Ministry of Health
and Social Protection of Population
of the Republic of Tajikistan

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FINAL REPORT
ASSESSMENT OF THE STATUS OF THE EMTCT PROGRAM IN THE REPUBLIC OF TAJIKISTAN AND PREPARING PRE-VALIDATION REPORT

November 2025



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The report was prepared by an international consultant
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November 2025

Abbreviations:

ANC	Antenatal Care
ART	Antiretroviral Treatment
DBS	Dried Blood Spot Testing
DHS	Demographic and Health Surveys
EECA	Eastern Europe and Central Asia
EMTCT	Elimination of Mother-to-Child Transmission
EID	Early Infant Diagnosis
GVAC	Global Validation Advisory Committee
HBsAg	Anti-HBs Antigen
HBV	Hepatitis B Virus
HepBD	Hepatitis Vaccine Birth Dose
HepB3	Hepatitis Vaccine 3-Dose Regimen
HIV	Human Immunodeficiency Virus
MICS	Multiple Indicator Cluster Survey
MoHSPP	Ministry of Health and Social Protection of Population of the Rep. of Tajikistan
MTCT	Mother-to-Child Transmission
NAAT	Nucleic Acid Amplification Test
NRHC	National Reproductive Health Center
NGO	Non-Governmental Organization
NVP	Nevirapine
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-Child Transmission
RC AIDS	Republican Center for Prevention and Control of AIDS
RCMSI	Republican Center for Medical Statistics and Information
RCCSV	Republican Clinical Center for Skin and Venereal Diseases
RCIP	Republican Center for Immunoprophylaxis
STIs	Sexually Transmitted Infections
TLD	Tenofovir Disoproxil + Lamivudine + Dolutegravir
UNDP	United Nations Development Programme
UNHCR	UN Refugee Agency
UNFPA	United Nations Population Fund
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WR	Wassermann Reaction
ZDV	Zidovudine

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- Sharipov Furkat (Director of AIDS center, Vakhdat city).

Purpose of the report

- To provide an assessment of country readiness for the validation of the elimination of mother to child transmission of HIV, hepatitis B, and syphilis.
- To familiarize national stakeholders with the requirements of, and methodology for, providing the quality data necessary for the validation process and providing the necessary training.
- To support national stakeholders and partners in preparing an action plan along with timeframes.
- To support the country on the way towards improving HIV, hepatitis B, and syphilis care and prevention for pregnant women and women of reproductive age.

Area of assessment

- Effectiveness of current interventions aimed at preventing MTCT of HIV, hepatitis, and syphilis, including the provision of treatment/prophylaxis for the three diseases to pregnant women and newborns.
- Integration of antenatal services within the primary healthcare system and the identification of barriers to the elimination of MTCT for HIV, hepatitis, and syphilis.
- Analyses of data on HIV, hepatitis, and syphilis testing, treatment coverage, and

outcomes for pregnant women and children to determine the program's impact.

- Identification of gaps and challenges in the current programs (HIV, syphilis, and HBV) and propose evidence-based recommendations for improvement.
- Engagement of stakeholders, including healthcare providers, policymakers, and community organizations, to gather insights and ensure a comprehensive assessment.

Executive summary

Tajikistan is one of the poorest countries of Central Asian region, with a population of 10.5 million people of whom approximately 40 per cent are children. Since 1991, it has been affected by political instability, which has led to an acute shortage of resources, and, in 2003, the end of the free healthcare program. The largest source of health spending is, until now, the out-of-pocket payments from patients. To address underfunding, formalize payments, and strengthen public healthcare, co-payments or user fees were formally introduced along with a basic benefit package in 2014. Pregnant women who register in care are entitled to some services without additional payment, such as antenatal care visits and hospital delivery.

Under the current National Health Strategy, the government of Tajikistan is committed to achieving universal health insurance for the population by 2030. The first step is the primary healthcare system (PHC). Still, access to public healthcare remains inadequate and the budget allocation unclear. Deaths due to ischemic heart disease are more frequent in women than in men, suggesting inequality in accessing healthcare. Rates of neonatal death and congenital anomalies are very high. Preterm birth complications contribute to 16.2 per cent deaths.

Nevertheless, health indicators are systematically improving for Tajikistan with support from international partners, such as the UNDP, UNHCR, WHO and UNICEF, UN Women, UNFPA, GIZ, USAID and others. As reported by Demographic and Health Surveys (DHS) 2023, 81 per cent of women received antenatal care (83.5 per cent up to 12 weeks of pregnancy), 95 per cent of births occurred in a medical facility, and 98 per cent were delivered by a skilled birth attendant. The number of home deliveries decreased from 22 per cent (for DHS 2012) to 5 per cent (for DHS 2023). Substantial steps were taken to improve birth registry, thus including children in healthcare. The country also started a health digitalization process.

The number of people living with HIV registered by the end of 2024 was 12,480 (estimated 15,213); of these 36.8 per cent were women. There is 6 – 7 per cent annual increase in new HIV cases among women per year over the last ten year. Over the past five years, the proportion of children among all new cases of infection has ranged between 11.4 per cent and 14.0 per cent with number of confirmed MTCTs found in approximately half the cases.

In terms of HIV monitoring and care, strong leadership is provided by the Republican AIDS Center (RC AIDS) as delegated by the Ministry of Health and Social Protection of the Population of the Republic of Tajikistan. Laboratory services for HIV diagnostics remain under central oversight and include testing for pregnant women, early infant diagnosis, and HIV treatment monitoring. The RC AIDS Laboratory is a reference facility with adequate quality assurance measures.

Clinical protocols for HIV diagnosis, surveillance, and care are prepared by assigned working groups of experts and are based on WHO and other international recommendations. The most recent update was made in 2022. Over 90 per cent of HIV patients (11,268 until end of 2024) are on antiretroviral therapy (ART) with the vast majority on WHO recommended fixed dose combination (TLD). Most children receive pediatric formulations of dolutegravir. The Republic of Tajikistan purchased the first batch of TLD for 1,068 patients using state money through the UNDP system. Decentralization is also taking place in HIV care, with 2,310 patients already under local healthcare centers at the beginning of October 2025. This indicates long term planning in the provision of HIV care.

Since 2011 the country has a strategy for universal HIV screening for all pregnant women twice during pregnancy. The current testing scheme in Tajikistan focuses on early testing in pregnancy, which works well as long as women register early with the ANC (before 12 weeks). For women who are not registered, and, also, HIV negative women who have an HIV positive partner, this might not be an effective strategy. This can be approached best through partner testing, which is not promoted enough nor is it free of charge.

Tajikistan has adapted progressive WHO recommendations, utilizing rapid HIV tests also for the testing of pregnant women. The tests are procured centrally, but only for the second test during pregnancy, the first one being dependent on local government procurement. This jeopardizes the HIV testing system, as most diagnostic laboratories in Tajikistan, including hospital laboratories, remain under private ownership and provide only paid services to patients.

Therefore, the first and most important recommendation is to ensure free of charge testing for all HIV, syphilis, and Hepatitis B illnesses during pregnancy, in the form of combined test (all in one) procured and distributed centrally. This approach also supports women centered care, preventing testing services from becoming fragmented.

An external evaluation of the elimination of MTCT for HIV, hepatitis B, and syphilis has never been conducted in Tajikistan. However, in 2023, the WHO conducted a comprehensive evaluation of the HIV program, issuing a number of recommendations that also addressed the MTCT area. A patient-centered approach and the provision of integrated services were strongly recommended, indicating that the triple elimination of MTCT should be considered a priority for implementing service integration.

Analyzing data provided for individual HIV transmission cases (mother and child pairs) reveals that more than half the number of mothers were diagnosed and had started on ART, but were eventually lost to care. The remaining cases were either diagnosed during pregnancy or at delivery. Linkage to care and retention in care is strongly influenced by psychosocial factors, such as poverty, health illiteracy, and stigma. The need for integrating social services access and peer-to-peer support with AIDS centers, along with specialized psychological care, was identified as a potential long-term solution through recent Community Led Monitoring surveys supported by the country UNAIDS office.

Hepatitis B and syphilis testing during pregnancy is exclusively performed as an out-of-pocket (OOP) cost. This undermines the reliability of centrally collected data, as well as surveillance and monitoring abilities. Strong leadership with a clear delegation of responsibilities is necessary to provide an adequate preventive strategy and enable country assessment. This is a burning issue, especially in terms of hepatitis B, as each year over 1,000 HBsAg (+) pregnant women give birth in Tajikistan. Even such fragmentary data justifies the urgent need to introduce measures to prevent both the vertical and horizontal transmission of HBV in delivery rooms and maternity wards.

Part of current assessment was devoted to calculating process and impact indicators for the country (2021, 2022, 2023, 2024), with substantial time spent together with RC AIDS staff on the analyses of the HIV database. While HIV MTCT rates and ART coverage in HIV-positive pregnant women remain close to validation targets, the HIV testing coverage of pregnant women is still not sufficient to pass the >95 per cent cut-off. Hepatitis B and syphilis related indicators cannot be yet evaluated due to the lack of reliable and reproducible data. Uncertainty about the number of pregnant women who had at least one ANC visit and were assisted by a trained healthcare provider is the most important scarcity. This number is a

denominator for being able to calculate testing rates during pregnancy, it is thus crucial for any possible assessment. The process of introducing e-health and the digitalization of pregnancy registry, along with providing a central registration number for each citizen on identification document using photography, is likely to impact this shortage. This requires further commitment from the government and support from international organizations, such as the UNDP, UNHCR, and UNFPA.

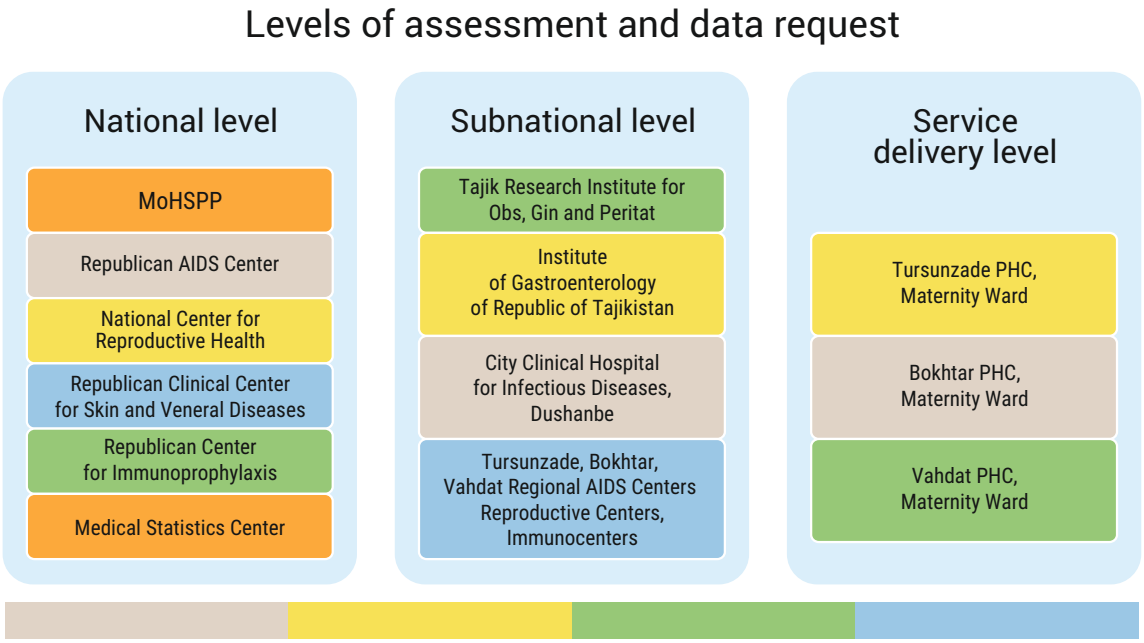
Although Tajikistan has never requested an evaluation from the Global Validation Advisory Committee (GVAC), there is a common understanding that this step is necessary, thus there is the political will to begin preparing for this process. This will require an analysis of how written protocols translate into clinical practice to define a plan of action and establish performance indicators that allow progress to be assessed in a structured manner. This needs to start with setting channels of communication and data exchange processes, both inter-sectoral, within governmental structures, and between institutions.

Methods of assessment

The assessment was performed in line with the Guidance on Criteria and Processes for Validation Elimination of Mother-To-Child Transmission of HIV, Syphilis and Hepatitis B Virus 2021, World Health Organization document (14). To ensure that the report includes all the relevant information necessary to prepare the country for applying for EMTCT validation, documents listed on the WHO website (Global Guidance on Criteria and Processes for Validation Elimination of Mother-to-Child Transmission of HIV, Syphilis and Hepatitis B Virus) were used as templates.

- Impact and process indicators were calculated according to the definitions and methodology indicated in Web Annex A and using data provided by the national monitoring and evaluation system (**Table 17, Appendix 3**). For each available parameter, detailed data on the source of this information was requested. For the qualitative assessment, individual cases of MTCT were reviewed and analyzed according to **Web Annex I**.
- Laboratory assessment was performed in both a qualitative and quantitative manner, and was done according to the template provided in **Web Annex E**. This should ideally include the types of tests used for HIV, syphilis and hepatitis B virus (HBV); the schedule for maternal testing during antenatal care (ANC) (and postpartum, if relevant); and infant testing after delivery. The external quality assurance (EQA) program and any additional in-country proficiency testing or lab quality assurance that is done, including for point-of-care (POC) rapid testing, was investigated.
- Human rights, gender equity, and community engagement assessment have been performed according to guidance provided by **Web Annex H**. The relevant legal acts, orders and recommendations were reviewed and provided as an appendix.

Figure 1. *Levels of assessment and data requests*



Validation at the **national level** was performed through e-mail communication, and on-line and in-person meetings with representatives of the Ministry of Health and Social Protection of Population (MoHSPP), the Republican AIDS Center (RC AIDS) and any other national authorities responsible for the monitoring, data aggregation, prevention, and setting of clinical management protocols for HIV, hepatitis, and sexually transmitted infections (STIs). All initial communication was facilitated by the UNICEF Country Office and later by an international expert on a pro-active coordinated basis in collaboration with RC AIDS.

Validation at the **sub-national level** included in-person meetings with medical specialists, laboratory personnel, and administration representatives of regional HIV/AIDS treatment centers, and other relevant services, such as dermato-venerology clinics, and antenatal in- and out-patient regional centers, which provide care at the regional level.

Validation at the **service delivery level** included personal visits to centers at the municipal level that provided services for the general population, women, and people living with HIV. In addition, meetings with personnel at medical centers, which represent a decentralized approach to service delivery, dermato-venerology clinics, local social care services, and voluntary counseling and testing facilities, were planned. Both on-line and on-site meetings were performed with major NGOs representing people living with HIV.

In-country visit

An in-country visit took place 14–21 September 2025 (in the **Appendix 4**, a detailed plan provides the specifics).

During the visit, four meetings with a “hands on” database were performed. Approximately 25 services in four cities were visited during 10 days: Dushanbe (10 centers), Tursunzoda (5

centers), Bokhtar (4 centers), and Vahdat (6 centers). In addition, face-to-face meetings were carried out with UNICEF Country Office members and UNAIDS representatives.

Community involvement

A face-to-face meeting with in-depth interviews was held with the representative of four NGOs serving statutory work for people living with HIV:

- Tajik Network of Women Living with HIV
- SPIN Plus
- Activist and peer consultant (Gulova Farishtamokh and Komilova Amina)

The above-mentioned organizations are providing statutory service for people living with HIV. To make interviews inclusive and comfortable for participants, the meeting was held at RC AIDS on Saturday to provide enough time flexibility for participants. The atmosphere was encouraging and the feedback was honest (the expressed opinions were anonymous).

One meeting at the Methadone Clinic and NGO, which provided support for people living with drug dependency, was held in Vahdat.

The consultant participated in a meeting presenting the final results of the project "Improving Health Services through Community-Led Monitoring (CLM)," carried out by the local NGO Tajik Network of Women Living with HIV with UNAIDS support. The meeting was attended by the representatives of key stakeholders, including MoHSPP.

Supervision, collaboration, and participation

Throughout the whole evaluation period, the consultant worked under the direct oversight of the Chief of Health & Nutrition Section and the Health Specialist from the UNICEF Country Office. The consultant worked closely with the national task force group, RC AIDS, and MoHSPP.

Two meetings with Working Group members were held; one after sharing the Inception Report but before the in-country visit, and one on the last day of the in-country visit, in order to present preliminary findings and to discuss them before finalizing the report.

Throughout the whole period of assessment, regular communication, aimed at delivering feedback and allowing discussion on assessment milestones and deliverables, was provided through WhatsApp calls, e-mail, on-line meetings, and chat.

Close collaboration included the following stakeholders:

- UNICEF Office in Tajikistan, Health and Nutrition section.
- Ministry of Health and Social Protection of Population of the Republic of Tajikistan (MoHSPP).
- Republican AIDS Center.

- MoHSPP's Maternal and Child Health department.
- National Reproductive Health Center.
- Reference Laboratory of Republican AIDS center.
- Relevant national institutes and clinical centers (e.g., dermato-venerology, immuno-prophylaxis, family medicine, obstetrics).
- NGOs and patient representatives.
- Relevant data administration institutions, where appropriate.

All necessary approvals and permissions were obtained by UNICEF staff members and from the relevant national authorities. Translations were available throughout the in-country visit, including for larger on-line meetings. Assessment was conducted in accordance with the United Nations Evaluation Group (UNEG) Ethical Guidelines, in such a way that considered local beliefs, manners, and customs. All participating people were informed about the context and purpose of the assessment, as well as about the confidentiality of the information being shared.

Documents and information provided during this process were used only for tasks related to the current assessment and are listed in **Appendix 4**.

Introduction

The Central Asia region encompasses five countries: Kazakhstan, Kyrgyzstan, Turkmenistan, Uzbekistan, and Tajikistan. Tajikistan is a presidential republic and has borders with Kyrgyzstan, Uzbekistan, Afghanistan, and China. More than 90 per cent of its land is mountains. Tajikistan consists of four provinces: the Sughd region, with the regional center in Khujand (1); Districts under Republic Subordination, with the center in Dushanbe (2); the Khatlon region, with the regional center in Bokhtar (3); and the Gorno-Badakhshan Autonomous Oblast (region), with the regional center in Khorog (4); as well as Dushanbe as the capital of Tajikistan (**Figure 2**). There are 67 administrative units in the country. Tajikistan was significantly affected by the collapse of the Soviet Union, which was followed by civil war. Since 1994 the country has been ruled by the President of Tajikistan, Emomali Rahmon.

Tajikistan has a population of approximately 10.5 million people (Agency on Statistics under the President of the Republic of Tajikistan), of whom approximately 40 per cent are children (World Bank data). Some 30 per cent of young people aged 15–24 are not in education, training, or employment, and this applies to 89 per cent of girls. Moreover, 40 per cent of Tajiks who seek work outside the country are younger than 30. Households whose members have migrated are subject to multiple deprivations: 78 per cent do not have adequate income to cover the cost of living and 93 per cent experience pronounced food deficiencies (EU and UNICEF and Save the Children. 2018. Protecting Children Affected by Migration in Southeast, South and Central Asia: Baseline Assessment).

Figure 2. *Geopolitical characteristics of the Republic of Tajikistan*



Tajikistan has a population of approximately 10.5 million people (Agency on Statistics under the President of the Republic of Tajikistan), of whom approximately 40 per cent are

children (World Bank data). Some 30 per cent of young people aged 15–24 are not in education, training, or employment, and this applies to 89 per cent of girls. Moreover, 40 per cent of Tajiks who seek work outside the country are younger than 30. Households whose members have migrated are subject to multiple deprivations: 78 per cent do not have adequate income to cover the cost of living and 93 per cent experience pronounced food deficiencies (EU and UNICEF and Save the Children. 2018. Protecting Children Affected by Migration in Southeast, South and Central Asia: Baseline Assessment).

Tajikistan's GDP growth was 7.2 per cent in 2019, similar to growth rates for the previous two years. The country's risk of debt distress is high given the elevated levels of publicly guaranteed debt: 53 per cent of GDP in 2018. Due to a limited state budget, increased resource allocation for social sector needs is unlikely in the short to medium term. Thus, labor migrant remittances remain a vital economic lifeline, representing approximately 30 per cent of GDP (Tajstat, UNICEF, World Bank. 2018. Child Poverty in Tajikistan. Available at http://stat.ww.tj/pages/Child_Poverty_Tajikistan_ f inal.pdf)

Health care

After the collapse of Soviet Union in 1991, many doctors left the country (1). In addition, the country had to start importing most of its essential medical supplies. This led to acute shortages and, in 2003, to the end of the free healthcare program. A basic benefit package (BBP) was introduced in 2014. To address underfunding, formalize payments and strengthen public healthcare, co-payments or user fees were introduced. The currently available benefits package in Tajikistan is regulated by the Healthcare Code of the Republic of Tajikistan, adopted by the Resolution of the Ministry of Health of the Republic of Tajikistan dated March 15, 2017, No. 712 and May 18, 2017, No. 374. This Code regulates public relations in the field of healthcare and is aimed at realizing the constitutional rights of citizens and protecting health. It includes free family doctor consultations, antenatal care, and health services for children under 1 year of age and children under 5 years with acute respiratory infection or diarrheal disease. According to a recent WHO report on primary healthcare financing, the most significant gaps in the current system are the narrow range of free-of-charge health services and the absence of basic laboratory services in the package (2). People with AIDS and tuberculosis are exempted from payment services, but for treatment of the main disease only.

