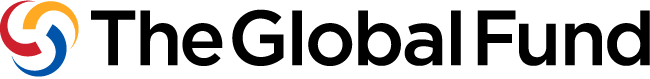
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| |  | | --- | | Funding Request Form  Allocation Period 2020-2022 |   Tailored for Focused Portfolios |

*Refer to the “Tailored for Focused Portfolios” Instructions to complete this form.*

Summary Information

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| **Country(s)** | Kazakhstan |
| **Component(s)** | HIV |
| **Planned grant(s) start date(s)** | 01 January 2021 |
| **Planned grant(s) end date(s)** | 31 December 2023 |
| **Principal Recipient(s)** | Kazakh Scientific Centre of Dermatology and Infectious Diseases of the Ministry of Health of the Republic of Kazakhstan (KNCDID) |
| **Currency** | US Dollar |
| **Allocation Funding Request Amount** | USD 7,197,500 |
| **Prioritised Above Allocation Request (PAAR) Amount[[1]](#footnote-2)** | USD 1,839,844 |
| **Matching Funds Request Amount[[2]](#footnote-3)**  (if applicable) | N/A |



# **Section 1: Funding Request and Prioritisation**

To respond to the questions below, refer to the *Instructions*, as well as national strategy documents, **Programmatic Gap Table(s), Funding Landscape Table(s), Performance Framework, Budget and Essential Data Table(s)**.

## Overall Context and Funding Priorities

a) Highlight the critical elements of the **country context** that informed the development of this funding request, including key and/or vulnerable populations, human rights and gender considerations.

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| **Epidemiology of HIV in Kazakhstan**  In 2019, Kazakhstan registered 3,675 new HIV cases, including 3,518 Kazakh citizens and 157 immigrants. Of these new HIV infections, 65,5% were males and 34,5% females. In 2018, Kazakhstan registered 16.8 HIV cases per 100,000 population, while in 2019 this number had increased to 19.1, an increase by 13.6%. The total number of PLHIV ever registered with health authorities is 25,753, with 21,951 in active care and 17,535 in treatment by the end of 2019 *(see Annex 2, slide 10).*  The ***most affected regions*** in Kazakhstan are Pavlodar with an incidence of 50 per 100,000 population; followed by Kostanay with 40.1; North Kazakhstan Region with 34.8; and Karaganda with 31.5. 62.7% of all cases are registered in AIDS clinical stage 1; 18.5% in clinical stage 2; 16.2% in clinical stage 3 and 2.7% in clinical stage 4.  ***AIDS-related deaths –*** In 2019, the AIDS mortality rate was 10/1000 PLHIV, compared to 11/1000 in 2018. The mortality rate in PLHIV from any other causes was 29 per 1000 PLHIV in 2018, compared to 26/1000 in 2019 *(see Annex 2, slide 37).*  ***HIV prevalence among pregnant women*** decreased from 2.7 in 2017 to 1.3 in 2019. Kazakhstan submitted a request to WHO for certification of elimination of mother-to-child transmission of HIV. In 2019 in Kazakhstan, 49 cases of HIV infection were registered among adolescents (10-19 years old) and 999 cases of HIV infection among young women (15-49 years old).  Kazakhstan still has a ***concentrated HIV epidemic***; in recent years, however, there has been a shift in terms of the highest number of new cases from PWID to MSM. HIV prevalence among sex workers (SWs) is considerably lower than among MSM and PWID: it decreased from 1.9% in 2017 to 1.4% in 2019 *(see Annex 2, slide 10).* Results from the last IBBS study in 2018 showed a decrease in HIV prevalence among PWID from 8.5% in 2016 and 7.9% in 2018 *(see Annex 6, p.1)*: this was the first decrease – albeit small – since a steady increase oh HIV among PWID since 2010 (see Figure 1). HCV rates among PWID are very high, although they have witnessed a considerable decline from 70.7% in 2014 to 52.9% in 2018. While the majority of PWID are males, females comprise a sizeable proportion of PWID, varying from 1.2% in Shymkent to 31% in Ekibastuz *(See Annex 4, p.4)*. From 1 January 2016 to 30 June 2017, 14.2% of all HIV cases reported were among *women* who inject drugs, which indicates a continued high risk of infection among this group of women. Women injecting drugs are less likely to report HIV infection via injecting drug use than through sexual intercourse, as injecting drug use by a female is a highly stigmatised behaviour, which may result in blaming them of illegal activity (drug possession) and may also jeopardise the custody of their children *(see Annex 3, p.10).*  **Figure 1: Prevalence of HIV, HCV and syphilis among PWID in Kazakhstan, 2010-2018** (ESR analysis in Epi Info) *(see Annex 4, Fig. 19, p.17)*  The increasing proportion of MSM among new HIV infections, compared to PWID, is evidenced by a clear increase in HIV prevalence from 3.2% in 2015 to 6.6% in 2019 *(see Figure 2 below)*  **Figure 2: Prevalence of HIV, HCV and syphilis (%) among MSM, Kazakhstan, 2007-2019** *(see Annex 5, Fig. 2, p. 4)*  A population size estimation of MSM in 2017 showed an estimated number of 62,000 *(see Annex 12; p.2),* but other studies indicate that the estimated number of MSM in Kazakhstan may be significantly higher (154,000).  During the last five years, Kazakhstan achieved significant results in terms of policy alignment and government funding to implement HIV prevention *interventions among MSM and transgender people,* including approving internal PrEP guidelines and reaching them with service.  **Emerging use of new psychoactive substances**  HIV transmission does not only occur only in “classical” PWID, but may increasingly also be seen in people who use so-called new psychoactive substances (NPS), both injecting or through other ways of administration. All Central Asian countries have reported the emergence of NPS to UNODC. Most NPS were identified in Kazakhstan and Uzbekistan, in particular synthetic cathinones and synthetic cannabinoids, and to a lesser extent phenylethylamines. Between 2013 and 2016 a total of 58 NPS were reported by the four Central Asian countries. In 2016, a pilot assessment of NPS use among people who received inpatient drug treatment in Kazakhstan was carried out. It showed that the proportion of patients nationwide who received addiction treatment for NPS as the primary substance was relatively low (3.2%) *(see Annex 16, p.4)*. However, there were large differences, with Almaty and Petropavlovsk regions reporting over 10% of people in treatment with an NPS dependence. Among the nationwide sample of NPS dependent individuals, 70% of those who ever used cathinones injected them. In Petropavlovsk, injecting of cathinones in the context of other factors (risk behaviour, scaled-up HIV testing) has been associated with an increase in HIV infections among problem drug users in 2017-2018 *(see Annex 16, p.4)*. One of the main reason why people used NPS was the absence of traditional drugs. In addition, NPS use is often associated with high-risk, unprotected sex with multiple non-regular partners, including so-called “chemsex”, also among MSM.  **90-90-90**  Kazakhstan is among countries that monitors the 90-90-90 Fast-Track targets. The national AIDS response is guided by an Action Plan that has been aligned to global UNAIDS and WHO policies. The National Health Programme *“Densaulyk”* states that “conditions for effective implementation of the international recommendations to fight HIV, including UNAIDS Strategy 90-90-90 have been created with the ambitious goal to eradicate HIV/AIDS” *(see Annex 9, p.6).*  Kazakhstan has seen steady progress towards the 90-90-90 targets. In 2019, the situation showed that 82% of PLHIV knew their status; 68% of those who knew their status received sustained ARV therapy; and 78% had viral suppression. Around 14% of the general population was ***tested*** for HIV in Kazakhstan in 2019; with 1.9% of the total amount of HIV tests done among key populations. In 2019, the diagnostic laboratories of 16 Regional AIDS Centres conducted 3,069,199 HIV tests, of which 3,518 people (0.11%) were confirmed HIV-positive by immunoblot.  ***Eliminate new HIV infections among children and paediatric HIV treatment –*** In Kazakhstan, health care for women during pregnancy, childbirth and the postnatal period is free of charge. All children born to HIV-infected mothers are provided with free infant nutrition up to one year of age. An electronic register of pregnant women has been created at the national level, which allows tracking all data on pregnant women from the moment of registration until the outcome of pregnancy. A decrease in HIV prevalence has been registered among pregnant women from 2.7 in 2017 to 1.3 and in 2019 and the country submitted a request to WHO for certification of elimination mother-to-child transmission of HIV.  Kazakhstan has updated its ***testing and treatment protocols*** in 2019, aligning them to the latest WHO recommendations. Coverage of ARV preventive treatment for HIV-infected pregnant women in 2019 was 98%, and 99% for newborns. The risk of perinatal transmission was 1.3%. In 2019 81,4% of infants born to women living with HIV received a virological test (EID) for HIV within two months of birth.  ***Combination HIV prevention* –** The best illustration of combination prevention in HIV is seen in prevention programmes for key populations (KPs). In this regard, the MOH, with support from NGOs, has developed and is currently funding projects for PWID, sex workers, PLHIV and to a lesser extent for MSM. Service packages have been developed to standardise services across the country and SOPs for outreach workers have been put in place. As such, Kazakhstan has followed WHO, UNODC, UNAIDS and UNFPA recommendations as the basis for national standards.  In 2019, Kazakhstan developed standards for assistance for KPs with HIV and STI testing, treatment of STIs and counselling at a single window. These services are currently being covered by the Compulsory Social Health Insurance (CSHI) fund.  *AmanBol* is the first ***HIV self-testing*** (HIVST) programme in the region, dedicated to providing inclusive service for MSM and transgender (TG) people.  **Eliminating gender inequalities and violence –** In 2019, HIV incidence in men 15-49 was higher with 0.45 per 1000 uninfected, compared to 0.22 in women in the same age group. However, in the group of 15-24 the incidence of women was higher with 0.13 per 1000 uninfected compared to men in the same age group 0.09 per 1000 uninfected. In 2019, the proportion of men was 65.5% (2018 - 62%), women 34.5% (2018 - 38%); the ratio of men to women is 1.9 to 1 *(see Annex 14, p.1).*  Kazakhstan has made significant progress in establishing the institutional framework for gender equality. Since 1995, the National Commission for Women's Affairs and Family and Demographic Policy has been operating as an advisory body under the President of the Republic of Kazakhstan. In order to address pressing gender issues, measures are being taken to increase women's participation in the economy through equal access to the labour market, financial and other resources. Kazakhstan maintains a steady level of employment for women. Women make up 49% of the total labour force. Women's participation in small and medium-sized businesses (SMEs) has increased significantly over the past five years. Among the registered active entrepreneurs, 43.2% are women (as of 1 January 2019).  A survey on the prevalence of ***violence against women*** was conducted in Kazakhstan in 2018. The survey, the first in Central Asia, found a high rate of domestic violence in Kazakhstan, with 17% of ever-partnered women aged 18-75 reporting experiencing physical or sexual partner violence and 21% psychological abuse *(see Annex 7; p.14, 17).* There are only 40 women crisis shelters in Kazakhstan and none of them provide services to women living with HIV/AIDS.  A clinical protocol for survivors of gender-based violence (GBV), including sexual violence, was developed on case management and algorithm of medical and social care services within the national health-care system. The new clinical protocol includes sections on post-exposure prophylaxis (PEP), early syndrome-based therapy of STIs, other medical services, as well as psychological support for GBV survivors. Cross-generational relationships and gender-based violence are two additional factors driving HIV transmission.  At the community level, ***stigma and discrimination*** facing key populations, such as FSWs, MSM and transgender (TG), as well as PLHIV continue to hinder their access to HIV information, services and HIV prevention commodities. Cultural attitudes of discrimination of sex work further isolate FSWs and increase their risk of violence, discrimination and HIV. Sex workers are vulnerable to violence, including from medical personnel, and their HIV status is frequently disclosed to third parties *(see Annex 3, p.66).* As a result, sex workers often do not seek timely diagnosis. In the case of an HIV-positive status, they do not perform diagnostics for viral load and immune status and, as a result, they experience a lack of timely HIV treatment and have poor adherence to ART.  Police raids and compulsory HIV testing, provided in conjunction with the AIDS Centres, violate the rights of sex workers to voluntarily diagnose HIV infection. Approaches used by the police force sex workers into hiding and avoid timely HIV testing and treatment in AIDS Centres *(see Annex 3, p.66).*  Despite increased HIV/AIDS awareness among the general population, various discriminatory circumstances remain. The Criminal Code of the Republic of Kazakhstan of July 3, 2014, No. 226-V ZRK, Art. 118. *"Infection with the Human Immunodeficiency Virus (HIV/AIDS)"* conditions criminal liability and prosecution for the risk of HIV infection. The Code mandates the criminal prosecution of deliberate HIV transmission, resulting in stigmatisation, challenging access to treatments, and inefficiency in HIV prevention measures. In addition to legal constraints, discrimination is observed in workspaces, academia, health centres, and other public institutions *(see Annex 3, p.8).* Discrimination and social isolation also contribute to increased vulnerability among marginrightalised groups such as people living with disabilities.  Women living with HIV have limited access to accommodation services in existing shelters that are designed to help victims of violence. The reasons for limited access to these services include ignorance of the ways of HIV transmission, high level of stigma in the society, and shortage of places in the shelters *(see Annex 3, p. 25).*  ***HIV-sensitive social protection* –** Kazakhstan has a strong social protection system, including for PLHIV. The social assistance for PLHIV in Kazakhstan is regulated by the Law of the Republic of Kazakhstan dated 05.10.1994 *"On Prevention and Treatment of HIV Infection and AIDS".* The Law stipulates that HIV testing as a pre-condition for employment is prohibited; a person with HIV cannot be dismissed from his job if s/he becomes HIV infected; discrimination in the workplace is prohibited by law, and care and support for Kazakh citizens with HIV in the country is fully provided free of charge.  The year 2019 became notorious after the involvement of the Ombudsman in solving the issue of discriminatory practices towards PLHIV with disabilities. The stipulation in Order 26 of 2015 of the Ministry of Social Protection, where PLHIV were excluded from the provision of social services to persons with disabilities, was removed.  **Community-based service delivery** for key populations is currently mainly financed through Global Fund support, and to a lesser extent through social contracting mechanisms, that are still being developed. The work of NGOs is being built around SOPs that have been developed in 2019 in consultation with NGOs for prevention services for KPs, PLHIV and social assistance delivered through NGOs. The SOP standardises the testing, prevention and care services and provides standards for the work delivered by NGO outreach and peer workers.  In 2019, 53 national and international NGOs worked in Kazakhstan on HIV issues in 14 out of 17 regions. Of these, 15 NGOs received State Social Orders for HIV-related work in 12 of the 17 regions under social contracting. In total, 29 NGOs worked for HIV prevention in key populations, of which five worked on social contracting for these groups.  **Investments**  In 2019, the government funding for the HIV programme covered around 95% of the national response. The government finances HIV prevention programmes for KPs; procurement and distribution of syringes, condoms and information materials; salaries of outreach workers at AIDS Centres; ARV treatment and PEP; procurement of drugs for opportunistic infections; diagnostics with procurement of test systems and organisation of testing for HIV infection and HIV-indicated diseases.  Results suggest that past investments have had an important impact on the HIV response. Had the HIV programme not been implemented from 2015 to 2017, it is estimated that in 2018 there could have been almost 170% more new HIV infections (almost 8,300 more infections) and over 220% more HIV-related deaths (approximately 2,800 more deaths) over this period.  As of 2018, the latest reported HIV programme budget for Kazakhstan was USD 38,008,076 with approximately 8.2% of the total budget having been invested in non-targeted HIV programmes. Given that over 60% of new HIV infections in Kazakhstan are estimated to have occurred among MSM in 2018, results suggest scaling up investment for HIV testing and prevention programmes targeting MSM.  To attain the 95-95-95 by 2030 targets, it is estimated that the annual HIV programme budget from 2019 to 2030 should be increased to 160% of the latest reported budget level (an additional USD 13M annually) and optimised with prioritisation of ART and HIV testing and prevention programmes targeting PWID and MSM *(see Annex 8, p. 8).* By 2030, this condition could facilitate Kazakhstan to have 95% of PLHIV be aware of their status; 98% of those diagnosed on treatment; and 95% of those on treatment to have achieved viral suppression.  ***Empowering people living with, at risk of and affected by HIV to know their rights and to access justice and legal service* –** The Stigma Index Study conducted in Kazakhstan in 2015 gives a good overview of the rights situation of PLHIV: 14.9% of PLHIV indicated that over the past 12 months they faced situations that can be qualified as a violation of their rights based on HIV-positive status. This included: detention against their will, quarantine, isolation or separation from other people – 3.1%; refusal to provide health or life insurance – 2.1%; forced disclosure of HIV status for the purpose of entry to another country – 1.8%; forced disclosure of HIV status when applying for a residence permit or citizenship – 1.5%; arrest or trial on charges related to HIV status – 0.8%. Results from the Stigma Index show that at least 18% of people living with HIV in Kazakhstan reported being denied health services. Health-care workers disclosing people’s HIV status without consent is also common: more than 25% reported that a health-care professional ever told other people about their HIV status without their consent; while 20% reported having been denied health services because of their HIV status at least once in the past 12 months. Discriminatory attitudes and misconceptions about HIV are also common. Similarly, almost 50% of respondents thought that children living with HIV should not be able to attend school with children who are not living with HIV *(see Annex 15, pp. 121, 123).*  In Kazakhstan, ***transgender people*** face discrimination. Transgender persons have the right to surgical procedures to change their sex – but little access to other rights[[3]](#footnote-4)*.*  In 2019 AFEW Kazakhstan introduced the so-called “Street Lawyers” model to NGOs working in HIV in Kazakhstan: experiences to date in Central Asia have shown their success in overcoming legal barriers to access to treatment and other violations of their rights. Street lawyers provide community-based, low-threshold access to legal support for the most vulnerable populations, including PWID, MSM, TG people and sex workers.  The *Human Rights Review for Kazakhstan for 2019* encompasses important violations of of PLHIV, such as denial of admission into crisis centres, refusal to provide social services to people with disabilities living with HIV and stigmatisation of HIV-positive women victims of violence. UNESCO in cooperation with UNAIDS, Kazakh Union of PLHIV and other partners developed and promoted a media campaigns to reduce stigma and discrimination against PLHIV, PWUD and transgender people.  **Integrating AIDS through people-centred systems to improve universal health coverage (UHC)**  In order to guarantee the sustainability of mutually supportive HIV-related prevention, treatment, care and support services, information and education, the Republic of Kazakhstan has integrated the services into the national public health care and primary health-care system to address the problem of co-infections and opportunistic diseases, especially for TB, drug use and mental health disorders, as well as services for sexual and reproductive health, including prevention, diagnostics and treatment of viral Hepatitis, cervical cancer and other sexually transmitted diseases, including human papillomavirus and services in response to sexual and gender-based violence, bearing in mind that women and girls are particularly vulnerable to such co-infections and opportunistic diseases.  Thus, the Narcological service introduced a ”single window” for PWID to provide testing for HIV, TB, and distribute methadone in one stop-point.  During restructuring in 2019, the narcological and mental health services were merged into a single institution: the *Republican Scientific-Practical Centre for Mental Health* (RSPCMH) of the Ministry of Health. The Centre provides integrated preventive, consultative and social assistance, diagnostics and treatment for people who inject drugs.  The Ministry of Health has also ensured the provision of integrated services for HIV, STIs and Hepatitis through integration of AIDS and STI services. The *Kazakh Scientific Centre of Dermatology and Infectious Diseases* (KSCDID) has developed a one stop shop (friendly cabinet) tariff plan that provides free HIV, STIs, Hepatitis and STI testing to key populations. |

