

**Name of event:** FY17 Quarter 1 results dissemination and PEPFAR stakeholders' meeting  
**Date:** January 24, 2017  
**Venue:** Conference room in the Republican Center for Immunoprophylaxis, 8 Chapaeva Street, Dushanbe, Tajikistan

The meeting was opened by Leslie Hayden, Deputy Chief of Mission, US Embassy in Tajikistan. Leslie Hayden welcomed the participants and mentioned the following in her opening remarks:

- The PEPFAR Central Asia program along with the national government and civil society is a critical partner in the national HIV response and in moving Tajikistan towards the achievement of the 90-90-90 goals and sustainable HIV epidemic control.
- With greater efficiency, focused programming, and the implementation of new policies to increase access to life-saving HIV treatment, we see many opportunities for further impact.
- Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional and international civil society and community stakeholders, multilateral partners and the host country government.
- In the spirit of this commitment to transparency and accountability, the interagency PEPFAR team will present annual results from the previous year's implementation (FY16) and share high-level strategic direction for the next planning period.

Leslie Hayden asked the participants to share their critical feedback on how PEPFAR program impact could be maximized and their suggestions for future program implementation.

**Aziz Nabidzhonov, Public Health Specialist, CDC Tajikistan** introduced himself and mentioned that PEPFAR program in Tajikistan is implemented through two US agencies, including USAID and CDC. Aziz also noted that USAID and CDC have prepared this presentation in the way that in the first part the results achieved during the period from October 1, 2015 to September 30, 2016 will be presented. Further, Aziz mentioned that the PEPFAR in Central Asia plans to develop a two-year regional operational plan (ROP17) for the period from October 1, 2017 to September 30, 2019. In the second part of the presentation, USAID and CDC on behalf of the PEPFAR program in Tajikistan would like to present to and discuss with the participants of the meeting the PEPFAR strategy for the planning period (ROP17). It was mentioned that it was a good time to discuss the PEPFAR strategy, as the country was also planning to develop and submit application for HIV grant from the Global Fund for the period 2018-2020. This meeting was one more opportunity to better coordinate activities among stakeholders in HIV area. Aziz expressed appreciation to the Republican AIDS Center, Republican Narcology center, international partners, employees, working in the field, due to whom the annual results were achieved.

**Arman Dairov, Regional Adviser for strategic information, USAID Central Asia** – started making presentation with provision information about activities implemented by the project HIV REACT, which reported on indicator "Know your HIV status", specially developed for this project. This indicator is intended to monitor the number of people who had a complete referral to a facility for HIV testing after release from penitentiary system. Arman mentioned that the achievement of only 19 and 23% of the planned annual targets for this indicator in Dushanbe and Khujand accordingly was explained by the fact that the project had started just in August 2016. It was presented that within the framework of the project HIV REACT the testing yield was 2%.

**Lola Yuldashev, Public Health Specialist, USAID Tajikistan** provided information on the activities implemented by the HIV Flagship project:

- The main implementation started in October 2016 with participation of three NGOs.
- Over the past period, the Ministry of Health and Social Protection of the Population of Tajikistan approved the use of saliva based HIV rapid diagnostic tests (HIV RDT) within the HIV Flagship project.
- A total of 666 PWID undergone HIV testing and 13 new HIV cases were found. The testing yield was about 2%.
- The project worked also with 80 people living with HIV (PLHIV) to improve ART adherence.

**Aziz** in his part of the presentation provided description and achieved results for the following indicators:

KP\_MAT - Number of people who inject drugs (PWID) on medication-assisted therapy (MAT) for at least 6 months of the reporting period.

- HTC\_TST - Number of individuals who received HIV Testing Services (HTS) and received their test results
- CARE\_CURR - Number of HIV-positive adults who received at least one of the following during the reporting period:
  - Clinical assessment (WHO staging) OR
  - CD4 count OR
  - Viral load
- TX\_NEW - Number of adults newly enrolled on antiretroviral therapy (ART)
- TX\_CURR - Number of adults currently receiving antiretroviral therapy (ART)
- TX\_RET - Percentage of adults known to be on treatment 12 months after initiation of antiretroviral therapy
- TX\_VIRAL - Percentage of adult ART patients with a viral load result documented in the medical record within the past 12 months

**Arman** presented information on the additional indicator «Adherence support» for which the HIV REACT project reported during the last year.