Pregnant women who are registered and attend regular check-ups are entitled to some laboratory tests and services without additional payment. According to official documents, pregnant women who attend antenatal services are eligible to receive free of charge hospital delivery.

Under the current National Health Strategy, the government of Tajikistan is committed to achieving universal health insurance for the population by 2030. The first step is the primary healthcare system. The largest source of health spending in Tajikistan is out-of-pocket payments (OOP) from patients, especially for specialized care services and medications. Access to public healthcare care remains inadequate, and budget allocation in Tajikistan is based more on the number of patients served rather than performance indicators. This is particularly important in the case of infectious disease treatment programs, where the health status of individuals and the containment of epidemics are influenced not only by the number of people undergoing treatment, but also by its effectiveness and retention in care. Tajikistan has also more limited manpower in comparison to other Central Asian Republics. In 2021,

there were only 213 medical doctors per 100,000 population (the average for Central Asian Republics was 265 per 100,000) and 475 nurses per 100,000 (the average for Central Asian Republics was 488 nurses per 100,000 population) (3).

The structure of public health financing is also of concern. In 2019, the share of inpatient care represented 44.3 per cent of health spending, while for outpatient care it was as little as 25.2 per cent. Only 2.1 per cent of health spending was allocated for prevention. Per capita healthcare spending is uneven across districts. In poorer districts, per capita spending is lower. This creates substantial inequalities in access to healthcare. Out-of-pocket payments have declined slightly but remain high, amounting to 63.5 per cent of health spending in 2021 (3).

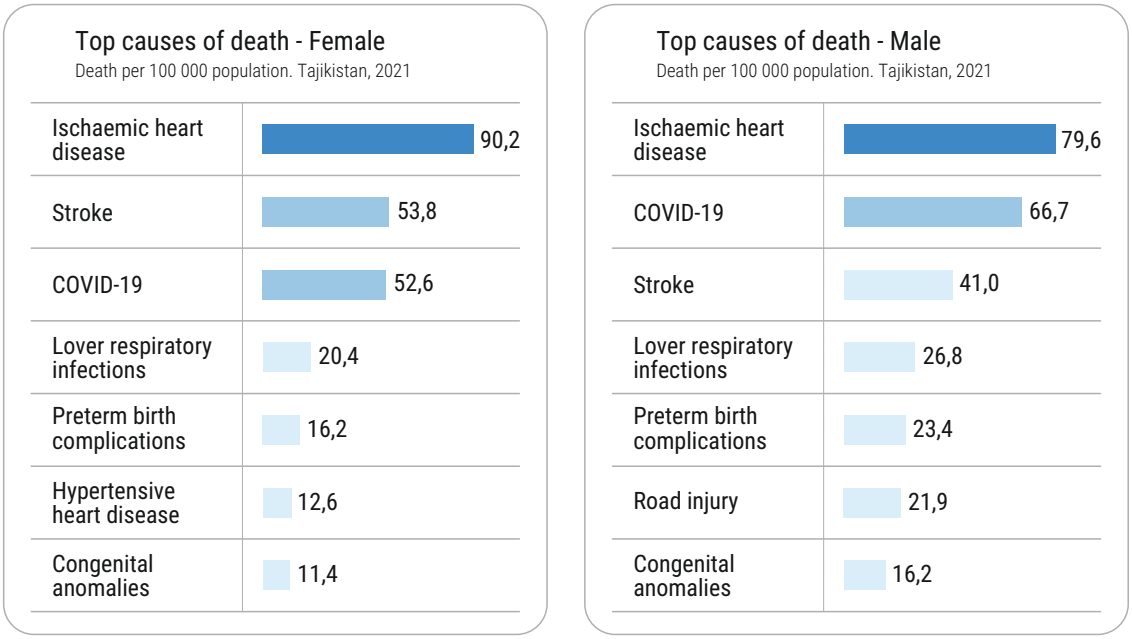
The reasons for the continued imbalance between inpatient and outpatient care, despite limited public resources and a relatively young population, originates from the oversized hospital sector. At the same time hospital resources are underutilized, with lower bed occupancy in district hospitals than in central hospitals. For example, the City Clinical Hospital of Infectious Diseases in Dushanbe has a department for HIV with a capacity of 20 beds. At the same time, patients need to cover the cost of most medical tests, radiological diagnostics, treatment, and food. As a result, there are around five hospitalizations, and two doctors appointed to cover the work per month. Hospitalizations are longer than in other countries, and often unnecessary. At the same time many hospitalizations are related to the preventable complications of diabetes and heart diseases, as well as maternal and child health complications (3). The top cause of death is noncommunicable diseases, with a predominance of ischemic heart disease for both genders, yet with much higher prevalence among women. Since male sex remains a strong risk factor for cardio-vascular disease, it can be assumed that women's access to care is jeopardized. The second most frequent cause of death is communicable, maternal, perinatal, and nutrition conditions. Preterm birth complications contribute to 16.2 per cent of deaths among females and 23.4 per cent of death among males (4). The leading cause of death is cardiovascular diseases, which reflects low levels of knowledge about health risks (diet, smoking, no exercise), low prophylaxis (statin use, screening for hypertension and diabetes), and poor access to diagnostics and medical interventions (**Table 1, Figure 3**).

Table 1. *Data on the causes of death, provided by Republican Center for Medical Statistics and Information.*

	2021		2022		2023		2024	
Causes of death	absolute count	per 100,000	absolute count	per 100,000	absolute count	per 100,000	absolute count	per 100,000
Total	39,112	399.0	31,206	312.6	32,397	318.1	33,777	324.8
Circulatory system diseases	19,062	194.5	14,259	142.8	15,026	147.6	16,108	154.9
Neoplasms	2,927	29.9	2,738	27.4	2,926	28.7	2,999	28.8
Respiratory diseases	3,614	36.9	1,752	17.6	1,940	19.1	2,241	21.5
Digestive diseases	1,400	14.3	1,094	11.0	1,192	11.7	1,290	12.4
Accidents, poisonings, and injuries	1,151	11.7	1,194	12.0	1,060	10.4	1,116	10.7
Infectious and parasitic diseases	237	2.4	185	1.9	254	2.5	313	3.0

Deaths due to ischemic heart disease are more frequent for women than men, possibly indicating inequality in access to healthcare. A worrying fact is that preterm death and congenital anomalies are very high.

Figure 3. *Top causes of deaths stratified by gender for any age group (source: https://data.who.int/countries/762)*



The country is advancing in its process of health digitalization, with leadership from the Republican Center for Medical Statistics and Information (RCMSI).

Nevertheless, health indicators are systematically improving for the Republic of Tajikistan. The country's population as of 2023 was 10,389,799 with a projected increase of 50 per cent to 15,574,642 by 2050 (4). Life expectancy at birth has improved by 6.17 years from 65.6 [65–66.2] years in 2000 to 71.8 [71.2–72.5] years in 2021. In 2023, it was on average 71.8 years at birth (73.5 years for female and 70.2 years for male). Tajikistan's fertility rate, as reported in 2022 by the World Bank, was 3.14 births per woman, compared to 3.31 in Uzbekistan, 2.8 in Kyrgyzstan, 2.62 in Turkmenistan, and world's average rate of 2.27 (5). Pregnant women, mothers, and children receive care in city and district health centers, reproductive health centers, HIV centers, rural health centers, health clinics, maternity schools, family medicine centers, and maternity hospitals.

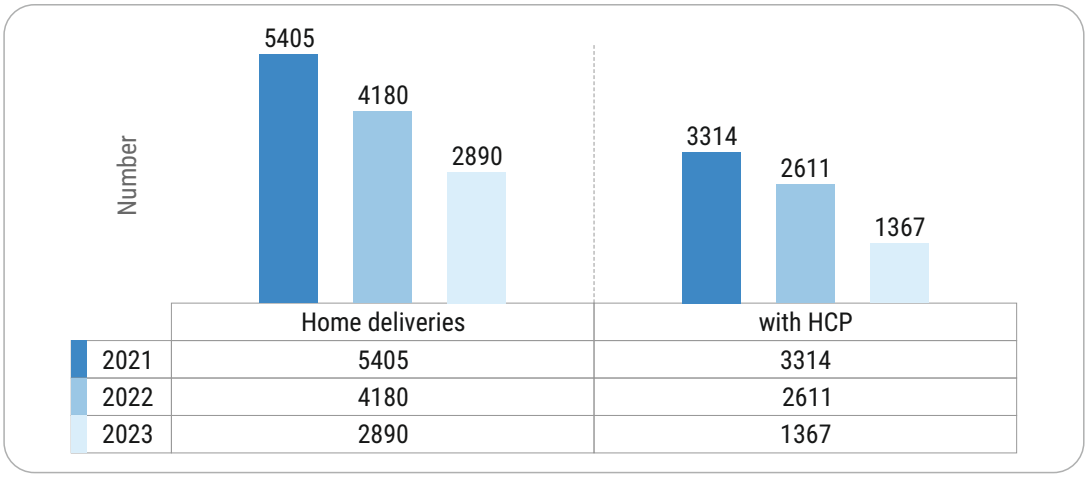
Antenatal care

Antenatal care (ANC) by a skilled professional is essential for monitoring pregnancy and reducing the risks of morbidity and mortality for mothers and babies during pregnancy, childbirth, and the postpartum period. In high resource countries, most pregnancies are followed by a skilled professional, and births occur in hospitals assisted by professional healthcare providers. In Tajikistan, barriers such as geographical restraints and poverty, as well as a shortage of medical staff and frequency of multi-child families, result in births occurring

outside healthcare facilities and frequently without the assistance of trained health care providers.

As depicted by the Demographic and Health Survey of Tajikistan (2023), in 2023, 62 per cent of women made four or more ANC visits during pregnancy and 75 per cent took iron supplements. In 2023, only 81 per cent of women received antenatal care from a skilled provider during for their last live birth, in the two years preceding the survey. This improved to 95 per cent of births occurring in medical facilities and 98 per cent delivered by a skilled birth attendant, in the two years preceding the last assessment in 2023. The number of home deliveries, and number of those assisted by health care providers are presented in **Figure 4**. As reported by Demographic and Health Surveys (DHS), it has decreased from 22 per cent (DHS 2012) to 5 per cent (DHS 2023).

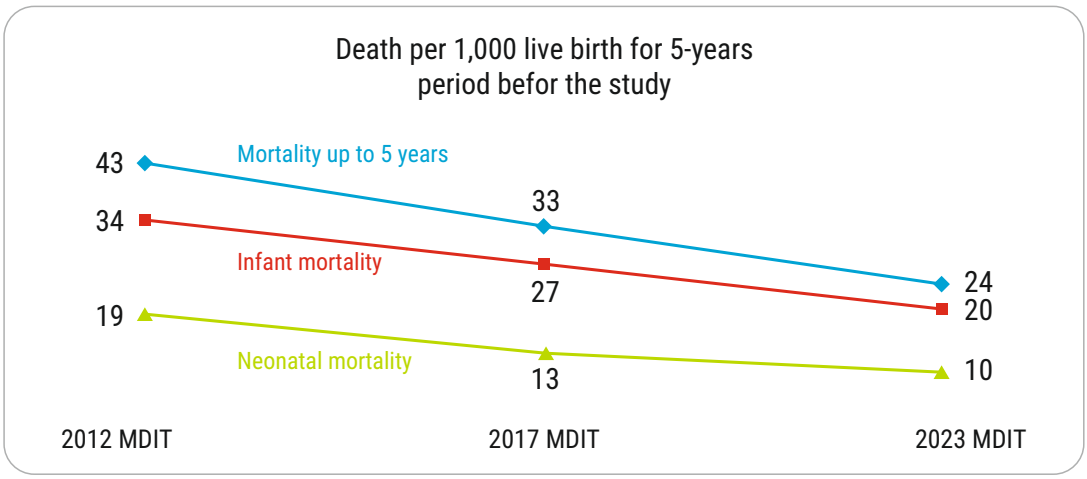
Figure 4. *Number of home deliveries and number of those assisted by health care providers (HCP) (Source: Republican Center for Medical Statistics and Information)*



	Home deliveries	with HCP
2021	5405	3314
2022	4180	2611
2023	2890	1367

As reported by the Demographic and Health Survey of Tajikistan (2023), mortality rates among infants are continuously declining (**Figure 5**).

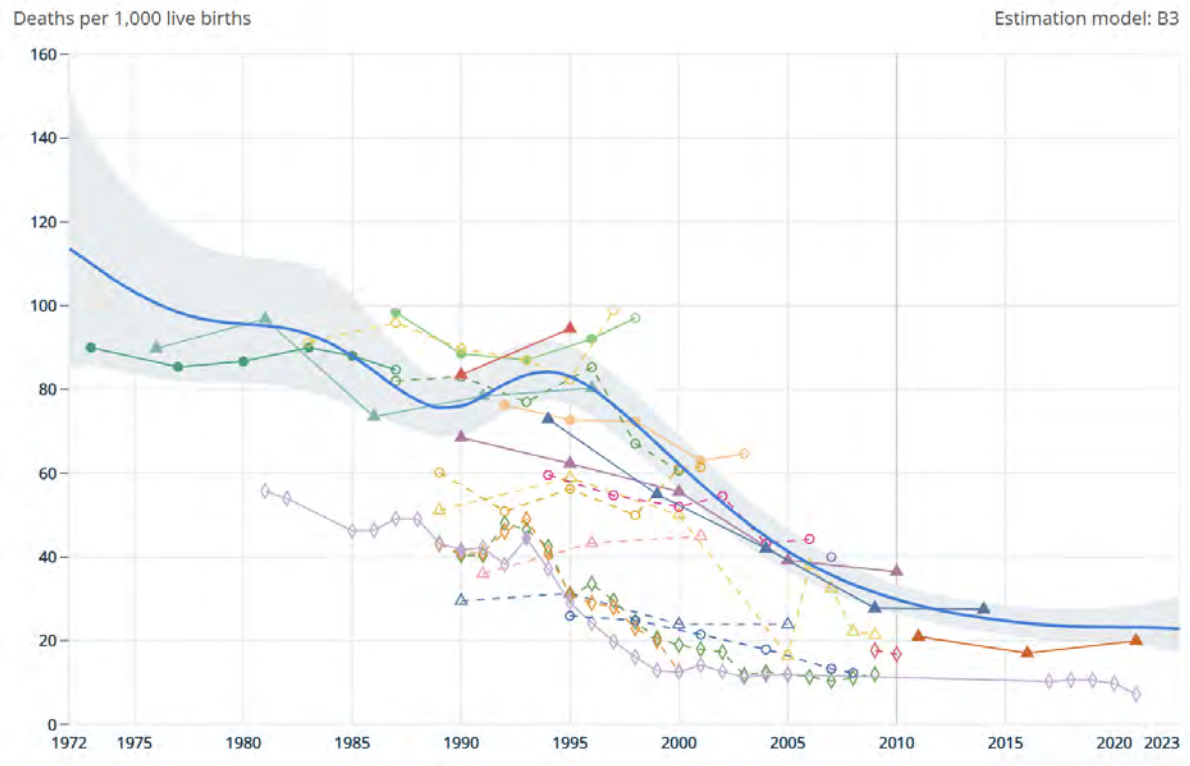
Figure 5. *Trends in infant mortality rates*



Demographic and Health Survey of Tajikistan, Key Performance Indicator Report 2023. Agency on Statistics under the President of the Republic of Tajikistan

However, while looking at the UN Inter-agency Group for Child Mortality Estimation's (https://childmortality.org) reports over the longer perspective, it is notable that the drop in the rate of infant deaths has slowed down substantially (**Figure 6**).

Figure 6. *Infant mortality rate in the Republic of Tajikistan by IGME (https://childmortality.org)*



As highlighted by recent commentary, 42 per cent of all neonatal deaths in the Eastern Europe and Central Asia (EECA) in 2022 occurred in just four countries: Turkey, Turkmenistan, Uzbekistan, and Tajikistan. Over half of deaths of under-five year-olds occurred during the neonatal period (Hucko A et al. Public Health Practice 2025;100668). This shows an area that still needs improvement and necessitates urgent action to strengthen maternal, neonatal, and child health services.

Pregnancy and birth registry

One of the most important parameters in relation to the assessment of antenatal care is the number of live births in a given year. The usual source for such information is the birth registry, but this can be only considered a reliable source if births are registered in a timely manner and completely.

Until recently the legislation allowed for free of charge child registration and birth certificate issuing only until the child was 3 months old. From 3 to 6 months this process was no longer free of charge, and above 6 months there was an additional fine to be paid. Furthermore, there were a number of bureaucratic barriers to timely birth registration that disproportionately affected mobile and migrant populations. For example, a marriage

certificate was needed to register a child. In the absence of such a document the mother could register a child only as a single parent, thus inflicting shame. Those without passports were also unable to complete the procedure.

However, during recent years, the Ministry of Justice, with help from international agencies - such as the UNDP, UNHCR, WHO and UNICEF, UN Women, and UNFPA - have begun a reform, which includes both reshaping the system and changing the legislation. Issuing birth certificates and birth registration were made free of charge from 1st January 2025: the new law adopted by the Resolution of the Majlisi Oli of the Republic of Tajikistan on 12 December 2024, No. 1505 and approved by the Resolution of the Government of the Republic of Tajikistan on 27 December 2024, No. 563. In addition, the process of registration was made significantly easier. For example, a statement from a midwife or any other person assisting the birth is sufficient to prove parenthood and enough to process birth registration.

UNDP supported the process of the digitalization of civil registry using computer equipment, technical software, and procedural structurization, starting from 2015 onward. It estimated that around 75 per cent of archived records were entered into the central computer registry.

From 2021, ten maternity wards have access to digital birth registration and can provide this process in real-time.

Up until now there has been no unique personal identifier in Tajikistan, and tax number is displayed on ID. The system was overseen by the Tax Committee with no other organization having access to this registry. As a result, this database could not be linked to any other databases to ensure the completeness of the civil registry. The remaining problem is undocumented citizens, who have no documents at all, those using Soviet passports, the Roma population, and undocumented refugees.

Table 2. *Number of pregnant women per year along with ANC follow-up*

	2021	2022	2023	2024
Data according to National Center for Reproductive Health				
Number of pregnant women who had at least one visit during their pregnancy by a health professional for reasons relating to the pregnancy	241,783	242,469	257,858	262,169
Number of pregnant women who had at least four visits during their pregnancy by a health professional for reasons relating to the pregnancy	131,138	135,887	143,881	153,108
Data according to Republican Center for Medical Statistics and Information (Form No. 32)				
Number of pregnant women per year (registered last year and still pregnant + newly registered pregnant women in the current year)	362,772	369,294	379,808	393,980
Number of pregnant women each year who received at least one antenatal visit (any)	181,588	186,264	190,863	210,208
Number of births in a medical institution (any type of institution)	230,190	254,050	264,151	208,258
Number of women who have had a live birth or a stillbirth in the given year	236,423	236,993	237,854	255,440

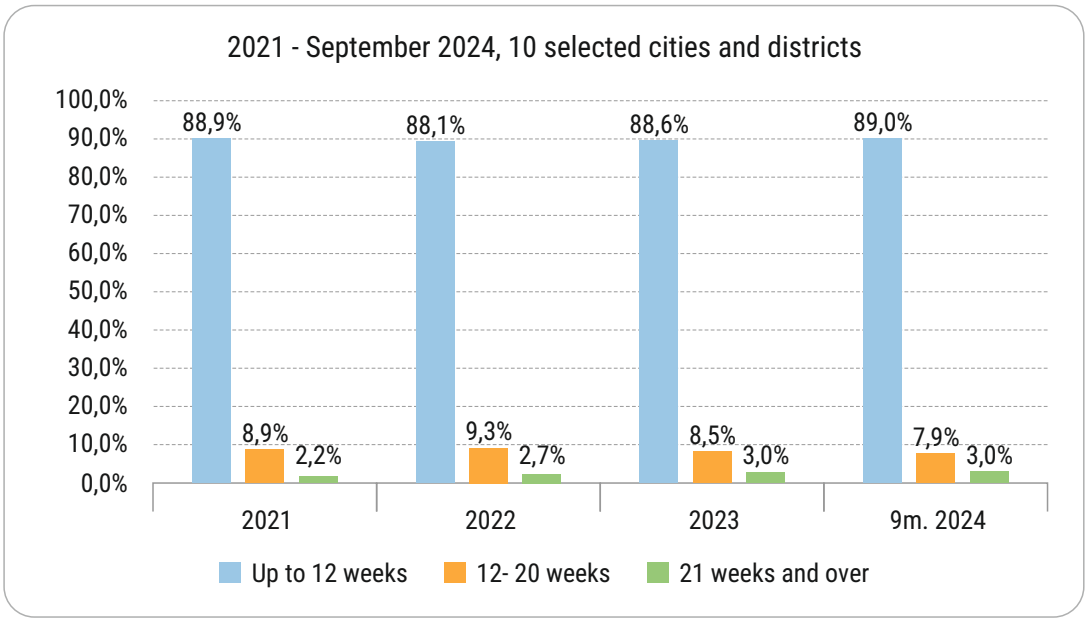
The pregnancy registry is subject to a large number of errors. In addition, the definitions used to provide numbers of pregnancies per year differ from institution to institution (**Table 2**). There is no adequate surrogate marker for the number of pregnancies, however, backward analyses of the birth registry should provide some insight into the number of women who were not in antenatal care during their whole pregnancy. Home deliveries, due to large proportion of women with many pregnancies, can also occur among women in ANC and cannot be assumed directly to be pregnancies that have not been followed by health care professionals.

