and received the GFATM Secretariat approval for continuing into Phase II starting January 2007. This evaluation focused on the outcome of Round 4 Phase I implementation.

### ***Round 6, 2007-2011, total 12.1 million USD with 4.8 million USD for Phase I***

#### ***Support to National AIDS response to scale-up HIV prevention and AIDS care services in Tajikistan***

Round 6 proposed to scale-up access to HIV prevention services for IDU, SW, MSM, and youth; develop a comprehensive medical care and referral system across public, private and NGO sectors; expand and strengthen Voluntary Counselling and Testing, and post test care and support; ensure an effective national blood safety system; and strengthen the health system including human resources, infrastructure development, operations

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<sup>8</sup> HIV/AIDS Programme Implementation, Global Fund Grants 2003-2006, Rapid Evaluation, July 2006.

research, and monitoring and evaluation in order to scale-up coordinated HIV, STI, TB and blood safety interventions.

In addition, Tajikistan received the GFATM TB grants in Round 3 (1.19 million USD) and Round 6 (15.8 million USD) and Round 5 Malaria grant (2.7 million USD).

### **Methods applied for the evaluation**

The evaluation team conducted the evaluation based on a review of documents made available by the Evaluation Focal Team (EFT) from the UNDP-GFATM GIU. The EFT was composed of Mr. Muratboki Beknazarov, UNDP/GIU Manager; Mr. Saleban Omar, HIV/AIDS and Malaria Adviser; Zebo Jalilova, Deputy Manager, GIU; and Mr. Muallimsho Sinavbarov, Monitoring and Evaluation officer; and the administration section of GIU.

Key informant interviews of implementers and beneficiaries as well as site-visits to implementing partners and their facilities were conducted. The informants and sites were selected by EFT/GIU for both UNDP joint advocacy programme and GFATM grant projects. Focus group discussions with major beneficiaries included migrants and their families, STI service providers, outreach workers, prisoners, street children, ART support providers – laboratory staff, epidemiologists, physicians and national AIDS center staff. (*Refer to Annex B List of people consulted and organizations visited*).

### **Composition of the Evaluation Team**

The evaluation team was composed of five members. All the team members were selected by GIU, UNDP. There was one international consultant (team leader), Lee-Nah Hsu, who had extensive experience in HIV and AIDS programmes, policies, strategies and development linkages, the GFATM grants, and evaluation of cross-cutting issues relevant to HIV and AIDS responses. These were in addition to experience with the United Nations system, including that of UNDP, and with both development and HIV NGOs as well as experience in Central Asia and Eastern and Central European Region. The team leader was responsible for reviewing relevant English documents provided by GIU/UNDP in addition to conducting field assessments, key informant interviews, focus group discussions with migrants and their families, providers and outreach workers for migrant health, for street children and with prisoners. In addition, the team leader was responsible for compiling the inputs received from the members of the evaluation team and synthesizing the results into this report. There were three national consultants. Mr Mansour Dodarbekov is the ART unit officer at the National AIDS Centre. He contributed to this evaluation by providing access to HIV epidemiologic and ART treatment data and suggestions related to ART. Ms. Sevara Rakhimovna is the director of a PLHIV support NGO. She provided insights on the challenges faced by PLHIV and NGOs in treatment, care and support; reviewed and synthesized reports to GIU from NGOs working with street children; and provided suggestions on improvement in treatment, care and support for PLHIV. Ms. Bozrikova Tatiana Nikolaevna is the director of Panorama, an NGO which conducted knowledge, attitude, behaviour and practice

(KABP) studies related to vulnerable groups. She was responsible for conducting focus group discussions with outreach workers for migrant services and for vulnerable youth. She also participated in the field visits to migrant friendly STI service centres, regional AIDS centres and NGOs dealing with street children and migrant outreach.

The evaluation team also included Mr. Muallimsho Sinavbarov, the monitoring and evaluation officer of the GIU, UNDP, Tajikistan. He made the selection of the sites, NGOs and partners for the field visits; provided Tajik-Russian interpretations as well as the scheduling of the evaluation visits. The team was supported by Ms. Valeria Trupanova, the English-Russian interpreter and translator, who accompanied and supported the evaluation team throughout the 2.5 weeks. The GIU and UNDP administration staff, including the public relations officer provided assistance which facilitated the work of the evaluation team.

### **Objectives of the evaluation**

The evaluation objectives were listed below<sup>9</sup>:

- to assess progress of UNDP's interventions towards achievement of the CPAP outcome - "*Public understanding of HIV/AIDS issues increased dramatically*" and
- to evaluate the efficacy of the strategies employed in contributing to the achievement of the outputs of the GFATM HIV Round 4 Phase I grant.

This evaluation report includes recommendations and strategies for the future HIV interventions in Tajikistan.

### **Outcomes to be evaluated**

There were two HIV programmes administered by UNDP Tajikistan to be evaluated as indicated below.

#### ***1) HIV/AIDS growth curbed to a stop – UN Joint Advocacy Programme***

The UNDP Tajikistan country office's HIV Project was to mobilize the United Nations system for joint advocacy on HIV policies and programmes in Tajikistan. The project's strategy was to apply intensive and hard-hitting advocacy efforts aimed at supporting diverse leadership for behavioral change amongst targeted groups; increase public awareness and understanding of risks; mobilize civil society and advocate to top leaders to acknowledge HIV and to introduce prevention and mitigation policies. The project objectives included engaging top public leadership, delivering unified United Nations support to priority actions, organizing awareness raising campaigns, building a strong United Nations inter-agency unit and supporting national coordination.

UNDP contributes to achieving ten outcomes in the Country Programme Action Plan (CPAP), 2005-2009 of Tajikistan. The outcome to be evaluated was stated in the CPAP as "*Public understanding of HIV/AIDS issues increased dramatically*".

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<sup>9</sup> Refer to the Terms of Reference of this outcome evaluation.

## ***2) Capacity to treat HIV/AIDS – GFATM grants on HIV/AIDS***

The GFATM grants supported the implementation of the Strategic Plan of the National Response to the HIV/AIDS epidemic in Tajikistan, 2003-2009. Round 4 Phase I focused on preventing transmission among migrants and their families in urban and rural areas by improving access to STI services; outreach to street children in cities; and to prisoners in penitentiary services nationwide; scaling up PLHIV access to ART, care and support; and monitoring and evaluation. The Programme also included strengthening public leadership on HIV prevention, improving cross-sectoral coordination, and continued dialogue between GO and NGOs at central and local levels.