- This indicator is intended to monitor number of PLHIV provided with minimum of one service to support adherence to ART.
- Since August 2016, under the HIV REACT project, a total of 60 PWID received services intended to support ART adherence.

**Lola** provided information on what was, during the reporting period, the PEPFAR program contribution to the development of policies. The following was highlighted:

- support for the successful policy development to pilot MAT in prison settings
- support for the revision of the national HIV testing algorithm to:
  - increase accessibility of Rapid HIV diagnostic testing (through including saliva based RTs)
  - reduce time required to obtain HIV diagnosis (through combinations of RDTs and enzyme immunoassays (EIAs) rather than EIA and Western blot)

- Support to the TWG to revise HIV treatment clinical guidelines based on 2016 WHO recommendations.

**Aziz** highlighted that the results of the PEPFAR program and the experience gained during the reporting period will be used to improve program implementation during ROP17. For example, within the PEPFAR program the work in the following areas will be intensified:

- decentralization of HIV testing, prevention and treatment services
- expanding coverage with VL testing
- improving new HIV case finding

Please see attached presentation for more detailed information.

Q&A session for the first part of the presentation that was devoted to the results achieved within the PEPFAR program during the reporting period.

**Ulugbek Aminov, Head of UNAIDS office in Tajikistan** - Activities started later, how much we are behind and are you going to support more activities next year for achieving the planned targets?

**Arman** – the results provided for the HIV REACT project reflects the activities implemented in the last quarter, starting from August 2016. We have the program data from previous years, but that time the target group was inmates. Now, in order to get a real picture of progress made towards 90-90-90 targets, the results will be reanalyzed and revised taking into consideration the new target group, which is prisoners who inject drugs.

**Aziz** – After finding new HIV cases, CDC is working with the health facilities in order to enroll and retain the newly identified PLHIV in the care and treatment programs. Enrollment and retention in the HIV care and treatment programs is a problem, but for the time being the pressing issue is new HIV cases finding. Estimated number of PLHIV is 16,000, and based on this estimated number, in the country very small proportion of PLHIV are on treatment. We should emphasize finding new HIV cases and provision HIV care and treatment services to the newly diagnosed PLHIV.

**Mavzuna Burkhanova, HIV grant manager, UNDP Tajikistan** having agreed that the case finding had to be increased, also mentioned that that at the same time there was a need to actively work with PLHIV which we already had. Mavzuna referring to the considerable underachievement told that few do not agree with Aziz, and confirmed that the detection should be increased, but at the same time it is necessary to work actively with the already identified PLHIV. Mavzuna citing low achievement on the indicator TX\_VIRAL (percentage of adults on ART who have documented the result of the analysis of viral load in the medical record in the last 12 months) in the Sughd region, noted the need to develop a strategy for the clinical approach to the existing identified PLHIV who receive ART. Mavzuna noted that the RAC has recently, as part of the Russian project, conducted research and identified major problems with resistance to treatment in patients receiving ART. In this regard, it is necessary to change the approach to the clinical management of people living with HIV, and to increase the coverage of testing for viral load.

**Ulugbek** - noted that in two weeks the country will start working on the application for the GF grant, and in this application, the country will make a commitment to achieve the UNAIDS goals 90-90-90. How realistic is achievement of these ambitious goals? Whether all the partners participating in this meeting would agree with that? Do we have a plan to accelerate the activities, so that we could provide justification to the GF?

**Marissa Courey, Health Scientist, Regional CDC office in Central Asia** - As I understood, the question is not about achievement for some indicators but about how we can improve achievement of our goals. I think that we urgently need to work on expanding VL testing coverage. I would like to ask ICAP to provide the latest information on the organization of the PCR laboratory in Sogd regional AIDS center.

**Anna Deryabina, Director, ICAP regional office in Central Asia.**

- Despite the fact that it took longer than it had been planned, the equipment for the PCR lab has been delivered and installed in the Sogd regional AIDS center.
- Together with the equipment required to organize PCR lab, one year supply of test systems for VL analysis was provided.
- Last week, in the newly organized PCR lab in Sughd regional AIDS center, ICAP started provision two-week training to the lab specialists on how to perform VL analysis.
- Thus, before the end of the current quarter, all patients receiving ART in the Sogd region should be get VL test.
- Anna also noted that it was not enough to have two PCR machines for the whole country. Even if we meet needs of Sughd region in VL testing, the testing coverage will still be an issue in the city of Dushanbe. In spite of availability of PCR lab in Dushanbe, this lab cannot provide VL testing services to all in need due to volume of patients as it serving PLHIV from the rest part of the country.