According to the *Report on the Results of the Assessment of the Implementation of Measures to Prevent Mother-to-Child Transmission of HIV in the Republic of Tajikistan*, prepared by Soliev A.A. (Deputy Director, RC AIDS), Yokubov I.R. (Head of the Monitoring and Evaluation Department, RC AIDS), and Vatanova S. D. (Gynecologist of the Dispensary Supervision Department, RC AIDS), for the years 2021–2024, nationwide, 11 per cent of pregnant women were not registered for antenatal care on time, which is approximately 28,000–31,000 (**Figure 7**).

The registration of pregnant women for antenatal care services in selected cities and districts was 89 per cent in the first stage (up to 12 weeks), 8 per cent in the second stage (12–20 weeks) and 3 per cent in the late stage (>21 weeks). More than 11 per cent of pregnant women (more than 19,467 pregnant women annually across 11 cities and districts over the past four years) have been registered for antenatal care in over 12 weeks of pregnancy across all cities and districts.

According to DHS 2023, the coverage of pregnant women for antenatal care up to 12 weeks of pregnancy was 83.5 per cent in 2023.

Figure 7. *Coverage of pregnant women for antenatal registration in 10 selected cities (source: Report of RC AIDS)*



In 2021, UNICEF commissioned the development of the "e-Perinatal Referral System" in Tajikistan to track referral data for maternal and newborn health services during the perinatal period (https://www.unicef.org/eca/documents/life-saving-investment-health-information-

systems). The system is a tracking and referral management tool that captures and monitors referral data in real-time. It not only allows for timely registration but ensures that high-risk cases are identified promptly and referred to appropriate healthcare facilities. The design is adapted to areas that have unstable internet connectivity, allowing both online and offline functionality. A pilot program was started in most remote areas and served as proof of concept.

Status of current normative documents, internal evaluations, and guidelines

Until the end of 2025, the act, the *National Program to Combat the HIV/AIDS Epidemic in the Republic of Tajikistan for the Period 2021–2025 (Resolution of the Government of the Republic of Tajikistan dated February 27, 2021, No. 50)* remains in force. However, the *National Program to Combat the HIV Epidemic Human and Parenteral Viral Hepatitis in the Republic of Tajikistan for the Period 2026–2030* has been submitted and is currently under consideration by the Government of the Republic of Tajikistan.

The following clinical protocols are currently in use in Tajikistan:

- Guidelines for Treatment and Care of HIV Infection (Adults and Adolescents), Dushanbe 2023.
- Management of Laboratory Diagnostics of HIV Infection in the Republic of Tajikistan, 2023.
- Clinical Protocol to Strengthen Measures to Prevent Mother-to-Child Transmission of HIV in the Republic of Tajikistan, 2023.
- Clinical Guidelines for the Diagnosis and Treatment of Viral and Non-Viral Liver Diseases, 2020.
- National Immunoprophylaxis Program in the Republic of Tajikistan for 2021–2025.
- Guidelines for the Use of Electronic HIV Case Monitoring, 2011.
- Clinical Protocol for the Treatment of Viral and Non-viral Hepatitis, 2020.

Furthermore, in 2023, the World Health Organization (WHO) conducted a comprehensive mid-term evaluation of the HIV program, issuing a number of recommendations. A patient-centered approach and the provision of integrated services were strongly recommended, indicating that the triple elimination of MTCT should be considered a priority for implementing service integration. Therefore, adaptation should address changes in the area of care for pregnant women.

An internal evaluation of the provision of services aimed at eliminating MTCT of HIV infection was conducted in the 2021 *Assessment of Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health in the Context of Universal Health Coverage in Tajikistan, 23 June 2021*. This evaluation reviewed the utilization of funds, patients engagement into care, and supply procurement in 11 selected cities and districts (7). Registration for antenatal care in pregnancy was very good, however, as many as 11 per cent were registered in the third trimester. This contributes to approximately 28,000–31,000 women who have not received HIV testing in early pregnancy.

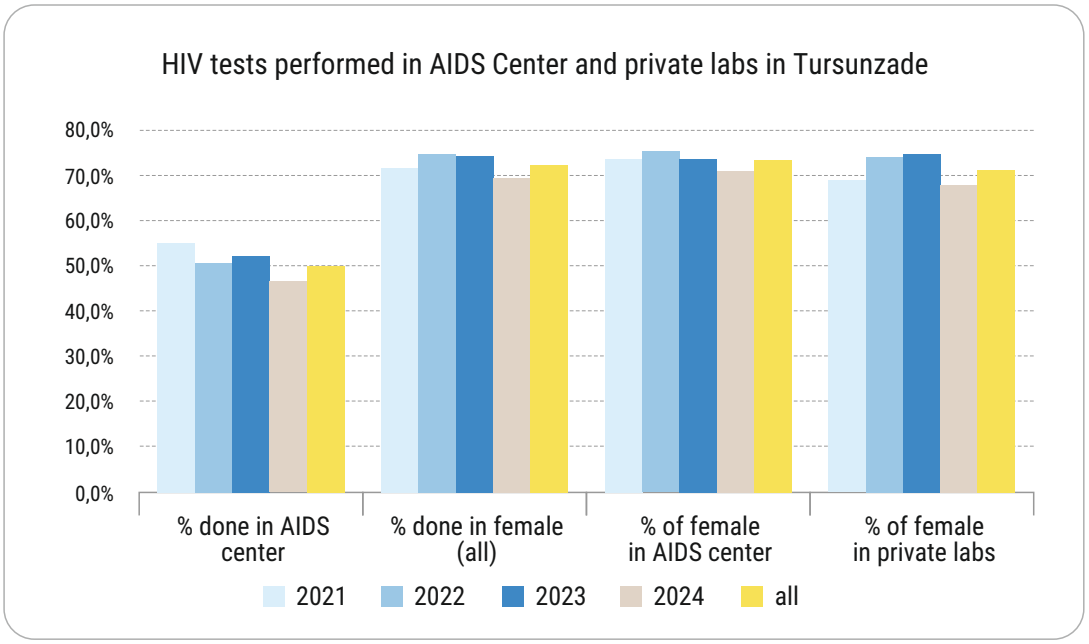
In selected cities and districts, local funds allocated to the purchase of diagnostics for pregnant women, including HIV tests, covered only 52.6 per cent of actual needs. Of the 11 cities and districts, only three fully met the demand for diagnostic materials, and in four cities, no funds were allocated for the purchase of tests at all. In the remaining four cities, the per centage of allocated funds ranged from 11 per cent to 53 per cent (7).

An external evaluation of the triple elimination MTCT for HIV, hepatitis B, and syphilis has never been conducted in Tajikistan. The country has never requested an evaluation from the GVAC, but there is the common understanding that this step is necessary, thus there is the political will to begin preparing for this process. This would require analyzing how written protocols translate into clinical practice to define a plan of action and establish performance indicators that allow progress to be assessed in a structured manner. The Ministry of Health and Social Protection of the Population has already assigned a Working Group (Appendix 1) and the UNICEF Country Office has provided support for international consultancy in order to provide technical assistance and support to the Ministry of Health and Social Protection of the Population of the Republic of Tajikistan in assessing the status of the EMTCT program and preparing a pre-validation report.

Laboratory assessment

Most diagnostic laboratories in Tajikistan, including hospital laboratories, remain in private ownership and provide only paid services to patients. This includes screening and confirmatory testing for HCV, HBV, HIV, and syphilis, including for pregnant women. The infection control and quality control of these services are not supervised. Most patients are referred by healthcare professionals, even from free of charge services, such as the PHC and ANC.

Figure 8. *Proportion of HIV tests performed in AIDS center and out of pocket in private labs (data provided by Regional AIDS Center in Tursunzoda, 2021-2024)*



Private laboratories remain the most likely centers to diagnose hepatitis and syphilis in the country. The patients need to cover tests OOP and also the cost of confirmatory diagnosis, even among key populations. As a result, there are over 400 HIV testing points, but the quality is very diverse and uncertain in many facilities. In addition, epidemiological surveillance and infection control are jeopardized. The example could be the report from Tursunzoda, where approximately half of all HIV rapid tests in 2021-2024 were performed in private laboratories (**Figure 8**). Of all tests performed in the region over 70 per cent were in women, with the trend being the same for private and public laboratories.

Laboratory services for HIV diagnostics in Tajikistan (**Table 3**) remain under central oversight and include testing of pregnant women, early infant diagnosis, and HIV treatment monitoring. The Republican AIDS Center Laboratory remains the reference facility, with modern equipment and proper measures of quality assurance.

The document *Management of Laboratory Diagnostics of HIV Infection in the Republic of Tajikistan, 2022* regulates the quality assurance processes. Section 11 lists the following indicators for the quality assessment of HIV infection diagnostics to be performed in the RC AIDS laboratory:

- Percentage of rejected blood samples (frequency: yearly; target indicator: <2 per cent);
- Percentage of positive HIV results confirmed in the third test from the first positive test (frequency: yearly; target indicator: >=98 per cent);
- Percentage of laboratories achieving error-free testing results in the HIV EQA program (frequency: yearly; target indicator: 100 per cent);
- Invalid results for each of T1, T2, T3 and the proportion of discordant results between T1 and T2/ T3 (frequency: twice per year; target indicator: <2 per cent).

The documentation is kept in paper form in a book, where all received samples are registered.

Table 3. *Laboratory services for HIV in Tajikistan (provided by RC AIDS)*

Region	National	Regional	City or district	IFA	PCR GeneXpert	NAAT DNA	CD4
Republican AIDS Center Laboratory (Reference lab)	1			1	1	1	1
Sughd (Khujand)		1		1	1	1	1
Bokhtar (Khatlon)		1		1	1	1	1
Kulob (Khatlon)		1		1	1	1	1
Khorog (GBAO)		1		1	1	1	1
Dushanbe			1	1	1	1	1
Tursunzoda			1	1			
Shahrinav			1	1			
Hisor			1	1	1		

Rudaki			1	1			
Vahdat			1	1	1		
Fayzobod			1	1			
Khuroson			1	1			
Shahrituz			1	1	1		
Qabadiyon			1	1			
J. Balkhi			1	1	1		
A. Jomi			1	1			
Yovan			1	1			
Kulob			1	1			
Danghara			1	1			
Norak			1	1			
Vose			1	1	1		
Farkhor			1	1			
Hamadoni			1	1			
Darvoz			1	1			
Rushon			1	1			
Murghob			1	1			
Ishkoshim			1	1			
Vanj			1	1			
Isfara			1	1			
Konibodom			1	1	1		
Buston			1	1			
B. Ghafurov			1	1			
Spitamen			1	1			
Istaravshan			1	1	1		
Panjakent			1	1	1		
Rasht			1		1		
Total	**1**	**4**	**32**	**36**	**15**	**6**	**6**

HIV

Epidemiology

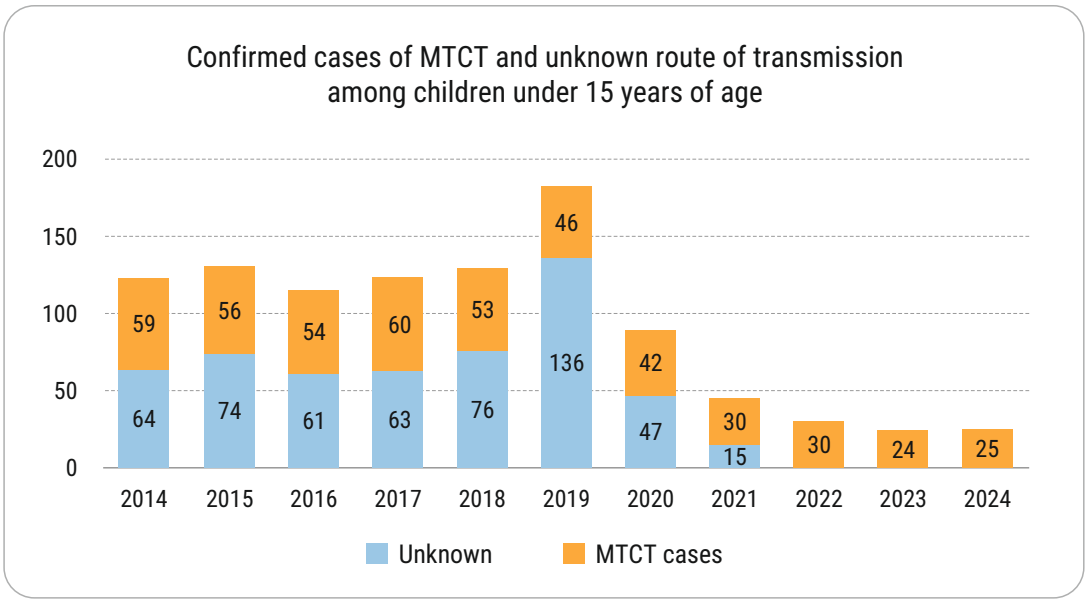
The number of people living with HIV and who know their status (HIV) in the country as of December 31, 2024 (reported in the Global AIDS Monitoring (GAM) narrative part) is 12,480 people, or 82 per cent of the estimated number of people living with HIV (approximately 15,213 people at the end of 2024) -the first 95 out of the 95-95-95 (in 2023 - 79 per cent). HIV

prevalence is 1.4 times higher among men than women in the general population. The proportion of registered new HIV cases is 63.2 per cent among men and 36.8 per cent among women. Over the last ten years, there has been a 6 per cent - 7 per cent annual increase in new HIV cases among women (DHS 2023).

The number of people receiving ART in the country as of December 31, 2024 is 11,268 people, 90 per cent (out of 12,480 people living with HIV who know their HIV status) - the second 95 out of the 95-95-95 (in 2023 – 90 per cent). Children constituted 9.08 per cent of all registered cases in 2022. This percentage is even larger, namely 9.97 per cent, while considering only those alive at the end of 2022 (1,083/10,861) (6). However according to the most recent internal assessment report, the age group 0 - 18 years (children) accounts for 12.5 per cent of the total number of people living with HIV (7). The country has observed an increasing trend in the number of new HIV cases among children under 14 years of age. Over the past five years, the proportion of children among all new cases of infection has ranged between 11.4 per cent and 14.0 per cent (7). The total number of children and adolescents under 18 years of age living with HIV and who know their HIV status as of December 31, 2024 was 1,022 (8.2 per cent of all PLHIV), of which 1,009 or 98.7 per cent receive ART.

As reported by WHO in the 2023 HIV care assessment, over half of new reported HIV cases who were =< 15 years of age in 2014 - 2021 had an unknown mode of transmission (**Figure 9**) (6). The particular reasons behind these high numbers were not investigated during the assessment. Of the 922 newly diagnosed HIV cases reported in 2021, 62 (7 per cent) were children under the age of 15. Of these, 20 (48 per cent) were attributed to mother-to-child transmission; for the remainder the mode of transmission was reported as nosocomial - 17 (27 per cent), or unknown - 15 (25 per cent). The reported HIV testing coverage among pregnant women was 87.3 per cent in 2022. Cases of MTCT occur among undiagnosed pregnant women—women who either did not get tested during their pregnancy, or (in remote areas) did not attend ANC and gave birth at home, or were lost to follow-up after delivery, potentially transmitting the infection through breastfeeding. (Report on activities that focused to assess and identify difficulties and barriers in the procurement chain mechanism, supply and provision of testing for pregnant women in healthcare facilities, UNFPA).

Figure 9. *Number of children under the age of 15, stratified by the route of transmission*



Tajikistan implemented a PMTCT program, first as pilot project in selected regions in 2008 and then nationally in 2010. All services within this framework are provided to pregnant women free of charge. In principle, HIV tests for the PMTCT program should be available free of charge to all pregnant women and are purchased at the expense of the state budget (the second rapid test during pregnancy) and local government budget (the first rapid test during pregnancy). In 2024, HIV testing (based on informed consent) was carried out in more than 94 per cent (in 2023 - about 96 per cent) of pregnant women who first sought and then were observed in antenatal clinics during the reporting period. As a result, 45 new cases of HIV were identified among pregnant women in 2023 and 46 in 2024. However, the vast majority of pregnant women living with HIV already know their status and are under the supervision of specialists in antenatal clinics and receive lifelong ART (227 in 2023 and 105 in 2024). Of infants born to mothers living with HIV in 2024, 99.6 per cent were covered by antiretroviral prophylaxis. The MTCT rate was 2.2 per cent in 2023 and 2.5 per cent in 2024. Early diagnosis of HIV infection in children born to HIV-positive mothers (virological test up to two months after birth) was performed in 241 (99 per cent) children in 2024.

Over the past five years, the proportion of children (under 18 years of age) among all new cases of HIV infection has been decreasing (a decrease of more than two times in 2024 compared to 2019).

According to *National Program to Combat the Epidemic of Human Immunodeficiency Virus Acquired Immunodeficiency Syndrome in the Republic of Tajikistan for 2021-2025*, the most affected regions are Dushanbe (incidence rate per 100,000 population, 29.3), Gorno-Badakhshan Autonomous Region (16.3), Sughd Region (14.0), and Khatlon Region (11.5) (8). These may indicate both the concentration of the epidemic in large cities and insufficient access to testing or stigmatization concerning testing (6,9).

In terms of gender, there is a trend towards an increasing proportion of men (59 per cent in 2019 and 64 per cent in 2022) and decreasing proportion of women (41 per cent in 2019 and 36 per cent in 2022). At the same time the main routes of HIV transmission remains sexual contact (71.7 per cent in 2019) (6,8). This could indicate stigma towards same-gender sex and therefore an underestimation of the population of men having sex with men (MSM). Another important factor is that the migration of men for economic reasons occurs on larger scale than for women, which results in a larger proportion of men among HIV cases. Population mobility, in particular economic migration to the Russian Federation and countries from Central Asia, remains an important problem, both in terms of retention in care and exposure to HIV, hepatitis, and STIs.

Injected drug use still contributes to a significant proportion of HIV transmissions (12.7 per cent in 2019). As of December 31, 2024, 599 people who inject drugs receive treatment and preventive care within the framework of the opioid substitution therapy (OST) program at OST points operating in all regions of the country on the basis of state medical institutions. The coverage of PWID by OST is 3.3 per cent of the estimated number of PWID in the country, which is approximately at the level of the previous year (2023, 3.4 per cent), without dynamics (GAM narrative 2024). The iatrogenic route of HIV infection is rare, but still occurs (8).

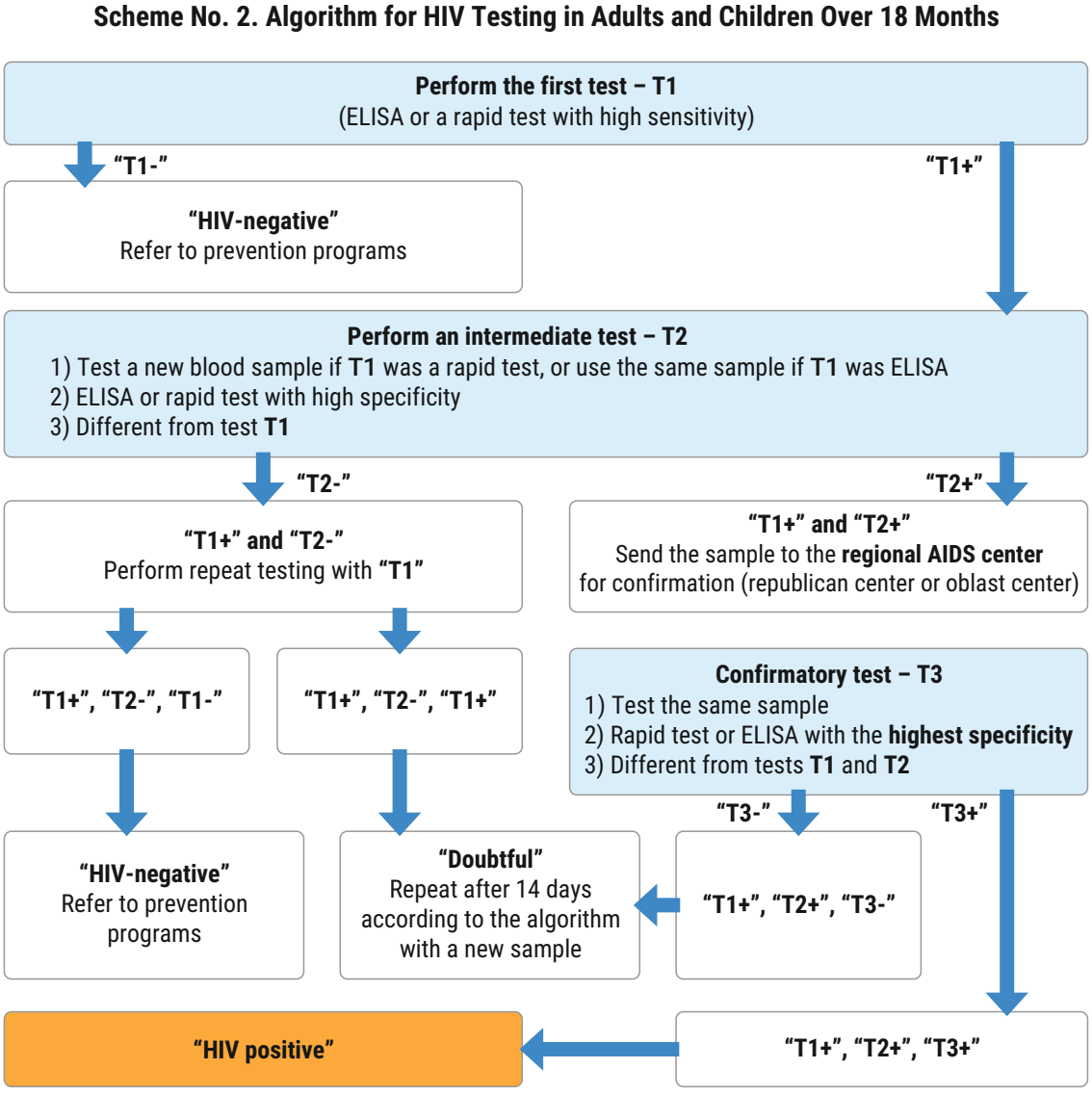
In terms of age distribution, the largest age group of people living with HIV (83.8 per cent) is of reproductive age (15–49 years). Among women, the dominant age group is 19–29 years old (8). This makes reproductive and sexual health services especially important within the holistic approach to care and the focus on interventions for eliminating STIs in pregnancy and the onward transmission to fetuses and newborns. Based on the results of a single test of pregnant women, out of 199,602, there were 63 new HIV cases (0.03 per cent) identified (data for 2021) (7).