### **Limitations of this evaluation**

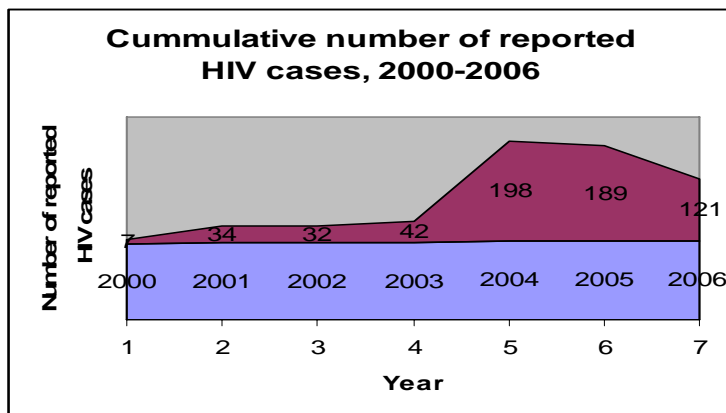
- The site visits were not necessarily representative of the overall programme. They did not include Gbao Oblast due to the closure of the access road in winter and the length of time required reaching the programme site at the border with Afghanistan.
- The Terms of Reference of this evaluation excluded a financial review of the programme implementation and thus excluded per se cost-effectiveness evaluation of the programme.
- Sex workers, IDU and MSM interventions were within Rd I and VI programmes thus not part of this evaluation. However, where critical, suggestions were made about activities targeting sex worker and IDU supported by GFATM grants.
- Due to time constraints, it was not feasible for the evaluation team to visit all the activity sites and organizations. The sites visited and people interviewed were selected by EFT/GIU and may not be representative of the overall programme.
- Project related reports and outputs, except those prepared by IOM on migrants, were in Tajik or Russian languages. The NGO reports were reviewed and synthesized by one national consultant. The results could not be verified by the team leader.
- Some of the interviews and focus group discussions were conducted in Tajik language which neither the national consultant responsible for focus group discussion nor the interpreter had the command of. The Monitoring and Evaluation Officer of GIU/UNDP assisted with Tajik-Russian interpretation. The GIU External Relations Officer assisted with translation of Tajik documents.

### III. SITUATION ANALYSIS

#### HIV situation in Tajikistan

The first HIV case in Tajikistan was reported in 1991. As of December 2006, cummulative 627 HIV cases have been officially reported and registered<sup>10</sup> (refer to the graph below). Officially, Tajikistan reported a 86 per 100,000 HIV prevalence as of December 2006<sup>11</sup>.

Among the reported HIV cases, 83% (520) were males. IDUs accounted for 66% of HIV infections. Of those HIV infected IDUs, 42% were less than 30 years of age<sup>12</sup>.



Among the HIV infected males, 13% were prisoners. At present, some prisoners were being released through an amnesty programme after the November 2006 presidential election. The total number of HIV infected prisoners would decrease at the end of this amnesty by

January 2007<sup>13</sup>. Labour migrants accounted for 9.6% of reported HIV cases. TB prevalence was reported at 74 per 100,000 in 2005 and 65 per 100,000 as of December 2006<sup>14</sup>. In addition, there were high rates of prevalence of hepatitis B, hepatitis C and syphilis.

There were many warning signs corresponding to expanding HIV epidemics. The reported HIV cases were only the tip of the ice-berg. This situation was of particular concern because many detected HIV cases were at a late stage of infection. These cases reflected infections which occurred five to ten years previously. If consorted and systematic efforts are not effectively pursued immediately, today's vulnerabilities would fuel HIV epidemics in the country tomorrow. HIV could undermine Tajikistan's current economic growth and development, particularly in view of its prevalence among migrant communities and the importance of remittances from migrant labourers for Tajikistan's economy.

<sup>10</sup> Source: Dr Mirzoev Azamdjon Safolovich, Director, NAC, Tajikistan, based on interview on 8<sup>th</sup> December 2006. The data source of the graph came from the National AIDS Centre.

<sup>11</sup> Source: National AIDS Centre. The reported number for December 2006 was incomplete. The final number for December would only be available in 2007 due to lag-time in receipt of reports.

<sup>12</sup> Source: National AIDS Centre.

<sup>13</sup> Source: Mr. Rustam Nurov, Chief of Medical Unit, Penitentiary Department, Ministry of Interior. Interview on 15<sup>th</sup> December 2006.

<sup>14</sup> Source: TB centre. The total reported number in 2007 was incomplete as some reports have not yet reached the TB centre.

Current responses centred around specific high-risk populations with STI focused approaches. There were few comprehensive, systematic responses dealing with the root causes relevant to HIV vulnerabilities in the country.

### **Tajikistan HIV vulnerabilities**

Key HIV vulnerabilities identified by the evaluation team are listed below:

- Weak economy correlated with weak health, education and development sectors.
- Gender inequity and cultural norms constrained women in seeking health care, particularly STI related services. Young wives of migrants required permission from their husband's family and must be accompanied by a relative before they can visit a health centre. These women were at risk of HIV exposure from their returning spouses or other contacts. Many wives of migrants who stayed behind in hometowns acquired STIs, including ulcerative STIs – increasing the risk for HIV transmissions.
- Young girls, particularly in rural communities, either did not go to school or had only a primary level of education. Most secondary schools were at a distance from rural villages. The daily travel required to attend school was both costly and not supported by local customs for young girls. The prevailing social perception continued to discourage the education of girls.
- Boys also had limited education. Some never went to school. Many did not go beyond primary school due to poverty. An increasing number of rural boys and girls migrated into cities for petty labour and some were recruited into sex work.
- A drug trafficking transit route: Afghanistan has increased its opium production and export. The long borders with Afghanistan facilitate the transit of drugs.
- An increasing injecting drug use population, particularly among youth. At the same time, a drug substitution therapy policy is currently pending.
- A large and growing number of seasonal labour migrants. The number of female migrants has been increasing steadily. More than 90% of seasonal migrants went to Russia where HIV, STIs including syphilis and IDU prevalences were high.
- A large number of undocumented Tajikistan labour migrants go to Russian and other countries. The undocumented nature of these migrants leaves them without access to health services and other legal protections during their transit and while they are in host countries.
- The post conflict transition economy with high unemployment further limited gainful employment opportunities particularly for rural populations and young people.
- Trafficking of people including of rural women to cities or other countries. Many of their families considered them as migrants working elsewhere.
- Interactive vulnerabilities: IDU, population mobility, sex work, children under difficult circumstance, including out of school youth and street children, stigma and discrimination against PLHIV, MSM, SW, IDU and prisoners, a relatively

low level of protective behaviours among both general and vulnerable populations. These factors synergistically perpetuate the HIV epidemics in the country.