Anna mentioned that it had been proved that dried blood spot (DBS) method can simplify the transportation and storage of blood samples. This method should be used in Tajikistan. In order to use this method VL platform should be changed. The cost of a new platform is about \$1 - 1.5 million. The country has to decide whether to include a new platform cost in the budget for the application for the next GF grant. Anna mentioned that she thought that it was worth doing as this will allow a good quality control system and expansion of VL testing coverage. Organization of PCR lab in Sughd will solve a problem with VL testing only in one region. In other regions, the VL testing coverage will still be low.

Another pressing issue is drug resistance. We need periodically monitor and track drug resistance, based on the existing indicators, or we need to build the capacity of existing laboratories. We are ready to start working on that.

Regarding the issue of new HIV case finding, Anna mentioned that even if we enroll on ART all patients who are on care (with already diagnosed HIV infection), with the testing yield of about 2%, the targets for the treatment indicators (TX\_NEW and TX\_CURR) will not be achieved in most sites. ICAP suggested to change the approach to the coverage with HIV testing in Isfara. It was proposed to conduct targeted HIV testing among people with AIDS-defining clinical conditions, among whom the probability of finding new HIV positive cases was supposed to be high. However, having tested 1,500 people with AIDS-defining clinical conditions, we did not find any new HIV positive case. That was not a problem with the quality of HIV test systems, as we used the 4<sup>th</sup> generation HIV tests. Therefore, the question "Are there 16,000 PLHIV as per the recent PLHIV size estimation in Tajikistan?" still remains open. Anna mentioned that we need to think about the use of alternative methods to estimate the size of the total population of PLHIV in Tajikistan. Kazakhstan plans to use the European and London PLHIV population size estimation model. If these models, after being used in Kazakhstan, will prove to provide reliable data, ICAP will propose to use the same models in Tajikistan.

**Gayane Tovmasyan, GF grant manager GF, UNDP Tajikistan** – Among which population was HIV testing conducted with tests procured by ICAP?

**Anna** - As GF supported HIV grant project and USAID supported HIV Flagship project test key populations, we also suggested to cover with HIV testing the general population, but only those with certain clinical conditions. During six months, the AIDS centers in Sughd region used ICAP provided HIV test systems to test people with codes 101, 102, 103, 104, 105, 106, 112, 113 (clinical conditions).

In the structure of HIV epidemiology, there is an increase HIV cases among women, wives of migrants, youth, among whom new HIV cases are found during pregnancy. Nevertheless, we should not be surprised if we see an increase in case finding among women, as it is explained by the fact that we are testing mainly women. Low case finding suggests that we need to change the HIV testing coverage, to target by testing the most at risk groups of population.

**Marissa** - For the purposes of targets planning within the PEPFAR program, the Spectrum data are used. The Spectrum program is used to estimate the size of the total population of PLHIV. The other, new methods estimate the size of PLHIV based on CD4 count. In Tajikistan, we identify new HIV cases, when people already have advanced HIV infection. Marissa mentioned that she could not say whether in Tajikistan there was that number of PLHIV, which we got from Spectrum. She noted that in order to find new HIV cases in the early stage of infection, the approach to HIV testing had to be changed in order to test those at the highest risk.

**Dilshod Sayburkhonov, Deputy Director of RAC** – Regarding SPECTRUM program, I would like to state that we are using results of March 2016. I have heard numerous times that some countries do not agree with the SPECTRUM data, and the program gives wrong projections. Along with other countries, Tajikistan is planning to apply new forecasting methods to estimate the number of PLHIV. In the development of the new National HVI Program we have used the estimated number of PLHIV of 15,720.