Given the country context, size of the Global Fund’s allocation, latest available data, and guidance in the allocation letter:

b) Summarise the **approach used for the prioritisation** of modules and interventions (or in the case of Payment for Results, the performance indicators and/or milestones).

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| **Description of the process of prioritisation**  A comprehensive ***National Dialogue*** (ND) was held with the active involvement of a wide range of national and regional stakeholders, and supported by the CCM Secretariat. Special support was provided by the Global Fund to support this dialogue among KPs. The dialogue involved a series of working meetings that started in February 2020. These meetings included discussions with 46 representatives of KP communities – including people who use drugs, sex workers, PLHIV, MSM and transgender people – from 13 cities from all corners of Kazakhstan. The KPs meetings were also attended by observers of the Kazakhstan Scientific Centre for Dermatology and Infectious Diseases (KNCDID, the former Republican AIDS Centre), UNAIDS and the CCM Secretariat. Key topics included the use of new psychoactive substances (NPS); opioid substitution therapy (OST); HIV testing; effectiveness of HIV prevention for KPs; ART for KPs living with HIV; availability and quality of data; stigma and discrimination; capacity of NGOs working with KPs; community mobilisation. In addition to these KP meetings, work meetings were also held with the Kazakhstan Union of PLHIV, KNCDID and UNAIDS to review the available data, national health policies and identify priorities. The final report[[4]](#footnote-5) of this National Dialogue process was subsequently used as a key input for the development of the Funding Request *(see Annex 13; p.1-20).*  In addition to the ND process, a ***call for proposals*** was launched by the CCM regarding key services to be considered for the FR. This included project proposals on topics including HIV prevention for KPs, including rapid testing; OST, overdose (OD) management and programmes for NPS users; PrEP; strengthening ART adherence by PLHIV and KPs; legal support for PLHIV and KPs; strengthening information systems on KP services; medical services for undocumented migrants; and social contracting.  In March 2020, an international consultant was recruited to coordinate the further development of the funding request. However, due to the Covid-19 pandemic, as of early March, all meetings and discussions had to take place through regular e-mail contact and teleconferences. The process continued with extensive discussions with all stakeholders regarding the priorities identified through the National Dialogue; the proposals for services and programmes; as well as key policy documents; epidemiological data; programme M&E data; the Global Fund Portfolio Analysis; and assessment reports[[5]](#footnote-6). This process allowed prioritising the proposed interventions to be included in the FR, based on the outcomes of the national dialogue and key policy and evaluation reports, with a view to strengthening the sustainability of the national HIV response. All materials were prepared in English and Russian and key documents were shared for feedback throughout the process with CCM as well as key technical and funding partners, including WHO, UNAIDS and US governmental partners.  **Guiding documents and principles**  The ***Portfolio Analysis*** was used as strategic guidance for the prioritisation of interventions for this Funding Request. Key priorities mentioned include the introduction and scale-up of new HIV testing modalities tailored to reach KPs; the introduction and scale-up of PrEP; further strengthening of viral load (VL) testing, including unification of VL testing technologies (as evidenced by strengthening of lab capacity); strengthening of differentiated service-delivery models focused on KPs in ART provision; addressing stigma and discrimination and other human rights-related barriers to support increased uptake and retention of KPs throughout the cascade.  In addition, prioritisation was guided by the ***application focus requirement*** specified in the ***Allocation Letter*** that 100% of allocated funding should focus on interventions that maintain or scale-up ***evidence-based interventions for key and vulnerable populations.*** This includes ***innovative service models and interventions*** that aim to strengthen prevention, testing, treatment and care. Examples of the result of these choices include: 1) an emphasis on HIV prevention serviced by NGOs in a *selected* number of Regions with *highest HIV rates;* and among those KPs that show the highest – even sharply increasing – HIV rates, i.e. MSM and TG people, and to a lesser extent PWID; while not prioritising SWs, who have lower HIV rates and whose services are covered by the State; 2) A ***focus on gaps*** in service delivery, such as OST; OD prevention and management; PrEP; and legal services for KPs and PLHIV; 3) A focus on ***patient-centred service models***, including peer counsellors strengthening ART adherence among PLHIV – especially those who are particularly vulnerable, such as PWID and TG; and with special attention for strengthening referral mechanisms and continuity of care; 4) a focus on ***equity of access***, i.e. focusing on those regions with the lowest ART adherence; on those regions with lower service coverage; access to ART for undocumented migrants.  Prioritisation of proposed interventions in this FR also builds on the findings and recommendations of the recent ***evaluation of the national HIV response*** *(see Annex 10; pp. 27-33).* These include: 1) strengthening the second and third of the 90-90-90 targets, specifically improving access to and continuity of ART; 2) Strengthening the role of NGOs and community-based service providers to improve the quality and coverage of HIV preventive services, OST, early HIV testing, linkage to care and ART adherence, particularly for PWID and MSM; 3) Improve timely linkage to and initiation of ART; 4) strengthening diagnosis and linkage to HIV treatment and care of undocumented citizens and migrant populations; and 5) Updating data collection systems.  Another key document for the prioritisation of interventions has been the recent *“****Assessment of the readiness of Kazakhstan for the transition to social contracting to ensure the sustainability of HIV-related services”*** *(see “Assessment of Readiness of the Republic of Kazakhstan to Ensure the Sustainability of HIV-related Services with Funding from the State Budget; pp. 20-21).* This assessment provides specific guidance in a number of areas: i) ensuring prioritisation of HIV prevention and M&E in the public health system; ii) improving the regulatory framework for addressing remaining gaps of the current social contracting mechanisms, as specified in the ‘readiness assessment’; iii) ensuring sustainable public funding of HIV prevention, care and support services; and iv) strengthening partnerships between civil society and government at the regional level. These recommendations are explicitly included in this funding request.  In addition, the recommendations of the 2019 ***Optima exercise***[[6]](#footnote-7) with regard to HIV resource optimisation were taken into account; these specifically included the importance of: 1) Scaling up antiretroviral therapy and 2) Maintaining investments for HIV testing and prevention programmes targeting MSM *(see Annex 8, p.1).*  Finally, the funding request aims to fill the gaps that are not yet adequately addressed by the current State response: this entails ***avoiding duplication of efforts***. Hence, the FR will not address *all* the remaining challenges of the national response, but ***complement*** existing or planned interventions by the Government and MOH: almost 95% of the current response is financed by the State. In this context, the FR does not have a major focus on strengthening PSM systems, as the MOH has already prioritised this and will be dealing with it. |

1. Fill in **one table for each disease component**, and an additional table for integrated or cross-cutting programming, such as TB/HIV or Resilient and Sustainable Systems for Health (RSSH) modules, to describe the areas prioritised for this funding request.