Late diagnosis is constantly high in Tajikistan, as 52 per cent of new HIV diagnosis are late presenters. At the same time, estimates for the continuum of care indicate that approximately 75 per cent of people living with HIV in Tajikistan are aware of their status, which remains far too optimistic in contrast to available data (6,8).

HIV Testing

The recommendation for testing during pregnancy has gradually been implemented since 2008, and since 2010 all cities and districts of the Republic have been included in the program. Since 2011 the country maintains a strategy of universal screening for all pregnant women twice during pregnancy. In 2017 a new PMTCT protocol recommended testing once, and only in the first trimester of pregnancy, with the second or repeated test to be offered only to pregnant women from risk groups or vulnerable groups. This has been changed again in the national program for 2021–2025 to universal and free of charge screening for all pregnant women.

Figure 10. *Testing algorithm for diagnosing HIV infection (source: Management of laboratory diagnostics of HIV infection in the Republic of Tajikistan, 2022)*



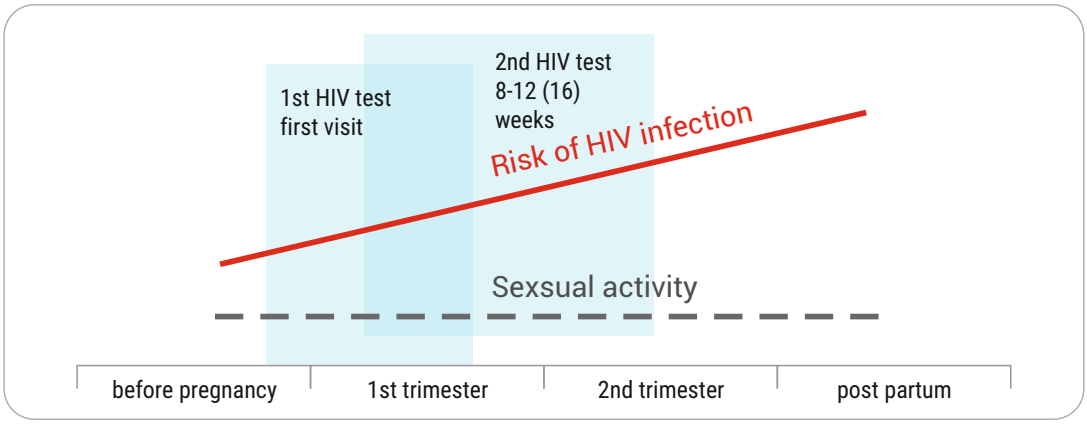
Tajikistan has adapted WHO recommendations for using an HIV testing strategy/algorithm that utilizes a combination of rapid diagnostic tests (express test) and/or enzyme-linked immunosorbent assays (ELISAs), **Figure 10**. According to national protocols, women can be tested for HIV using rapid diagnostic tests or enzyme-linked immunosorbent assay (ELISA) at the level of health facilities, maternity hospitals, and HIV centers. In districts where ELISA is available, ELISA testing is a priority for pregnant women.

HIV testing of pregnant women should be performed at the PHC/ANC level. The first test at the time of registering for pregnancy care and second one after 8–12 weeks, but not later than 16 weeks—in order to cover the "window" period. This choice of periods reflects earlier gaps in testing, mainly related to misunderstanding the language of the recommendation. As a result, if women registered to care after the indication for first testing, the test was not performed at all. However, the current choice of wording might also be difficult to understand.

As indicated by the *Report on the Results of the Assessment of the Implementation of Measures to Prevent Mother-to-Child Transmission of HIV in the Republic of Tajikistan, an assessment performed in 2024* in 10 cities and districts showed that the coverage of HIV testing in early pregnancy (up to 12 weeks) declined during 2021–2024, from 100 per cent in 2021 to 88.6 per cent in 2024. In total, 92.4 per cent of women received at least one test during their pregnancy. A second (repeated) test was performed in 52.2 per cent of cases out of the total number of women who had their first test performed, and in 48.2 per cent of the women who underwent antenatal registration (161,793 people). Out of a total of 46 pregnant women diagnosed with HIV infection, 15 were diagnosed in the late stages of pregnancy.

The current testing scheme in Tajikistan is focusing on early testing. This strategy allows women who are HIV positive but unaware of this infection to be identified. Another scenario involves women who are HIV negative but have an HIV positive partner or husband who is either unaware of his HIV infection or aware of it but not adherent to antiretroviral therapy. The risk of acquiring HIV for such women is not constant but increasing over the time of the pregnancy, reaching its peak in postpartum. This explains why women are not infected before pregnancy but acquired the infection during pregnancy. Early testing in such a scenario will not cover this risk, which increases over the time of pregnancy, even with same sexual activity. This risk scenario can only be covered by partner testing, testing late in pregnancy, or testing during breastfeeding. Partner testing seems to be the most adequate method, yet in practice it is very difficult to perform. **Figure 11** illustrates a change in the risk of acquiring HIV during pregnancy with the same pattern of sexual behavior and the same HIV-positive partner (based on Theron et al. 2021). Scenario with two tests performed in accordance with protocol.

Figure 11. *Illustration of simplified model of the risk of HIV acquisition during pregnancy*



During the current assessment, in most visited services, pregnant women undergo HIV testing during antenatal registration as an OOP cost. According to local data obtained from the AIDS center in Tursunzade city, 43.29 per cent to 52.27 per cent of tests performed on women were OOP (**Table 4**).

This is well in line with the outcomes of the assessment performed by RC AIDS in 10 cities and districts in 2024, stating that in the context of the majority of health care facilities and reproductive health centers, there were no conditions for the free HIV testing of pregnant women (*Report on the Results of the Assessment of the Implementation of Measures to Prevent Mother-to-Child Transmission of HIV in the Republic of Tajikistan, 2024*).

Table 4. *Testing for HIV in Tursunzoda city, 2021–2024 (n=143925)*

Year	percentage of tests performed in private facilities on women (all) (per cent)	percentage of tests performed in private facilities on men (all)(per cent)
2021	43.29	49.29
2022	48.95	50.23
2023	48.06	46.91
2024	52.27	55.89
All	**48.81**	**51.31**

The document of the national AIDS program indicates that "[t]he main reasons for the incomplete coverage of pregnant women with HIV testing remain[s] the lack of funds to purchase tests in local governments, and the untimely registration of some pregnant women, in particular from remote rural areas." This is in agreement with evaluation performed by RC AIDS in 2024, which showed that out of 11 cities and districts, only three districts have fully met the requirements for the purchase of diagnostic materials, and in four districts no funds have been allocated for the purchase of tests at all. In the remaining four districts, the percentage of allocated funds ranges from 11 per cent to 53 per cent. Consequentially, the procurement of rapid HIV tests is not structured, depends on local mechanisms, and undermines the effectiveness of the whole prevention program. **Photo 1** documents the variability in rapid tests available at healthcare facilities that provide testing for pregnant women.

However, during the current assessment most of visited services referred women to laboratories performing OOP diagnostics, even when rapid HIV tests purchased centrally by RC AIDS were available. The common explanation used for this was that women prefer to do all tests at one facility, and they need to do other diagnostic tests at private laboratories anyway. This statement has no firm, tangible evidence and in all of the services visited the document stating clearly which services are free of charge was not made publicly available in any form. Therefore, to address these types of common statements, it is necessary to assess patients' opinions and their awareness of their rights.

Photo 1. *HIV rapid (express) tests available at healthcare facilities visited during the in-country visit. (photos by J.Kowalska)*












In the current assessment, no evidence was found of any structured control over the implementation of the Clinical Protocol on Strengthening Measures to Prevent Mother-to-Child Transmission of HIV in the Republic of Tajikistan, approved by order of the Ministry of Health and Social Protection of the Population of the Republic of Tajikistan No. 876 dated 09/30/2021 at the level of primary healthcare, reproductive health centers, and maternity hospitals. The only center following systematically the statistics was Tajik Research Institute for Obstetrics, Gynecology and Perinatology (**Table 5**).

Meetings with the centers' staff showed there was a need for and an interest in obtaining training in the field of HIV. Yet, it was clear that such training should reflect the specific needs of a given service and their factual capabilities.

Table 5. *Statistical data on pregnant women admitted to the Tajik Research Institute for Obstetrics, Gynecology and Perinatology*

	2021	2022	2023	2024	First 9 months of 2025
Number of pregnant women hospitalized (for delivery)	11,841	13,813	13,953	14,607	14,421
Pregnant women who underwent HIV testing	4,249	6,868	4,849	5,483	3,058
Positive HIV test results among hospitalized pregnant women	-	3	3	3	-
HIV-positive pregnant women who were hospitalized and gave birth	12	15	9	12	10
Cesarean section in HIV-positive women	7	11	8	9	8
Due to obstetric indications (of the above)	5		1	3	2

Table 6. *Country data for the testing of HIV during pregnancy are provided by RC AIDS*

Number of women tested for HIV in pregnancy:	2021	2022	2023	2024
Total number of tests	275,206	329,692	373,809	401,578
Tested once	209,379	210,771	234,439	248,639
Tested twice	65,827	118,921	139,370	152,939

As already discussed in the Antenatal care section, the number of home deliveries is decreasing, but, still, in 2023 over 1,500 births were not assisted by a skilled health professional. The question then arises as to how to ensure that women receive an HIV test, if it has not been performed during pregnancy.

Table 7. *New HIV cases among pregnant women in 2024 stratified by gestational age (source RC AIDS)*

№	Region	Up until 12 weeks	13–21 weeks	22–32 weeks	33 weeks and up	At delivery	Total
Total n (per cent)		6 (13.3)	16 (35.5)	11(24.4)	6 (13.3)	6 (13.3)	45 (100)
1	Dushanbe		2	2	3		7
2	Rudaki		3				3
3	Tursunzoda						0
4	Hisor		2			1	3
5	Vahdat	1	1	2	1	1	6
6	Bokhtar		1				1
7	Vakhsh	1	1				2
8	Kushoniyon	1	1			2	4
9	Yovon				1		1
10	A. Jomi	1	1		1		3
11	Shahrituz			1			1
12	Levakant	1		1			2
13	Kulob city					1	1
18	Vose		1				1
21	Hamadoni			1		1	2
23	Kulob district			2			2
10	Spitamen	1					1
11	Istaravshan		2				2
12	B. Ghafurov		1	1			2
13	Asht			1			1

The number of children diagnosed with HIV per year remains continuously high in Tajikistan (**Table 8**). During the last 10 years, 418 children have been diagnosed with an HIV infection. Only in a few cases was the mother diagnosed during pregnancy. Most of the diagnoses are made in children older than 18 months and therefore will not be included in calculations concerning the impact indicator, as per the WHO definition. This, however, indicates the impact of jeopardized accessibility to antenatal care facilities, inadequate access to HIV testing during pregnancy, and, as a result, late diagnosis in children.

Table 8. *Number of children with HIV infection 2015 - 2024*

Year of diagnosis	Total number of new diagnoses	
2015	55	Children with vertical HIV infection from 2015 to 2020. (Clinical protocol to strengthen measures to prevent mother-to-child transmission of HIV in the Republic of Tajikistan)
2016	53	
2017	60	
2018	53	
2019	45	
2020	42	
2021	31	Numbers from the Regional AIDS Center Database (Infotracker)
2022	30	
2023	24	
2024	25	
2015–2024	418	

Early infant diagnosis

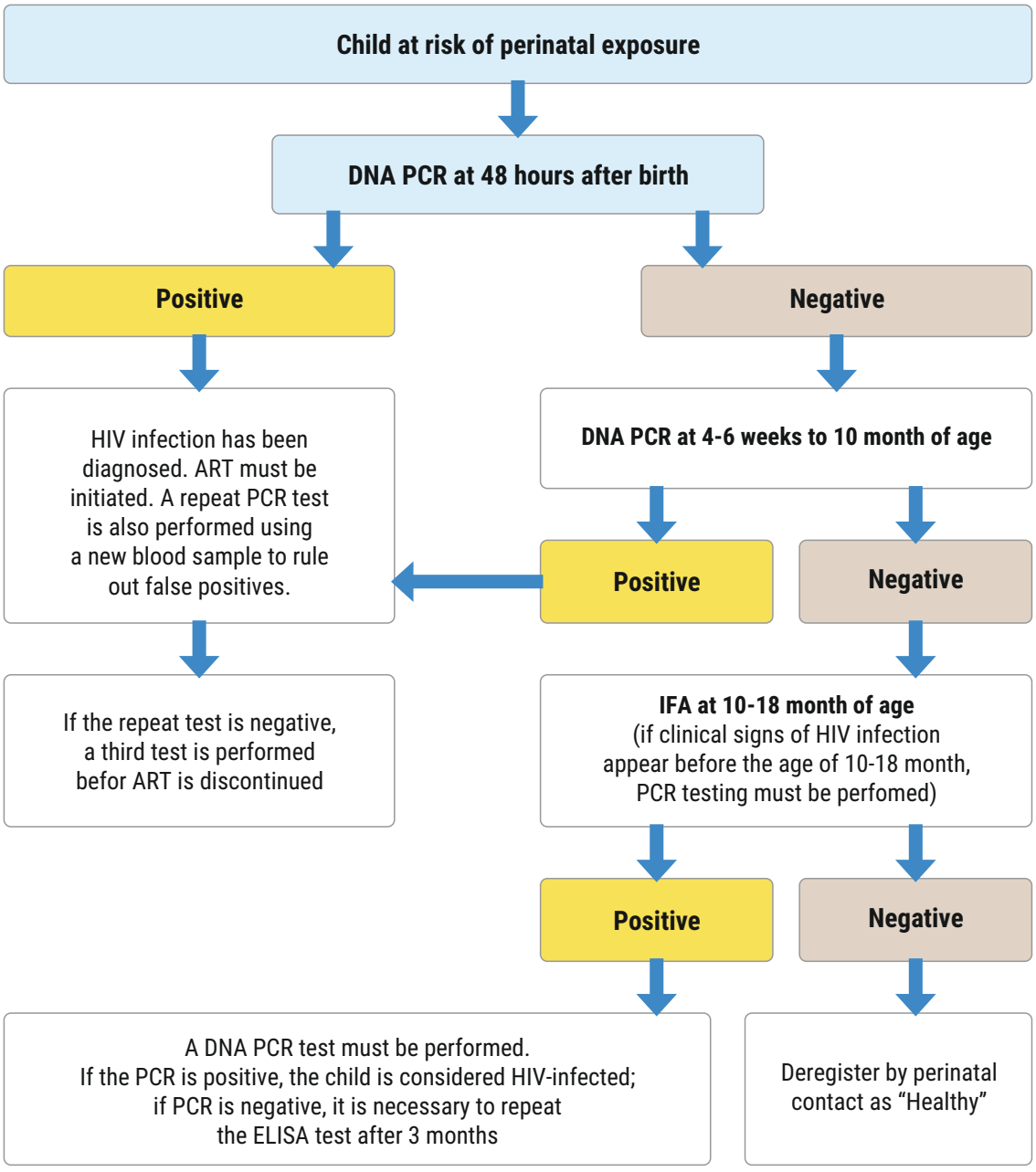
The WHO recommends early infant diagnosis (EID) for all HIV-exposed infants to enable timely antiretroviral treatment and to reduce mortality. In accordance with WHO guidelines infants should be tested using nucleic acid testing (NAT) within 48 hours of birth, then at 4 - 6 weeks (or as soon as possible after this, before two months of age), and at nine months. Early diagnosis applies not only to neonates, but also to any infant under the age of 18 months. Children at the age of 18 months and older can be tested using the same serologic tests as adults.

EID is performed using dried blood spot testing (DBS). It is an important and accessible method of HIV testing in infants, particularly in resource-limited settings. It involves collecting a blood sample from a heel or finger prick, which is then dried on filter paper. The dried sample is stable at room temperature, eliminating the need for refrigerated transport, and is then sent to the laboratory for PCR testing to determine HIV status.

The national protocol for *Management of Laboratory Diagnostics of HIV Infection in the Republic of Tajikistan, 2022*, describes this process in section 6.3, titled "Diagnosis of HIV Infection in Children Born to HIV-Infected Mothers," and it is being overseen centrally by RC AIDS (**Graph 1**). However, the protocol does not describe the process for obtaining samples or the procedures for ensuring the timely reporting of test results to clinical centers.

Graph 1. *The algorithm for testing HIV infection in children born to HIV-infected mothers*

Scheme №3. Algorithm for testing for HIV infection in children born to HIV-infected mothers.



The current assessment investigated the following practical process. The dried blood spot samples should be taken by a neonatologist at the time of delivery and transported to Dushanbe. All NAT tests for EID are performed centrally at the RC AIDS Laboratory in order to ascertain quality assurance and epidemiological supervision (**Photo 2**).

Photo 2. *RC AIDS Laboratory (photos by J.Kowalska)*



Dried blood spot testing kit



PCR section



Reference laboratory



GenExpert with energy back-up set

This system works well in the centers where births by mothers living with HIV are not incidental. An example of such a center is the Tajik Research Institute for Obstetrics, Gynecology and Perinatology (**Photo 3**). Other centers do not have dried spot kits on site, and they need to be delivered by the regional or local AIDS Center. Currently, there is no procedure set in place at RC AIDS laboratory to ensure that the turnaround time for reporting test results to health facilities and caregivers is rapid; this would optimize the benefit from NAT at birth.

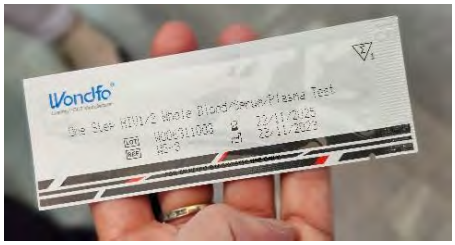
Photo 3. *HIV MTCTP "tool box" in Tajik Research Institute for Obstetrics, Gynecology and Perinatology and anonymized medical documentation presenting performance of tests during pregnancy*



HIV PMTCT kit box



Neonatal PEP components



Rapid HIV test



Dried blood spot kit



Medical documentation indicating tests and dates of testing

Table 9. *Early infant diagnosis in Tajikistan (data provided by RC AIDS)*

	2021	2022	2023	2024
Number of infants born to HIV positive mothers	197	252	245	246
Received first DNA/PCR HIV Test	188	242	241	241
Received second DNA/PCR HIV Test	179	238	237	239
Received DNA/PCR HIV Test (first or second)	191	244	241	241
Number of children with HIV positive result(s)	2	5	4	5

HIV care

The Ministry of Health and Social Protection of the Population of the Republic of Tajikistan (MoHSPP) maintains responsibility for the provision and renewal of *National Program to Combat the Epidemic of Human Immunodeficiency Virus Acquired Immunodeficiency Syndrome in the Republic of Tajikistan* and all clinical protocols for HIV diagnosis, care and prevention. The most recent guidelines include:

- Guidelines for treatment and care of HIV infection (adults and adolescents), Dushanbe 2023.
- Management of laboratory diagnostics of HIV infection in the Republic of Tajikistan, 2023.
- Clinical protocol to strengthen measures to prevent mother-to-child transmission of HIV in the Republic of Tajikistan, 2023.