- Limited capacity and coordination system in place for GOs, NGOs and international communities in agriculture, health, labour, migration management, planning, transport, and other relevant sectors to respond to HIV epidemics efficiently.

### **The specific situation of target populations**

*Migrants* The International Organisation for Migration (IOM) has estimated at approximately 1 million the number of Tajik nationals working abroad. Migrants accounted for nearly 17% of productive population of the country and support mostly rural households. Nearly 90% of migrants have been to Russia with others going to Kazakstan, Turkey and Europe. The migrant generated an estimated 660 million USD remittances annually compared to a state budget of approximately 430 million.

Many migrants were undocumented, thus they did not have health insurance and the employers did not provide health services or insurance in the case of accidents. An increasing number of migrants form a second family in Russia. A large proportion of migrants were seasonal. They would emigrate in spring and summer and return home for autumn and winter. Diseases including STI and HIV were transmitted between host, transit and source communities. A Sharq<sup>15</sup> study found less than 10% of migrants practice safe sex while away from home.

*Youth* A 2005 UNIFEM KABP survey showed that 50% of youth 15 to 24 years old in Tajikistan knew about HIV transmission and prevention. Social and economic realities influence their behaviours. Young people, encountering difficulties adjusting themselves to lack of employment and availability of drugs on the streets, joined high HIV risk populations such as injecting drug users and sex workers.

*Prisoners* The 2005 sentinel surveillance among prisoners found 27.6 % hepatitis C, 21.4% syphilis, and 6.7% HIV among a random sample of 402 prisoners from 2 prisons. TB has been prevalent among prisoners.

*PLHIV on ART* A cumulative total of 67 eligible PLHIV received ART out of a total of 627 HIV positive cases identified. Some of the ART recipients were in prison. The fact that most ART recipients began at a late stage of AIDS reflected late case detection. There were more PLHIVs identified who were eligible for treatment than those who actually received ART due to various service, social and economic barriers.

*Monitoring and evaluation capacity* Supervisory visits to project sites have been made by implementers. However, the frequency, quality and content of monitoring varied.

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<sup>15</sup> A social research entity in Tajikistan collaborated with IOM and conducted a migrant study including a small survey of Tajik migrants in Russia.

## IV. EVALUATION FINDINGS

Tajikistan has made impressive stride in its HIV responses through the support of UNDP's Joint UN Advocacy project, the substantial GFATM grant support and the support of other international entities. Although the challenges are numerous, HIV donor supports continue to increase in Tajikistan.

**Policies** The joint United Nations system has assisted the Government of Tajikistan in implementing several policy improvements. The National HIV/AIDS laws have been updated to align more with international standards. The National AIDS Strategic Plan, 2006-2010 has been prepared and focused on multi-sectoral collaboration in HIV prevention and care. Key goals included reducing HIV prevalence and improving health status of PLHIV. The National AIDS treatment protocol was approved by the Ministry of Health in February of 2005. ARVs have now been included in the essential drug list of the country.

**Coordination** In 2005, the Government restructured the national coordination mechanism into one National Coordination Committee for AIDS, TB and Malaria (NCC). Its membership included representatives from GOs, international and local NGOs including a PLHIV NGO, the state religion committee, United Nations organisations and bilateral donors. The NCC is supported by a Secretariat for its daily operations.

Unfortunately, the evaluation team was unable to consult with the Secretariat focal point. The person has been on study leave abroad and there was no interim arrangement to cover this absence.

*Sectoral coordination* Non-health sectors such as the penitentiary of the Ministry of Interior and Labour Migration Service of the Ministry of Labour were partners to the national HIV responses. These sectoral responses were on STI prevention and ART provision. These sectors have additional potential to contribute from each's own comparative advantages and mandates. By encouraging these development sectors' own unique contributions, it would strengthen the effectiveness and sustainability of Tajikistan's HIV resilience .

At present, HIV interventions have mainly been supported by international organizations to implement the National AIDS Strategies. Tajikistan also benefitted from several Central Asian regional initiatives for HIV responses. Several organizations are involved in interventions with IDU, migrants, prisoners, street children and on school curriculum. The coordination among funding organizations was done through consultative meetings. Actual coordination in implementation was left to individual NGOs or GOs who receive grants from multiple donor sources.

### **Overall results to date**

- ART started in February 2006 covering 67 PLHIVs (22 females and 45 males) out of a cumulative number of 627 reported cases<sup>16</sup> in the country. Among those on

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<sup>16</sup> Data source: National AIDS Center, as of December 2006.

ART, 7 (2 females and 5 males) have died, most of whom were at a late stage of disease when ART was initiated.

- From 2005 to 2006, 150,627 HIV tests were conducted, 60% were on men. Of these tests, 310 were positive. These tests covered hospital surgeries, health care workers, uniform service personnel, anonymous testing as well as VCTs that included prisoners, migrant workers and their wives in addition to IDUs, SWs and others.
- *Migrant friendly STI services* have been established in 30 districts, 5 implemented by the State Migration Service of the Ministry of Labour and Social Welfare and 25 by IOM and its network of NGOs. Together more than 8,152 clients were served, 4,624 tested for STI and 2,260 for HIV, while 2,320 received free syndromic treatment<sup>17</sup>.
- *Prison STI services* have been established in 18 out of 21 facilities, 16 of which are functional. In addition to providing syndromic STI treatment, there were a total of 128 PLHIV identified in prison. Among those, 18 were on ART. The actual number is changing with the start of an amnesty programme following the presidential election in November 2006. The amnesty process will end in January 2007.
- *Trust Centres for street youth*: Both outreach workers and interviewed youth demonstrated clear HIV knowledge. Some street youth reached have since continued to attend school. TV, radio, pamphlets, mobile theater performances have been disseminated through both national and local channels.
- *M&E*- In addition to VCT, there were rapid surveys conducted by NGOs and surveillance conducted by NAC. The Country Response Information System (CRIS) has been planned for national implementation in 2007. The HIV and AIDS data intake form has been revised and efforts are being made to coordinate between NAC and national medical statistics services.

## **Population specific outcomes**

- **Labour migrants and their families**

Thirty selected sites were renovated into migrant friendly free STI service centres<sup>18</sup>. Five of these centres are managed by the Labour Migration Services of the Ministry of Labour

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<sup>17</sup> The actual number today would be higher as these data were based on reports available as of September 2006.