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| Component | **HIV** |
| Module/  Interven-tions | **NOTE: *More details about services are provided in the “Rationale” section.***  **Module 1: PREVENTION**   * 1. ***Condom and lubricant programming*** – This intervention will focus on ensuring adequate availability of condoms and lubricants – in particular for MSM and TG, and to a lesser extent for PWID and users of new psychoactive substances (NPS) – complementing key prevention commodities on a limited scale, with the State gradually absorbing this component.   2. ***Behaviour change interventions*** (MSM, TG & PWID) – This includes support for NGO outreach workers (ORWs) in high-prevalence priority regions for MSM/TG (6 regions: Aktobe, East-Kazakhstan, Pavlodar, Karaganda, Nur-Sultan and Shymkent) and PWID (3 regions: Karaganda, Kostanay and Nur-Sultan); these ORWs are in addition to ORWs already financed by the Government.   3. ***Behaviour change interventions*** ***for Transgender people*** – This involves the development of a HIV-prevention service package, tailored to the HIV risk profile and service needs of Transgender people; as well as capacity building and roll-out in 4 priority regions (Aktobe, Karaganda, Shymkent & Nur-Sultan).   4. ***Pre-Exposure Prophylaxis*** (PrEP) – This involves a PrEP programme among MSM and TG in 6 regions.   5. ***Opioid substitution therapy and other medically assisted drug dependence treatment*** – This involves systematic, large-scale advocacy for OST and strengthening the sustainability and expansion of the OST programme.   6. ***Overdose (OD) prevention and management*** – This includes: 1) Improving the availability of Overdose therapy; 2) Sustainability of the use of antidote therapy for opioid overdoses.   7. ***Interventions for young key populations*** – Development of programmes for *users of New Psychoactive Substances* (NPS) – This will include 1) a clinical and epidemiological study on NPS and its prevalence in 2021; 2) the development of a Road map for the prevention of NPS (2021); 3) Capacity building of mental health professionals.   **Module 2: DIFFERENTIATED HIV TESTING SERVICES**   * 1. ***Community-based testing*** – This involves the procurement and distribution of oral HIV test kits to NGOs working with MSM/TG in six regions; PWID in three regions as well as for all 261 AIDS Centre outreach workers. Government will increasingly absorb these costs with 20% in 2021 and 40% in 2022 and 60% in 2023.   2. ***HIV self-testing (HIVST)*** – This involves HIVST for 1) Sexual and parenteral (drug-use) partners of PLHIV; and 2) Discordant couples in 3 regions: Karaganda and Almaty regions and Nur-Sultan city. Government will increasingly absorb the HIVST cost (20% in 2021 and 40% in 2022 and 60% in 2023), with a view to expanding to other Regions as of 2024.   **Module 3: TREATMENT, CARE AND SUPPORT**   * 1. ***Differentiated ART service delivery and HIV care – Strengthening the Test-Treat Cascade*** with special focus on strengthening retention in care and adherence to ART with support from NGOs; NGOs peer counsellors will motivate clients for self-testing with rapid oral tests. In case of positive results, the partners would be referred to NGOs working with PLHIV for services of treatment, care and support, specifically among PLHIV in 3 regions (Karaganda, Nur-Sultan and Almaty Region).   2. ***Differentiated ART service delivery and HIV care – Continuity of ART for 171 undocumented foreign migrants,*** with gradual absorption of these patients by Government (121 in 2023)   3. ***Strengthening effective patient monitoring and VL testing –*** Viral load suppression (third 90) is key in determining the effectiveness of ART. In this context the grant will support the procurement of standardised WHO-prequalified automated PCR machines.   **Module 4: REDUCING HUMAN RIGHTS-RELATED BARRIERS TO HIV/TB SERVICES**   * 1. ***Stigma and discrimination reduction*** – Development of a National Strategic Plan to advocate for the protection of the rights of PLHIV and combat HIV-related stigma & discrimination.   2. ***HIV and HIV/TB- related legal services*** – This includes: 1) Create and train "Street Lawyers" from among staff and outreach workers of NGOs and AIDS Centres in all 17 Regions to support PLHIV and KPs to remove legal barriers, stigma, discrimination and criminalisation in order to ensure access to HIV prevention and treatment services; 2) Provision of Legal assistance to PLHIV and KPs in all 17 Regions to address legal barriers to health-care access, cases of stigma & discrimination, and other human rights violations. 3) Provision of legal support by professional lawyers to PLHIV and/or KPs in need. These lawyers will also provide supervision, quality assurance and mentorship to street lawyers.   **Module 5: HEALTH SECTOR MANAGEMENT AND PLANNING**   * 1. ***National health sector strategies and financing: Strengthening Sustainable financing for HIV prevention services for KPs by NGOs*** – This involves technical support to further strengthening and roll-out of Social Contracting mechanisms -- such as State Grants and State Social Contracts, as well the inclusion of HIV prevention, care and support services in Compulsory Social Health Insurance (CSHI). This includes: 1) Definition of HIV services that can be funded through SGs SSOs; 2) Tariffication of service packages; and 3) Budget advocacy.   2. ***National health sector strategies and financing:*** ***Inclusion of key HIV prevention, care and support services in CSHI coverage*** – Technical support for the development of tariffication of HIV services.   **Module 6: RSSH: COMMUNITY SYSTEMS STRENGTHENING**   * 1. ***Institutional capacity building, planning and leadership development*** – This includes strengthening of institutional capacity of NGOs that provide services to key population in selected priority regions, through webinars, training workshops and on-site mentoring, tailored to NGOs’ specific needs.   2. ***Social mobilisation, building community linkages and coordination*** – this includes efforts to strengthen partnerships and linkages between civil society and Government institutions for better coordination and collaboration in service delivery to PLHIV and KPs, including post-release continuity of ART and TB treatment.   **Module 7: RSSH: HEALTH MANAGEMENT INFORMATION SYSTEMS AND M&E**   * 1. ***Programme and data quality*** – This includes the improvement and roll-out of the Database of Individual Client Records (DICR) system, by introducing a system for identifying customers by QR code to all service providers (including CSOs). In addition, the grant will support procurement of equipment to support the DICR system, as well as capacity building.   **Module 8: PROGRAMME MANAGEMENT**   * 1. ***Grant management –*** This includes all the activities related to grant management by the PR. |
| Priority populations | ***MSM, Transgender people and PWID***: see more details below (“barriers” and “rationale” sections) |
| Barriers and inequities | * ***Stigma & discrimination by health-care workers*** hamper access to health care in general and to HIV services and ART in particular, for all KPs as well as PLHIV: most often PLHIV in Kazakhstan face some discrimination from health workers: A Stigma Index study revealed that 25% of PLHIV faced disclosure of information about their HIV status; one-third of PLHIV did not receive counselling on reproductive capabilities; and 25% of PLHIV were told by health-care workers not to have children. Injecting drug use and having been to prison further increased this stigma and discrimination. Discrimination and social isolation also contribute to increased vulnerability among marginalised groups such as *people living with disabilities*. * ***Societal stigma and discrimination of MSM and Transgender people*** – While Kazakhstan decriminalised consensual same-sex conduct in 1998, a climate of intense homophobia remains *(see Annex 3, pp. 11-13)*. Legal recognition of TG people is still very limited. The report *“That’s When I Realized I Was Nobody’: A Climate of Fear for LGBT People in Kazakhstan”* (2015) documents pervasive homophobic attitudes, hateful treatment and failure of police and other government agencies to protect LGBTI in Kazakhstan. * ***Police harassment*** hampers access for PWID and SWs to HIV prevention services. * ***Limited access to HIV prevention services for KPs***, due to limited prioritisation of KP services in most regions. In principle, the State budget covers all condoms and lubricants for KPs in all 17 regions, but budget allocations by Regional authorities for condoms and lubricants have been insufficient, resulting in a structural lack of these commodities, especially for MSM**;** this is partly due to the fact that MSM were not prioritised as much as PWID in the past, but a sharp increase in HIV prevalence among MSM has increased the need for prevention commodities. In 2019, the available condoms for MSM met only 57% of the need of those MSM reached with services; for lubricants this was merely 27%. For PWID, only 77% of the need for condoms among those reached with services was met. * ***Lack of data and absence of HIV services tailored to the specific needs of transgender people:*** despite the distinct risk behaviours and vulnerabilities of TG people, they are not specifically targeted. * ***Access to testing, ART and proper follow-up still face challenges***: the current status of the 90-90-90 test-treatment cascade targets is 82-68-78. Overall awareness of HIV status among PLHIV is 82%, but varies across regions: e.g. only 68% of PLHIV in Turkestan know their status. Access to testing is lower among KPs: active HIV testing through community outreach represents only one-fifth (20,4%) of all testing. HIV testing coverage for KPs is highest among SWs (69.8%) but considerably lower for PWID (39.5%); and very low for MSM (7.8%). This is the result of limited access to services for MSM, as they have not been adequately prioritised. A recent evaluation revealed that KPs considered the lack of broader access to community-based testing, either at NGO premises or as self-testing, as a major issue, due to their widespread concerns about confidentiality and stigma by health-care workers. Trust points at Polyclinics were seen as particularly high risk for being seen by others. In addition, the new regulations regarding anonymous testing, due to recent changes of the HIV-testing regulations, which now require ID cards for all ELISA testing, create an additional barrier to testing *(see Annex 10; p. 15).* To date, however, community-based testing with rapid oral tests has been very limited; and most testing is blood-based, hence dependent on medical staff at AIDS Centres; which limits access for KPs. * ***PrEP is not available in Kazakhstan:*** this is particularly important for KPs who engage in high-risk behaviours, and have limited access to HIV-prevention services, such as MSM and TG people. * ***Enrolment in ART is relatively low***: at the end of 2019, only 68% of PLHIV who know their HIV status (n=17,535) were on ART; and of these PLHIV on ART, only 78% (n=13,605) had viral suppression. Thus only 43% of all PLHIV had viral suppression. This is partly due to delays in getting PLHIV enrolled in ART: the duration from first HIV test till confirmation is about two weeks to one month; and from first HIV test to initiation of ART about one to one and a half month *(see Annex 10; p. 15).* In the past 3 years, there have been problems with the timely delivery of ARV drugs, which led to replacement of treatment regimens in patients, abandonment of ART and late initiation of ART. In 2019, 543 ART patients were lost to follow up. * In addition, ***undocumented migrants with HIV do not have access to free-of-charge ART:*** due to their legal status, the State cannot provide them with free ART. * ***OST availability is very limited and coverage very low***, due to systematic opposition to OST by certain sectors of Government as well as some sectors of society that have run active anti-OST campaigns. Although OST was already introduced in 2008, coverage is still extremely low: in May 2020, a mere 284 clients received OST, just 3.3% of all registered people with opioid addiction. This is even lower when compared to the total estimated number of PWID. * ***Very limited access to overdose (OD) treatment for PWID:*** despite an 18% increase of overdoses from 2018 to 2019, access to Naloxone at the community level is extremely limited, resulting in many preventable deaths. * ***There is no access to harm reduction services for PWID in prisons***: this results in interruption of OST, and problems with overdoses after release from prison. The funding request does not address this issue, as it is an element of ongoing policy discussions. * ***Lack of access to HIV prevention services for users of newly psychoactive substances (NPS).*** NPS use has doubled in recent years and is used as pills, inhaled, as well as injected. However, there is insufficient knowledge about NPS and effective services are not available for mostly young NPS users, leaving them vulnerable to HIV infection through needle sharing and unprotected sex.   ***The grant will systematically address these barriers and inequities by***: 1) strengthening availability of high-quality condoms and lubricants for MSM, TG, PWID and NPS users, with special attention for young drug users; as well as support for NGOs to provide comprehensive programming; 2) developing special services for TG people; 3) strengthening access to community-based testing for KPs and HIV self-testing for partners of PLHIV; 4) introducing PrEP for MSM and TG; 5) strengthening access to OST and OD treatment services through systematic and large-scale advocacy and capacity building; 6) Developing service models for NPS users; 7) strengthening ART adherence support by “peer counsellors”, especially for PWID with HIV; in addition, the grant will strengthen viral load testing through the procurement of standardised PCR equipment in 15 regions; 8) ensuring continuity of ART and legal support for undocumented migrants; 9) developing a national strategic plan on stigma and discrimination; and 10) providing legal support and enhancing legal literacy for KPs by street and professional lawyers. ***Details are in the next section (“Rationale”).***  Despite the barriers and inequities mentioned, much progress has been, and continues to be made in the above areas. |
| Rationale | The prioritisation of the selected modules and interventions listed above is based on two fundamental principles: ***1) Strengthening sustainability***; and ***2) Ensuring continuity, quality and coverage of services*.**  **1. STRENGTHENING SUSTAINABILITY**  **Sustainability** has been a key thrust of the national HIV response since many years: the Kazakh government already finances 95% of the national response to HIV. Not only does this include government facilities and staff, and the bulk of commodities for prevention, testing and treatment; it also includes community outreach workers employed by Regional AIDS Centres; as well as State funding for NGOs providing HIV-related services to KPs and PLHIV. Currently, the Government finances 57% of all outreach workers.  However, ***sustainability*** goes beyond sustained ***financing*** andincludes many dimensions, such as ***programmatic, health and community systems-related, governance, human rights and political***. The key components of this Funding Request aim to systematically address all these dimensions:  **1. Strengthening financial sustainability** – The current grant has been focusing on putting in place ***social contracting*** legislation and mechanisms that will allow the government at different levels – national, regional and akimat – to finance HIV service delivery to PLHIV and key populations (KPs) by NGOs – thus further contributing to sustainability of the national response, including through NGOs. In 2019, however, these social contracts (State Social Orders and State Grants) still only represented a very small proportion of the total State budget for HIV (0.2%, USD 63,600). While the ***legal framework and regulations*** for social contracting (through State Grants and State Social Orders) are in place, the actual allocation of State funding through State Social Orders or Grants at the regional and local (akimat) level is still insufficient to cover all NGO services, due to a number of factors:  a) At the local level, ***social contracting remains predominantly geared towards social services for certain vulnerable groups***, such as the elderly and the disabled – not to health and social services for key populations (KPs). HIV services have been included in the social contracting mechanism, but in practice, most social contracts are still awarded to traditional “social” services.  b) ***HIV prevention services for KPs remain under-prioritised by local authorities:*** in 2019, the total allocation for HIV prevention represented only 4.8% of the total budget for HIV. This is reflected by insufficient State allocations for outreach workers and key commodities, such as syringes, but especially for condoms and lubricants. Thus, despite the available Government commitment and funding, HIV services – especially those provided to KPs by NGOs – are not yet fully financed by the State, and still depend on supplemental funding from the Global Fund for key commodities and outreach workers.  In this context, this Funding Request seeks to ***further strengthen sustainable funding*** for HIV prevention among KPs through the following Interventions:  ***Intervention 5.1: Strengthening and roll-out of Social Contracting mechanism*** – As part of the current grant, HIV-related services have already been integrated in the overall legal framework and regulations for **social contracting**. However, further technical assistance (TA) will be needed in the 2021-2023 period to develop a clear system of indicators for planning, budgeting and evaluating the effectiveness of services for KPs and PLHIV provided by NGOs. In addition, the TA will support tariffication of HIV services, which is a key requirement for social contracting. In addition, budget advocacy will be supported in selected Regions with the highest HIV rates among KPs, to strengthening social contracting for NGO services to KPs.  ***Intervention 5.2: Incorporating HIV services under the Compulsory Social Health Insurance (CSHI)*** – The CSHI is currently in the process of being established and rolled out. In this context, the grant will support technical assistance (240 consultancy days per year) at the KNCDID in Almaty to provide legal and technical assistance to support the incorporation of HIV prevention and care services in the CSHI system. This requires developing official definitions, tariffication and mechanisms (SOPs) for subcontracting of HIV-related health, prevention, care and support services. This staff position will also support other tasks, such as issues related to the legalisation of HIV-infected undocumented migrants *(see Module 4).*  **2. Strengthening programmatic sustainability** – Despite considerable achievements with regard to financial sustainability, significant challenges remain regarding the ***programmatic*** sustainability and continuity of HIV prevention, care and treatment services. Programmatic sustainability is hampered by ***inadequate service models*** that fail to meet the needs of key populations (KPs), resulting in ***poor uptake and coverage***. In addition, there are still important ***gaps with regard to key services***, especially for KPs.  In this regard, this Funding Request seeks support for strengthening the quality and comprehensiveness of service models. This includes interventions to ***introduce innovative approaches and fill gaps in service delivery*** in the field of ***HIV prevention for KPs***, such as: i) services tailored to transgender people; ii) PrEP for MSM and TG people; iii) Opioid substitution therapy (OST) and overdose management for PWID; and iv) programmes for users of new psychoactive substances (NPS), with special attention for the special needs of female drug users. The funding request does not seek support for SW programmes, as these are relatively well-covered by government services, and HIV prevalence among SWs has shown a steadily declining trend in the past years. In addition, the grant will support innovative approaches to ***HIV testing and treatment support*** with a view to achieving the 95-95-95 Fast-Track Targets for ending the AIDS epidemic by 2030. This includes: v) Community-based HIV testing with rapid oral tests; vi) HIV self-testing. Community-based and self-testing will both contribute to strengthening the “test-and-start” approach; vii) Community-based support to strengthen ART adherence; as well as support for effective patient monitoring through viral load testing (PCR machines); and: viii) ensuring access to ART for undocumented migrants with HIV. In this regard, the new grant will support the ***following Interventions:***  ***Intervention 1.3: Programme development for Transgender people (TG)*** – To date, HIV prevention services for TG people have been implemented in combination with MSM, without taking into account the specific HIV risks and vulnerabilities, and different service needs. E.g. in many countries, TG are at much higher risk for HIV, as many engage in sex work with many non-regular partners. In this context, it is important to develop a special service package for TG people, that will be better tailored to their unique service needs, and thus more (cost) effective in preventing HIV among this population. The Grant will support the following activities: 1) A rapid assessment and population size estimation will be done in 2021 to identify TG people’s specific risk profile and behaviours, human rights-related barriers in accessing services, as well as priority service needs; 2) The results of the assessment will inform and the development of a service package and implementation modalities tailored to TG people’s needs; 3) Capacity building of 25 Government and NGO staff and ORWs working with TG people; 4) As of 2021, Q3, the service package will be implemented in 4 Regions that are known to host many TG people (Aktobe, Karaganda, Shymkent and Nur-Sultan). Specialised ORWs for TG will be supported through existing NGOs working with MSM. In addition to condoms, lubricants and HIV testing, the package may include support for consultations with endocrinologists on hormone therapy etc.  ***Intervention 1.4: Pre-Exposure Prophylaxis (PrEP)*** – In the past, the national response to HIV in Kazakhstan was predominantly focused on HIV prevention among PWID, with MSM given much less attention. However, recent data show a clear increase of HIV prevalence among MSM, as well as widespread high-risk behaviours, including multiple sex partners, low condom use, as well as sexual contacts with women by a majority of MSM (69%) *(ECOM, 2018)*. Thus, MSM may have a considerable impact on the general HIV epidemiologic situation in the coming years and more emphasis is needed for HIV prevention among MSM. In this context, PrEP is an evidence-based HIV prevention intervention, which may be cost-effective among MSM and TG people *(see Annex 10; pp. 4 & 14)*. To date, however, there has been no experience with PrEP in Kazakhstan. Therefore, the grant will support a 2-year PrEP demonstration project in 2021 and 2022 for MSM and TG; starting with 100 clients in 2 Regions in 2021 (Nur-Sultan and Shymkent), and expanding to 300 clients in 4 regions in 2022. If successful, the results of the PrEP demonstration project will be used as the basis for expansion of PrEP to 600 MSM and TG clients in 6 regions with high HIV prevalence among MSM as of 2023, with full financial support by the Government.  