The Republican Center for Prevention and Control of AIDS in Tajikistan (RC AIDS) is responsible for overseeing the execution of the *National Program*. This includes collecting epidemiological data, central procurement and distribution logistics, running a reference laboratory, patients' care, and assistance for residents of other regions temporarily residing in Dushanbe. The responsibilities also include leadership and coordination, oversight of service provision, training of staff, mentorship, and the quality improvement cycle. The representatives of RC AIDS are involved in work performed by MoHSPP, such as national programs, clinical protocols, and legislation.

The decentralization taking place in HIV care is one of most important steps in implementing patient centered care, with many services being available at same place and time. This is especially important for a country like Tajikistan, where geographic distance and poor public transportation are key factors in the unsatisfactory retention in care. This is also crucial for engagement in antenatal care. Tajikistan began the decentralization of HIV services by incorporating them into local level public health services. At the beginning of 2023 1,486 patients were already under local healthcare centers.

As indicated in the WHO report, substantial progress has been achieved on the Tajikistan side with the optimization of antiretroviral treatment (ART) regimens, especially switching to fixed dose combination (TLD): treatment coverage among those diagnosed in 2022 was 97.8 per cent (6). Pediatric formulations of 5 mg and 10 mg dolutegravir are also available, and most children living with HIV receive first-line ART regimens containing mainly DTG. Viral load testing is performed in almost 90 per cent (2025, about 90 per cent) of pediatric patients receiving ART. Suppressed viral load is observed in almost 90 per cent (2025, 90 per cent) of pediatric cases.

National protocol recommends that ART should be started in all adolescents and adults living with HIV, pregnant and breastfeeding women, and children under 15 years of age, regardless of the clinical stage of the disease, HIV viral load and CD4 cell count. Pregnant women should be started on ART regardless of gestational age.

Infants born to HIV-positive mothers receive neonatal PEP according to WHO recommendations. Infants at high risk are defined as:

- born to mothers known to be HIV-infected and who have received ART for less than four weeks at delivery;
- born to mothers known to be HIV-infected and with a viral load of >1,000 copies/mL within four weeks before delivery, if viral load data are available;
- born to mothers whose HIV infection is incidentally discovered during pregnancy or breastfeeding;
- HIV-exposed infants who are newly diagnosed postpartum, with or without a negative perinatal HIV test;
- breastfed infants.

Clinical protocol recommends formula feeding of all babies born to HIV-positive mothers, however exclusive breastfeeding may be an alternative to breastfeeding, provided that both mother and child are receiving antiretroviral therapy (Section 7.3.2, Breastfeeding). Powdered milk should be provided free of charge. However, according to the results of the 2023 assessment by RC AIDS, the funds allocated to 11 cities and districts in 2024 can only cover 26.6 per cent of the annual demand for powdered milk. Table 10 presents data obtained from Infotracker database describing HIV care for women living with HIV, including women who become pregnant while on therapy and newly diagnosed during pregnancy.

Table 10. *HIV care for women living with HIV, including pregnancy (absolute numbers, source: Infotracker)*

Year	2021	2022	2023	2024
All women living with HIV				
Number of women with HIV	5,074	5,455	5,858	6,239
Number of women with HIV in care and receiving ARV	3,864	4,167	4,537	4,721
Number of women with a new HIV diagnosis	344	375	405	379
Pregnant women living with HIV				
Number of HIV pregnant women who gave live birth in a given year	200	252	251	247
Number of pregnant women already receiving ARV	216	263	272	251
Number of new diagnoses during pregnancy	48	44	45	46
Number of new diagnoses during pregnancy, who started ARV	44	38	36	41
Children living with HIV				
Number of new child diagnoses in a given year	31	30	24	25
Number of vertical transmissions in a given year (as per WHO definition)	2	1	1	6

The Republic of Tajikistan has started purchasing antiretroviral medications through the UNDP system at the expense of the Global Fund to Fight HIV/TB/Malaria, and in 2025 the first batch of TLD, for 1,068 patients, was purchased using state money through the UNDP system. This indicates long term planning and stability for the provision of HIV care.

Case by case description

During the current assessment, digitalized data were reviewed for the years 2021–2025 to collect the necessary information to be able to calculate HIV-related indicators. WHO **Web Annex I** template was used. Four meetings were held using a hands-on database. The working team included the deputy director for epidemiological surveillance, employees of the epidemiological department and a gynecologist from the dispensary department of the Republican AIDS Center.

Analyzing data provided for individual transmission cases (mother and child pairs) reveals that the most frequent scenario is when the mother has been diagnosed and started on ART but is eventually lost to care (9/16; 56.2 per cent), **Table 11**.

The remaining cases were either diagnosed during pregnancy or at delivery (**Table 7**). Linkage to care and retention in care is strongly influenced by psychosocial factors, such as poverty, health illiteracy, and stigma. Addressing these factors with targeted interventions is very limited but could potentially involve access to social services and peer-to-peer support at AIDS centers. Integrating such services, along with specialized psychological care, has been identified through surveys carried out by Community Led Monitoring (see Stigma and discrimination section).

Table 11. *Case by case description according to WHO Web Annex I (Sample case report form, Appendix 5)*

YEAR	2021	2021	2022	2022	2022	2022	2025
Case ID	170/2008	68/2016	747/2022	874/2021	637/2021	279/2019	871/13
Anonymized maternal							
Date of first prenatal visit	17.03.2021	11.12.2020	08.06.2022	01.01.2022	20.09.2021		02.08.2022
Gestational week of first prenatal	24	18	34	35	31	40	30
If known positive: Date of HIV diagnosis	06.05.2008	27.01.2016	08.06.2022	01.01.2022	17.09.2021	28.03.2019	23.08.2013
If known positive: Antiretroviral (ARV) regimen	TLD	TLD	TLD	TLD	TLD	TDF/FTC/EFV	TLD
If known positive: Date of initiation on ARV	18.03.2021	22.07.2016	08.06.2022	14.12.2021	20.09.2021	TLD from 03.10.2020 until 18.01.2022	from 23.08.2019 until 06.10.2021 from 02.08.2022
Diagnosed during current pregnancy: Date of first HIV test	WLHIV	WLHIV	in pregnancy	in pregnancy	14.09.2021	WLHIV	WLHIV
Diagnosed during current pregnancy: Gestational age at first	N/A	N/A	17.05.2022	14.12.2021	31	N/A	N/A
Diagnosed during current pregnancy: Results of first HIV test	N/A	N/A	Positve Rapid	Positve Rapid	Positve Rapid	N/A	N/A
Diagnosed during current pregnancy: Dates of subsequent HIV	N/A	N/A	06.06.2022	14.12.2021	14.09.2021	N/A	N/A
Diagnosed during current pregnancy: Gestational age at	N/A	N/A	34	33	31	N/A	N/A
Diagnosed during current pregnancy: Results of subsequent	N/A	N/A	Positive IFA	Positive IFA	Positive IFA	N/A	N/A
Treatment adherence status	No	No	ART	ART	ART from 20.09.2021	ART from 28.03.2019 until 18.01.2022	from 02.08.2022
Viral loads: Dates of testing during	No	12.10.2020	29.06.2022	10.12.2021	12.10.2021	11.02.2021	17.06.2020
Viral loads: Results during pregnancy	No	332913	130000	213000	588	40	1590000
Viral loads: Dates of last testing before delivery	07.06.2021	01.03.2021	No	24.01.2022	24.05.2022	after delivery 27.04.2023	after delivery 31.01.2023
Viral loads: Results of last testing	45	49	No	69	208084	55800	1210000
Other relevant maternal diagnoses (for example, syphilis, TB)	M+	M+/1st pregnancy	M+ (first husband)	M+	M+	M-	M+
Anonymized neonate	035/2021	58/2021	91/2022	14/2023	183/2024	1584/2024	2023 БОХТАР
Date of delivery	28.06.2021	09.03.2021	01.07.2022	28.01.2022	17.11.2022	18.11.2022	27.12.2022
Type of delivery	vaginal	vaginal	C-section	vaginal	vaginal		vaginal
Estimated gestational age at delivery (in weeks)	38	30	37-38	38-39	39	40	Unknown
Birth weight (in grams)							
Vital status	Positive	Positive	Positive	Positive	Positive	Positive	Positive
Types of ARV used as prophylaxis	AZT+3TC	No	AZT+3TC+NVP	AZT+3TC	AZT+3TC+NVP	No	Unknown
Dates of ARV prophylaxis	28.06.2021	N/A	01.07.2022	28.01.2022	17.11.2022	No	Unknown
Duration of ARV prophylaxis	16.07.2021	N/A	01.07.2022	26.02.2022	17.12.2022	No	Unknown
Dates of 1st PCR test	06.07.2021	01.04.2021	31.08.2022	02.02.2022	22.11.2022	05.05.2023	01.02.2023
Result of PCR test	Positive	Positive	Positive	Positive	Positive	Positive	Positive
Dates of 2nd PCR test	12.07.2021	No	19.09.2022	11.04.2022	No	05.06.2023	10.03.2023
Result of PCR test	Positive	No	Positive	Positive	No	Positive	Positive
Dates of final antibody test	N/A	N/A	19.09.2022	15.12.2023	06.07.2024	09.07.2024	02.01.2025
Types of final antibody test	N/A	N/A	PCR-DNK	PCR-DNK	PCR-DNK	IFA	IFA
Result of final antibody test	N/A	N/A	Positive	Positive	Positive	Positive	Positive
Types of ARV if HIV-infected	N/A	N/A	AZT+3TC+NVP until 31.08.2023	AZT+3TC+NVP	AZT/3TC+DTG	ABC/3TC+DTG	AZT+3TC+NVP
Dates of ARV if HIV-infected	N/A	N/A	19.10.2022	15.12.2023	06.07.2024	18.07.2024	from 04.04.2023 until 29.05.2025 change
Duration of ARV if HIV-infected	N/A	N/A	Continues	Continues	Continues	Continues	Continues
Types, dates and duration of ARV if HIV-infected	N/A	N/A	ABC/3TC+DTG from 31.08.2023	ABC/3TC+DTG since 02.09.2024	AZT/3TC+DTG from 06.07.2024	ABC/3TC+DTG from 18.07.2024	AZT/3TC+DTG
Types of nutrition	formula	formula	formula	formula	formula	смешанное	formula
If breastfeeding, specify time periods	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other relevant information (describe attempts to follow up, if applicable)	dead - 16.07.2021	dead - 10.03.2021	alive	alive	alive	alive	alive
Причины смерти							

2023	2023	2023	2023	2024	2024	2024	2024	2025
1118/2018	928/2023	419/2018	689/2024	1485/2018	233/2024	854/2023	1081/2011	660/2025
15.08.2023	29.11.2023	15.07.2022	02.09.2024	Unknown	01.04.2024	01.07.2024	01.11.2023	Unknown
26	34	14	Unknown	Unknown	23	26	35	Unknown
28.08.2018	23.11.2023	02.04.2018	11.09.2024	15.11.2018	13.03.2024	02.11.2023	22.09.2011	after delivery 22.08.2025
TLD	TLD	TLD	TLD	TLD	TLD	TLD	TDF/FTC/EFV, TLD	TLD
28.08.2018 не превержена 10.06.2024 года	TDF/3TC/DTG since 29.11.2023 until	14.07.2022	02.09.2024	15.11.2018 from 02.04.2020 TLD	13.03.2024	07.11.2023	18.10.2016 and on 22.04.2020 change to TLD	12.09.2025
WLHIV	in pregnancy	WLHIV	02.09.2024	WLHIV	13.03.2024	WLHIV	WLHIV	Unknown
N/A	23.11.2023	N/A	Unknown	N/A	21	N/A	N/A	Unknown
N/A	Positve Rapid	N/A	Positve Rapid	N/A	Positve Rapid	N/A	N/A	Unknown
N/A	28.11.2023	N/A	05.09.2024	N/A	29.03.2024	N/A	N/A	Unknown
N/A	34	N/A	Unknown	N/A	23	N/A	N/A	Unknown
N/A	Positive IFA	N/A	Positive IFA	N/A	Positive IFA	N/A	N/A	Unknown
ART	ART	ART	ART from 02.09.2024	from 02.04.2020 until 24.07.2020 from	ART from 13.03.2024	on ART	on ART	on ART
15.08.2023	24.11.2023	07.06.2022	02.09.2024	22.11.2023	15.03.2024	03.11.2023	20.10.2020	No
228000	177000	212000	3050000	36	68340	896000	11900	No
27.09.2023	N/A	04.09.2023	04.03.2025	after delivery 23.11.2024	after delivery 14.09.2024	23.08.2024	14.11.2023	after delivery 26.08.2025
84600	N/A	199000	145	85400	36	238000	1660	63000
M+	M-	No	M+	M+	Unknown	Unknown	M+	M+
133/2024	111/2023	16/2024	73/2024 БОУТАР	83/ДНК/2024	66/2024	86/ДНК/2025	675/2025 БОУТАР	1060/2025 РНК
13.11.2023	13.12.2023	06.01.2023	31.05.2023	11.11.2024	24.06.2024	11.09.2024	06.01.2024	07.08.2024
C-section	C-section	vaginal	Unknown	Unknown	vaginal	C-section	vaginal	
38	36	40	Unknown	Unknown	36	35	41	
Positive	Positive	Positive	Positive	Positive	Positive	Positive	Positive	Positive
AZT+3TC+NVP	AZT+3TC+NVP	AZT+3TC+NVP	Unknown	No	AZT+3TC+NVP	AZT	AZT+3TC+NVP	No
13.11.2023	13.12.2023	06.01.2023	Unknown	No	01.07.2024	11.09.2024	01.01.2024	No
11.12.2023	11.01.2024	нет данных	Unknown	No	29.07.2024	09.12.2024	30.01.2025	No
23.11.2023	20.12.2023	12.01.2023	04.09.2024	25.11.2024	25.06.2024	17.09.2024	08.01.2025	04.09.2025
Positive	Positive	Negative	Positive	Positive	Negative	Negative	Positive	Positive
29.11.2023	08.01.2024	01.02.2024	12.09.2024	28.11.2024	13.09.2024	05.08.2025	04.06.2025	02.10.2025
2400	Positive	Positive	Positive	Positive	Positive	Positive	RNK-Positive-	RNK-Positive-
02.01.2024	08.01.2024	09.02.2024	02.01.2025	02.01.2025	14.09.2024	01.09.2025	27.05.2025	01.09.2025
PCR-DNK	PCR-DNK	IFA	PCR-DNK	PCR-DNK	PCR-DNK	PCR-DNK	IFA	PCR-DNK
Positive	Positive	Positive	Positive	Positive	Positive	Positive	Positive	Positive
AZT+3TC+NVP until	AZT+3TC+NVP until	ABC/3TC+DTG	AZT+3TC+NVP	ABC/3TC+DTG	No	AZT/3TC+DTG	AZT/3TC+DTG	AZT/3TC+DTG
11.12.2023	11.01.2024	16.02.2024	02.09.2024	from 24.12.2024 until 30.06.2025	No	17.09.2025	16.06.2025	12.09.2025
Continues	N/A	Continues	from	End on	No	Continues	Continues	Continues
ABC/3TC+DTG until 23.06.2023	N/A	ABC/3TC+DTG ; 16.022024	from 03.06.2025 ABC/3TC+DTG	ABC/3TC+DTG	No	Unknown	AZT/3TC+DTG	AZT/3TC+DTG
formula	formula	formula	Unknown	formula	смешанное	смешанное	formula	Unknown
N/A	N/A	N/A	Unknown	N/A	N/A	N/A	N/A	N/A
alive	dead - 13.01.2024	alive	alive	dead - 11.07.2025	dead - 21.10.2024	alive	alive	alive
					other OI			

Syphilis

Epidemiology

As a remainder of the post-Soviet construction of the healthcare system, syphilis and other sexually transmitted infections (STIs) remain isolated from HIV and hepatitis care. In 2017 Tajikistan reported a congenital syphilis case rate of 2.9 per 100,000 live births (eight cases), and zero cases in 2018 and 2019 (11). Cases of congenital syphilis have been reported sporadically, and routine data reporting coverage remains incomplete **Table 12**.

Table 12. *Registered syphilis cases in the Republic of Tajikistan (N/100,000 population)*

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Syphilis	335 3.9	322 3.7	407 4.6	371 4.1	424 4.6	218 2.3	**266** **2.7**	**333** **3.4**	**368** **3.6**	**306** **2.9**
Men	-	-	-	-	-	-	**165**	**194**	**206**	**203**
Women	-	-	-	-	-	-	**101**	**139**	**162**	**106**
Gonorrhea	418 4.9	377 4.4	384 4.3	255 2.8	189 2.1	116 1.2	136 1.4	106 1.1	86 0.8	77 0.7
Trichomoniasis	452 5.3	384 4.4	4 07 4.6	368 4.1	265 2.8	150 1.6	151 1.6	158 1.6	94 0.9	109 1.1
Chlamydia	135 1.6	62 0.7	107 1.2	183 2.1	166 1.8	172 1.8	124 1.3	161 1.6	136 1.3	143 1.4
Herpes	146 1.7	130 1.5	232 2.6	360 3.9	225 2.4	330 3.5	257 2.7	329 3.3	291 2.9	258 2.5

Source: data provided by the Head of Republican Center for Skin and Venereological Diseases. The number of persons tested, and the number of negative results was not provided; the size of population tested that was needed to calculate the rate, was also not provided.

According to clinical protocol, each woman should be tested twice during pregnancy, using the Wassermann reaction (WR) test. Data provided by the National Center for Reproductive Health (NCRH) indicate the number of tests performed and the coverage for syphilis testing during pregnancy, however, the denominator for these calculations has not been provided. Form 32 collects data on the number of pregnant women per year in total, which includes those registered last year and who are still pregnant, and newly registered pregnant women in the current year. Therefore, the percentage cannot be interpreted directly as test coverage. The second row in **Table 13** presents a recalculation of the WR testing coverage rate using, as the denominator, the number of pregnant women in a given year provided by the same institution.

Table 13. *Wassermann reaction (WR) tests performed on pregnant women in Tajikistan, stratified by year (source: data provided by NCRH on 30.10.2025)*

	2021		2022		2023		2024	
	n	%	n	%	n	%	n	%
WR, 1st	217,122	95.8	236,919	99.3	242,931	99.4	252,961	99.5
Number of pregnant women*	241,783	89.8	242,469	97.7	257,858	94.2	262,169	98.3
WR, 2nd	199,736	90.9	219,284	91.9	227,155	92.9	239,681	94.2

WR - Wassermann reaction test

* number of pregnant women who had at least one visit during their pregnancy by a health professional for reasons relating to the pregnancy in a given year; provided by NCRH

Case by case evaluation

Data on registered cases of congenital syphilis were provided by Akhmadzoda Maruf Akhmad, the Chief Physician of the Republican Clinical Center for Skin and Venereal Diseases.

In 2022, there were four cases all in Khatlon region: one case was in Khuroson district, two in Kushoniyon district, and one in Jaihun district: one boy and three girls.

Three pregnant women who resided in the Russian Federation came to Tajikistan to give birth. The mother of one newborn girl was the spouse of a migrant worker. The three pregnant women received outpatient treatment and one - inpatient treatment. All newborns received inpatient treatment; two of them returned to the Russian Federation, and two remained in Tajikistan and were removed from the register. All children were born without any signs other than a positive Wassermann test.

In 2023, one case of congenital syphilis was identified and recorded in the city of Vahdat. Both parents resided in the Russian Federation and arrived in Tajikistan for the birth. After birth, they were diagnosed with syphilis, and both parents received outpatient treatment. The newborn received inpatient treatment and was removed from the register.

In 2024, two cases were identified: one from the Hissor District of Republican Subordination and one from the city of Panjakent in the Sughd Region. The newborn (a boy) and his mother from Hissor received outpatient treatment, remained on the register, and were then removed from the register. The pregnant woman (a housewife) did not seek medical attention at her place of residence. The newborn from the city of Panjakent was born in the Russian Federation on January 4, 2024. Unfortunately, the child died on March 30, 2024.

This year (2025), one case of congenital syphilis was identified in the Panj district. The father is a migrant laborer in the Russian Federation, and the pregnant wife returned to Tajikistan during the second trimester and was diagnosed there. She received outpatient treatment during her pregnancy. The newborn received inpatient treatment at the city's skin hospital and is currently under observation.

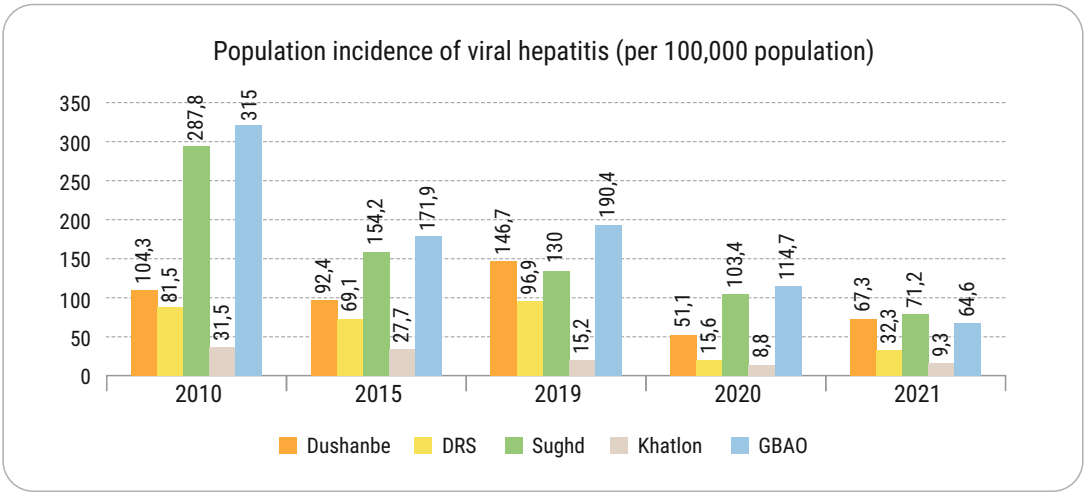
From the above, it can be concluded that 87.5 per cent of congenital syphilis cases from 2022 to the present occurred in families of labor migrants. All the pregnant women were housewives and lived in rural areas.