<sup>18</sup> The services are in Khorog city and Ishkashim in GBAO, Muminobod, Kolhozabad, Yavan, Vahsh districts; Kulyab city, Shurabad, Vose, Hamadoni, Pyandzh, Kumsangir, Shaartuz in the Khatlon region, Asht, Ainy, Gaffurov, Kanibadam. Pendjikent Khujand, Gonchi, Isfara, Matchai Kuhi districts in the Sughd region and Rasht, Faizabad, Vahdat, Tursunzade, Varzob, Gissar, Rudaki and Nurabad districts in the nationally administered region. Railway and airports at Khujand and Dushanbe.

and Social Welfare. The remaining 25 centres are managed by a network of NGOs affiliated with IOM. According to the September 2006 progress report prepared by IOM, Tajikistan, three articles were published and 23 radio spots were broadcasted, 9,971 events such as meetings, discussion groups, mobile theatres were held; 148,783 labour migrants and their families were targeted; 181,208 booklets and 123,932 condoms were distributed. The volume of services provided by each centre was variable and of uneven quality. This was partly a reflection of the size of the total population covered, the coordination between NGO outreach workers, volunteers and the medical providers as well as the quality of performance of the physicians assigned by the Ministry of Health to these centres.

The average number of outputs from each of the Labour Migration Service administered centres was lower than that of the IOM network of NGOs. This had led to the replacement of the national coordinator of the Labour Migration Service assigned for the implementation of this activity in September 2006. Subsequently, several outreach workers were replaced in these five centres operated by the Labour Migration Service. The impact of these actions on performance improvement would be seen over time.

Overall, 631,757 migrants and family were reached to date, 1,160,000 copies of IEC materials distributed. Three local radio stations: “Savdoi Dushanbe”, Shifo” and “Nilufar” broadcasted HIV prevention messages in Tajik and Russian languages. Round tables and a series of seminars were organized for the personnel of the airlines and railway companies. A total of 293 people participated in the seminars. Approximately 13,100 brochures and 16,128 condoms were handed over for distribution to passengers. The airline passengers were more receptive than railway passengers. At some sites, there was great resistance to out-right condom promotion.

*Issues* The numbers reported were of varying reliability. For example, some counted the number of visits instead of the actual number of individuals served. The people, both males and females served by the migrant centres were not necessarily from the migrant communities. These centres are newly created parallel services, which stands along-side the existing reproductive health, dermatological and venereal diseases or urological services. The supposedly free services would still need laboratory services from existing polyclinics for confirmatory tests of syphilis and chlamydia-- two prevalent STIs in communities. Attempts to recreate laboratory facilities within these newly created, parallel STI services for migrants, would dilute the existing health care system.

An IOM study among the migrants found that 93% of surveyed labor migrants had heard about HIV. However, only 26% of them had correct HIV prevention knowledge<sup>19</sup>. Focus group discussions and key informant interviews indicated that many women from migrant communities had subjective complaints reflecting possible STIs. Other STIs in women were asymptomatic thus they did not have indications for them to seek medical care. However, they faced constraints in seeking care at the migrant friendly STI service centres. The women have to take care of their children or work in the fields. The distance from rural villages to the 30 centres required costly transportation, which was also time

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<sup>19</sup> IOM migrant study report, October 2006 presented at the Round table in December 2006.

consuming. In addition, many mothers-in-law did not permit these women to travel outside of their villages in the absence of their husbands. The motivation for visits by migrants' wife was further hindered as majority of the physicians at the centres are males. The local culture discouraged women from getting male physicians to perform STI examinations.

As for male migrants, most of them were only in Tajikistan during autumn and winter. Having been away the rest of the year, they were busy catching up with family obligations and chores when they return. The number of active male migrants to these centres was low. Few male migrants visited centres operated by female doctors.

The overall service volumes for the 30 centres was low based on the visit records provided by National Venereal Diseases Centre and the records of centres visited. The demand existed. The service volume and direct feedback from targeted beneficiaries, outreach workers and physicians indicated multiple barriers arising from the current arrangements.

The doctors for these centres were appointed and employed by the Ministry of Health. IOM and its network of NGOs conducted outreach activities to promote these centres. However, the quality and performance of these centres were outside of IOM and of its partners' control. The available examination table, the equipment and facilities provided by the GFATM were underutilized. At times, the assigned physicians' ability to use the microscope, make a diagnosis or handling the instruments, did not give the evaluator confidence. Much of the equipment, supply and set-up of the centres were under-utilized. Condoms and gloves were in abundant supply. At certain centres, the information brochures were available in languages not used by the particular communities. At other centres, there was a shortage of the particular language version of the same brochures.

The capabilities of the network of NGOs affiliated with IOM for this intervention could be better utilized. For example, these NGO teams could promote HIV prevention among migrant communities. The outreach should not be limited to migrants and their wives, but also include their entire family. This would require shifting the emphasis from promoting the centres for individual services to actually conducting HIV preventive behavioural change communications for the migrant communities.

The brochures used were mainly information in text form. Most rural community residents did not have high levels of education. Based on the principles of behavioural change communication, alternative and varied means of media and non-text forms of communication would be more relevant and effective. Some of IOM's network of NGOs had coordinated with local authorities to include HIV awareness raising in other locally organized gatherings.

There is a need to target the different audiences and to reduce the service seeking barriers as part of the communication efforts. The indicator used "*correctly cite the name of the centre physician*" did not reflect actual service utilization nor STI reduction.

- **Street children**

The term street children were used broadly in Tajikistan to cover what UNICEF had termed “children under difficult circumstances”. The priority, in accordance with the Round 4 proposal, should be to target true street children in the urban settings. These street children lived on the streets or abandoned construction sites. Many of them sniff glue or took up smoking and drug use. Some were orphans or migrated into urban cities from rural communities. Several engage in petty crimes or violence for survival. There were both males and females. The female street children and some boys were lured into sex work and some engage in drug use. They were the most vulnerable amongst the various types of children currently covered by this intervention.

Most of the children covered by the street children projects were not street children as defined internationally. For example, most of these children have a home where they stay and have one or both parents. Some were attending schools irregularly or dropped out of school. Many of these children work at the markets (bazaars) or at parking lots. These children help their families by selling plastic bags, marketable products or pushing carts in order to earn income. Some children never went to school because their families were unable to afford the expenses related to attending schools.

There was no clear definition when the term “street children” was used in Tajikistan. It resulted in less effective targeting for outreach and interventions. It also made the estimation of the number of street children problematic and thus affects monitoring and evaluation. For example, some young outreach workers simply visited homes to reach female children who did not go to school and were not on the streets. Others reached children who were working, but stayed with families and still attending school. Among the NGOs visited for “street children” projects, only DINA in Sughd region actually reached real street children. The success of DINA in its outreach related to the quality of their selection and training of outreach workers, the comprehensive activities of DINA including on drug use, training for street business, etc. True street children often engage in risky behaviours such as sex work and drug use and may have complex psycho-social problems. An NGO who does not deal with drugs, sex work or youth counseling would be weak in their outreach efforts.