The PrEP demonstration project will be implemented by the KNCDID with technical support from a local research company team, which will manage implementation of the PrEP project and conduct operational research to assess its outcomes and cost-effectiveness. Procurement includes PrEP drugs and rapid oral test kits. Other activities include a comprehensive information campaigns to create demand (website, social media, videos and IEC materials); capacity building of staff; and the development of instruments for adherence support, such as a website to provide digitalised access to information about PrEP, FAQs and application for smart phones to ensure adherence.  ***Intervention 1.5: Opioid substitution therapy (OST)*** – OST has a positive impact on the lives of PWID and their partners and families, as it allows them to normalise their life, without the need to find money to pay for drugs. OST improves wellbeing by preventing physical withdrawal; helps to stabilise the lives of PWID and reduces the harms related to the use of heroin or other opioids, including HIV infection. OST was first introduced in two Regions Kazakhstan in October 2008, and currently 13 OST sites are functioning. The legal framework for OST is in place; Methadone hydrochloride is registered as a medicine; and a Clinical Protocol for OST has been approved. In addition, an OST Road Map was adopted for 2019-2020.  To date, the ***experience with OST has been suboptimal: despite support for OST by the MOH, there has been strong, organised opposition against OST by certain sectors in government, as well as civil society.*** At the same time, there was no common strategy to expand OST, with ***poor c***ollaboration between institutions involved in drug treatment and those dealing with HIV. An analysis of the OST work from 2008 to date identified three major challenges: ***1) Lack of trust, negative attitudes and high stigma towards OST and drug use*** among some decision-makers; health-care staff and the general population. Previous sensitisation campaigns on OST had poor results, as they lacked a clear, consistent focus. ***2) Poor sustainability of the OST programme:***The registration of Methadone hydrochloride will expire in December 2020, and no other substitution drugs are registered in Kazakhstan. Furthermore, there are challenges related to procurement, storage and delivery of OST drugs (related to the special classification of methadone as a restricted drug), which threatens the continuity of the OST programme. ***3) Very low OST coverage:*** As of 4 May 2020, 284 clients received OST, just 3.3% of all registered people with opioid addiction – and even lower compared to the *estimated* number of PWID. The low uptake of OST services is due to several factors, including the limited number of OST sites, with no sites at all in 7 out of 16 regions/cities; the limited schedule of the OST sites; rigid attachment of clients to OST rooms; and inability to receive OST in other medical facilities, e.g. during hospitalisation, business trips or relocation to regions without OST services. Similarly, there are no take-home dosages nor mobile distribution.  In addition, attitudes to OST among PWID have been affected by perceived lack of continuity and suboptimal quality of services, limiting their interest in being enrolled.  In this context, **a radical change in strategy is needed:** the Republican Scientific-Practical Centre for Mental Health (RSPCMH) developed a comprehensive plan to expand the availability, accessibility and coverage of OST in Kazakhstan. **The OST expansion plan consists of 3 major components:** a) A comprehensive OST capacity-building programme; b) Strengthening the sustainability of the OST programme; and c) Expansion of the OST programme. In this context, the grant will support the following activities:  A) A ***comprehensive OST Capacity-building programme (2021 and 2022)*** targeting key decision-makers and service providers to PWID at all levels in order to strengthen their expertise, knowledge and understanding of the specific components and benefits of OST services. This will include capacity building of Narcologists, AIDS Centre staff, Outreach workers, key decision makersand PWID on all aspects related to OST. Special attention will be given to the ensuring equal access for female PWID.  B) ***Strengthening the sustainability of the OST programme*** – This includes: *1) Procurement of Methadone Hydrochloride* for two years (2021-2023), to increase the number of participants to 700 patients per year. The MOH will cover the costs of logistics and storage; *2) Preparation of official documents for: i) introduction of Methadone and Buprenorphine on the List of medicines and medical devices* and on the Kazakhstan National Formulary (KNF); as well as extension of the registration of Methadone; and ii) Justification and preparation for the procurement of OST drugs from the State budget as of 2024; iii) improvement of clinical protocols related to OST; *3) Capacity building for 19 OST multidisciplinary teams on comprehensive medical and social service delivery*, incl. support for ART adherence. Capacity building will also include gender sensitisation for OST staff, to ensure women’s special needs are addressed: out of the current clients on the OST programme, 57 are women, four of whom gave birth while on OST, highlighting the need for special attention to their needs. In addition, OST will be part of a study tour for 7 mental health specialists that will include OST, OD management and NPS use (see intervention 1.7). *4) Regular coordination meetings* between different MOH departments regarding OST, Overdose Management and NPS use; as well as annual meetings with Heads of Regional Mental Health Centres.  C) ***Expansion of the OST programme*** – The Government will support the expansion of the OST programme at additional sites and will cover all staffing and operational costs. The GF grant will support annual monitoring visits to 17 regions to assess the quality of OST service delivery and solve problems.  D) In addition, the Global Fund grant will ***support the RSPCMH as a sub-recipient with long-term technical assistance*** (TA) by 4 expertsfrom 2021 to 2023: these experts will provide dedicated support to the implementation of all interventions related to strengthening OST (1.5); Introducing OD prevention (1.6); and Development of NPS services (1.7). Global Fund support for this TA is crucial, since the Republican Mental Health Centre (RSPCMH) is responsible for *clinical treatment* of drug addiction, and can therefore not contract special programme management staff. These staff will be based at, and work in close collaboration with the RSPCMH.  ***Intervention 1.6 Overdose prevention and management*** – In recent years, there has been an increase in poisoning with psychoactive substances due to overdose (OD): from 2018 to 2019 it increased by 18.4% (from 688 to 843 cases). A PSI study among 503 PWID in 2010 found that, in the previous year 24.1% survived an overdose; 48.5% witnessed overdoses; and 25.5% witnessed fatal overdoses*.* Furthermore, a study in 2013 by UNODC in Kazakhstan revealed that 57.7% of registered patients with opioid dependence and 38.6% of unregistered patients had an overdose experience *(see Annex 11, p.3).* The true scale of OD is even bigger, as many cases are not officially reported.  WHO recommends the use of Naloxone for OD treatment. Results from a study conducted in 2017-2020 in Almaty in the context of the joint UNODC-WHO initiative “Stop Overdose Safely” (S-O-S), found that the training and delivery of Naloxone kits at the ***community level*** helped prevent deaths from overdoses in many cases. However, the ***current OD response, including the use of Naloxone, is extremely limited*** due to the following reasons***: 1) Limited availability*** of Naloxone due to the existing regulatory framework: it is on List A of toxic and narcotic drugs, which limits its distribution as a prescription drug to the necessary groups at the community level such as PHC doctors and outreach workers*.* ***2) registration of Naloxone has expired;*** ***3) lack of competence in the use of Naloxone*** by medical specialists and non-medical workers; and ***4) Lack of an approved protocol for its use***.  In this context, the Grant will support improving the availability and use of Naloxone for OD treatment at the community level through the following activities: ***1) Support the re-registration of the injectable and intranasal form of Naloxone*** and introducing the drug into the relevant regulatory legal acts; ***2) Support for amendments*** to regulatory documents to ***allow dispensing Naloxone and Naltrexone without prescription*** through the pharmacy network; ***3) Development of an algorithm (protocol) for the use of Naloxone and Naltrexone*** in Kazakhstan; and ***4) Training of national trainers*** from among doctors, doctors-narcologists, toxicologists, general practitioners, emergency doctors on treatment of OD and disorders caused by the use of NPS. Given the registration of Naloxone on List A of toxic and narcotic drugs, training of community outreach workers is not foreseen for the duration of the grant, but will be considered for the near future. In addition, overdose management will be part of a study tour for 7 mental health specialists that will include OST, OD management and NPS use (see next intervention 1.7).  ***Intervention 1.7: Development of programmes on new psychoactive substances (NPS)*** – In recent years, there has been a marked increase in the use of so-called NPS: a study in 2019 found that the number of people using NPS in Kazakhstan had increased dramatically. Similarly, the proportion of drug-related hospitalisations due to NSPs increased 2.5-fold, reaching 10% in some regions in 2018 *(see Annex 16, p.4).* The highest prevalence of NPS use was observed among young men aged 25-30 years. Almost half (45.6%) of respondents knew at least one NPS; 6.3% had ever used any synthetic drug; and 2.4% had used NPS in the past 30 days *(see Annex 17, slide 13).* The highest NPS use is seen in North Kazakhstan region, Nur-Sultan and Almaty. The use of NPS includes a wide range of methods, including injection, but accurate data is not available on the extent of injection use of NPS. In addition, NPS use is associated with increased levels of high-risk, unprotected sex with multiple sex partners, including among MSM (e.g. “chemsex’). Thus, the increase in NPS use represents a new challenge to HIV prevention.  Given the rapid emergence of NPS in Kazakhstan, there is ***very limited knowledge and expertise on NPS among mental health and drug-treatment specialists,*** and on how best to deal with NPS use, including in the context of HIV prevention. NPS users are predominantly young, and may not be reached by existing harm reduction programmes for PWID. In this context, the Grant will support a number of activities to improve the knowledge about NPS, and to facilitate the development of adequate prevention and treatment programmes for NPS use; these include: ***1) a clinical and epidemiological study on NPS*** and its prevalence in 2021, with special attention for gender-related differences in NPS use and associated risks**; *2)*** The results of this study will be used to inform the ***development of a Road map for the prevention of NPS***(2021); ***3) Capacity building of mental health professionals*** will include: i) a 5-day study tour for seven (7) Mental Health specialists to a clinic specialised in NPS (UK) in 2021; ii) Development of a training module for Cascade (TOT) training of Health-care workers on NPS; iii) Annual training of 25 national trainers (TOT) on OD prevention and NPS issues (2021-2023). This increased capacity will facilitate the development of service-delivery models for NPS users and the involvement of NGOs currently already involved in harm-reduction services for PWID. Activities (i) and (ii) are combined with training on OD management under Activity 1.6.4.  ***Intervention 2.1 Strengthen community-based HIV testing among KPs by NGO outreach workers*** – At the end of 2019, of the estimated total number of PLHIV of 31,378 *(see Annex 2, slide 10),* 25,753 (82.1%) alive PLHIV were officially registered and know their status. The overall 82% HIV awareness varies from 68% in Turkestan region to 91% in Mangistau region. In 2019, about 3 million HIV tests were conducted among 2.4 million Kazakhstan citizens (14% of the total population). The bulk (79,6%) of all HIV testing is passive testing of the healthy population, with low detectability of new cases (only 0.05%). ***Active HIV testing represents only one-fifth (20,4%) of all testing,*** with most HIV cases detected among KPs (18%); by clinical indications (26.4%); and by epidemiological indications (14.4%).  In this context, and in accordance with the findings of the ***Global Fund Portfolio Analysis***, it is important to introduce and strengthen testing modalities (e.g. community-based and self-testing) that address the needs of hard-to-reach members of KPs who face barriers in accessing facility-based testing services.  For KPs, HIV testing coverage is highest among sex workers (69.8%) and considerably lower for PWID (39.5%); while it is very low for MSM (7.8%). Currently, HIV infection testing for PWID and MSM is provided using rapid blood tests by medical staff at Trust Points and Friendly Clinics. However, PWID and MSM do not always have access and/or wish to be tested at medical facilities. Therefore, ***community-based rapid oral testing*** by NGOs and ORWs provides a better opportunity to scale up coverage of PWID and MSM with HIV testing, as it drastically shortens the time to get the test result, and is favoured because it is done through outreach in their own communities. However, since ***rapid oral testing is still in the process of being introduced in the country***, Regional AIDS Centres cannot purchase these tests in full volume, because the State allocation for 180 million KZT is approved for rapid blood tests for 3 years. Therefore, advocacy is planned during 2020-2021 for reprofiling funds to allow the procurement of rapid oral tests.  Given these current limitations, Global Fund support is needed to ***1) support part of the total need for rapid oral tests.*** In this regard, the grant will cover: i) a decreasing proportion of the total need of ***OraQuick tests for ORWs from AIDS Centres*** in all 17 Regions of Kazakhstan: ***80% in 2021, 60% in 2022, and 40% 2023.*** The State will cover the remaining part, and will cover 100% of the OraQuick test needs of AIDS Centres as of 2024. ii) In addition, the grant will cover ***100% of OraQuick needs of Outreach workers at NGOs*** in selected regions, where NGOs work with KPs and PLHIV: for MSM and TG these include Aktobe, East-Kazakhstan, Karaganda, Pavlodar, Nur-Sultan city & Shymkent city; for PWID: Karaganda, Kostanay & Nur-Sultan city; and for PLHIV: Karaganda, Almaty Region & Nur-Sultan city *(for more details see Attachment 5А "Oral Quick Test Calculation").* The State will increasingly procure OraQuick testing in all regions, including for local NGOs. Special attention will be given to reaching female PWID, who are typically harder to reach than male PWID.  In addition to increasingly absorbing the procurement of OraQuick tests, the State will support ***capacity building of staff and outreach workers at NGOs and AIDS Centres in community-based HIV*** testing and counselling in all Regions.  ***Intervention 2.2 Introduce and scale up HIV self-testing (HIVST) among discordant couples*** – In addition to community-based rapid oral testing, *HIV self-testing (HIVST)* can add value to the existing testing approaches, especially for KPs who fear a lack of confidentiality of test results, particularly in public facilities. There is limited experience with HIVST in Kazakhstan, which was introduced with PEPFAR support in Q1 of 2020: of the 85 tests distributed, 55 results were reported, with 18 HIV-positive cases. Thus, HIVST may have potential to find new HIV cases that could so far not be detected through the regular testing channels. HIVST will be introduced among sexual and parenteral (drug-use) partners of PLHIV, as well as among discordant couples in 3 regions: Karaganda and Almaty regions and Nur-Sultan city. HIVST test kits will be distributed through NGOs. State funding will gradually absorb the cost of the test kits, with 40% in 2022 and 60% in 2023. If the results are promising, HIV self-testing will be expanded to other Regions as well. The State will finance capacity building in HIVST of 30 staff and outreach workers of NGOs and AIDS Centres in 2021, with refresher training in 2022 and 2023.  ***Intervention 3.1 Community-based support to strengthen ART adherence*** – The ***current status of 90-90-90 test-treatment cascade targets is 82-68-78.*** Since 2009, ART has been fully covered by the State. As evidenced by the cascade data, ART enrolment in Kazakhstan is relatively low: at the end of 2019, 17,535 PLHIV were on ART (68.1% of PLHIV who know their HIV status). And of these PLHIV on ART, 13,605 patients (78%) had viral suppression. Over the past 3 years, there have been problems with the timely delivery of ARV drugs to the Regional and City AIDS Centres, which led to the replacement of treatment regimens in patients, abandonment of ART and untimely initiation of therapy. Thus, in 2019, 543 ART patients were lost to follow up.  In this regard, it is important to note that the existing procurement challenges are already being addressed. Since 2013, the MOH has been developing an e-government policy. In 2020, it introduced the concept of ***digitisation of procurement as part of this e-government policy***, which will allow online monitoring of stocks of drugs in real time. In this context, procurement will become ***e-procurement[[7]](#footnote-8)*** and forecasting will be strengthened through the introduction of electronic tools. An electronic tool for forecasting of ARVs has already been introduced for the AIDS service and was applied in 2019 to forecast ARVs for 2020. Other modules for HIV-related procurement will follow in 2021 and are expected to strengthen the procurement system. In addition, a ***CDC project will support PSM systems strengthening*** in the next three years. However, the Funding Request seeks support for the procurement of key health products to ensure continuity of care and prevention services in the short term.  In this context, special attention is needed to ***strengthen ART adherence*** with a view to achieving the 95-95-95 goals, especially in Regions with large numbers of PLHIV and relatively high numbers of lost to follow-up. A recent evaluation found that peer counsellors and NGO-based social support services for PLHIV are key to improving HIV linkage to care and adherence *(see Annex 10; pp. 18, 28, 31).* Therefore, key activities in the context of this intervention will focus on strengthening retention in care and adherence to ART, specifically among PWID ***in 3 regions with the highest number of PLHIV*** (Karaganda, Nur-Sultan and Almaty region). Due to the large number of ART patients, Regional AIDS Centres in these 3 regions lack the capacity to follow up on all lost-to-follow-up cases. ART adherence will be strengthened by targeting communities to identify new HIV cases and follow them up to ensure that KPs are fully engaged in HIV prevention, care and treatment services. ***Partnerships*** ***between AIDS Centres and local NGOs*** play a key role: NGOs will employ peer counsellors to help PLHIV access treatment and care and ensure proper ART adherence.NGO peer counsellors will motivate clients for self-testing with rapid oral tests. In case of positive results, the partners would be referred to NGOs working with PLHIV for services of treatment, care and support for PLHIV. Currently, more than half (52%) of the peer counsellors working with PLHIV are women: working with female outreach workers has shown to increase access to clients, fostered trust, better counseling on safe behaviours, reproductive health, HIV/STI prevention, testing and ART adherence. ***Specific activities include:***  ***1) Annual capacity building on ART adherence support for staff of NGOs providing service to KPs and their partner health-care institutions****,* in 3 Regions with the highest number of PLHIV and ART patients.An existing module will be used, as well as workshops and webinars  ***2) Development and implementation of innovative tools for counselling, psychosocial and adherence support for PLHIV***. These tools include: *i) an Internet bot for PLHIV* on where to receive information and support; ii) a website linked to the internet bot, with region-specific information on ART and other services available to PLHIV; iii) Internet applications to support ART adherence; timing of medical examinations; and reporting ART side effects and interruption of ARV drugs; and iv) an *on-line chat system* with medical and social support staff, both physicians and peer counsellors. This will also allow addressing issues related to (self) stigma.  ***3) Provision of Adherence and social support for PLHIV who show poor adherence and retention in 3 priority regions*** (Karaganda, Nur-Sultan city and Almaty region)***.*** This involves using the tools developed under Activity (2), and will be integrated in existing service packages of NGOs and AIDS Centres.A total of ***26 Peer counsellors*** will provide: 1) Psychosocial support; 2) Mediation between clients and government AIDS Centres; 3) Accompany ART patients to health facilities for diagnostic and other medical services; 4) Social support; 5) Support in HIV testing and counselling for sexual and drug-use partners; 6) Provide information and education material, referral to other NGOs; including to street lawyers and other legal support. The new grant will be used to introduce new approaches for the work of NGOs with PLHIV, with remuneration based on successful identification, enrolment in ART and reduction of the viral load of PLHIV clients.  It is important to mention that the planned expansion of OST services will contribute to ART adherence among HIV-infected PWID. However, this will require further scaling up of OST by Government during and after the next Global Fund grant (2021-2023).  If the approach of using peer counsellors is successful in these 3 regions, Government will support the further expansion of the approach to additional regions with ART Adherence problems.  ***Intervention 3.2 ART and other medical support for undocumented migrants*** – The grant will support procurement of ARV drugs for 171 undocumented migrants living with HIV: Government laws do not allow providing free health services to this vulnerable population. Hence the grant will provide for legal support for their documentation to legalise their status, with a view to facilitating coverage of these migrants by the State. As part of additional medical services in relation to ART, special attention will be given to gender-related vulnerabilities of these undocumented migrants. The State is expected to cover 51 patients in 2022 and 120 of these patients by 2022 and 2023, assuming their status will have been legalised.  ***Intervention 3.3: Strengthening effective patient monitoring and VL testing*** – One of the key findings of a recent assessment of the HIV laboratory system in Kazakhstan[[8]](#footnote-9) was that many different types of laboratory equipment were used, and that a lot of lab equipment was outdated with “significant wear and tear”. Another key finding was that the laboratory network for viral load (VL) testing was not fully optimised, resulting in some labs with significant underuse and other labs with insufficient capacity. ***Key recommendations*** in this context included: i) Procurement of standardised and automated equipment to ensure unification of all laboratories for the procurement of tests from the same supplier; ii) Use of high-throughput automated instruments in high-volume sites and promote additional capacity to provide other testing such as EID and STI; and iii) Equipment built on a single platform with similar technological framework.  