**Zukhro Nurlyaminova, Clinician Specialist of RAC** – I would like to talk about ART coverage and retention indicators. To the date, only 24 % of newly identified cases were already lost to follow up: they have not been taken on care, and thus did not initiate ARV treatment. Epidemiologically, they represent the source of infection and in a couple of years we can find these people being co-infected or presenting AIDS defining clinical conditions. 30% of new cases are being identified at the advanced stage of HIV infection. Thus, testing should be done on time to be able to identify infection at its early stage, otherwise we are not going to achieve 90-90-90 goals. Regarding the country indicator on ART retention, we have to count the number of people who continue to take ARVs 12 months after initiation of treatment. The coverage by viral load testing should also be improved: this is the best method to monitor treatment failure and poor adherence to ART that leads to drug resistance. We should consider improvement of adherence as our priority. It is not a secret that patients sometimes do not follow the prescribed regimen or do not take ARVs regularly. The fact that most of the patients on ART still have detectable VL in certain period of being on ART is unacceptable. This indicates poor adherence and treatment failure, including drug resistance. I think the projects should focus on treatment adherence support, and if after 6 month of being on ART, a patient has undetectable VL, then it points out that peer navigators are doing a great job.

**Mavzuna Burkhanova.** Low coverage with VL testing in Soghd oblast is the result of not only the absence of PCR lab and interruption in reagents supply. Earlier, before 2016, the blood samples from Soghd have been transported to Dushanbe for analysis. At the expense of GF grant funds UNDP has procured five GeneXpert machines to be installed in oblast AIDS centers and used for VL testing. From

the next week, we will start trainings in Kurgan-Tube on using these GeneXpert machines for VL testing. Soghd example is not the worst one, GBAO performed 0 VL tests.

**Dilshod Sayburkhonov** – RAC statistics show that only a small number of patients have received VL test. Out of 3,637 patients on ARV treatment, only 1,272 went through the VL testing. In 78.2%, based on the results of VL tests, the treatment was effective. This year the situation with VL testing improved and hopefully it will improve further with organizing PCR lab in Sughd region.

**Mavzuna Burkhanova** – I suggest to wait for annual data from RAC and analyze it to see if testing is targeted. Perhaps we test wrong people and many test-kits are used for nothing. Let's wait for RAC results and revisit testing strategy, as currently the testing yield is only 2%.

**Dilshod Sayburkhonov** – I wanted to note about nature of epidemic. We have to know what kind of groups to cover with HIV testing. RAC is doing analysis of all HIV cases registered in 2016, and later, in early February, we plan to gather all partners and present the results. The nature of epidemic has changed: more HIV cases are currently found among migrants and their partners (wives). Official data says that in 2016 14.8 % of all new cases were coded as labor migrants. Again, all these data are being analyzed and the results will be presented in February to include this information into the new GF application.

**Gayane Tovmasyan.** On one hand we have to understand and recognize the nature of epidemic. On the other hand, donors who ensure financing have their own requirements and spheres where they can provide assistance. From the side of GF I can assure we will not be allowed to include new groups of population in the next grant application. The country should prove epidemiologically that HIV prevalence is increasing in other than key population groups. Then this evidence can be used for justification and reflected in the GF application. As for now, it is not reasonable to hope to include new population groups into the coming GF grant application. The proposal should be submitted in March 2017 and the country is expected to stick the same priorities as it was in the previous application with some material change. Most of the things depend on work of other partners: each of them is planning to cover certain activities or specific component. For instance, USAID's HIV Flagship Project takes on their shoulders the huge part of community-based work. If they are going to continue, it will save us some finances that can be used to support other activities. Nevertheless, key populations will remain the priority and it is very unlikely we will be able to make a profound change of the strategy. The other questions that I would suggest to discuss today is to focus on stakeholders' priorities: will they be able to revisit the testing approaches? As we are talking about targeted HIV testing there is a possibility for programs implemented by different partners to compliment each other rather than duplicate. We test key populations, USAID is testing key populations as well, but the other big group that we do not know about is out of our sight and is not covered. Today is a right time to discuss if partners can revisit the directions of their work although everything depend on donor's requirements and country projects.

**Saidmumin Kholov.** To ease the overload of RAC laboratory, and if they do not mind, we can involve the national public health reference laboratory (NPHRL) into the PCR diagnostics. Upon NPHRL request, their specialist is now taking a 10-day course on PCR diagnostics in Khujand. ICAP Project can delivery test-kits for VL testing to cover AIDS centers patients in Dushanbe and, possibly, the city of Gissar. They do not have problems in transporting blood samples to NPHRL for analysis by PCR machine up to the moment when GeneXpert machines start functioning.

**Dilshod Sayburkhonov** – The problem is in incorrect blood samples collection, transportation and storage. It results in getting samples of bad quality that can not be analyzed properly. This, in turn, leads to low coverage by VL testing.