Taking into account these inconsistencies among youth surveyed on the streets, 10% of them were aware of HIV prevention. Based on NGO reports to GIU/UNDP, 8,567 “street children” were reached with IEC materials and behavioral change education and communication.

Focus group discussions with outreach workers and youth gathered by the NGOs visited reflected a high level of knowledge and information received by these youth. The pseudo-street children reached were articulate, well-informed on HIV and preferred to gain more knowledge and receive a greater variety of inputs. Street theaters performed with varying quality. IOM engaged professionals to assist NGOs in improving the quality and effectiveness of such theaters.

DINA demonstrated the feasibility of utilizing the outreach opportunity to provide training to these children. The activities attracted these children as they could gain marketable skills outside of school. Computer and language skills training had been used successfully in other countries for these children and were planned by DINA and a few other NGOs. Other NGOs were implementing multiple projects for youth. The numeric targets they reported might be mixed with the results of other projects. For NGO capacity building and sustainability, it would be relevant to consider a strategic approach with a longer range organization plan. It could maximize the various donor inputs instead of having piece-meal pilot projects without sustainable outcome for the organization or the beneficiaries.

Evaluation of BCC elsewhere has shown that it would be useful to engage these different groups of children to develop their own group-specific communication tools and materials. It would not only diversify the simplistic IEC brochures currently produced, which were of limited impact. It could also be more relevant for the children being targeted. It was not effective to mass produce large quantities of few text form of IEC materials at the start of the grant for distribution during the entire five-year grant period. A more effective approach for BCC would be to adapt and adjust the medium, the content, and the tools over time. The latter approach would allow responsiveness to the shifting needs of the audience and better targeting of BCC.

- **Prisoners**

Sixteen out of eighteen STI service points have been established in prisons. These included Dushanbe, Nurek, Vahdat, Kulyab, Istaravshan, Khudjand, Kurgan-Tyube, Yavan and Khorog cities. Prisoners were provided HIV preventive information. Contests for posters were held and the winning ones were produced. Condom distribution in prisons was delayed until September 2005. There were still difficulties with distribution in prisons. Prisoners were afraid of stigma and persecution by prison wardens or their peers for homosexual contacts. The condom distribution points inside the prison were to include friendly cabinets, family meeting rooms, medical units, rooms for educational work. At the only prison the evaluation team was given access to visit, condoms were only available at the longer-term family visit quarters and at the STI service. The numbers of condoms distributed inside the prison were too minimal to have any impact on disease prevention.

The proposed IDU harm reduction in prison was still pending approval by the authorities. Nearly 35,000 copies of information brochures in Tajik and Russian were distributed inside the prisons. AFEW, OSI and SDC had trainer modules for health workers in prison. According to the Penitentiary Service, 1,452 prisoners received STI syndromic treatment, and 34,472 copies of IEC materials on HIV and STI prevention. The prisoners interviewed had a good knowledge of HIV. The medication supplied might need to be reviewed to ensure prescription of the most effective treatment.

It would be a good opportunity to introduce DOTS therapy in a confined environment where compliance could be monitored. It would be necessary to combine the TB and HIV prevention and management to ensure early detection and management of co-infections.

Opportunistic infection medications and regular monitoring on physiologic parameters need to be available and provided to the PLHIVs in prison.

- **Anti-retroviral therapy**

**VCCT** HIV counseling and testing services were provided by the governmental health care structures such as central district hospitals, regional centers of sanitary and epidemiological surveillance, national and regional centers of AIDS prevention and control and centers of blood safety (in total 134 points). In addition, special service centres created through GFATM grants for IDUs, SWs, labor migrants and prisoners allowed for pre-test counseling. According to GIU progress reports, 74 people were trained in pre and post test counseling. However, the current process of VCT was disjointed. Normally trust points or trust centre doctors, maternity ward nurses and physicians, reproductive health clinics or dermatological and venereal diseases clinics might be the first point of contact for a potential PLHIV. These providers were able to provide pre-test counseling with a client. A blood sample was sent to the designated testing laboratory. If the test result was positive, the first line providers were cut off from the client from that point on. An AIDS epidemiology team would then take over. This approach resulted in the fragmentation of the VCT process. There is no assurance of proper and qualified post test counseling. This approach also contributed to PLHIV's reluctance to receive ART as no trust was built at the pre-test stage with those who took over once a positive test result was confirmed.

Voluntary Counseling and Confidential Testing (VCCT) have been regularly conducted in many countries including those in the Balkans. In particular, NGOs have been more successful than public establishments in reaching high-risk or marginalized populations for VCCT. With careful selection and appropriate professional training, NGO staff has demonstrated their competence in conducting VCCT with rapid tests. The NGOs report the results, both positive and negative to the national AIDS centre. The engagement of quality NGOs in VCCT would allow rapid expansion of VCCT in communities and potentially improved uptake of ART among eligible PLHIVs. Without adopting a partnership between NGOs and GOs in VCCT, it would be difficult to rapidly scale up early case detection and treatment. At present, rapid test kits were only available in limited public settings.

Several AIDS centre laboratories had two Elisa machines: one from GFATM, the other from other donors. Other districts had none. It would be useful to redistribute the GFATM Elisa counters to ensure optimization of resources.

**ART** Round 4 GFATM grant provided the first opportunity for the national availability of ART in Tajikistan. Although the Phase started in January 2005, the first PLHIV who received ART was in February 2006. As of now, 67 PLHIVs have received ART out of a total of 627 reported HIV cases. The number of PLHIV receiving ART is low for various reasons. Most of the physicians trained on ART under GFATM support were not active in ART. Others not formally trained were providing ART. Key informants indicated several barriers as follows:

- The separation of pre-test counseling from testing,
- the separation of testing from notification,
- the separation of notification from treatment provision,
- the separation of monitoring of CD4 counts and the monitoring and management of other physiologic parameters,
- the stigma and discrimination from medical professionals towards PLHIV,
- the fear of losing employment or families if identified by others as a PLHIVs,
- the refusal of medical providers to treat PLHIVs on non-ART related ailments including dental procedures, maternal labour and delivery, and
- the shortage of protective barriers in medical settings (gloves, gowns, masks, etc.), and the lack of PEP kits.

Ten laboratory staff received CD4 count training. One of the activities proposed under Round 4 was to include ART training in medical and nursing schools. This activity has not started.