As mentioned under Intervention 3.1, special attention is needed to strengthen ART adherence with a view to achieving the 95-95-95 goals. In this context, regular treatment monitoring (VL testing) is essential. In many regions, however, outdated and inadequate lab equipment for VL testing is seriously hampering effective treatment monitoring and needs urgent replacement. In this regard, the Global Fund ***Portfolio Analysis*** also emphasised the need to further strengthen VL testing services, including the ***unification of VL testing technologies*** used. ***Specific activities*** in this regard include:  ***1) Procurement of 15 closed-type PCR Platforms with automated Nucleic Acid isolation* –** According to current legislation, each Region procures its own machines and test systems from regional public budgets. This results in different types of PCR machines in all Regions, with some ensuring 50 ml sensitivity and others 1000 ml sensitivity. Currently, most regional laboratories use Russian VL test systems and open-type PCR equipment with manual analysis that are not WHO pre-qualified. Despite the low cost of both machines and tests, they provide ***poor value for money,*** as they are characterised by low sensitivity; excessive manual labour to perform the tests; and high risk of incorrect results. In addition, some Regions witness stockouts of tests. This significantly limits lab capacity with an ever-increasing number of PLHIV.  In this context, additional automatic PCR equipment is urgently needed, but is hampered by current procurement rules. If a one-time national procurement is made with Global Fund support, the MOH will ensure procurement of tests and systems from the national budget going forward, which will reduce the risk of stock-outs, increase quality of treatment (standard 50 ml) and reduce costs for the test systems. Previous experience with the central procurement of Xpert cartridges for TB saw access increase substantially. In the current context of poor VL testing, central procurement of the laboratory equipment will contribute to medium and long-term programmatic sustainability and value for money.  Every year, Regional AIDS Centres carry out more than 42,000 tests for HV. In the case of regional procurement of varying types of automated platforms, the State will spend annually spend about KZT 1.1 billion (approx. USD 2.7 million) for the procurement of PCR reagents. On the other hand, central procurement of high-quality VL test systems and reagents will achieve a discount of up to 30%, and will save about KZT 330 million (approx. USD 820,000) each year, which can be directed to other needs.  ***2) Procurement of viral load (VL) PCR kits for the new PCR platforms*** (see previous) – To date, procurement of lab equipment and consumables has been done locally. As a result, there is no unification of VL equipment and tests in Regional AIDS Centres; while the systematic lack of funding leads to interruptions in VL monitoring. In this context, central procurement of PCR test kits for VL testing by the State is considered, but this new procedure will take many months. In this connection, partial support for the procurement of PCR kits is requested ***to bridge part of 2021*** (200 test kits; 30% of annual need), since the 2021 MOH budget has already been submitted and cannot include these PCR kits for the new PCR machines.  ***3) Technical support for Laboratory Diagnostics*** – As a result of the completion of the ICAP project, the AIDS service lost international technical support for laboratory diagnostics regarding: i) coordination between KNCDID and Global Fund on HIV diagnostics, ART monitoring and biosafety; ii) development of quality standards for the lab system; iii) monitoring of AIDS laboratories; iv) assistance to external quality assurance; v) communication with labs in EECA region. Currently, KNCDID staffing does not provide for such a position; hence short-term support in 2021 is needed from the Global Fund to ensure continuity till January 2022.  **3. Strengthening systems-related sustainability** is a key aspect of sustainability. Civil society organisations play a key role in HIV prevention among KPs, as they focus on the communities where KPs live and work, and they are often more trusted by KPs than State institutions. Similarly, resilient health systems are essential to providing care, support and treatment to PLHIV, including KPs with HIV. Effective coordination, linkages and referral systems between community and State health systems are crucial for an effective continuum of care. In this regard, the Grant will support the following interventions: i) strengthening of the institutional capacity of NGO service providers; ii) Social mobilisation, building community linkages and coordination; and iii) Strengthening the integration and digitalisation of health information systems.  ***Intervention 6.1***: ***Institutional capacity building, planning and leadership development*** – While considerable investments have been made to strengthen civil society, the number and capacity of NGO HIV service providers remain limited, especially for MSM and TG. Strengthening their institutional capacity will contribute to: i) improved service delivery; ii) better coordination and collaboration with State institutions; and iii) improved networking and partnerships at the national and local level with authorities and decision makers, with a view to facilitating mobilisation of resources from authorities (e.g. social contracting). ***Specific activities*** include institutional capacity strengthening throughout the 3 years of the grant through: i) webinars (available to all 17 Regions); ii) training workshops and iii) on-site mentoring to strengthen NGO systems in 8 priority Regions. The focus will be on strengthening NGO ***systems*** – rather than merely staff training – in 8 regions where the grant will support programmes for KPs and PLHIV (Karaganda (MSM/TG, PWID, PLHIV), Nur-Sultan (MSM/TG, PWID, PLHIV), Shymkent (MSM/TG), Aktobe (MSM/TG), Pavlodar (MSM/TG), East-Kazakhstan (MSM/TG), Kostanay (PWID) and Almaty *Region* (PLHIV).  ***Intervention 6.2***: ***Social mobilisation, building community linkages and coordination –*** In addition to strengthening *institutional capacity of NGOs*, ***strengthening partnerships and linkages between civil society and Government*** institutions is key to effective collaboration and partnerships, and thus contributes to the sustainability of services and referral networks *(see “Assessment of Readiness of the Republic of Kazakhstan to Ensure the Sustainability of HIV-related Services with Funding from the State Budget; p.21)*. Such Government-NGO partnerships are the basis for: i) National and local *resource mobilisation and social contracting*; ii) Effective *referral networks* for HIV/STI prevention, treatment and care between government and NGO service providers; including continuity of services, such as post-release programmes; iii) *Joint sensitisation and planning* for sustainable local HIV/STI responses and related health and social problems; iv) Joint programmes by government and NGOs on HIV/STIs, TB, harm reduction, and other diseases such as Hepatitis B and C. ***Specific activities*** include ***ongoing sensitisation and community-mobilisation to strengthen partnerships between*** 1) national and 2) regional and akimat government sectors, Ministries and NGOs providing services to KPs; as well as other stakeholders, such as Prison authorities. In addition, this will strengthen civil society capacity for community-based monitoring.  ***Intervention 7.1***: ***Strengthening Health Management and Information Systems and M&E –*** Currently, Kazakhstan is strengthening the availability and effectiveness of medical care through the integration of information systems, the use of mobile digital applications, the introduction of electronic health passports and the transition to paperless hospitals. The E-health Care programme is part of the Government’s *“Digital Kazakhstan”* programme, which aims to increase living standards of citizens, using digital techniques[[9]](#footnote-10). In this context, a ***Database of Individual Client Records*** (DICR) was developed in 2020, which allows getting data on all indicators, with automatic breakdowns by test result, gender, age groups and type/place of coverage of KPs with preventive programmes. In 2021 and 2022, the grant will support the further improvement and roll-out of the DICR system, by introducing a system for identifying customers by QR code to all government and non-governmental organisations providing HIV services. Specific activities in this regard include: i) the development of the QR code system; ii) procurement of tablet computers for outreach workers at NGOs and AIDS Centres (with government co-financing tablets for government-run service points); and iii) Capacity building of HIV service providers and outreach workers on the use of the DICR system, including the QR codes.  **4. Strengthening human rights-related sustainability** – Human rights-related barriers to HIV services are among the most hard-to-change, structural factors hampering sustainability. Key examples affecting the sustainability of HIV services include: i) stigma and discrimination of PLHIV and KPs in the health-care system; ii) de-prioritising key services for KPs (such as the systematic opposition to OST and harm reduction services for PWID in prisons); and iii) harassment of KPs by law-enforcement agents. In this context, the grant will support the following ***two interventions***:  ***Intervention 4.1: Stigma and discrimination reduction*** – Stigma and discrimination of PLHIV and KPs remain a barrier to accessing HIV-related and other health services. In this context a Stigma Index study is being conducted in 2020. The results of the first such study in 2015 revealed that most often PLHIV in Kazakhstan faced some discrimination from health workers: 25% of PLHIV faced disclosure of information about their HIV status; one-third of PLHIV did not receive counselling on their reproductive capabilities; and 25% of PLHIV were advised by health-care workers not have children. Injecting drug use and having been to prison further exacerbated this stigma and discrimination.  1) In this regard, in 2021, the grant will support the development ***National Strategic Plan to advocate for the protection of the rights of PLHIV*** and combat HIV-related stigma and discrimination, based on the results of the Stigma Index study in 2020. Special attention will be given to the gender-related disparities and vulnerabilities facing PLHIV.  2) In addition, in 2023, the grant will support a ***follow-up Stigma Index study among 700 PLHIV*** to allow monitoring trends and further inform the national response to stigma and discrimination, including the adjustment of legislation and policies. Special attention will be given to gender-related stigma towards PLHIV.  ***Intervention 4.2: HIV and HIV/TB- related legal services*** – Legal support is a key service for PLHIV and KPs in cases when their human rights are violated or in cases of stigma, discrimination or abuse by law enforcement officials. In this regard, experiences with so-called ***“Street lawyers”*** in Central Asia have shown their success in overcoming legal barriers to access to treatment and other violations of their rights. *Street lawyers* provide community-based, low-threshold access to legal support for the most vulnerable populations, including PWID, MSM, TG people and sex workers. They can respond to the legal needs of entire communities through mediation, negotiations, education, legal advice and public campaigns. In addition, complex cases can be referred to professional lawyers. Without such legal support, it will be difficult to achieve the 90-90-90 test-treatment cascade goals. The grant will support the following specific activities: ***1) the recruitment and training of 17 Street lawyers*** from among outreach and social workers from AIDS Centres and NGOs in all 17 Regions and cities with high numbers of KPs living with HIV. This includes training and ongoing support through monthly online webinars by a legal expert. ***2) Provision of Legal assistance by 17 Street Lawyers to PLHIV and KPs in all Regions*** to address legal barriers to health-care access, cases of stigma and discrimination, and other human rights violations. Special attention will be given to gender-specific legal barriers, e.g. the authority over their children of women who use drugs or engage in sex work. In addition, Shadow reports on cases of Human rights violations will be submitted to Government and UN agencies in 2022 and 2023. ***3) Legal support by 9 professional lawyers*** will back up the work of street lawyers in all regions in complex cases; and they will provide formal supervision, quality assurance and mentorship to street lawyers. As of 2024, the existing system of State-provided free-of-charge legal services will be used.  **2. ENSURING CONTINUITY, QUALITY AND COVERAGE OF SERVICES**  As described above, the main focus of the funding request is to ***strengthen the sustainability*** of the national response from a multi-dimensional perspective of financial, health and community *systems*, as well as sustainable *programmatic* approaches and removing *human rights*-related barriers. In addition, the grant will also support the ***continuity of HIV services for key populations*** – notably MSM, transgender (TG) people and PWID.  Despite strong commitment and support from the Kazakh government – which finances 95% of the national response and has been investing in social contracting and compulsory social health insurance to support HIV services – during the grant period 2021-2023, ***challenges are expected to remain*** with regard to service delivery to selected KPs, particularly for MSM, TG people and to a lesser extent for PWID. These challenges are related to the following factors: ***1) inadequate supply and poor quality of key commodities*** *(see Annex 10; pp.13 & 30)*, especially in regions with large numbers of KPs; ***2) inadequate support for NGO outreach workers*** from Regional governments.  Global Fund support in the next three years will be vital to ensure continuity of key HIV prevention services for KPs in a limited number of priority regions. Guaranteeing the continuity and quality of these services is a sine qua non for the future sustainability of these services.  ***Intervention 1.1: Ensuring adequate availability of condoms, lubricants for KPs*** – In Kazakhstan, the estimated number of MSM is 62,000 *(see Annex 12; p.2).* In recent years, there has been a marked increase of HIV infections among MSM: from 0.6% in 2012, to 1.2% (2013), 3.2% (2015) and 6.6% in 2019 *(see Figure 2, p. 3 of this Funding Request).* The highest HIV prevalence among MSM is found in 6 out of 17 Regions: Aktobe (11.7%), East-Kazakhstan (Ust-Kamenogorsk) (10.5%,) Shymkent (10%), Karaganda (9%); Pavlodar (9%), Nur-Sultan (8%). In this context, the grant will support HIV prevention among MSM and TG in these 6 regions, in addition to the support provided by the State through AIDS Centres and commodities.  In principle, the State budget covers all condoms for MSM in all Regions, but lubricants are not covered. To date, however, allocations by Regional authorities for condoms and lubricants for MSM have been insufficient, due to the lack of prioritisation of MSM and TG people to date, and other competing priorities. In 2019, the available quantities only covered 57% of the need for condoms and a mere 27% of the need for lubricants among the MSM reached with services *(see Attachment 3).* Therefore, as mentioned above *(see Intervention 6.2),* the Global Fund grant will support sensitisation of local decision-makers, building of community linkages and capacity-building to strengthen the allocation of funds from regional budgets to MSM. In the next 3 years, however, Global Fund support for ***additional condoms and lubricants*** will be vital to ensure the adequate delivery of HIV prevention services among MSM and TG – particularly in the 6 Regions (Pavlodar, East Kazakhstan/Ust-Kamenogorsk, Karaganda, Nur-Sultan, Shymkent, and Aktobe cities) with the highest HIV rates among MSM. In addition, the grant will support the procurement of condoms of a quality that is acceptable to MSM, since the quality of the cheapest type of condoms currently provided does not satisfy most MSM.  In this regard, the ***Global Fund grant will support NGOs working with MSM and TG with condoms and lubricants in the 6 Regions with the highest HIV rates among MSM.*** Government will cover condoms and lubricants for MSM through *AIDS Centres* in these 6 regions, as well as in other regions. The grant will cover 45% of the total NGO need in 2021; 35% in 2022; and 25% in 2023. In addition, the grant will support 10% of the NGO need for condoms and lubricants for MSM and TGs in the other 10 Regions, to complement the amounts provided to MSM by Regional AIDS Centres. The State will increasingly absorb the remaining NGO needs in the course of 2021-2023: this will be done by strengthening the existing mechanisms of social contracting, such as the State Social Orders and State Grants (*for details see Attachment 4\_Advantage NGO by MSM\_ENG).*  In addition, the grant will also support ***condoms for drug users***. Anticipating the increased need for condoms among PWID as well as young NPS users, the grant will support ***10% of the total need for condoms among drug users in all regions, for a total of 2,043,360 condoms for 3 years.*** As of 2024, the Compulsory Social Health Insurance (CSHI) will be fully covering these needs.  In Kazakhstan, the estimated number of PWID is 94,600. According to 2018 epidemiological surveillance data, HIV prevalence among PWID was 7.9%, and Syphilis 9.2%. Since 2017, Kazakhstan has experienced an increase in the use of synthetic drugs, so-called New Psychoactive Substances (NPS), including among young PWID. The prevalence of STI symptoms among PWID is 8.4%. The share of PWID who used a condom during their last sexual intercourse with a regular partner is only 34.6%, with an occasional partner 33.3% *(see Annex 4, p. 8).*  In principle, the State budget covers all condoms for ***PWID*** in all 17 regions. However, the available quantities of condoms do not meet the needs of PWID: in 2019, on average 92 condoms were distributed per PWID, with the normative being 120 pcs. Thus, in 2019, condom provision for PWID only covered 77% of the need of those covered *(see details in Attachment 2\_Planned purchase of condoms for PWID\_ENG).* In addition to people who *inject* drugs, users of NPS use these drugs in various ways, including injection. However, due to the nature of NPS, which are also used as sexual stimulants (so-called *chemsex*), NPS users are likely to engage in more high-risk sex practices than PWID. In this regard, it is expected that these NPS users will need more condoms. Currently, there are not yet specific programmes targeting these NPS users, which is why special interventions are included in thus funding request (see Intervention 1.7).  ***Intervention 1.2: Support for NGO outreach workers in key Regions with high HIV rates among KPs*** – Outreach work is an essential approach to reach KPs. In this regard, the Government is supporting outreach workers (ORWs) at Regional AIDS Centres in all Regions, while the GF grant supports ORWs at NGOs. The State currently already covers 63% of ORWs for PWID; 30% of ORWs for MSM; and 48% of ORWs for sex workers: in total, the State covers 57% of all ORWs for all KPs. The Global Fund grant covers the remaining 43% of ORWs, i.e. those working at NGOs in selected high-prevalence regions.  For the new grant (2021-2023), It is planned to continue using elements of the current grant implementation model, with the ***Global Fund supporting NGO ORWs in selected priority Regions***; and the ***State covering ORWs employed by AIDS Centres in all Regions***, as well as the majority of commodities (syringes, condoms, lubricants) (with limited Global Fund support, as described under 1.1).  In this context, ***the new grant will support: i) 61 ORWs (2021-2023) for MSM in 6 priority Regions/cities*** (Aktobe, East-Kazakhstan, Pavlodar, Karaganda, Nur-Sultan and Shymkent); ***ii) 4 ORWs for TG people (2021-2023) in 4 priority Regions*** (Aktobe, Karaganda, Shymkent & Nur-Sultan); as well as: ***iii) ORWs for PWID (70 in 2021; 60 in 2022; and 50 in 2023) in 3 priority Regions*** (Karaganda and Kostanay regions and Nur-Sultan): special attention will also be given to ensure female ORWs can reach female PWID. E.g., out of 110 outreach workers in NGOs currently working among PWIDs, 36 (33%) are women. Attracting women outreach workers has increased access to clients, fostered trust, better counselling on safe behaviour, reproductive health, HIV prevention, STIs, testing and ART, as well as counselling aimed at preventing violence from sexual and injecting partners.  The State will increasingly absorb the costs of these ORWs for PWID. GF support for SW ORWs is no longer requested, and will be covered 100% by the State. The Grant will allow maintaining adequate coverage and quality of outreach work for MSM, TG and PWID in the most affected Regions, while at the same time strengthening the capacity and commitment of the State to increasingly cover these ORWs and key commodities by the end of the grant period (December 2023).  2) In addition, in 2021, the grant will support ***capacity building of NGO and Government staff*** working with KPs (MSM, TG, PWID) on harm reduction and other HIV services for KPs. This will involve 4-day training of 20 people (ToT), who will subsequently conduct cascade (ToT) training of ORWs and nurses in 16 regions (in 2021). These trainings will focus on strengthening the quality of services; client-orientation of services; differential needs of male and female and associated gender inequity affecting female PWID and PLHIV; specific vulnerabilities and needs of young PWID; specific needs of TG people and MSM, including chemsex among MSM etc. While specific services in prisons are not part of this funding request, Prison Authorities will be included in community mobilisation activities (see Intervention 6.2) to strengthen post-release continuity of ART and TB treatment. |
| Expected Outcome | The overall expected outcome of the proposed interventions is a ***sustainable national response to HIV.*** All interventions have been explicitly prioritised with the various dimensions of sustainability in mind. This includes investments in financial, community and health systems; removing human rights-related barriers; as well as development of comprehensive, high-quality and innovative services. ***1) Financial sustainability*** will be strengthened by strengthening sustainable financing through integration of HIV in social contracting and Compulsory Social Health Insurance; ***2) Programmatic sustainability*** will benefit from strengthening the coverage, quality and comprehensiveness of service models, by introducing innovative approaches and filling gaps in HIV service delivery for KPs; ***3)*** ***Systems-related sustainability*** involves ***community*** ***systems*** strengthening by strengthening CSO institutional capacity; and building community linkages and partnerships between CSOs and State institutions; as well as key components of the ***health system*** (HMIS and Lab systems); and ***4) Human rights-related sustainability*** will be strengthened by addressing the structural forces in society, that hamper effective HIV programming; by addressing stigma and discrimination; and removing legal barriers. ***More details of the outcomes are mentioned in the “Rationale” section above.***  In addition, the ***Performance Framework*** (attached) provides details on the targets for key impact, outcome and coverage indicators, as well as Work Plan Tracking Measures for core components of the Funding Request. |