**Anna Deryabina** – Do you impose quotes for VL testing for oblasts?

**Dilshod Sayburkhonov** – No, there is no any quotes.

**Break**

**Presentation is attached**

Lola, Aziz continue presentation after break, inviting partners for further discussion and provision of recommendations and feedback.

**Start of Discussion.**

**Ulugbek Aminov, UNAIDS** – Going back to ideas on HIV testing yield improvement. 16,000 PLHIV is an estimated number. According to the last statistics for 9 months of 2016, in 70% of cases, there was the sexual mode of transmission, 5% of cases presented vertical transmission plus unknown transmission. Possibly, unidentified PLHIV pertain to other than key population group. We have to identify this group and cover by testing. However, we have to wait for RAC annual results for 2016. Perhaps, migration factor negatively affects the situation: 18% of newly found PLHIV reported labour migration in the history. We recognize we are still not able to increase the testing yield. Currently, RAC performs additional epidemiological investigation of new cases found in 2016 and it already lasted for 2 months.

**Dilshod Sayburkhonov** – In 64 % of cases newly identified in 2016 the way of transmission was sexual. All of these cases are entered into the electronic HIV case management system. We will look into the percentage of those associated with labour migration factor. We are expecting the results to be finalized by the end of January and then we will present them.

**Ulugbek Aminov** – Just a comment: 50% of cases newly identified in nine months of 2016 were among women. There is still much work to do with key population groups and this is right. Nevertheless, there is a source of infection we do not know about and do not cover. We should be alert of that.

**Aziz** – Speaking about labour migrants, the questions is how we find HIV cases among them? Do they seek for testing services themselves as part of routine examination? Or they seek care because of the certain clinical conditions? If they want to be tested for HIV because of presence of certain clinical conditions, then it means significant amount of time passed since the moment of contracting HIV infection, and diseases is diagnosed at its advance stage.

**Dilshod Sayburkhonov** – We find most of the cases among contacts and those presenting with clinical conditions.

**Aziz** – Speaking about proportion of migrants found to be HIV positive because of certain clinical conditions, it takes a certain amount of time for HIV infection to progress up to advance stage. When we

do epidemiological investigation do we ask whether the client was in labour migration around 3-4 year ago?

**Dilshod Sayburkhonov** – Correct, we clarify this questions and document a year and period of labour migration. Thus, we have to also analyze data from patients' epidemiological cards.

**Anna Deryabina** – Colleagues, the fact of increasing HIV incidence among women is explainable. We are mostly testing women, and their partners as migrants are being tested as contacts: they are either women's sexual partners or coming for testing because of presence of clinical conditions. Those clinical conditions are not always AIDS-defining clinical conditions. People may want to get HIV testing because of the requirements to get such testing before planned surgery, for instance. I suggested to conduct IBBS among labour migrants as just analysis of the existing statistical data will not give us a real picture. Now, with support from CDC, RAC develops a protocol for IBBS among PWID and FSW that is expected to be approved. This protocol can then be adapted for the IBBS among migrants. We recognize that IBBS exercise is resource consuming and expensive. The cost of commodities (test kits and compensation packages) and fees for staff involved in data collection could be funded through the Global Fund grant. CDC/ICAP could provide TA.

**Ulugbek** - There are funds available for the study, but the RAC requires TA.

**Marissa** – Retrospective analysis in this case does make sense and is cost-effective. At the same time, I wanted to clarify whether a control group was taken into account in the process of analysis? In case-control study, where both groups are matched on demographic variables (age and sex), it makes sense to compare results and see if drug injection factor is not influential anymore. It allows to trace the effect of migration and other factors that may be associated with HIV infection.

**Olga Samoilova, Deputy chief of party, The regional office of the USAID funded HIV Flagship project in Central Asia:** Migration, itself has a negative impact, but the main modes of HIV transmission are still sexual and injection. All the analysis that we are doing, we need to decide how to find the most at risk to HIV infection group and to make it possible to find new HIV cases in early stage of the disease. Regarding the emphasis on testing of sexual partners, it is very important, but it is very difficult to implement due to cultural context. It is especially difficult to attract women. WHO recommends the use of assisted self-testing method. Efforts should be made to apply in the real life new recommendations to increase testing coverage.