There were significant gaps in monitoring and management of PLHIV on ART. To ensure confidentiality and free laboratory testing of other physiologic parameters, it would be necessary to strengthen coordination and collaboration between hospital laboratories and ART providers. ART management ought to be done by existing medical services without creating a parallel treatment system.

**PMCT** From the beginning of the programme, 7 pregnant women were registered with HIV: 3 of them did not received PMTCT due to miscarriages and the other 4 pregnant women received ARV prophylaxis. The GIU reported that 98 health workers were trained on ART for adults and children as well as on PMCT. Eleven maternity centres provide PMCT counseling. However, the HIV tests for pregnant women were sent to the AIDS centres. On several occasions, the process delayed the diagnosis of HIV on mothers thus the newborn did not receive PMCT prophylaxis. According to the key informant physicians, the maternity centres had no rapid HIV tests. There is at present, a two-week turn-around time for confirmatory tests. It would be important to improve the logistic coordination between maternity services and AIDS centres. It would also be necessary for the maternity centres to have the capability for PMCT counseling and HIV rapid tests. These are important considerations for reaching the sixth goal for PRSP and for achieving the HIV goal in MDGs.

- **Capacity building for monitoring and evaluation (M&E)**

Over 40 monitoring and evaluation specialists have already been trained by UNAIDS, WHO and other partners. GFATM support for monitoring and evaluation capacity could better focus on improving the system in support of the three-one principle. Harmonizing monitoring and evaluation resources would improve knowledge and information about HIV in Tajikistan. Harmonizing monitoring and evaluation between the GFATM TB and HIV grants implementation could also strengthen the outcomes of both diseases. For HIV grants, the RCVD, IOM and GIU had conducted joint monitoring. However, synchronized monitoring and evaluation from multiple donors of the implementation of NGO and GO activities would create improved synergy of interventions.

At present, data on HIV include routine case registration, regular sero-surveillance among specific populations, rapid assessments and special studies. Small scale sero-surveillance has been conducted in 2005 and 2006. The CRIS will be rolled out in 2007 with assistance from UNAIDS. There has been a growing number of donor support and implementers on HIV and TB activities in Tajikistan. The HIV bulletin produced by the Sughd regional expert committee contained epidemiologic data, policy and intervention updates. This could be a good example to consider for producing a national HIV-TB annual report.

## V. STRATEGIC OPPORTUNITIES FOR HIV RESPONSES

**Strengths** Tajikistan has strong donor and international community support in HIV prevention, drug demand reduction and TB control from the health side. There are also planned and on-going support for education, economics, and infrastructure construction from the development side. Migration from different strata of the society contributed to having well-educated Tajik populations from both within and outside Tajikistan. There are several Central Asian regional initiatives and alliances in infrastructure development, political, economic, scientific and health sectors. Civil societies are developing in the country. There are natural resources and an agricultural base. Water resources for hydro-electricity are available. Large migrant remittances support the livelihood of rural poor households.

**Weaknesses** Tajikistan relies on neighboring countries to supply gas for heating and energy. There is heavy dependence on donor support for basic infrastructure and public systems including on education and health. The civil war affected education, health, science and technology sectors, which are now in the process of recovery. Well-educated Tajiks sought employment abroad, with private sectors or international organizations, which have reduced the pool of talent for public sector services. Health providers and services do not have quality assurance or accountability. The health system has been further fragmented due to different donors supporting various vertical structures. There is a lack of coordination and cooperation within and between sectors. The education sector has not kept pace with modern pedagogy or curriculum development. Geographic barriers with mountainous terrain challenge logistics and create obstacles for monitoring and management coordination of HIV, TB and other diseases. The agricultural sector has been weakened by civil war and is making a slow and uncertain recovery. A large number of productive age population works outside of the country. The size of population below the poverty line is large.

**Opportunities** HIV, based on reported prevalence, is at an early stage of diffusion in Tajikistan. Improved capabilities in case detection can unveil new cases. There are several GFATM grants available. There is an opportunity to build and strengthen a sound HIV response system. Such a system needs to be multi-sectoral with the health sector functioning as the focal point. This would require strengthening the health system with vertical and horizontal integration to reduce vertical and horizontal fragmentation. UNDP needs to mobilize development sector contributions for HIV vulnerability reduction based

on each sector's expertise and mandate thus contributing to strengthen the effectiveness of the current medical interventions.

The availability of financial resources allows broader coverage and scale-up of proven effective interventions. There is an opportunity to enhance coordinated system-wide responses within the health and non-health sectors among the donor community. As reflected in the NASP, better-targeted and coordinated training for health managers and service providers must take place so that precious resources are not squandered on repetitive or unutilized people post training. Those selected for training should be required to provide services upon completion of their training. Those who did not provide such services should return the funds invested in them so others could be trained and take on the functions.

The current resources would enable outreach to migrant communities by sending carefully selected physicians to regularly visit the remote villages. They could reach more clients and, by coordinating and collaborating with rural village health stations, it could strengthen the capacity of those providers and centres. To expect, at present, the migrant communities, especially women, to travel long distances to visit the services reduced drastically the number of potential clients served and the potential effectiveness of such interventions. The policy of placing emphasis on migration is a sound one in view of the considerable size and role of migration in the country. This is also why its implementation needs to be improved to increase effectiveness.

**Threats** There are a growing number of street children, particularly from poor rural communities. There is an increase in children with one or both parents absent, due to migration for employment, imprisonment or death during the civil war. Other threats include an unpredictable future donor support, rapid escalation of HIV epidemics, reduced natural resources including water supply. On the other hand, there is a question of the absorption capacity of the multiple HIV funds, both from GFATM and other donor sources. The risk of aiming at short-term expediency might harm the overall effort of a health system strengthening because of these fragmented, vertical interventions. The increasing fragmentation of services and creation of vertical parallel STI services within the same health care facilities is but one of the many illustrations of the current approach.

Internally, from within the Ministry of Health, there are opportunities to systematically coordinate and integrate HIV preventative services, including VCCT for HIV screening, improvement in early detection and coverage of PMCT, and coordinating with penitentiary services for post-discharge continuity of treatment management. If these opportunities are not seized now, they could become threats that could overturn the gains one aimed to achieve with the current investment.