1. Does any aspect of this funding request use a **Payment for Results** modality?

Yes  **No**

1. **Opportunities for integration:** Explain how the proposed investments take into consideration:

* Needs across the three diseases and other related health programmes;
* Links with the broader health systems to improve disease outcomes, efficiency and programme sustainability.

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| To date, State funding already covers 95% of the national HIV response, which includes TB-HIV and HCV-related services for KPs. This funding request aims to contribute to systemic gaps that still exist, and which include both HIV-specific interventions, and interventions aimed to address systems issues. In this regard, the proposed investments of this Funding Request not only take into consideration the needs across HIV and TB, or links with the broader health system, but also try to contribute to the integration of HIV in *broader* public systems. This includes incorporating HIV services in compulsory social health insurance, as well as in broader social contracting systems, that allow HIV service provision by civil society organisations to key populations.  As mentioned earlier, the funding request has a major focus on ***strengthening sustainability***, and in this context, it includes many interventions to strengthen community systems as well as health systems beyond the specific area of HIV. These include:   1. Removing human rights-related barriers to services for KPs – such as interventions to ***reduce stigma and discrimination*** of KPs and PLHIV or providing legal support to KPs, PLHIV and undocumented migrants – will also benefit their access to TB, Hepatitis C and overall health-care services, as well as social services and support systems; 2. ***Strengthening social contracting*** will also benefit NGO service delivery to KPs in other areas, including TB, HCV, sexual and reproductive health, and harm reduction programmes; 3. The overall strong focus on strengthening ***community-based interventions*** will benefit health and social programmes for key and vulnerable populations beyond HIV, TB and broader health issues. This includes support for outreach work among KPs in priority regions that are currently under-served; community-based HIV testing; community-based OD management programmes; community-based support for ART adherence; community-based legal services by street lawyers, for KPs, PLHIV and undocumented migrants; interventions aimed to forge community linkages between NGOs and State institutions beyond the mere field of HIV; and strengthening the institutional capacity of NGOs. All these interventions have a ***knock-on effect on broader health and community systems beyond HIV,*** as they strengthen KPs’ and PLHIV’s access to health and social services, as well as sustainable financing for these services. 4. Strengthening components of the health system will not only benefit HIV services: e.g. ***supporting a system of QR codes*** among all service providers and service points for PLHIV and KPs will facilitate their access to other services as well. Similarly, strengthening laboratory systems will have benefits beyond HIV. |

1. Summarise how the funding request complies with the **application focus requirements** specified in the allocation letter.

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| The Funding request complies with the application focus requirement that 100% of allocation funding should focus on interventions that maintain or scale-up evidence-based ***interventions for key and vulnerable populations***. All proposed interventions aim to strengthen the sustainability and continuity of HIV prevention, care and treatment services for KPs (especially MSM, TG people and PWID) and PLHIV. This includes the introduction of ***innovative services***, such as HIV self-testing, services for users of new psychoactive substances (NPS), as well as interventions to fill service gaps, such as OST and community-based OD management for PWID; and PrEP for MSM. The grant will also ***continuity of services for KPs*** in selected Regions by supporting a buffer stock of key commodities; as well as support for NGO outreach workers for KPs.  In addition to these innovative services, the FR aims to ***reduce*** ***human rights-related barriers to HIV for KPs and PLHIV,*** by addressing stigma and discrimination, and offering community-based legal support to KPs and PLHIV.  The FR also includes many activities to ***promote transition readiness***, such as support for social contracting mechanisms; integration HIV services in the Compulsory Social Health Insurance (CSHI); institutional strengthening of NGOs; and supporting partnership and community linkages between State institutions and NGOs providing services to KPs. In addition. The FR includes interventions to strengthen specific components of the health system (HMIS, Laboratory). |

1. Explain how this funding request reflects **value for money**, including examples of improvement in value for money compared to the current allocation period. To respond, refer to the Instructions for the aspects of value for money that should be considered.

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| ***Maximising Value for Money*** (VfM) has been a key principle throughout the development of the funding request (FR). As already mentioned, strengthening ***sustainability*** is the major focus of the FR. Similarly, ***effectiveness*** of the grant is central to the FR, as it aims to strengthen the ***quality and comprehensiveness*** of key HIV prevention, testing and care and treatment services. Examples include efforts to strengthen service models for TG people and users of NPS; ensure adequate levels of high-quality commodities for MSM, TGs and PWID; and creating overall supportive policy environments that ensure effective policies and financing of key interventions for KPs. Examples of specific ***challenges to VfM*** include lost investments due to:   * High loss to follow up of ART patients, especially among PWID * High cost of finding new HIV cases due to inefficient testing systems * Poor health outcomes due to low quality and poor comprehensiveness of services * Poor ART adherence among PWID living with HIV due to low availability and accessibility of OST services * Low uptake of prevention, care and treatment services due to stigma and discrimination of KPs and PLHIV.   Comparing VfM of the FR with the current grant is difficult, as the current grant mainly focuses on strengthening social contracting mechanisms as well as service delivery, while the FR includes *additional* interventions that aim to improve quality and comprehensiveness of services; remove human-rights-related barriers to service uptake; and additional efforts to strengthen community systems (CSS). However, it is expected that the combination of these different interventions will have a catalytic effect, i.e. it may increase VfM, because it not only focuses on supporting the development of social contracting mechanisms and service delivery, but also on strengthening capacity of NGOs to successfully apply for social contracts, as well as strengthen partnerships between NGOs and local authorities.  **Economy** –The funding request includes procurement of health products and human resources. Health products include condoms, lubricants, rapid oral tests, ARV drugs (for PrEP for MSM and ART for migrants), methadone, tablet computers, as well as laboratory equipment. Human resources include technical assistance as well as salaries for NGO staff and outreach workers.  Procurement of health products will be done using a Procurement Agent (UNDP served as such before), whose systems are designed to ensure transparency, accountability, cost effectiveness and value-for-money. This implies specific attention for economy, by ensuring the ***lowest sustainable costs for quality health products*** that produce effective health outcomes. This will involve transparent and competitive procedures for the purchase of quality-assured health products at the reference price for these products.  Special attention will be given to ***high quality*** of health products, to ensure that they effectively meet the requirements of the users. A good example in this regard are high-quality condoms that meet the expectations of MSM and TG people: while these may have a higher unit price than the cheapest available condoms, higher uptake of these high-quality condoms will ensure VfM, and will set a standard for subsequent procurement by the State of these commodities for MSM and TG people specifically. Similarly, rapid oral testing using OraQuick test will provide economy because of their higher acceptability and therefore higher uptake by KPs. In another example, PrEP is expected to be a cost-saving intervention, as it is predicted to result in substantial health benefits because of reductions in HIV infections. Whether it will turn out to also be a good investment, will depend on adherence rates, and if scaled up, on programme coverage.  The selection of implementing organisations shall be carried out on a ***competitive*** basis as much as possible – except in cases where existing subrecipients and/or implementers have been providing satisfactory services at a competitive price, or when a particular service provider is in a unique position to provide these services, such as the Republican Scientific-Practical Centre for Mental Health (RSPCMH) with regard to clinical services for drug users. In all other cases, competitive bidding will be used to select service providers that offers the best value for money.  Salaries for NGO outreach workers will be fully in line with those of government-employed outreach workers, based at Regional AIDS Centres.  **Efficiency** – The funding request (FR) aims to strengthen efficiency of the national response both at the *programmatic* and *systems* level (see below). It aims to maximise outputs, outcomes and impact by focusing on key populations and geographic regions most affected by HIV; while also taking into account the support by other donors, specifically PEPFAR; as well as focusing on those KPs that are least covered by government programmes, i.e. particularly MSM and TG (and to a lesser extent PWID). The FR will focus on interventions that can add value to existing programmes, e.g. through innovative approaches or by strengthening supportive environments.  ***Allocative efficiency*** – At the ***programmatic*** level, the funding request will contribute to efficiency by focusing on KPs with the highest HIV prevalence rate, and lowest coverage with interventions: in this regard, no funds are sought for sex worker services (which State programmes will continue to provide), while major emphasis has been given to strengthening services for MSM and TG people, who are currently particularly under-served; as well as PWID. In addition, the grant will focus on regions with the highest HIV prevalence among MSM[[10]](#footnote-11): Aktobe, 11.7%; East Kazakhstan, 10.5%; Shymkent, 10.0%; Karaganda and Pavlodar, both 9.0%; and Nur-Sultan, 8% (the overall HIV rate among MSM in 2019 was 6.6%). At the ***systems*** level, the funding request *balances* investments in health and community *systems* strengthening with programmatic interventions. Systems-related investments will contribute to ongoing government and health reforms, e.g. by building on and strengthening existing social contracting systems, as well as compulsory social health insurance. These systems investments will be complemented by *interventions* that can make a difference – not as much by scaling up coverage, but by introducing *innovations* (e.g. rapid oral testing) and *novel service models* (e.g. for ART adherence support or street lawyers; or emerging key populations such as users of new psychoactive substances), as well as strengthening legal rights and supporting critical enablers, e.g. through systematic advocacy for OST and OD prevention.  In 2019, an ***Optima exercise***[[11]](#footnote-12) *(see Annex 8; p.1)* was conducted to support the efficient allocation of national resources for health. Key recommendations for ***HIV resource optimisation*** include: ***1) Scaling up antiretroviral therapy*** (ART), which could lead to increased treatment coverage of people diagnosed with HIV from 58% (status quo) to 68% (optimized) in 2019: as mentioned above, the funding request will support this through adherence support by peer counsellors for PLHIV. ***2) Maintaining investments for HIV testing and prevention programmes targeting MSM:*** given that over 60% of new HIV infections occurred among MSM in 2018, investment in HIV testing and prevention programmes targeting this group should be scaled-up at the 100% budget level. Should additional resources become available, investment in MSM programmes should continue to be scaled-up, along with investment in PrEP targeting MSM: both components are included in this funding request.  ***Technical efficiency*** – At the ***programmatic*** level, several proposed interventions aim to minimise the cost of service delivery while achieving the desired health outcomes. This involves interventions that will catalyse existing services, thus reducing their unit cost per outcome achieved. E.g. HIV testing will be more efficient by strengthening community-based testing and HIVST among KPs, as this will yield more HIV cases detected than facility-based testing, thus bringing down the unit cost per HIV case detected. Similarly, strengthening ART adherence among KPs living with HIV (especially PWID) will lead to better treatment outcomes, thus reducing lost investments in HIV testing and enrolling patients in ART who would otherwise be lost to follow up. The standardisation of PCR equipment through centralised procurement – supported by the grant – will increase VfM ***by reducing*** excessive manual labour to perform the tests; and by lowering the risk of incorrect results. In addition, standardisation of equipment and lab commodities will reduce the risk of stock-outs, increase quality of treatment (standard 50 ml) and reduce costs for the test systems. As mentioned earlier, the central procurement of high-quality VL test systems and reagents will achieve a discount of up to 30%, and will save about KZT 330 million (approx. USD 820,000) each year, which can be directed to other needs.  Similarly, creating a supportive environment for OST will reduce the unit cost per PWID enrolled in ART, by greatly enhancing ART adherence among HIV-infected PWID. PrEP for MSM and TG people will reduce the unit cost of prevention, testing and treatment costs for these populations, by more efficiently averting avoidable new HIV infections. At the ***systems*** level, the funding request will contribute to technical efficiency by investing in health system components that will benefit multiple disease programmes; e.g. proposed investments in the laboratory system will benefit both HIV and TB programmes. Similarly, legal support for PLHIV and KPs will benefit both HIV and TB outcomes. The proposed interventions to strengthening community systems will improve alignment of services between the State and NGOs, and thus contribute to efficiency.  **Equity** – The country dialogue process is based on an intensive process of actively involving key populations as the main stakeholders in this FR. This has allowed systematically identifying human rights and gender-related barriers to service access, uptake and retention, which lead to inequalities in health outcomes for KPs and PLHIV. Addressing these inequalities is a key programmatic priority of this funding request.  These ***barriers*** have been systematically addressed through the proposed interventions of this FR, which is focused on the HIV prevention, testing, care and treatment needs of KPs and PLHIV.  With regard to ***financial barriers*** to service access and uptake, the continued support for developing effective ***social contracting mechanisms*** (Intervention 5.1) and inclusion of HIV services for KPs as part of the ***compulsory social health insurance*** (Intervention 5.2) aims to strengthen equity in particular.  Similarly, ***human rights-related barriers*** will be addressed by the development of service models that are better tailored to the needs of TG people (intervention 1.3) and KPs with HIV (e.g. Art Support by peer counsellors, intervention 3.1). In addition, interventions 1.5 and 1.6 aim to guarantee PWID’s right to OST and OD treatment; while interventions 2.1 and 2.2 aim to improve access to community-based testing and HIVST for KPs. Intervention 3.2 will contribute to the right to free ART (financed by the State) for undocumented migrants. Human right-s related barriers will further be addressed by providing legal support to KPs through community-based street lawyers and professional legal support.  ***Strengthening community systems*** is a major focus area of the FR, involving major investments in strengthening the institutional capacity of NGOs (Intervention 6.1), as well as strengthening community linkages between government institutions and civil society (Intervention 6.2) with a view to strengthening the access of KPs and PLHIV to health services and HIV services in particular. |