Hepatitis B

Epidemiology

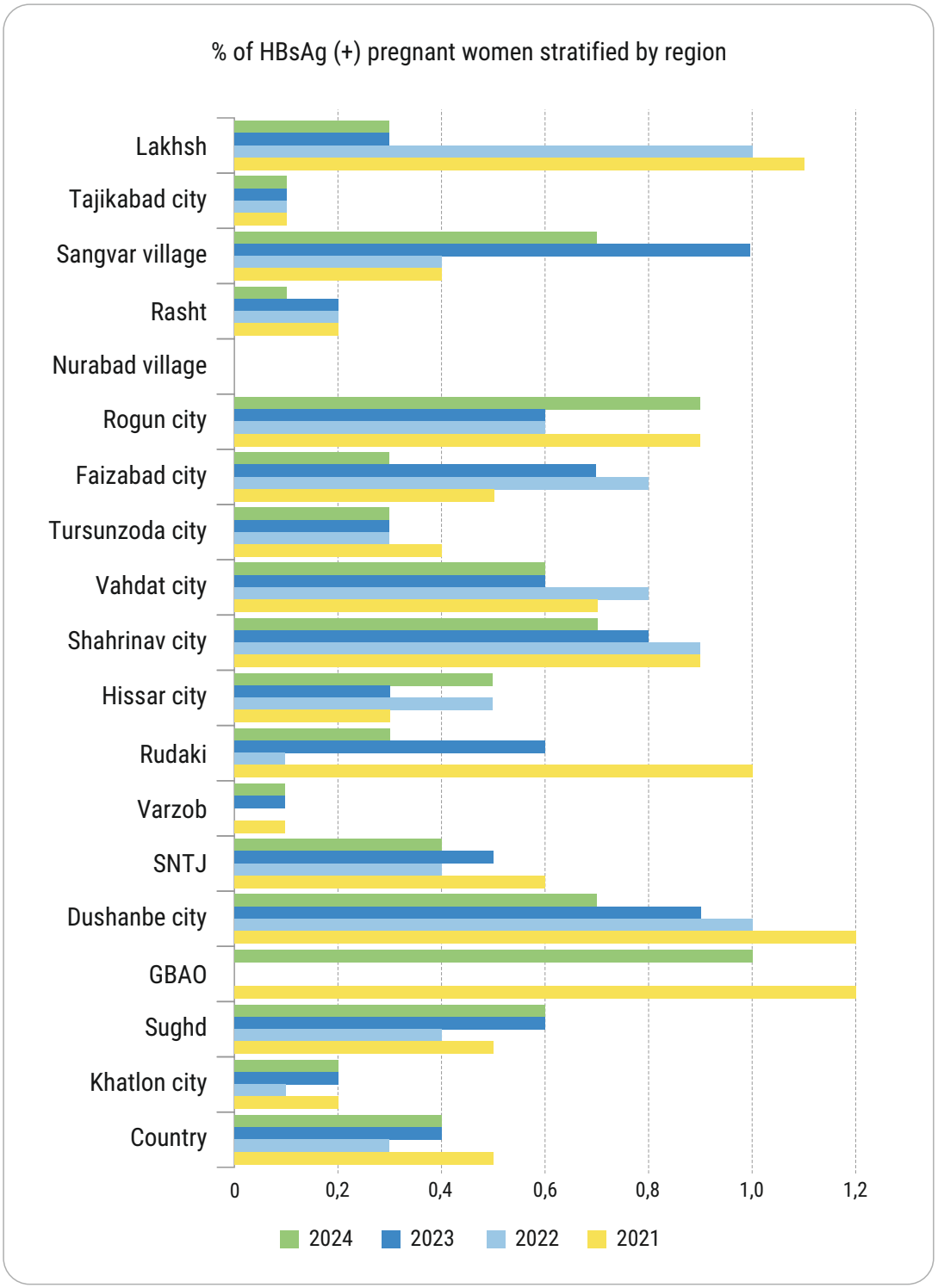
Epidemiological data are reported through multiple pathways and to different institutions that have oversight. Data on hepatitis testing among pregnant women is reported by Regional Reproductive Centers to the NCRH but is not analyzed centrally and is not included in the statistical and epidemiological reports for the country. For example, for 2022, 2023, and 2024 (the first is available in pdf and two latter only in paper book format), hepatitis is reported as a combined number, with no division for HAV, HBV, or HCV (**Figure 12**).

Figure 12. *"Diseases related to viral hepatitis Epidemiological Data," published in the Statistical book for 2021 (10)*



Data on hepatitis testing among pregnant women is not included in medical statistics, but it is reported by regional reproductive health centers to the NCRH on special forms and is analyzed centrally (**Figure 13**).

Figure 13. *Data on the prevalence of HBsAg (+) among pregnant women, stratified by year and region (Source:RCRH)*



During in country visit, forms from Vahdat city were made available and compared to centralized data (**Table 14**).

Table 14. *Data on hepatitis B and C testing among pregnant women, provided by Vahdat Reproductive Health Center for the region*

	2024	2025
Nr (per cent) of women who had test performed	8,242 (100%)	8,139 (100%)
Nr (per cent) of women with HBsAg positive	83 (1.01%)	65 (0.80%)
Nr (per cent) of women with anti-HCV positive	4 (0.012%)	8 (0.098%)
Nr (per cent) of women with I WR positive	1 (0.012%)	0 (0.000%)

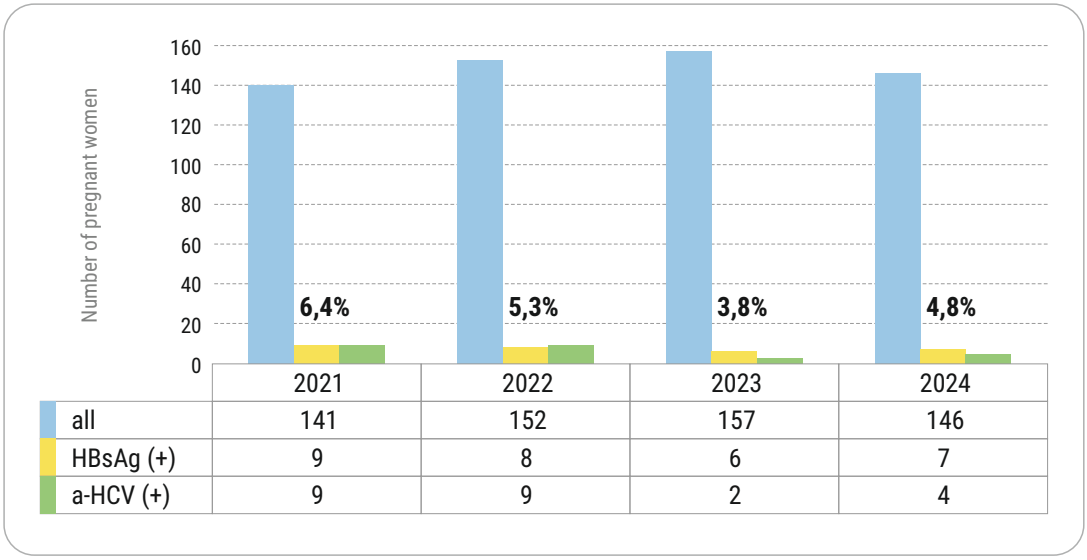
Data provided by the RCRH for this assessment varied to some extent from data provided by region. For example, according to regional data from Vahdat, in 2024 the incidence of HBsAg (+) among pregnant women was 1.01 per cent (83 cases) while the RCRH data shows 0.6 per cent (65 cases). The absolute difference being, therefore, 18 cases. This underlines the importance of the incorporation of data triangulation into routine surveillance along with written procedures for data mergers (**Table 15**). An even more important aspect is providing a clear definition of cases. So far, the vast majority of data comes from OOP rapid tests performed in private laboratories that have uncertain quality and reporting. This is especially important in respect to the introduction of digitalization, with the leading role taken by RCMSI.

Table 15. *Data on hepatitis B and C testing among pregnant women, provided by the RCRH*

Name of city and district	HBsAg tests		Positive HBsAg		Anti-HCV tests		Positive anti-HCV	
	n	%	n	%	n	%	n	%
	2021							
Republic	214,709	95.4	1,127	0.5	179,453	79.7	118	0.5
Vahdat city	9,060	98.4	67	0.7	1,394	15.1	3	0.2
	2022							
Republic	235,191	98.9	915	0.3	204,037	86.0	168	0.1
Vahdat city	9,723	100	83	0.8	9,723	100	3	0.03
	2023							
Republic	241,790	99.1	1,131	0.4	198,219	81.2	151	0.1
Vahdat city	10,091	99.1	62	0.6	1,244	12.2	1	0.1
	2024							
Republic	250,345	98.6	1,082	0.4	204,222	80.4	188	0.1
Vahdat city	10,899	99.3	65	0.6	1,510	13.7	9	0.6

Nevertheless, even if based on OOP rapid testing, centralized data provided by RCRH indicate a high prevalence of HBsAg positive cases among pregnant women (0.4 per cent in 2024, which is 1,082 pregnant women). Among the high-risk group (women living with HIV), the rates of HBsAg (+) were three to six times higher, depending on the year (**Figure 14**).

Figure 14. *Data for hepatitis testing among HIV-positive pregnant women, reported by RC AIDS (Infotracker)*



	2021	2022	2023	2024
all	141	152	157	146
HBsAg (+)	9	8	6	7
a-HCV (+)	9	9	2	4

Tajikistan has a high fertility rate; thus, many deliveries occur per year and per maternity center. On average Tajik women have three deliveries during their lifetimes, therefore more than one possible exposure. The odds of HBV nosocomial infection for pregnant women are therefore very high, not only because of the prevalence of HBV infection in this population, but also in relation to having multiple exposures. This warrants the urgent introduction of measures for preventing both vertical and horizontal transmission in the delivery room and maternity wards.

Vaccination against hepatitis B in children was introduced in 2002 in Tajikistan, gradually including consecutive birth cohorts. The oldest immunized population is now at the age of 23. It is therefore essential to offer HBV vaccination to all pregnant women who were born before 2002 with at least two and preferentially all three doses during their pregnancies. This approach will build sustained immunoprotection among women of reproductive age. Secondly, there is an urgent need to immediately introduce tenofovir disoproxil therapy for HBV infected women who are pregnant: planning for at least 1,000 patients yearly.

Vaccination against Hepatitis B and other prevention programs

Vaccination against hepatitis B for children was introduced in Tajikistan in 2002, with support from UNICEF, WHO, GAVI (The Vaccine Alliance), and other stakeholders. It is currently entirely based on maternity hospitals (where Hep-BD is provided) and PHC (where three further doses are given as part of pentavalent vaccine) (**Photo 4**).

Photo 4. *Vaccination program in the primary health service in Bokhtar 22.09.2025*



Mothers assisting a nurse during a vaccination visit to the PHC in Vahdat.



Fridge for vaccines purchased from GAVI funds



Pentavalent vaccine, including HepB dose, at the PHC in Tursunzade



HepBD in a fridge, Maternal hospital, Vahdat

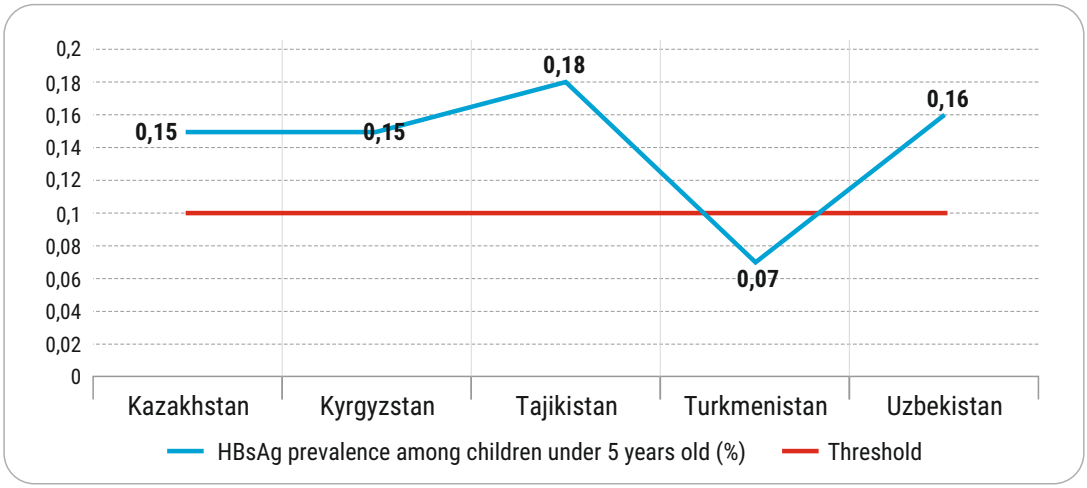
UNICEF assists in fund raising and centralized procurement processes, as well as supporting cold chain logistics, while the Republican Center for Immunoprophylaxis of Tajikistan (RCIP) is responsible for surveillance and reporting. RCIP reports annually on the coverage of hepatitis B vaccination among children—both Hep-BD and Hep3D. A timely birth dose (Hep-BD) is defined as occurring within 24 hours of birth. The reported Hep-BD and the third dose coverage for 2021–2025 as provided by RCIP are presented in **Table 16**. Of note, the source data will be needed in paper or electronic file form for the purpose of any future validation. The final validation of the successful vaccination program would be as a seroprevalence study.

Table 16. *Target group and coverage of Hep-BD and Penta vaccines (source: RCIP)*

	2021			2022			2023			2024		
	Target group	Coverage	per cent	Target group	Coverage	per cent	Target group	Coverage	per cent	Target group	Coverage	per cent
Hep-BD	225,359	223,727	99.3	240,766	238,739	99.2	246,316	244,757	99.4	260,758	259,309	99.4
PENTA -1	237,196	229,657	96.8	242,234	237,897	98.2	241,996	237,908	98.3	252,222	247,516	98.1
PENTA -2	237,196	229,308	96.7	242,234	235,536	97.2	241,996	234,972	97.1	252,222	245,765	97.4
PENTA -3	237,196	229,584	96.8	242,234	233,841	96.5	241,996	233,340	96.4	252,222	243,817	96.7

In 2023, the European Technical Advisory Group of Experts (ETAGE) on Immunization validated Kyrgyzstan, Turkmenistan, and Uzbekistan for achieving hepatitis B control targets by displaying consistency in vaccination policies for hepatitis B with appropriate coverage for screening for HBsAg in antenatal care. These countries documented success in the PMTCT of hepatitis B among vaccinated cohorts (**Figure 15**). According to the report two countries are currently conducting the next rounds of seroprevalence surveys (Kazakhstan, Kyrgyzstan), the results of which will be available in 2025. Tajikistan has not yet performed an assessment of HBsAg seroprevalence and therefore was not considered in this evaluation. Figure 15 presents data published in ETAGE report, but the source of the value of 0.18 seroprevalence has not been indicated. According to this data, HBsAg seroprevalence in children under five years old in Tajikistan was 0.18 per cent. Official data indicate only 6.3 per cent of people living with HBV infection have been diagnosed, and only 14.9 per cent of those diagnosed have been treated (Country data for the Global hepatitis reporting 2023).

Figure 15. *HBsAg prevalence among children under the age of 5 in Central Asia*



There is, in general, a lack of centrally collected data on seroprevalence and access to vaccination and treatment for adults. *Clinical Guidelines for the Diagnosis and Treatment of Viral and Non-Viral Liver Diseases* was prepared by Research Institute of Gastroenterology in

2020. However, in terms of overseeing the viral hepatitis epidemic and clinical care in Tajikistan, there is no central delegation and therefore no leadership yet. It is planned that responsibilities for epidemiological surveillance, tests, and drug procurement will be delegated to RC AIDS, while treatment and clinical follow-up will be delegated to the Institute of Gastroenterology of the Republic of Tajikistan.

Childhood prevalence is a proxy for HBV incidence and could serve to estimate the seroprevalence for the county. The ≤0.1 per cent HBsAg prevalence can be measured among either 5-year-olds, 1-year-olds, or those aged 1-5 years, according to existing country surveillance and data collection activities. For those regions and countries with a long history of high hepatitis B vaccination coverage (e.g., WHO Region of the Americas) and that already conduct school based serosurveys, there could be flexibility for conducting serosurveys in children >5 years.

The only prophylaxis for HBV infection is currently available in the form of "at birth vaccination" against hepatitis B. Currently, treatment with tenofovir is not available for HBV mono-infection. However, there is a plan to start this soon, with central procurement and distribution of tenofovir disoproxil by RC AIDS and clinical responsibility by the Institute of Gastroenterology.

Calculating process and impact indicators and case analyses for Tajikistan

The number of pregnant women who had at least one ANC visit and were assisted by a trained healthcare provider is the most important metric to adequately calculate process indicators. At the same time, this is the most difficult number to validate, if the pregnancy registry is not provided in a timely and accurate way. As described earlier, Tajikistan progressed significantly, working together with international partners on improving birth registry, but this does not directly translate into pregnancy registry. The problem of late reporting in pregnancy remains a significant barrier to any preventive pregnancy program, including EMTCT for HIV, syphilis, and hepatitis B.

Impact indicators are more reliably calculated, as the majority of data comes from the digital monitoring system run by RC AIDS (Infotracker). When using the WHO definition of HIV transmission cases, HIV MTCT is below the 2 per cent threshold (except for 2024), however it needs to be mentioned that most children are still diagnosed with HIV after 18 months of life (**Table 17, Table 18**). This is probably impacted by pregnant women not being followed up during pregnancy, giving birth at home, and not showing up in the system. Some cases are not diagnosed until the child is approaching school age (also see **Table 7**).

Table 17. *Impact and process indicators for HIV, Syphilis, and hepatitis B*

		Indicator	2021	2022	2023	2024	Data source/ Comment
Impact indicators		HIV mother-to-child transmission (MTCT) rate (per cent)					
	HIV	Born in a given year and diagnosed in this or next year As per WHO definition*	**3.38%** 7/207 **0.97%** 2/207	**1.59%** 4/252 **1.98%** 5/252	**0.80%** 2/251 **1.59%** 4/251	**0.81%** 2/247 **2.02%** 5/247	RC AIDS database (Infotracker) *diagnosed during first 18 months assigned to year of birth
	Syphilis	Annual rate of congenital syphilis cases (including syphilis-associated stillbirths) per 100,000 live births	-	**<50** n=4	**<50** n=1	**<50** n=2	Republican Clinical Center for Skin and Venereal Diseases of Tajikistan (numbers provided via email)
	HBV	HBsAg prevalence among ≤5-year-old birth cohort	-	-	-	-	-
Process	**All**	ANC1 coverage (per cent)	?	?	**81.0%***	?	Denominator uncertain * DHS 2023
	HIV	HIV testing coverage of pregnant women (per cent)	**86.6%** 209,379/ 241,783	**86.9%** 210,771/ 242,469	**90.9%** 234,439/ 257,858	**94.8%** 248,639/ 262,169	**Nominator:** RC AIDS **Denominator:** NCRH
		ART coverage of HIV-positive pregnant women (per cent)	**98.2%** 216/220	**97.8%** 263/269	**95.9%** 261/272	**97.6%** 245/251	RC AIDS database (Infotracker)
	Syphilis	Syphilis testing coverage of pregnant women among those attending at least 1 ANC visit (per cent)	**82.6%** 199,379/ 241,783	**99.5%** 241,353/ 242,469	**96.5%** 248,884/ 257,858	**100%** 262,169/ 262,169	Republican Clinical Center for Skin and Venereal Diseases of Tajikistan
		Adequate treatment coverage of syphilis-positive pregnant women	-	-	-	-	Note: treated with benzathine penicillin
	HBV	HBV testing coverage of pregnant women (per cent)	-	-	-	-	Not performed
		Coverage with 3 doses of hepatitis B vaccine (HepB3) in infants (per cent)	**96.8%**	**96.5%**	**96.4%**	**96.7%**	RCIP; Note: The source data for nominator and denominator were not validated
		Coverage with timely hepatitis B birth dose vaccine (HepB-BD) (per cent)	**99.3%**	**99.2%**	**99.4%**	**99.4%**	

Red color marks indicators below the Validation targets;
Green color marks indicators meeting the Validation targets.