## **Strategies**

***Apply good governance principles through an Early Warning Rapid Response System to reduce vulnerabilities and build national resilience***<sup>20</sup>

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<sup>20</sup> Building a dynamic democratic governance and HIV resilient society, February 2004, UNDP, South East Asia HIV and Development Programme. [www.hivdevelopment.org](http://www.hivdevelopment.org)

Present HIV vulnerabilities in Tajikistan are linked directly to socio-economic, development and gender inequality. Strategies to reduce HIV vulnerability would be well-advised to focus on building HIV resilience. By linking development factors in HIV responses in Tajikistan, it would be consistent with the framing of the NDS, NASP and working toward achieving the MDGs. There are multiple warning signs for impending or already growing HIV epidemics in Tajikistan. A health-sector focused response is no longer sufficient to stem the tide of the epidemics. Coordinating with development sectors and engaging development partners to reduce social and economic vulnerabilities and by improving gender equity as well as strengthening education (both formal and informal education) could contribute to controlling the growth of HIV.

Utilizing *a systems approach*, one could consider both vertical and horizontal integration of HIV prevention. This would require strengthening the capacity of central and regional AIDS centres as focal points and facilitators for monitoring, evaluation, projection, and planning at national and regional levels. It would also require placing HIV prevention, treatment, care and support back into the existing health system. Strengthen the system instead of creating parallel, fragmented stand alone services to increase potential sustainability. The short-term approach in health worker remunerations for each target population services distorts the overall health system personnel remuneration scale. Migrant peer HIV prevention outreach, workplace HIV prevention policies and programmes, including for hospitals and clinics, need to be strengthened. Advocacy and engagement of business leaders, both private and public, could be considered through the United Nations advocacy programme.

*Social marketing* for behavioural change through engaging the target populations as the creators, motivators implementers of activities could improve the effectiveness of prevention. The multiple printed IEC text materials in isolation without other enabling factors are not effective. The example of DINA's strategic planning and holistic approach to a person under difficult circumstances, be it an IDU, a street child or a discharged prisoner, by providing social support, legal assistance, skills education for economic improvements and healthy life styles would motivate the target populations more effectively and sustainably. These approaches would require collaboration with development sectors. Most of these issues are outside of the purview of the health sectors.

The issue of *gender* transformation within the cultural, social, educational and economic context must be tackled. This is particularly urgent in view of the increasing number of female migrants. Education for girls is not an option but a necessity for HIV vulnerability reduction and resilience building as well as for national development. Education could take place in both formal and informal settings.

*Participation* Greater involvement of people living with HIV (GIPA) and target populations can reduce stigma and discrimination, engage the target populations, improve the effectiveness of behavioural change communication and the responsiveness of policies and of service provision.

***Visionary strategic leadership*** The new composition of the Ministry of Health has an opportunity to create a visionary strategic leadership. By providing the leadership, it could usher in a strengthened system to reduce vulnerabilities and strengthen resilience to emerging diseases such as HIV, and re-emerging diseases such as TB.

## **VI. CONCLUSIONS AND RECOMMENDATIONS**

### **Conclusions**

UNDP has facilitated the achievement of impressive results through its role as the UN coordinator, through its UN system joint advocacy programme, and its role as the principle recipient of GFATM grants. The Tajikistan government and people have taken major first steps in strengthening the capacities and creating an enabling environment for effective HIV responses. While there are strengths and weaknesses, undeniably, this is the opportune time for concerted, strategic actions to reduce the threats by building capacity and introducing resilience in Tajikistan to respond to HIV.

The opportunity of systematically building a strong and sustainable health system in Tajikistan is now. Ensuring impact on HIV and TB, it would be the opportunity to integrate these two diseases services in the health system structure. The advantage would be the vertical as well as horizontal integration (disease specific and system relevant).

Considering the continuum of the migration cycle from source, transit to host communities, it would be important to recruit migrants themselves to be peer educators throughout the entire continuum of migration. Planning for the investment of remittances to build the resilience of families and individuals need to start right from the time an individual begins to contemplate migration. One needs to promote the skills and talents gained from working outside to bring them back to benefit their source communities and strengthen the marketable skills of new migrants.

Tajikistan, with the UN administered GFATM grants and coordination support, can improve the resilience of its migrant communities, build the capacity of civil societies, build the social work sector, and strengthen public and civil society collaboration. Having now three years of IEC on HIV, it is the time to develop a BCC strategy that can be implemented and scaled-up during the Phase II of Round 4 and in Round 6.

### **Recommendations**

Tajikistan has demonstrated its potential and capabilities to make a difference. There are many committed professionals on the ground. There are talented senior professionals in leadership positions. The building blocks are available for an effective programme. What is necessary now is to coordinate the vertical elements of the health system in order to complement the horizontal ones. This means linking the fragmented pieces together into a dynamic system. The following recommendations are provided because the effectiveness of the programme is greatly related to its capacity to organize itself as a system, which means coordinating existing activities.

The recommendations are of three types: coordination of existing activities to create synergies; improving specific activities, and new activities. All three are inter-related, but the first two types are the most important.

#### **A. UN system joint advocacy and GFATM grants implementation**

- ***Governance***

Strengthen coordination of HIV vulnerability reduction related interventions especially in the area of *transparency, accountability, efficiency, effectiveness and access to information* among the implementing partners, both GOs and NGOs. This would include improved collaboration and building synergy among the GFATM grants (round 1, 4 and 6 of HIV and TB and Malaria) implementation and reduce the creation of fragmented vertical structures or stand alone-parallel services for each identified risk population: SW, IDU, migrants, etc. at district and lower levels.

Current research has confirmed the rapid progression of malaria infection among the HIV infected. This situation should be dealt with by both the HIV and the malaria programmes. TB-HIV co-infection detection and management must be strengthened as a matter of priority, particularly in prisons.

UNDP's PR function could continue to help shepherd the strengthening of Tajikistan's health system to efficiently utilize the large amount of international grants. Such neutral assistance would facilitate the absorption of this influx of large financial support. The goal is for the government to provide substantial investment in its health system, and to develop a transparent financial accountability and reporting system, to take over the administering of future international funds.

- ***Intersectoral collaboration***

Consistent with the Tajikistan Poverty Reduction Strategy Paper (PRSP), mobility related HIV vulnerability reduction can be effective through strengthened coordination with the agriculture, construction, transport, commerce, tourism and poverty reduction sectors. Reduction of migrants and their families' HIV vulnerabilities ought to incorporate these sectoral contributions among migrant source communities.

- ***Coordination among national, international organizations and donors***

This would require the national AIDS centre and its regional and district entities to be the coordinator and facilitator while delegating the ART, VCT services to existing GO and NGO facilities. The critical facilitator role would allow efficient scaling up of both VCT and ART and improved outreach for preventive interventions including the provision of STI services.