## Matching Funds (if applicable)

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| **Not applicable** |

# **Section 2: Operationalisation and Implementation Arrangements**

To respond to the questions below, refer to the *Instructions* and an updated **Implementation Arrangement Map**[[12]](#footnote-13).

1. Describe how the proposed **implementation arrangements** will ensure efficient programme delivery.

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| The attached ***Implementation Arrangements Map*** gives an overview of the roles and responsibilities of the different institutions involved in grant implementation.  The MOH-based ***Kazakh Scientific Centre of Dermatology and Infectious Diseases (KNCDID)*** will continue to be the PR. As an MOH-based institution, the selection of the KNCDID as PR will support national ownership and will build national capacity for programme implementation. The Project Implementation Unit (PIU) will execute its functions in accordance with Global Fund requirements and in compliance with the national legislation. The PR/PIU will develop workplans for project implementation and will present performance reports to the CCM. The current PR/PIU possesses strong technical management capacity, which will allow the smooth continuation of the Global Fund grants, and transition from the current grant to the next one. The PR/PIU will be responsible for all operational and managerial issues related to implementation of the grant, including:   1. Grant Programme management, including financial management and coordination 2. Harmonisation and coordination of the National HIV, STI, and Hepatitis programme 3. Organisational, methodological and technical assistance to Regional AIDS Centres and NGOs at the regional level 4. Management, coordination and oversight of SRs –NGOs at the national level and in 8 priority regions 5. Management and coordination of SRs and subcontractors, including NGO service providers in 8 priority regions; as well as SRs providing specialised services and/or programmes 6. Monitoring and supervision of grant implementation 7. Procurement of technical assistance and human resources (NGO staff and outreach workers; experts). Procurement of health products will be delegated to an international procurement agent (see below).   ***Sub-recipients*** – A number of SRs will be responsible for the implementation of specific components of the grant, in accordance with their specific responsibilities and/or technical expertise. One SR has already been pre-selected: the MOH-based ***Republican Scientific-Practical Centre for Mental Health (RSPCMH)*** will be responsible for implementing three major interventions (1.5, 1.6 and 1.7) related to strengthening OST, Overdose management and development of programmes for NPS users. The RSPCMH being under the MOH will facilitate the integration of these components in the services provided by the MOH.  Other SRs will include ***NGO service providers in 8 regions*** that have been prioritised for HIV service delivery to KPs (Aktobe, Almaty Region, East Kazakhstan, Karaganda, Kostanay, Nur-Sultan, Pavlodar and Shymkent); as well as SRs yet to be selected through a competitive bidding process to provide ***specialised services and interventions***, including: 1) services for PLHIV (e.g. NGO capacity building, HIVST, reducing stigma and discrimination); 2) the introduction of a PrEP programme; 3) Legal support for KPs and PLHIV, including for undocumented migrants with HIV; 4) the further development of social contracting mechanisms for HIV services; 5) incorporation of HIV services in Compulsory Social Health Insurance (CSHI); 6) strengthening the institutional capacity of NGOs; and 7) advocacy and strengthening partnerships at the regional level.  Some national institutions with demonstrated capacity have already shown an interest in being involved in the implementation of these services, and/or have submitted specific project proposals to that effect. However, the final selection of SRs will be subject to a transparent comperegulatory titive bidding process, in accordance with Global Fund rules and regulations, to be held in the course of 2020, except in cases where existing subrecipients and/or implementers have been providing satisfactory services at a competitive price, or when a particular service provider is in a unique position to provide these services, such as the Republican Scientific-Practical Centre for Mental Health (RSPCMH) with regard to clinical services for drug users.  ***International Procurement Agent (IPA)*** – The PR/PIU will delegate functions of procurement of health and non-health products to a procurement agent (potentially UNDP, which successfully fulfilled this role before), including condoms, lubricants, ARV drugs (for migrants), rapid oral test kits, Methadone, as well as computer and laboratory equipment. |

1. Describe the role that **community-based organisations** will play under the implementation arrangements.

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| CBOs and NGOs play a key role in the implementation arrangements. As explained in section 2.a, ***NGO service providers*** to KPs (MSM, TG people and PWID) and PLHIV will be involved in HIV service delivery to KPs and PLHIV in 8 priority regions, with higher HIV prevalence among KPs, and/or high numbers of KPs and PLHIV. In these regions, CBOs and NGOs will work in close collaboration and coordination with the Regional AIDS Centres, which will also be involved in service delivery to KPs and PLHIV through State-financed outreach workers. Some of the CBOs and NGOs that will be involved in direct service delivery are already involved in service delivery under the current grant and are likely to continue as such. Additional NGO service providers will be contracted in the newly selected priority Regions. These NGOs will be selected based on their experience and technical expertise in service delivery; active involvement of KPs in the NGOs activities will be a key selection criterion. In addition, NGOs with representation of KPs on their board and/or management will be prioritised to ensure proper representation of their constituents. The specific roles and other involvement of CBOs/NGOs in the grant include the following:  ***1. NGOs that play a key role in service delivery*** will benefit from support for programme staff and outreach workers; as well as provision of key commodities (condoms and lubricants, oral test kits) and capacity building. CBOs and NGOs will be involved in the following types of activities and services:   * Delivery of HIV prevention services to MSM, TG people and PLHIV (8 regions) (interventions 1.1-1.2) * Service delivery for TG (intervention 1.3) * PrEP for MSM and TG people (intervention 1.4) * Community-based testing for KPs and HIVST for partners of PLHIV (interventions 2.1 & 2.2) * Supporting to strengthen ART adherence among PLHIV, especially PWID   ***2. NGOs/CBOs will benefit from the strong investments in the development of sustainable finance mechanisms****,* including Intervention 5.1: Strengthening social contracting (through State Social Orders and Stage Grants), as well as Intervention 5.2: Support for the inclusion of HIV services for KPs in the Compulsory Social Health Insurance (CSHI).  ***3. NGOs/CBOs will benefit from technical and institutional capacity building*** (Intervention 6.1): this includes capacity building in wide range of technical areas related to service delivery; as well as an extensive programme to strengthen the institutional & organisational capacity of CSOs, with a focus on strengthening organisational systems.  ***4. NGOs/CBOs will benefit from strengthening of linkages, partnerships and******coordination*** between State authorities and CSOs at the national, regional and akimat level (Intervention 6.2). This systematic effort to forge partnerships at all levels, will facilitate collaboration in service delivery, as well as in mobilisation of resources for CSOs from State authorities. |

1. Is the Principal Recipient an **international institution** (for example, international NGO or UN agency)?

Yes  **No**

1. Describe the **top three anticipated implementation risks** that might negatively affect: (i) the delivery of the programme objectives supported by the Global Fund; and/or (ii) the broader health system. Then, describe the mitigation measures that address these risks.

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| **Key Implementation Risks** | **Corresponding Mitigation Measures** |
| ***Covid-19*** may have a serious and long-lasting impact, particularly on key and vulnerable populations, and disadvantaged communities: Covid-19 measure may hamper HIV and harm reduction services; it may over-burden the health system; it may take away financial resources from the State that are needed to absorb the cost of HIV services supported by the GF grant. This may include fulfilment of co-financing commit-ments, especially in the context of a projected contraction of the global and Kazakh economy. | It is difficult to anticipate the long-lasting health and economic impact of Covid-19. At the service-delivery level, HIV programmes for KPs have continued, albeit with special measures and facing certain restrictions. This shows the resilience of these programmes and the commitment of government and civil society services even under very difficult circumstances. The funding request has a number of components that aim to strengthen community systems and sustainable finance for HIV programmes. This includes support for social contracting and social health insurance support for HIV programmes (Interventions 5.1 and 5.2). In addition, measures to strengthen community systems (e.g. Interventions 6.2, 4.1 and 4.2) are also expected to strengthen continuity of services despite the impact of Covid-19. Furthermore, strengthening the institutional capacity of NGOs (Intervention 6.1) will strengthen their ability to continue service delivery even under difficult economic circumstances. |
| ***Insufficient prioritisation by regional authorities to allocate funds to HIV prevention services by NGOs***, resulting in inadequate funds to gradually absorb the cost of service delivery, and/or expand key services beyond priority Regions supported by the grant. In addition, insufficient interest of NGOs to use existing social contracting mechanisms. | The funding request addresses this risk by strengthening government commitments at national and local levels. This includes: 1) written commitments already given by the central Government to fulfil co-financing requirements; as well as: 2) Intervention 6.2 specifically aims to strengthen commitment and budget allocations by regional Governments to HIV services for KPs, including by NGOs. This will be done by strengthening local partnerships between government and civil society organisations. |
| ***Political and societal opposition to OST programmes*** | The funding request includes a major intervention to specifically address the lack of support for OST among certain elements of society by supporting ongoing, systematic advocacy and sensitisation programmes, which will also include capacity building of Narcological staff. This aims to change the current context and strengthen active support among the highest decision makers for this core intervention. |

1. Does the funding request envisage a **joint investment platform** with other institutions?

Yes  **No**

# **Section 3: Co-Financing, Sustainability and Transition**

To respond to the questions below, refer to the *Instructions*, the domestic financing section of the allocation letter, the [Sustainability, Transition and Co-Financing Guidance Note](https://www.theglobalfund.org/en/funding-model/applying/resources/), **Funding Landscape Table(s)**, **Programmatic Gap Table(s)**, **Transition Workplan** and **Transition Readiness Assessment** (if available)[[13]](#footnote-14).

## 3.1 Co-Financing

1. Have **co-financing commitments** for the **current** allocation period been realised?

**Yes**  No

If **yes**, attach supporting documentation demonstrating the extent to which co-financing commitments have been met.

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| * **Supporting documentation attached** |

1. Do **co-financing commitments** for the **next** allocation period meet minimum requirements to fully access the co-financing incentive?

**Yes**  No

If details on commitments are available, attach supporting documentation demonstrating the extent to which co-financing commitments have been made.

If co-financing commitments do not meet minimum requirements, explain why.

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| * **Supporting documentation attached** |

1. Summarise the **programmatic areas** to be supported by domestic co-financing in the next allocation period. In particular:

i. The financing of key programme costs of national disease plans and/or health systems;

ii. The planned uptake of interventions currently funded by the Global Fund.

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| ***i. The financing of key programme costs of national disease plans and/or health systems:***  Kazakhstan will increase State funding for national health from 3.3% currently to 4.7% of GDP by the end of 2023. The Government is also increasing salaries of all health workers to ensure that the country moves faster to free public health care for all services.  State finance already covers 95% of the HIV national response. This covers most care and treatment-related services, testing, as well as outreach workers for KPs and PLHIV based at AIDS Centres. A gradual increase in State co-financing will be a cross-cutting aim throughout the funding request: the main reason for requesting Global Fund support for procurement, is that this is often related to: ***i) new or innovative interventions***, for which short-term GF support will help speed up implementation; ***ii) Current procurement rules*** where Regions are responsible for procurement, and which do not allow procurement at the central level; ***iii) current problems with inadequate allocations by local Regional authorities*** to specific HIV interventions for KPs, especially for MSM and TG: this includes insufficient levels if funding for condoms and lubricants. The grant will help guarantee adequate service delivery in priority Regions, while supporting budget advocacy for increased local budget allocation.  It is important to note that the Funding Request is *not* seeking support from the Global Fund for strengthening the existing ***procurement systems***, as these problems are already being addressed in two ways: 1) in the next three years, a ***CDC project will support PSM systems strengthening***; 2) in 2020, Kazakhstan introduced the concept of ***digitisation of procurement as part of the e-government policy*** that was started in 2013, which will allow online monitoring of stocks of drugs in real time. In this context, procurement will become ***e-procurement[[14]](#footnote-15)*** and forecasting will be strengthened through the introduction of electronic tools. An electronic tool for forecasting of ARVs has already been introduced for the AIDS service and was applied in 2019 to forecast ARVs for 2020. The remaining HIV modules are will follow in the next year.  In this regard, it is important to note that the State already finances the bulk of all HIV-related programmes and services in all 17 Regions; While the Global Fund grant will support strategic interventions in a limited number of Regions, the State will gradually absorb those costs, while also covering the other Regions that are not covered by the grant. Specific co-financing by the State is specified below:  ***ii. The planned uptake of interventions currently funded by the Global Fund:***  ***Health products and drugs***   * The State finances all ***commodities for SWs***; in addition, 100% of syringes and alcohol wipes for PWID. In 6 priority Regions for MSM that will be supported by the new grant with ***condoms & lubricants for MSM and TGs,*** in 2021-2023 period, the State will co-finance an increasing proportion (55%-65%-75%) of the total need in these 6 Regions. In the other 11 Regions, the State will finance 90% of the total condom and lubricant needs throughout 2021-2023. * The State will also cover 90% of condoms for PWID and NPS users in 2021-2023 (10% GF support) * In the context of a PrEP pilot, the State will finance the expansion from 300 to 600 clients in 2023 (ARV drugs and OraQuick tests) * The State will increasingly co-finance ARVs for 171 undocumented foreign migrants with HIV: 51 patients in 2022; 120 in 2023 and all 171+ as of 2024. * The State will finance 100% of the procurement of Methadone as of 1 January 2024.   ***Human resources***   * ***Strengthening of OST services:*** I this context, the State will support capacity building of Narcologists, AIDS Centre staff, Outreach workers and PWID: this represents approx. 14.4% (USD 70,400) of the costs of the OST advocacy and training activities. In addition, the State will also finance the cost of staff, opening of new OST outlets and operational costs. * ***ART adherence support by peer counsellors:*** the grant will support 26 peer counsellors in 3 priority states: the State will co-finance the expansion of ART Adherence support by Peer counsellors in selected other priority regions   ***Programmes for KVPs***   * Currently, the Government of Kazakhstan supports 57% of all ***outreach worker salaries*** in the country. The current grant supports a total of 196 ORWs (for PWID, SW and MSM) in selected regions: 110 ORWs for PWID in 3 regions; 60 ORWs for SWs in 3 regions; and 26 ORWs for MSM in 4 regions. * The Funding request seeks funding from the GF to support Outreach work in selected Regions with highest burden of disease. ***GF support for SW ORWs is no longer requested***. Government already finances Government ORWs, nurses and other staff at Regional AIDS Centres. In 3 Regions supported by the GF, the State will increasingly absorb NGO-based ORWs through social contracting: GF support for PWID ORWs will decrease from 70 in 2021 to 60 in 2022 and 50 in 2023. Similarly, the State will absorb decreasing numbers of ORWs for MSM in 6 regions. * ***Community-based rapid oral testing and HIVST***: State will co-finance 20-40-60% of OraQuick tests (2021-2023) among KPs in all 17 regions; in addition, the State will finance 25% and 50% of OraQuick tests for HIVST in 2022 and 2023. * ***Legal support for KPs and PLHIV*** will be provided in 4 Regions by the grant; the State already finances free legal support in all regions: this will increasingly focus on PLHIV and KPs as well in the course of 2021-2023. * The State already covers the bulk of the cost of developing social contracting and ***Compulsory Social Health Insurance*** (CSHI). The grant will support strengthening of ***sustainable funding for KPs*** by strengthening ***social contracting*** mechanisms, as well as integrating HIV prevention services for KPs in CSHI***:*** this aims to increase co-financing of NGO services for KPs by the State in the course of 2021-2023. * The grant will support ***strengthening of institutional capacity of NGOs***; the State also has mechanisms in place to strengthen civil society, which will co-finance this kind of interventions. In addition, the state will co-finance 40% (USD 8,000; 2022) and 70% (USD 14,000; 2023) of the costs for mentoring of 20 NGOs per year.   ***Equipment:***   * The State will co-finance 161 Tablet computers for Fixed and Mobile Trust Points and Friendly Rooms/Cabinets (26% of all costs); while the GF grant will cover Tablets for ORWs of AIDS Centres and NGOs (n=453) |

**3.2 Sustainability and Transition**

1. Based on the analysis in the **Funding Landscape Table(s),** describe the funding need and anticipated funding, highlighting gaps for major programme areas in the next allocation period.