**Anna:** There is a certain percentage of people who refuse to visit AIDS centers, and other facilities, including NGOs providing HIV testing services to undergo HIV testing. WHO has recently issued recommendations on self-testing. The idea of self-testing involves providing instruction to the client for conducting self-testing and making decision in case reactive test result. It makes sense piloting this method among those groups who refuse to come to the medical facilities to undergo HIV testing.

**Marissa:** - I would like to ask what kind of work was conducted with migrants before, what lessons have been learned and what we can do now to identify those migrants who practice the most risky behavior. It is impossible to cover all labor migrant as there are about 1.5 million of them in Tajikistan.

**Mirzoev, Communication specialist, PSI Tajikistan:** I think that the situation with the prevalence of HIV infection among migrants is not so bad. According to 2010 survey, HIV prevalence among migrants was 0.03%.

**Ulughbek:** I would like to support Anna's allegation that implementation of IBBS among migrants is necessary. As for HIV self-testing, we may pilot and start distributing HIV test kits through pharmacies that people could buy them by themselves. As for expanding MAT coverage, BBC released a video about mobile MAT clinics. We may think of taking similar approach while providing MAT services.

**Zuhro:** Returning to HIV self-testing, it is quite widespread in developed countries, where people/patients are normally used to get required services once they know their test result. On the contrary, people in Tajikistan can hardly be persuaded to take a test in the laboratory of AIDS Center. It is unlikely they will buy a self-test kit to check their status. Our experience shows that even though people know their HIV positive test result, they still do not want to get any further services or to confirm the result and continue HIV diagnostics.

**Anna:** I want to speak about the issue of decentralization of HIV services. This issue is being discussed, and it is especially important for the city of Dushanbe. In addition to decentralization, another important issue is piloting differentiated service delivery model as part of the attempt to decentralized HIV service delivery. Currently ICAP is developing a proposal for CDC on a differentiated approach to the management of stable patients receiving antiretroviral therapy. This proposal is being developed in accordance with WHO recommendations for revision of the frequency of patient visits to medical facilities, the list of services that can be provided at the PHC level, taking into account the characteristics of the health care system.

With regard to coverage of prisoners with HIV testing, they mainly tested after release from prisons. None of the organization supports the provision of medical services for HIV-positive inmates when they are in the penitentiary system. Now we discuss that in addition to geographic expansion (Shakhrinav and Tursunzade), we also need to cover the penitentiary system.

**Malakhov:** We used to think the PWID has a leading position among the groups most vulnerable to HIV infection. If we have a person who is a migrant, it doesn't guarantee that he/she is not a person who never inject drugs or he/she does not have a sex partner who might be a person who injects drugs. Everything is interconnected. At the same time, we will have to improve integration of the services. Not all of Narcology Centers across the country are adequately equipped to perform HIV testing. However, according to the [MOHSP] protocol, we ensured all MAT clinics to have a high capacity for conducting HIV testing. Thus, probably it is worth considering to scale up integration of the services between AIDS Centers and Narcology centers. For example, the prevalence among PWID has decreased from 55,7% to 12,3%. It may mean that we are still too much concentrating at PWID. Whilst, we would propose to arrange some other activities such as IBBS implementation, working at improvement of outreach activity attributes (such as confidential conversations, etc.) that would benefit too. As for expansion of the services, and in terms of HIV testing and HIV treatment through increasing of accessibility to the services, we may provide an example of ideal operations within MAT clinics when we [Narcology Centers] are able to provide not only methadone in MAT clinics but ART treatment too. It won't require any additional funding as we have existing structure and experience already. We just have to integrate both of them in one. For instance, most of MAT clinics are currently funded by UNDP Global Fund. There are different rumors among our [MAT clinics] clients that once Global Fund is left the country, they

won't get any further treatment. So it would make sense to consider how sustainable our projects and activities would be if one day all our donors would disappear. According to Prikaz #600, we will have to create technical working group and develop working plan until 2020-2025. *In order to work with legislation, we have to undertake all required steps. (не поняла - к чему это?)*. Regarding mobile MAT clinics, one Narcologist can serve those districts (such as Badakhstan) where there is a lack of medical facilities/capacity or shortage of staff. However for this we will have to develop required legislative basis to allow mobile MAT clinics to distribute methadone in the target areas.