For example, UNODC's Central Asian Republics regional harm reduction programme Tajikistan component could facilitate reaching through the narcology services the drug users to receive VCT. When relevant, these centres could assist in initiating ART. Coordination should be developed with the World Bank regional HIV programme and

Soros Foundation harm reduction projects, to reduce duplicative approaches and facilitate broadening the types and scope of interventions.

- ***Systematic migration management & support***

Reducing migration related HIV vulnerabilities is a key to reducing the STI and HIV epidemics among migrant communities and prevents disease spreading. It would require a strengthened migration management system. State Migration Services in collaboration with the Ministry of Foreign Affairs and the Ministry responsible for economic development, need to coordinate and provide international and legal mechanisms; pre-departure, post-arrival, returnee reintegration programmes; planned investment in home communities; and rights education and protection systems between source, transit and host settings.

- ***Health system strengthening***

In view of the health systems strengthening activities proposed in the Round 6 grant, it is critical to expand HIV VCT to primary health care (PHC) levels at existing rural village health stations, maternal and child health service facilities in polyclinics, and maternity services in hospitals. It is necessary to take into account the health reform plans and reduce the proliferation of vertical structures. This would improve timely responses in PMCT and early HIV detection and timely ART among those eligible cases. Universal precaution measures should be enforced in all medical and health service facilities with adequate provision of protective barriers. Post-exposure prophylaxis procedures and kits should be made available in all medical and laboratory facilities. Future consideration of pre-exposure prophylaxis can be elaborated through the Ministry of Health in collaboration with WHO and UNAIDS.

- ***Regional collaboration***

Learning from good practices internationally, IOM, in collaboration with UNDP regional centre and country offices, has a unique role in assisting the government of Tajikistan to promote the reduction of mobility related HIV vulnerabilities. For example, facilitate a regional coordination mechanism between China, Russia, Kyrgyzstan, Uzbekistan and Kazakhstan or bilateral agreement between Turkey and Tajikistan.

## **B. GFATM Round 4 Phase II specific recommendations**

Reduce HIV vulnerabilities are a preventive intervention incorporating development interventions to create an enabling environment.

### ***Behavioural change communication***

Round 4 Phase II is the time to shift focus from IEC to actual BCC. Consider mobilizing cultural resources of local populations and strengthen collaboration with religious leaders and organizations. To be effective, BCC requires peer-based and peer-developed approaches, content and communications. For example, engage street children to design their communications. Engage migrants to develop their communications and outreach. Reduce as much as possible printed text material for distribution.

Consider developing strategic communication, education strategies and responses that would deal with the root causes of HIV vulnerability. Interventions must incorporate development interventions (socio-economic and gender aspects) beyond the health dimensions. Monitoring and evaluation must get beyond numeric targets to assess the positive and negative impacts on the health system, on gender equity, on poverty and on disease. Evaluation must reflect the conceptual linkage with the MDGs, the NDP, the PRSPs and the NASP. UNDP has a unique role through its PCAP to build sustainability and generate positive impact on people's livelihood.

### ***Migrants and their families***

- Provide STI services in migrant source communities in collaboration with rural village health clinics by bringing qualified physicians to the villages regularly. For example, select doctors to visit remote rural villages in coordination with outreach workers. Adjust activities to reflect the seasonality of migration.
- Rotate between male and female doctors according to the seasonality of migration to improve service access for both male and female clients.
- Ensure balanced number of male and female outreach workers and recruit from migrant families. Rotate male and female outreach workers to ensure reaching both migrants and their families.
- Recruit migrants to provide peer-education in host communities where they work and live.
- Include STI and HIV VCT in general health screening. Carefully select and train VCT counselors and provide rapid HIV tests at PHC level. Engage PHC providers to support ART management by infectious diseases specialists.
- Provide and coordinate Chlamydia and syphilis tests for migrants, SW, IDU and prisoners through arrangements with laboratories.
- Facilitate migrant family support networks including telecommunications and safe transfer of remittances with migrants abroad. Build migrant community's capacity for planned investment of remittances.
- Gender equity must be central to the GF supported interventions to prevent systematic or further contribute to gender bias.
- Include regular home visits for early detection of pregnancies, HIV screening VCT, and introduction of infant feeding packages for post-partum HIV positive mothers by strengthening outreach to migrant communities.

### ***Prisoners***

- Strengthen TB-HIV co-infection management, ensure 100% TB screening and treatment, provide TB diagnostic tools including x-ray for prison TB service.
- Provide full range of TB treatment drugs as required with particular attention to prevent MDR-TB and for XDR-TB to emerge in Tajikistan. In view of the latter threat, it is critical to ensure treatment adherence.
- Make VCT rapid test, condoms and laboratory tests for Chlamydia and syphilis available.
- Ensure quality OI and ART with regular monitoring of drug intolerance, reactions and resistance for PLHIVs in penitentiaries.

- Establish discharge planning with post-discharge support for continuity of treatment of STI, TB and ART and social services, reinstatement of identity card, employment assistance, employable skills training and psychological support for transition back to family and society.

### ***Street children***

- Strengthen priority efforts to reach true street youth, particularly vulnerable females. Involve these children in designing non-text behavioural change communication and life skills building.
- Design interventions to tackle the root causes and provide marketable skills training such as use of computer, languages, accounting and provide psychosocial counseling. Engage peer support group, liaise with schools to facilitate part-time schooling where feasible.
- Inform and devise mechanisms with local police to protect street children.

### ***ART for PLHIV***

- Develop and introduce ART management and syndromic treatment into medical and nursing school curriculum as indicated in the Round 4 proposal. Careful select family medicine/primary care providers for ART management at regional, district and sub-district levels to ensure continuity of care.
- Provide ART through infectious disease services and utilize trained ART providers to ensure quality of care, specifically on reducing stigma, discrimination, and adhering to confidentiality. These measures should be reflected in provider performance accountability.
- Arrange with laboratory to provide the necessary laboratory tests in monitoring, early detection and treatment of OIs, drug intolerance or resistance.
- Build PLHIV capacity in advocacy, positive living, treatment literacy, and adherence and expand self-support networks in each region linking to international network.
- Establish legal aid for PLHIV to protect their rights, confidentiality and against discriminatory practices.
- Prioritize strengthening of the PMCT mechanism including providing rapid HIV testing and counseling at maternity hospitals, and ensuring prompt confirmatory testing and communication.

### ***Monitoring and evaluation***

- Ministry of Health to consider introduce quality assurance and performance accountability on provider competency, adherence to service protocols, respect of patient rights and confidentiality, timely testing, follow-up and referral arrangements.
- Re-allocate Elisa counters to ensure equitable resource utilization.
- Promote the national, regional and district AIDS centres as facilitator, coordinator and monitor of HIV prevention, ART care and support.