Also, describe how (i)national authorities will work to secure additional funding or new sources of funding, and/or (ii)pursue efficiencies to ensure sufficient support for key interventions, particularly those currently funded by the Global Fund.

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| The ***total funding need*** for the 2021-2023 period is ***USD 194,834,389*** *(see details in Funding Landscape Table).* Available domestic resources expected from the State amount to USD 181,820,951, i.e. 93% of the total need. State funding includes all key programme areas, including HIV services for KPs provided by Regional AIDS Centres.  In addition, small amounts of funding are expected from UN agencies (UNAIDS, UNDP, UNFPA, UNICEF) and the Elton John Foundation, totalling approx. USD 4.4 million for three years. Taking into account the new Global Fund allocation (approx. USD 7.2 million), the total amount of expected external resources is approx. USD 11.6 million. Thanks to the large investments committed by the State (approx. USD 60.6 million per year), a small funding gap of approx. USD 1.4 million (0.7% of the total need) is expected.  This funding gap includes NGO services for KPs and PLHIV, which are not fully funded by the State. While mechanisms are in place for social contracting of such services, these are currently not yet fully supportive of HIV-related services by NGOs; also because these State Social Orders and Grants depend on allocations by regional authorities, which do not always cover the full need. The government aims to strengthen these mechanisms for civil society involvement and financing of key public services by further strengthening of existing social contracting mechanisms, e.g. allowing grants for longer periods, as well as larger amounts. This would strengthen more sustainable State funding for HIV services provided by NGOs. In this regard, the recent *“Assessment of the readiness of Kazakhstan for the transition to social contracting to ensure the sustainability of HIV-related services”* in December 2019 provides specific guidance in a number of areas: i) ensuring prioritisation of HIV prevention and M&E in the public health system; ii) improving the regulatory framework for addressing remaining gaps of the social contracting system; iii) ensuring sustainable public funding of HIV prevention, care and support services; and iv) strengthening partnerships between civil society and government at the regional level. These recommendations are explicitly included in this funding request  In addition, the Government is developing the Compulsory Social Health Insurance (CSHI) system, which will also cover HIV-related treatment and care services. The funding request aims to support the incorporation of HIV prevention services in this CSHI system: this would also allow reimbursement of services provided by NGOs. In the next 3 years, the CSHI system, as well as the various social contracting mechanisms, particularly at the Regional and Akimat level, are expected to partially fill the current funding gap.  In this regard, the Funding Request includes several activities to help bridge the funding gaps by supporting budget advocacy and social mobilisation activities with authorities at different levels *(see more details in the next section (3.2.b).* |

1. Highlight **challenges** related to sustainability (see indicative list in the *Instructions*). Explain how these challenges will be addressed either through this funding request or other sources. If already described in the national strategy, sustainability and/or transition plan, and/or other documentation submitted with the funding request, refer to relevant sections of those documents.

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| As discussed in section 1, ***sustainability*** goes beyond sustained ***financing*** andincludes other dimensions, such as ***programmatic, health and community systems-related, governance, human rights and political***.  **1) Challenges to Financial sustainability** – The national response to HIV in Kazakhstan has benefitted from strong Government commitment, as evidenced by the fact that it currently finances approx. 95% of the *national response* to HIV. In 2018, the reported national HIV programme budget was USD 38.7 million *(UNAIDS, 2020).* Future funds for HIV will likely benefit from a planned increase in funding for national health from the current 3.3% to 4.7% of GDP by 2023. Government funding for HIVcovers State medical facilities and staff; the bulk of drugs and commodities for prevention, testing and treatment; as well as community outreach workers employed by Regional AIDS Centres. In addition, there are several mechanisms for ***State funding of NGOs*** (State Social Orders, State Grants and Awards) and efforts are underway to include HIV prevention for KPs in the new Health Code to stimulate allocation of social contracts for KP groups at the level of Akimats *(see Annex 10; p.6)*. To date, however, access to these State funds has been limited for NGOs working in the HIV field, as social contracting has traditionally not been awarded to HIV programmes. In addition, budget allocations to HIV by local government have been suboptimal, as HIV is not always given top priority in the context of many competing priorities. Thus, in 2019, social contracts for NGOs still only represented a very small proportion of the total State budget for HIV (0.2%, USD 63,600).  In addition, Kazakhstan is in the process of introducing ***Compulsory Social Health Insurance (CSHI)[[15]](#footnote-16),*** which aims to guarantee free medical care to all citizens. CSHI will cover first aid, out-patient and polyclinic care, Inpatient care and hospital-assisted care. In comparison to the relatively unreliable and more short-term social contracting mechanisms, CSHI may offer better opportunities for sustainability of HIV services, including those offered by NGOs. However, the system is still in the process of being rolled out and at this stage it is not yet fully clear to what extent it will cover all aspects of HIV prevention, care and treatment. Especially HIV services for KPs offered by NGOs may not be included in the CSHI. In this context, the Funding request will specifically support the incorporation of HIV-related services as part of the CSHI system, including those delivered by CSOs/NGOs.  ***Key actions to strengthen financial sustainability*** – As described in section 1.1, the grant will specifically support strengthening the eligibility for social contracting of HIV prevention services for KPs by NGOs (Intervention 5.1); as well as strengthening partnerships and linkages between local authorities and NGOs to facilitate the allocation of social contracts in the field of HIV to NGOs (Intervention 6.2). In addition, the grant will support the integration of all HIV-related prevention, care and treatment services – including NGO services for KPs – in the CSHI system (Intervention 5.2).  **2) Programmatic sustainability challenges** – Programmatic sustainability and continuity of HIV prevention, care and treatment services are hampered by ***inadequate service models*** that fail to meet the needs of key populations (KPs) as well as PLHIV, resulting in ***poor uptake and coverage***. This is further exacerbated by the failure to generate appropriate demand for services. In addition, there are still important ***gaps with regard to key services***, especially for KPs. Specific challenges include stigma and discrimination affecting access to health services for PLHIV and KPs; suboptimal access to HIV prevention services for KPs, e.g. due to a lack of community-based rapid testing and HIV self-testing; poor availability and insufficient quality of condoms and lubricants in some Regions; non-availability of PrEP for high-risk KPs; lack of HIV prevention services tailored to the service needs of TG people; Poor availability and very low coverage of OST and OD treatment for PWID; lack of programmes for users of new psychoactive substances (NPS); inadequate peer support for ART adherence; as well as lack of free ART for undocumented migrants.  The challenges mentioned are partly due to continued problems with drug supply chain, forecasting, stock management, stock outs and other PSM-related problems.  ***Key actions to strengthen programmatic sustainability*** – As described in section 1.1, the grant will systematically address all these challenges by supporting the development and roll-out of ***innovative HIV testing and prevention services*** and differentiated service delivery for KPs (e.g. PrEP, community-based and self-testing; programmes for TG people and NPS drug users); advocacy and capacity building for OST and OD treatment programmes; ***strengthening innovative models for ART adherence*** (peer counsellors for KPs with HIV); and legal and medical support for undocumented foreign migrants. In addition, the grant will support the availability of high-quality condoms and lubricants for MSM, TG people and PWID in selected Regions, which will ensure continuity of HIV services to KPs. ***All these interventions will be gradually taken over by State funding***, with increasing contributions by government in year 2 and 3 of the grant, to ensure sustainability.  The funding request will not specifically support interventions to strengthen the systemic ***procurement***-related problems mentioned, as these are already being addressed in the context of the government’s e-health initiative, which includes a specific ***e-procurement component*** that started being rolled out since last year.  **3) Sustainability challenges related to Health and Community systems** – relate to community and health systems. As mentioned, government investments in the health system are expected to increase in the coming years. The introduction of the Compulsory Social Health Insurance (CSHI) system will strengthen people’s access to free health care. However, (self) stigma and discrimination in the health system limit access for PLHIV and KPs. Similarly, inadequate allocation of funds to HIV prevention services for KPs hamper their access to a range of services.  Challenges also exist in ***community systems***: despite existing collaboration between state institutions and NGOs in HIV service delivery and state funding for NGOs (see above), many civil society organisations have weak organisational capacity to access government funding. This is evidenced by poor linkages and partnerships with government institutions; unreliable funding and over-dependency on external donors; weak financial, human resource and M&E systems; and lack of strategic planning.  ***Key actions to strengthen systems-related sustainability*** – The grant will support *community systems* by: i) strengthening the institutional capacity of NGO service providers; ii) strengthening partnerships, referral linkages and coordination between NGOs and State institutions working in the HIV field. The grant will also help strengthen specific gaps in the *health system* that affect HIV service delivery. This includes: iii) digitalisation of information systems for HIV prevention services; iv) addressing HIV-related stigma and discrimination by health-care workers; as well as: iv) filling critical short-term gaps in laboratory systems for HIV and TB. |

1. If you have developed and implemented a transition workplan in the current allocation cycle, provide a status **update** as to what has been achieved.

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| A formal Transition Plan has not been developed yet, but in December 2019 an *“Assessment of the readiness of Kazakhstan for the transition to social contracting to ensure the sustainability of HIV-related services” (see “Assessment of Readiness of the Republic of Kazakhstan to Ensure the Sustainability of HIV-related Services with Funding from the State Budget)* was conducted. A Road map is being developed. Since 2018, a separate programme has been in place to achieve future sustainability of HIV services. The assessment found no structural barriers to an effective transition to national financing and sustainability of HIV services. |

# **Annex 1: Documents Checklist**

Use the list below to verify the completeness of your application package:

|  |  |
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|  | Funding Request Form |
|  | Programmatic Gap Table(s) |
|  | Funding Landscape Table(s) |
|  | Performance Framework |
|  | Budget |
|  | Prioritised above allocation request (PAAR) |
|  | Implementation Arrangement Map(s)[[16]](#footnote-17) |
|  | Essential Data Tables (updated) |
|  | CCM Endorsement of Funding Request |
|  | CCM Statement of Compliance |
|  | Supporting documentation to confirm meeting co-financing requirements for the current allocation period |
|  | Supporting documentation for co-financing commitments for the next allocation period |
|  | Transition Workplan (if available) |
|  | Transition Readiness Assessment (if available) *(Transition assessment focused on social contracting)* |
|  | National Strategic Plans (Health Sector and Disease specific) |
|  | All supporting documentation referenced in the funding request |
|  | Health Product Management Tool (if applicable) |
|  | List of Abbreviations and Annexes |

1. PAARs can only be submitted with the Funding Request. To complete a PAAR, fill-in the Excel template that you will receive from the Global Fund Secretariat. [↑](#footnote-ref-2)
2. This is only relevant for applicants with designated matching funds as indicated in the allocation letter. [↑](#footnote-ref-3)
3. openDemocracy (2019). “In Kazakhstan, Transgender People Face Discrimination”, https://www.opendemocracy.net/en/odr/kazakhstan-transgender-discrimination-ru-en/ [↑](#footnote-ref-4)
4. Roshchupkin, G. (2020). *Report on Meetings of Representatives of Key Communities in the Framework of the National Dialogue in the Republic of Kazakhstan.* Almaty. [↑](#footnote-ref-5)
5. Key documents included the Optima exercise, CDC Laboratory Assessment and APMG review. These and other key documents and reports consulted are attached as Annexes to this Funding Request. [↑](#footnote-ref-6)
6. [http://optimamodel.com/pubs/Kazakhstan\_2020.pdf](https://nam03.safelinks.protection.outlook.com/?url=http%3A%2F%2Foptimamodel.com%2Fpubs%2FKazakhstan_2020.pdf&data=02%7C01%7CCorina.Maxim%40theglobalfund.org%7C8f15f3e3b06443105b1e08d80d1083eb%7C7792090987824efbaaf144ac114d7c03%7C0%7C0%7C637273711880863475&sdata=6FzLo20Q1z2ZArL20OzpaDoY%2FssiYlh0gxexvPxs%2BKY%3D&reserved=0) [↑](#footnote-ref-7)
7. <https://goszakup.gov.kz/> is the Kazakhstan Government website for electronic State procurement. [↑](#footnote-ref-8)
8. Kalmyrzaev, B. (2020). *Optimization of HIV Laboratory Diagnostics in the Republic of Kazakhstan.* Almaty: US Centers for Diseases Control (CDC) in Central Asia. [↑](#footnote-ref-9)
9. https://egov.kz/cms/en/digital-kazakhstan [↑](#footnote-ref-10)
10. For details, refer to Attachment 4: “Prevention work among MSM in the Republic of Kazakhstan” [↑](#footnote-ref-11)
11. [http://optimamodel.com/pubs/Kazakhstan\_2020.pdf](https://nam03.safelinks.protection.outlook.com/?url=http%3A%2F%2Foptimamodel.com%2Fpubs%2FKazakhstan_2020.pdf&data=02%7C01%7CCorina.Maxim%40theglobalfund.org%7C8f15f3e3b06443105b1e08d80d1083eb%7C7792090987824efbaaf144ac114d7c03%7C0%7C0%7C637273711880863475&sdata=6FzLo20Q1z2ZArL20OzpaDoY%2FssiYlh0gxexvPxs%2BKY%3D&reserved=0) [↑](#footnote-ref-12)
12. An updated implementation arrangement map is mandatory if the programme is continuing with the same PR(s). In cases where the PR is changing, the implementation arrangement map may be submitted at the grant-making stage. [↑](#footnote-ref-13)
13. Note that information derived from the supporting documentation provided in response to the questions below, including information on funding landscape or domestic commitments, may be made publicly available by the Global Fund. [↑](#footnote-ref-14)
14. <https://goszakup.gov.kz/> is the Kazakhstan Government website for electronic State procurement. [↑](#footnote-ref-15)
15. https://egov.kz/cms/en/articles/health\_care/osms [↑](#footnote-ref-16)
16. An updated implementation arrangement map is mandatory if the programme is continuing with the same PR(s). In cases where the PR is changing, the implementation arrangement map may be submitted at the grant-making stage. [↑](#footnote-ref-17)