Table 18. *Validation targets for the above key process and impact indicators*

		Indicator	Target
Impact indicators	**HIV**	HIV mother-to-child transmission (MTCT) rate (per cent)	**<2%**
		Annual rate of new pediatric HIV infections per 100,000 live births	**<50**
	Syphilis	Annual rate of congenital syphilis cases (including syphilis-associated stillbirths) per 100,000 live births	**<50**
	HBV	HBV MTCT rate (per cent)*	**≤2%**
Process indicators	**All**	ANC1 coverage	**>95%**
	HIV	HIV testing coverage of pregnant women	**>95%**
		ART coverage of HIV-positive pregnant women	**>95%**
	Syphilis	Syphilis testing coverage of pregnant women among those attending at least 1 ANC visit	**>95%**
		Adequate treatment coverage of syphilis-positive pregnant women	**>95%**
	HBV	HBV testing coverage of pregnant women*	**≥90%**
		Antiviral coverage for eligible HBsAg-positive women*	**≥90%**
		Coverage with 3 doses of hepatitis B vaccine (HepB3) in infants	**≥90%**
		Coverage with timely hepatitis B birth dose vaccine (HepB-BD)	**≥90%**

Data availability and quality assessment

Tajikistan has been reporting to the Global AIDS Monitoring database on most indicators since 2011–2012. Data on syphilis among pregnant women is not available. National HIV monitoring data are collected under the supervision of the State Institution RC AIDS, which is responsible for data collection and epidemiological surveillance of HIV, as well as coordinating many processes with a delegation from MoHSPP. RC AIDS runs a successfully functioning electronic database (Infotracker).

All relevant data for HIV treatment and care are digitalized and collected from all regions of the country, including public health centers, through the electronic database on-line access managed by RC AIDS. In addition, in 2024, 450 specialists from laboratories and testing-points that conduct HIV testing were trained on the topic "Working in the Database of Registration of HIV Testing for Public and Private Medical Institutions (DBPI)," and more than 250 laboratories (both public and private) were connected to the National HIV Testing Registry—this is an online system for collecting, storing, and processing information about people who have been tested for HIV infection (12).

Currently available data on antenatal care are not systematically collected, thus show discrepancies and remain difficult to interpret. For example, the Republican Center for Medical Statistics and Information (RCMSI) reports the number of pregnant women per year (registered last year and still pregnant plus newly registered pregnant women in the current year), but the number of pregnant women received at least one antenatal visit each year is only provided for new pregnancies occurring in a given year (**Table 19**). Data are also not aligned with reports published by RCMSI in statistics books.

Table 19. *Data provided by Republican Center for Medical Statistics and Information*

Data	2021	2022	2023	2024	Source of data (Health Form number)
Number of pregnant women per year (registered last year and still pregnant + newly registered pregnant women in the current year)	362,772	369,294	379,808	393,980	Form No. 32
Number of pregnant women each year who received at least 1 antenatal visit (any)	181,588	186,264	190,863	210,208	Form No. 32
Number of home births	5,405	4,154	2,872	2,154	RAM
Number of births in a medical institution (any type of institution)	230,190	254,050	264,151	208,258	Form No. 32
# abortions	12,021	11,658	12,203	12,760	Form No. 13
Number of births	235,595	258,206	267,041	282,324	Form No. 32
Number of live births	224,654	239,490	246,836	262,461	Form No. 25
Number of stillbirths	1,761	1,981	1,934	1,852	Form No. 25
Number of term births	-	-	-	-	
Number of preterm births (after 22 weeks and before 37 weeks)	3,257	2,931	3,047	3,642	Form No. 32
Maternal mortality during childbirth*	40	42	43	53	Form No. 32
Neonatal mortality rate (0–27 days)	9.1	8.6	8.4	8.3	Form No. 25
* number of women who died during pregnancy, childbirth, or within 42 days of pregnancy termination from complications related to the pregnancy					

Gender equity

The most recent document reporting on gender is the *Gender Assessment Of National HIV Response, Republic of Tajikistan* (published 2024). It was conducted by the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), in close collaboration with the Tajikistan Network of Women Living with HIV. The assessment was carried out by M. Boltaeva, in consultation with experts specializing in HIV and gender equality. According to the assessment, women living with HIV were more likely (95 per cent) than men (82 per cent) to experience stigma. Married women often remain unaware of their husband's HIV status, as husbands conceal their HIV-positive status and do not take ART. Quite often, a woman's HIV infection is discovered during antenatal care. If a woman's HIV-positive status becomes known within the family, she is often considered responsible for the infection and may be subject to stigma, isolation, violence, and other factors.

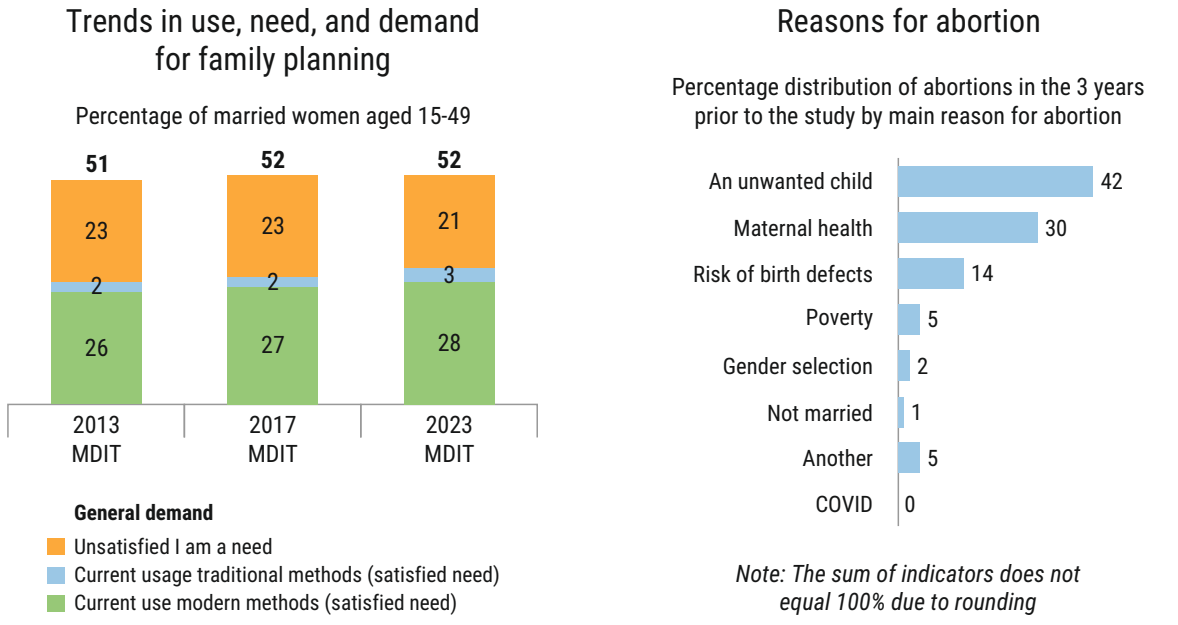
As described by the assessment, cases of violence against women have been reported frequently in Tajikistan. In 2018 the Committee on the Elimination of Discrimination against Women, reported that 97 per cent of men and 72 per cent of women believe that a woman should endure violence in order to preserve her family

(https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbol-no=CEDAW/C/TJK/CO/6&Lang=En).

However, the comparison of two DHS surveys shows that the proportion of women aged 15–49 who had ever experienced physical or sexual violence decreased from 24 per cent in 2017 to 12 per cent in 2023 (DHS, 2017, 2023). The prevalence of physical, sexual, or emotional violence against women by a husband/partner decreased from 31 per cent in 2017 to 16 per cent in 2023 (DHS, 2023). Between 2 per cent and 6 per cent of women have experienced sexual violence perpetrated by their current/most recent intimate partner (DHS 2023, UNDP 2021) (15). A new area of threat comes into play, namely the cyberbullying and violence against women and girls on social networks and in the digital space. According to NGOs, this form has become more frequent in recent years.

According to the DHS 2023, 7 per cent of teenage women (15–19 years old) have at some time become pregnant, 3 per cent had a live birth, and 5 per cent are currently pregnant. Adolescents under 18 years of age require parental consent to receive Sexual and Reproductive Health care, which results in significant restrictions in access to contraception for this age group. This also has an impact on education and awareness among younger women. As a result, sexual and reproductive health services are mostly attended by women who are married and already have the desired number of children. Even in this group, only 32 per cent of women use any method of contraception, including 28 per cent who use a modern method and 3 per cent of women who use a traditional method (interrupted intercourse). Intrauterine device remains the most used contraceptive method among married women (18 per cent) followed by a male condom (4 per cent). Half of surveyed women remained unsatisfied with family planning (**Figure 16**).

Figure 16. *The prevalence of contraception methods among married women and reasons for abortion (DHS 2023)*



The most recent Multiple Indicator Cluster Survey was performed by UNICEF in 2005 (https://mics.unicef.org). There is an urgent need to provide new systematic assessments to understand the broader aspects and dynamics of gender equity in the country, also in the context of pregnancy and childhood (15).

Human rights and the legal act assessment

Significant efforts have been undertaken to adapt changes aiming to decriminalize law and fight stigma (9,13). As indicated earlier, the supervision of legal acts in accordance with the rights of people living with HIV lies within the official responsibility of RC AIDS. The center is in continuous contact with major NGOs, which allows for necessary consultations and insight from the community of people living with HIV. It is an important area, as there are still concerns regarding the Tajikistan government's approach to the criminalization of HIV transmission.

Currently, several legal acts may contribute to the criminalization of HIV. The main act is Art.125 of the Criminal Code, which relates to HIV "exposure" and transmission with substantially higher penalties than those relating to other diseases. To cite exactly:

1. Knowingly placing another person in danger of being infected with the human immunodeficiency virus,

   – shall be punishable by restraint of liberty for a term of up to three years or imprisonment for a term of up to two years.

2. Infection of another person with the human immunodeficiency virus by a person who knew that he/she had this disease,

   – shall be punishable by deprivation of liberty for a term of two to five years.

3. The act provided for in the second part of this article, committed:

   a) in relation to two or more persons;

   b) in relation to a known minor,

   – shall be punishable by deprivation of liberty for a term of five to ten years.

According to the *Gender Assessment of National HIV Response, Republic of Tajikistan* (published 2024), of 14 criminal cases handled by the Human Rights Center (HRC, 2024), 12 were initiated under Article 125 of the Criminal Code of the Republic of Tajikistan. Of these 14, six were initiated against men and eight against women.

In comparison, Article 126, which covers other "venereal diseases," does not criminalize "exposure," while transmission results in a fine or correctional labor for one to two years, or a fine or imprisonment for up to two years where committed against multiple people or minors. To cite exactly:

1. Infection of another person with a venereal disease by a person knowing that they have the disease,

   – shall be punishable by a fine of two hundred to five hundred times the calculated rate or by correctional labor for a term of one to two years.

2. The same act committed:

   a) against two or more persons;

   b) against a person known to be a minor,

   – shall be punishable by a fine of five hundred to seven hundred times the calculated rate or by imprisonment for a term of up to two years.

However, the Plenum of the Supreme Court on December 26, 2023, Tajikistan, through a new resolution, asked that issues related to criminal liability for HIV exposure and transmission under Article 125 of the Criminal Code to be examined more objectively. The resolution obliges judicial practice to take into consideration that people on antiretroviral treatment with undetectable viral load cannot transmit HIV. This fact was commented on by Lancet as Tajikistan's tentative steps to tackling HIV (16).

In 2018, the Criminal Code of the Republic of Tajikistan has included articles that could lead to criminal liability for "likes," reposts, comments, and other reactions to materials deemed extremist or that incite terrorism. In particular:

- Article 179, Part (3) of the Criminal Code – "public calls to commit terrorist crimes and/or public justification of terrorist activity." This article carries a penalty of up to 15 years in prison.
- Article 307, Part (1) of the Criminal Code – "public calls to extremist activity and public justification of extremism." This article carries a penalty of up to 12 years in prison.
- On May 14, 2025, President Emomali Rahmon signed a law amending the Criminal Code, decriminalizing “likes” and "other signs of approval" on social media.

However, the provisions of the Criminal Code that criminalized likes, emojis, reposts, and similar actions, when they were perceived as supporting extremist or terrorist publications, were removed. The amendments concern Article 179(3) and Article 307(1) of the Criminal Code.

Furthermore, according to Government Order Nr 475 (2018), people living with HIV are prohibited from studying for a medical occupation and, according to Order Nr 406 (2004), people living with HIV are prohibited from adopting children.

There are no laws in the Republic of Tajikistan criminalizing drug use or sexual orientation. Adolescents under 18 years of age require parental consent to receive Sexual and Reproductive Health care, HIV testing, and HIV treatment. HIV testing is required before marriage and for medical examinations upon admission to educational institutions.

Tajikistan’s history of national programs for the prevention and control of HIV and STIs:

- National program for the prevention and control of HIV/AIDS and STIs in the Republic of Tajikistan for the period 1997–1998 (Resolution of the Government of the Republic of Tajikistan dated 04/09/1997, No. 163).
- Strategic plan for the prevention of the threat of the spread of HIV/AIDS in the Republic of Tajikistan for the period 2002–2005 (Resolution of the Government of the Republic of Tajikistan dated 01.10.2002, No. 389).
- National program for the prevention and control of HIV/AIDS and STIs in the Republic of Tajikistan for the period up to 2007 (Resolution of the Government of the Republic of Tajikistan dated 30.12.2000, No. 516).
- Program to combat the spread of HIV/AIDS in the Republic of Tajikistan for the period 2007–2010 (Resolution of the Government of the Republic of Tajikistan dated 03.03.2007, No. 86).
- Program to combat the HIV epidemic in the Republic of Tajikistan for the period 2011–2015 (Resolution of the GoT of October 30, 2010, No. 562).

- National Program to Combat the HIV Epidemic in the Republic of Tajikistan for the Period 2017–2020 (Resolution of the Government of Tajikistan dated February 25, 2017, No. 89).
- National program to combat the HIV/AIDS epidemic in the Republic of Tajikistan for the period 2021–2025 (Resolution of the Government of the Republic of Tajikistan dated February 27, 2021, No. 50).

The next National program to combat the HIV/AIDS epidemic in the Republic of Tajikistan for the period 2026–2030 (which is currently under consideration by the Government of the Republic of Tajikistan) prioritizes six major areas:

1. The strengthening and expanding preventive measures that provide a unified, comprehensive approach to combating human immunodeficiency virus and parenteral viral hepatitis is aimed at significantly reducing the incidence rate; improving public health; ensuring equal access to preventive services, diagnosis, and treatment; raising public awareness; and eliminating stigma and discrimination associated with these diseases.
2. Improving diagnostics and testing through the introduction of modern testing systems, the widespread use of highly sensitive and rapid methods for detecting human immunodeficiency virus and parenteral viral hepatitis and ensuring access to testing for all key and vulnerable population groups.
3. Ensuring continuous and effective treatment by creating a sustainable system of ongoing monitoring and the updating of treatment protocols, and access to modern medications, which allows for the optimization of therapy and improvement of patients' quality of life.
4. Strengthening the healthcare system and inter-sectoral collaboration through resource integration, human resource development, and infrastructure improvement, as well as establishing effective cooperation between healthcare, social protection, education, and public administration to create a unified and comprehensive system of public service.
5. Protecting rights and providing social and legal support through the implementation of a range of measures aimed at ensuring equal access to medical, social, and legal services; overcoming stigma and discrimination; and developing an effective legal framework to protect the interests of key and vulnerable population groups.
6. Monitoring, evaluating, and managing quality through systematic control, analysis of key indicators, and the prompt adjustment of programs to continuously improve the efficiency and quality of the services provided.

The implementation of the National Program’s major areas for the period 2026–2030 will involve the following governmental institutions:

- Ministry of Health and Social Protection of the Population;
- Ministry of Education and Science;
- Ministry of Justice;
- Ministry of Internal Affairs;
- Ministry of Finance;
- Ministry of Labor, Migration and Employment;
- Ministry of Culture;

- Committee on Youth and Sports;
- Committee on Women and Family Affairs;
- Committee on Religious Affairs, Regulation of National Traditions, Celebrations and Rituals;
- Committee on Television and Radio Broadcasting;
- Local executive bodies of state power;
- National Coordinating Committee to Combat Acquired Immunodeficiency Syndrome, Tuberculosis, and Malaria;
- Supreme Court;
- Public organizations.

Stigma and discrimination

Stigma and discrimination is rarely assessed in Tajikistan. The last Stigma Index Survey set was performed in 2021, showing clear patterns of fear for disclosure of HIV status, which influenced actions limiting social life, access to healthcare, and pro-family decisions (**Tables 20-22**). Friends, neighbors, and people's own children were the groups highlighted that the respondent seldom shared their HIV status with. This indicates a high-level fear of not being accepted or even stigmatized by the social environment.

Table 20. *Disclosing HIV status (Stigma Index Report)*

14	Groups	Yes	No	N/A	If "Yes", was your status ever disclosed to this person/group without your consent?
a.	Your husband/wife/partner(s)	58,5	19,0	22,5	4,3
b.	Your children	14,8	74,4	10,8	1,1
c.	Other family members	70,0	29,4	0,6	6,5
d.	Your friends	14,9	84,3	0,8	3,1
e.	Your neighbors	6,4	91,8	1,8	4,3
f.	Your employer(s)	6,1	37,9	56,0	0,5
g.	Your co-workers	5,5	38,9	55,6	0,6
h.	Your teacher(s) school administrator(s)	0,5	15,2	84,3	0,3
i.	Your classmates	0,5	27,5	72,0	0,1
j.	Local leaders	2,4	75,5	22,2	1,5
k.	Authority figures (e.g., police, judges, prosecutors, law enforcement, etc.)	10,2	65,4	24,4	5,4

At the same time, disclosing HIV status was indicated as being a positive or somewhat positive experience by 70 per cent of women and 51.1 per cent of men. In approximately 60 per cent of both men and women who responded to the survey, people who they decided to

share the information about their HIV status with were supportive and the overall experience was positive.

Table 21. *Experience when disclosing their status (Stigma Index Report)*

Statement: In general disclosing your HIV status to people you are close to has been a positive experience														
Options	**Total PLHIV**		**PLHIV**				**MSM**		**SW**		**PWUD**		**Transgender**	
			Women		**Men**									
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Agree	252	23,0	129	22,6	123	23,2	5	18,5	20	23,0	54	26,0	3	37,5
Somewhat agree	418	38,0	270	47,4	148	27,9	10	37,0	27	31,0	69	33,2	3	37,5
Disagree	361	33,0	141	24,7	220	41,5	12	44,4	35	40,2	73	35,1	2	25,0
n/a	69	6,0	30	5,3	39	7,4	0	0,0	5	5,7	12	5,8	0	0,0
TOTAL	**1100**	**100**	**570**	**100**	**530**	**100**	**27**	**100**	**87**	**100**	**208**	**100**	**8**	**100**
Statement: In general, people you are close to were supportive when they first learned about your HIV status														
Agree	328	30,0	152	26,7	176	33,2	9	33,3	15	17,2	91	43,8	2	25,0
Somewhat agree	408	37,0	231	40,5	177	33,4	9	33,3	24	27,6	55	26,4	4	50,0
Disagree	238	22,0	101	17,7	137	25,8	9	33,3	34	39,1	52	25,0	4	25,0
n/a	126	11,0	86	15,1	40	7,5	0	0,0	14	16,1	10	4,8	0	0,0
TOTAL	**1100**	**100**	**570**	**100**	**530**	**100**	**27**	**100**	**87**	**100**	**208**	**100**	**8**	**100**

HIV status was associated with the choice of not going to a healthcare facility by 26.8 per cent of women and 18.2 per cent of men living with HIV. It was also not a significant barrier to seeking social support or attending social gatherings. However, it had a bigger impact on seeking a job, which could be related to receiving state support.