**Aziz:** We were in Penjikent in November 2016. A number of patients at MAT clinics was not high. According to what people said us, the main problem for patients remains transportation. As they face obstacles with reaching the MAT clinic. The reason might be in weak coordination and interaction. We are talking about purchasing of new vehicle for mobile MAT clinics while there is a pretty new car in the AIDS Center in Penjikent. You all have a direct subordination chain to the Ministry of Health, so there might be a better intercommunication and mutual help.

**Ulughbek:** Does it mean that now we have to pay a special attention to sex partners?

**Malakhov:** There are about 700 PWID in MAT clinics, what if they all come with their sex partners.

**Irina:** We have some observation that patients of MAT clinics do never disclose their HIV status. They even don't do it at home.

**Ulughbek:** It is hard to reach.

**Olga:** Real-world experience shows and according to the Assisted Partner Notification, Peer-to-peer tool has been recognized as one of most effective. It may help to conduct conversations with partners. It is worthwhile to make a try it especially if it is expected to have oral HIV testing. These strategies are working. We would like to do something that really works. If people are not willing to be frank with their partners, the Peer-to-Peer may help. Let's see if it moves this forward.

**Mavzuna:** Initially, there was not any intention to procure HIV test for this groups of people. Thus, we believe that we will have to justify re-focusing towards sex partners.

**Marissa:** There is a low HIV cases detection rate in MAT clinics. It is pretty good as it demonstrates effectiveness of these programs. In addition, it points out the necessity to revise of HIV case detection strategy.

**Mansur:** According to the regulation, all primarily contacted are being examined, while all discordant pair are registered. So the later people are examined once in 6 months. Each of our pilot site has all these lists of people and all of them do have regular examination. We receive reports on this on a constant basis. PWID with confirmed HIV positive status and their sex partners have been examined and tested. Our health visitors/nurses do work with their sex partners. These pilot sites are running during 6 months. For example, in Isfara one sex partner has been revealed for these 6 months.

**Anna:** It is astonishing that all three countries demonstrate a low threshold of HIV case detection rate among discordant partners. Perhaps, they are practicing protected/safe sex. We do testing among permanent sex partners.

**Saidmumin:** As for accessibility of MAT, another important aspect is to distribute methadone dose directly to the patients. We have been discussing this issue for a while, however final decision hadn't made yet. Although, an entire mechanism of methadone distribution is presented in details in protocols.

**Malakhov:** There is a number of legislative documents in Tajikistan that regulate this issue. If we give them a dose - it is not a crime, while storage and sale of methadone might be perceived as a break of law.

**Anna:** You do not distribute morphine-containing medicine directly to your patients, don't you?

**Malakhov:** All narcotic drugs are made on a red prescription for health evidence-based approach. There is a strict control and reporting of all medicines. Now we are working at this issue. There are some problems in particular at this stage. Jointly with Ministry of Health we are developing a law on usage psychotropic drugs and precursors. If there are no any hurdles at the legislative level, we would disseminate them directly to the patients.

**Saidmumin:** The issue raised about transition of methadone from liquid to powdered form based on example from Kyrgyzstan. The Department of pharmacy got primary agreement and readiness to cooperate on this.

**Malakhov:** This issue had been raised and discussed at the national level. There is a need to find state pharmacy, so that they have authority to prepare medicines. We are expecting to prepare the liquid from powder. Now we are working with the Department of Pharmacy. We also plan to discuss it during technical working group.

**Mavzuna:** I do support using of powdered form of methadone as it is quite sustainable. There is a probability that the country will import powder by its own. The price for powder is quite cost-effective. We definitely have to discuss this at the technical working group meetings. As for mobile MAT clinics, I would agree with Aziz. It would not be straightforward to justify the purchase of the vehicles and how it will be sustainable in future. There is no specific course for Narcologists at the National center of staff training.

**Malakhov:** There is such a course, but it is on a paid basis. Before it was 2-year course. Now this is a 4-month course, albeit there are no students who double be willing to take this course. We even had a discussion with the Regional Health Department of GBAO. There might be a scholarship for this course, but so far it doesn't go far.

**Mavzuna:** As for HIV medication adherence, there are a lot of myths around it. My suggestion is to ask PSI to work with communities to diminish the level of these myths.

CDC and USAID staff provided the meeting participants with their contact information so latter on they could share additional commentaries or recommendation (if any). They expressed gratitude for those who participated in the meeting.

**Appendices:**

1. Initial list of participants
2. Attendance sheet
3. Meeting agenda
4. PPT presentation