Table 22. *Actions related to HIV status (Stigma Index 2021)*

I have chosen not to attend social gatherings														
Options	**Total PLHIV**		**PLHIV**				**MSM**		**SW**		**PWUD**		**Transgender**	
			Women		**Men**									
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Yes	180	16,0	111	19,5	66	12,6	7	25,9	29	33,3	38	18,3	3	37,5
No	809	74,0	394	69,1	410	78,5	18	66,7	48	55,2	154	74,0	5	62,5
n/a	111	10,0	65	11?4	46	8,8	2	7,4	10	11,5	16	7,7	0	0,0
TOTAL	**1100**	**100**	**570**	**100**	**522**	**100**	**27**	**100**	**87**	**100**	**208**	**100**	**8**	**100**
I avoided going to a clinic or hospital when I needed to														
Yes	251	23,0	153	26,8	95	18,2	4	14,8	25	28,7	49	23,6	3	37,5
No	815	74,0	404	70,9	406	77,8	22	81,5	60	69,0	153	73,6	5	62,5
n/a	34	3,0	13	2,3	21	4,0	1	3,7	2	2,3	6	2,9	0	0,0
TOTAL	**1100**	**100**	**570**	**100**	**522**	**100**	**27**	**100**	**87**	**100**	**208**	**100**	**8**	**100**

I have chosen not to apply for a job(s)														
Yes	347	32,0	226	39,6	119	22,8	3	11,1	30	34,5	47	22,6	2	25,0
No	580	53,0	214	37,5	360	69,0	20	74,1	48	55,2	139	66,8	6	75,0
n/a	173	16,0	130	22,8	43	8,2	4	14,8	9	10,3	22	10,6	0	0,0
TOTAL	**1100**	**100**	**570**	**100**	**522**	**100**	**27**	**100**	**87**	**100**	**208**	**100**	**8**	**100**
I have chosen not to seek social support														
Yes	135	12,0	73	12,8	59	11,3	5	18,5	27	31,0	35	16,8	3	37,5
No	680	62,0	343	60,2	333	63,8	21	77,8	51	58,6	137	65,9	4	50,0
n/a	285	26,0	154	27,0	130	24,9	1	3,7	9	10,3	36	17,3	1	12,5
TOTAL	**1100**	**100**	**570**	**100**	**522**	**100**	**27**	**100**	**87**	**100**	**208**	**100**	**8**	**100**

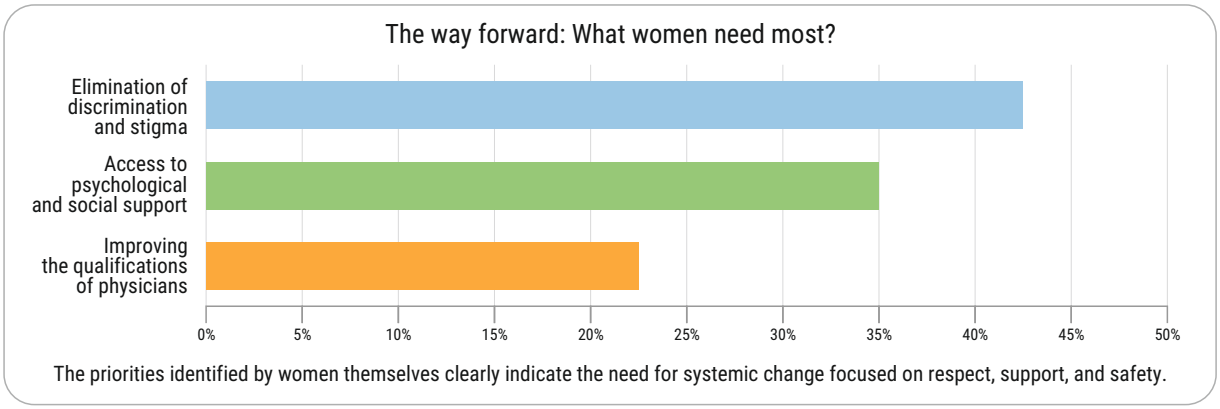
The most recent analysis of the quality of health services for women living with HIV in Dushanbe and the RRS "Голоса, которые должны быть услышаны" (**Voices that need to be heard**) was performed in June–July 2025 by the "Tajik Network of Women Living with HIV," with support from the UNAIDS Country Office, and it represents a Community Led Monitoring element of healthcare outcome measures.

The purpose of the survey was to assess the quality of medical services for women living with HIV and identify the barriers they face. The survey included 40 respondents from Dushanbe and the Districts of Republican Subordination. The questions covered the frequency of visits to medical facilities, accessibility of care, staff attitudes, awareness, barriers, physician qualifications, availability of child care recommendations, experiences of discrimination, psychological support, comfort level, and suggestions for improvement.

Fear of being judged is a major barrier for women in accessing healthcare. Respondents reported instances where medical staff refused to deliver babies, demanded private rooms, or violated confidentiality. Women face anxiety, depression, and feelings of guilt, especially during pregnancy and after childbirth. These underscore the impact of internalized stigma on the well-being of women living with HIV in Tajikistan (**Figure 17**).

Although most women receive basic information, almost 25 per cent complained that it is insufficient or difficult to understand. This is especially true for child care, nutrition, and HIV prevention.

Figure 17. *What is the most important need for women living with HIV in Tajikistan*



Some women reported violations of Decree No. 600, which guarantees free services. Demanding payment for tests, refusing appointments, and sharing data with third parties all undermine trust in the system.

The authors of the survey concluded that rights protection in the provision of healthcare for women living with HIV is urgently needed. This includes strengthening the enforcement of Resolution No. 600 and the introduction of a complaints and feedback mechanism that protects confidentiality. The survey identified invisible barriers that included administrative and logistical difficulties, which were underestimated by medical staff but were a significant obstacle for women. To improve the situation, it is necessary to audit and streamline internal processes and consider providing targeted assistance with transportation and funding.

According to the survey medical staff see stigma as a problem that is "gradually declining," while women experience it as a dominant, paralyzing fear. This fundamental discrepancy in perception means that, for medical staff, the problem is more of an ethical one, while for patients, it is an existential threat to their health and well-being.

It is important to note in this section that certain elements in the HIV care system may increase stigma, especially internalized stigma, without having any proven additive role in controlling the epidemic. One of these elements is the epidemiological assessment carried out throughout the process of confirming the HIV diagnosis. Currently, this process includes a step that involves an epidemiologist contacting the patient to collect information on the mode of infection and on risk behaviors. This information could be collected by an HCP caring for patient who is able to provide a more intimate and trusted space for the patient. Epidemiological investigation could be performed using an HCP or ANC specialist, thus avoiding the patient's direct involvement.

Summary of strengths and gaps

The strengths and gaps identified for the field of HIV, Hepatitis B, and syphilis MTCTP during the assessment are summarized in bullet points below.

Strengths

- Significant improvement in coverage in ANC.
- Birth registry in place and digitalization of the registration process.
- Simplified HIV testing scheme (skipped Western blot).
- Broad coverage of HIV testing among pregnant women, including access to rapid testing.
- Clinical protocols for HIV testing, treatment, and PMTCT are set and approved by MoHSPP.
- Strong leadership from Republican AIDS Center responsible for oversight, and good personal communication with AIDS centers at the regional and local levels.
- Access to contraception for women living with HIV through reproductive health care.
- Access to rapid HIV testing at the PHC and ANC level.
- Availability of ART for pregnant women.
- Availability of PEP for newborns.

- Early HIV diagnosis provided for children born to mothers living with HIV.
- In depth analysis of MTCT cases for HIV and syphilis.

Overall gaps

- Poverty and distance to nearest healthcare center is continuing barrier to accessing medical care.
- Women from households affected by poverty remain outside medical care until delivery.
- Nationwide, 11 per cent of pregnant women are not registered for antenatal care on time.
- Not all births are registered immediately after delivery.
- Large proportion of services, including HIV and syphilis testing among pregnant women, remain OOP cost.
- Poor access to testing among non-pregnant women.
- Medical service delivery is not based on patient centered care principle (e.g., contraception and STI testing, pregnancy care and blood tests taken by different services).
- Poor utilization of partner testing for HIV and STIs.
- Missed opportunities for education on HIV, Hepatitis B, and syphilis.
- Healthcare system is not based on performance indicators.
- Vertical structure of services delivered: dermato-venerological sector separated from HIV, hepatitis is under gastroenterology.
- Low awareness about health, including STIs, infection-related cancer (e.g., HPV and HBV).
- The lack of assessment of patients' opinions and patients' awareness of their own rights.

Specific gaps - syphilis

- Lack of central leadership in terms of access to diagnostics and its modernization, as well as free of charge standard of care therapy.
- No unified surveillance system (fragmented data).
- Lack of data quality assessment, no data triangulation or cross-checks performed.
- No partner testing, even if syphilis is diagnosed in a married person.
- Low utilization of syphilis testing (rapid testing available but only as OOP).
- No clinical protocol or recommendations for treatment.

Specific gaps - hepatitis B

- Lack of an institution responsible for hepatitis surveillance or central leadership for treatment in terms of access to diagnostics and its modernization, as well as for free of charge standard of care therapy.
- No public or OOP access to HepB vaccination for adults, including pregnant and reproductive aged women.
- No access to free of charge rapid testing, even for pregnant women.
- No access to tenofovir disoproxil prophylaxis for HBsAg (+) pregnant women.

Recommendations

Based on the analyses of all the provided documents and data, and as a result of virtual and in-county meetings, the following recommendations are provided for strengthening Tajikistan on the way towards eliminating the MTCT of HIV, hepatitis B, and syphilis.

Healthcare system:

1. Improve health literacy in society, including about HIV, hepatitis, and STIs (engage healthcare providers to empower patients, provide governmental funding for NGOs based education, mobilize unused resources among medical staff).
2. Ensure inter-sectoral communication within governmental structures to maximize resources.
3. Develop and legitimize channels of communication and data exchange processes both inter-sectoral within governmental structures and between institutions.
4. Merge the resources of Reproductive Health Centers and the PHC and acknowledge the great importance of both areas in maternity health and knowledge exchange.
5. Prevent outflow of current manpower in healthcare, especially the PHC, reproductive care, and maternity care (increase in salaries, postgraduate education opportunities, and the introduction of other incentives).
6. Introduce national benchmarking of access to free of charge healthcare services and provide equal access for all pregnant women to HIV, hepatitis, and syphilis testing.
7. Acknowledge good performers (e.g., certification process, financial bonus).
8. Introduce women centered care for pregnant women by integrating all services in one place and free of charge.
9. Eliminate logistical and financial barriers to accessing ANC facilities for pregnant women.
10. Ensure integrated care services both for pregnant and non-pregnant women (link the PHC with family planning and gynecological care).
11. Strengthen rights protection in the provision of healthcare for women, including the reinforcement of Resolution No. 600, provide transparent information for patients about free services and patients' rights.
12. Introduce a complaints and feedback mechanism that protects patients' identity; include Community Led Monitoring or Patient Reported Outcome Measures (PROMS).
13. Ensure confidentiality and intimacy for women, especially during maternity, when stigma intensifies in moments of vulnerability.
14. Integrate NGOs, serving statutory services for people living with HIV, with healthcare facilities in the area of peer-to-peer and social support services and providing state-based financing.
15. Publish reports and use them to adjust policy.

HIV, syphilis, and hepatitis B testing

1. Provide free of charge testing for HIV, hepatitis B, and syphilis in the form of co-testing (HIV, HBsAg and syphilis treponemal Ag) to all pregnant women, which is covered centrally by the state budget through centralized procurement.
2. Ensure >95 per cent coverage of the above-mentioned HIV, hepatitis B, and syphilis testing among pregnant women.
3. Provide access for all women of reproductive age to free of charge testing for HIV, HBsA, and syphilis treponemal Ag, irrespective of their marital status.
4. Define key indicators for the PMTCT of HIV, hepatitis B, and syphilis, to be followed consequently for all pregnant women (preferably use established international indicators provided by WHO).
5. Include data collected on testing for HIV, hepatitis, and syphilis during pregnancy in yearly Statistical Reports, with clear reference to number of performed tests and their results, as well as nominator and denominator allowing calculations of rates for key indicators.
6. Ensure the creation of a data collection system in order to follow key indicators (see point 4 and 5).
7. Offer broader access to pregnant women's partner testing, especially through health services, adapted to local customs and social acceptance (e.g., home-based testing).
8. Introduce a test at delivery for all previously negative pregnant women who are migrants, who have a partner who is a migrant, or who have a partner not tested for HIV.
9. Ensure a process in which women who have been tested for HIV, hepatic B, and syphilis at delivery are not discharged before receiving the test results (this includes early infant diagnosis).
10. Perform an in-depth analysis of HIV condition-based testing by codes along with a positivity rate for each code (to target interventions).
11. Remove the epidemiologist confirmation step for obtaining an HIV diagnosis—this may increase stigmatization and delay the result being provided to the patient.
12. Provide HIV testing for women with cervical dysplasia and cervical cancer.
13. Provide HIV testing for women with prescribed contraception and who are not using condoms.
14. Provide HIV testing for mothers after home delivery.

HIV PMTCT program components

1. Provide on-site access at maternity hospitals to TLD for rapid treatment start for all women diagnosed with HIV during delivery, independent of the timing of diagnosis (before or after delivery).
2. Consider allocating GeneXpert to the Tajik Research Institute of Obstetrics, Gynecology and Perinatology for rapid diagnostics during pregnancy.
3. Strengthen Early Infant Diagnosis procedures with the provision of 24/7 services to obtain results, with immediate communication to neonatologist for starting presumptive therapy

for babies.

4. Investigate breastfeeding practices among mothers living with HIV.
5. Provide better support for mothers who do not breastfeed, including pharmacological cessation of lactation and free formula milk adapted to the tolerance of the newborn/infant and/or as prescribed by a doctor.
6. Increase outside-of-PMTCT testing (e.g., symptom based) for newborns and infants for HIV (condition-based testing).
7. Plan and provide strict annual control of the PHC, ANC, reproductive health centers, maternity hospitals, and AIDS centers.
8. Ensure there is a process so that key indicators are included in the digitalization process and analyses are structured accordingly (HBsAg and anti-HCV prevalence).
9. Engage digital health to improve medical data access (Health card).
10. Continue to work towards legislation acknowledging U=U messaging in HIV and the barriers existing in legislation, in particular Article 125 of the Criminal Code.

Hepatitis B PMTCT program components

1. Clearly delegate responsibilities related to the diagnosis, treatment, and surveillance of hepatitis B infection in the Republic of Tajikistan.
2. Introduce free of charge, rapid HBV testing and vaccination against HBV for all pregnant women (start with a pilot project).
3. Provide access to tenofovir disoproxil for all HBsAg (+) pregnant women.

Syphilis PMTCT program components

1. Strong leadership is necessary for the syphilis epidemic management in the country, with clear delegation for reporting and adequately addressing the epidemic trend.

Data quality and access

1. Prioritize digitalization in health in order to collect data and outcomes of interest necessary for building healthcare that is tailored to national needs and targeted interventions.
2. Outcomes for eMTCT should be planned ahead of digitalization and consulted with key stakeholders - this assessment provides a review of all necessary nominators and denominators to calculate the impact indicators allowing for triple elimination validation.
3. As data are collected by different institutions (e.g., Tax Committee, Civil Status Registry, RC AIDS, NCRH, and RCMSI), legislation adapted to data protection is necessary to merge this data.
4. Quality control mechanisms for data collection should be introduced, along with written protocols for this process (signed and dated).
5. Establish internal and external data auditing - this should be included in the process of quality control.

Next steps

After the situational analysis provided above, an action plan should be developed that leverages the identified system strengths and opportunities to enhance health system capacity, addressing the gaps and challenges identified, based on the best global practices. Planning and prioritization should aim to provide context-specific solutions to close identified gaps.

The detailed planning process should aim to strategically integrate both disease-specific and shared approaches for the three infections discussed and other relevant program areas, such as sexual and reproductive health, maternal newborn and child care, communicable and non-communicable diseases, and others, for a more effective people-centered response. This highlights the need for all relevant programs, including civil society and community representatives, to be involved at every stage, taking ownership of the process of planning, organizing, and implementing triple elimination. For planning to succeed, there must be national policies in place to achieve the goal of triple elimination. The development of the action plan should be guided by the principles of the WHO Triple Elimination Framework.

The planning process requires leadership and management. The working group established for the assessment can continue to work and provide overall strategic direction, oversight, and accountability for planning. In addition to the technical working group, public health, financial experts, and community representatives should be present to provide detailed input on specific technical components of the plan, such as various programmatic areas and interventions, monitoring and evaluation, and costing and budgeting. The triple elimination action plan requires resources, including a budget to cover the costs of the activities that need to be undertaken.

This process should be led and coordinated by senior management in the Ministry of Health and Social Protection of Population, utilizing a dedicated technical working group that brings together the relevant stakeholders, including leadership teams across disease control programs and implementation platforms. All experts involved in the development of the action plan should remember that achieving triple elimination is dependent on meeting the needs and supporting the rights of women, newborns, children, and families.

As soon as the action plan is approved by MoHSPP, the responsible health authorities should coordinate and implement all relevant programs across partners and stakeholders, including coordinated community engagement for smooth implementation. Monitoring and evaluation of the action plan at the national and subnational levels should be an important part of the implementation stage. Constant progress monitoring will allow timely course corrections as needed.

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APPENDIX 1. List of Thematic Working Group members for EMTCT assessment, Republic of Tajikistan

№	Name and surname	Affiliation	Position
1.	Amirzoda Abduholik	MoHSP	Deputy Minister (communicable diseases, sanitary – epidemiology services)
2.	Abdusamatzoda Zulfia	MoHSP	Deputy Minister (MCH)
3.	Avgonov Zioyvuddin	Secretariat of National Coordination Committee (HIV/TB/Malaria)	Secretary
4.	Davlatzoda Said	MoHSP	Head of department for sanitary and epidemiological safety, emergency situations and emergency medical care
5.	Nabizoda Zoir	MoHSP	Head of department for organization of health services to mothers, children and family planning
6.	Sharifzoda Zaynullo	MoHSP	Head of department for economics and budget planning
7.	Zokirjonzoda Dilrabo	MoHSP	Head of unit, safe motherhood and family planning
8.	Mannonov Olimjon	MoHSP	Head of unit, PHC
9.	Jafarov Navruz	Agency for control of sanitary – epidemiological services and situation	Deputy director
10.	Sattorov Safarhon	Republican Center for AIDS Prevention and Control	Director
11.	Soliev Alijon	Republican Center for AIDS Prevention and Control	Deputy director
12.	Yokubov Izzatullo	Republican Center for AIDS Prevention and Control	Head of unit
13.	Ihtiyarova Hanifa	Republican Center for AIDS Prevention and Control	Head of unit
14.	Karimova Farzona	Republican Center for AIDS Prevention and Control	Head of unit
15.	Holnazarov Ramshed	Republican Center for AIDS Prevention and Control	Head of unit
16.	Vatanova Saodat	Republican Center for AIDS Prevention and Control	Obstetrician-gynecologist
17.	Majitova Tatyana	Republican Center for AIDS Prevention and Control	Pediatrician
18.	Boymurodov Kamoliddin	Republican Center for AIDS Prevention and Control	Medical doctor
19.	Ahmadzoda Maruf	Republican Clinical Center of Skin and Sexually Transmitted	Director

		Diseases	
20.	Bobiev Armiyo	Republican Clinical Center of Skin and Sexually Transmitted Diseases	Deputy director
21.	Gulov Hurshed	Republican Clinical Center of Skin and Sexually Transmitted Diseases	Head of laboratory
22.	Munisai Holmurod	Republican Clinical Center of Skin and Sexually Transmitted Diseases	Head of unit
23.	Kosimov Azizullo	MoHSP	Chief dermato-venerologist
24.	Shamsullozoda Manuchehr	Republican Center for Medical Statistics and Information	Director
25.	Saidzoda Fayzali	Republican Immunoprophylaxis center	Director
26.	Saidova Hafiza	National Center for Reproductive Health	Director
27.	Nabieva Munira	National Center for Reproductive Health Health center	Focal point for HIV related interventions
28.	Ganiev Behruz	Institute of Gastroenterology	Deputy director
29.	Mavjigul Azizulloeva	UNICEF	Health Specialist
30.	Hamidova Aziza	UNAIDS	Country Director
31.	Safarov Abdulahad	WHO	Specialist
32.	Tohirov Ravshan	UNFPA	Specialist
33.	Haydarova Takhmina	PO “Tajik Network of Women Living with HIV”	Executive Director
34.	Komilova Amina	Republican Center for AIDS Prevention and Control	Peer consultant

APPENDIX 2. List of documents provided for desk review

№	Name of documents	Name of document	Provided by
1.	Any prior assessments by WHO on HIV, syphilis, hepatitis	1.1. Viral hepatitis in European region. 1.2. Global Hepatitis Report 2024. 1.3. Comprehensive HIV programme Review in Tajikistan, 2023, WHO. 1.4. Gender assessment of the national responses to HIV. 2024. 1.5. Demographic and Health Survey. 2023. 1.6. Demographic and Medical Survey. Key Performance Indicators. 2023. 1.7. Health Systems in Action Tajikistan. 2024 Edition. 1.8. Primary health care financing: a situation assessment and policy options for Tajikistan.	Fakhriddin Nizamov Mavjigul Azizulloeva Own search
2.	Clinical protocols (or legal act) for testing and treatment of HIV, syphilis, hepatitis	2.1 National program on HIV for the period 2021- 2025. 2.2 ARVT treatment protocol. 2.3 Guideline on laboratory diagnostics of HIV. 2.4 PMTCT clinical protocol. 2.5 Clinical protocol on treatment of virus and non- virus hepatitis (in Tajik language).	Alijon Soliev
3.	National vaccination program	3.1 National immunization program 2021-2025.	Alijon Soliev
4.	Description of healthcare delivery model (the framework for delivering care, including the roles of providers, payment structures, and the integration of various services)		
5.	Description of care delivery model in Tajikistan for pregnant women and post-delivery including pediatric care		
6.	Description of care delivery model in Tajikistan for HIV, STIs and hepatitis		
7.	Electronic surveillance systems - list of collected variables	The list of collected variables for HIV is presented in 3 online maps used (7.1., 7.2., 7.3., 7.4.) There is no electronic system for syphilis and hepatitis in the country. Guidelines for the Use of Electronic Monitoring of HIV Infection Cases. Almaty 2010 Guidelines for the implementation of electronic tracking of HIV cases. Dushanbe 2011	Alijon Soliev
8.	EMTCT road-map progress reports (if available)	Не имеется. 8.1 The PMTCT assessment report, 2024, is available (in Tajik).	Alijon Soliev

9.	Surveillance/monitoring and evaluation (M&E) manual(s), plans and policies (if available)	9.1 National M&E plan.	Alijon Soliev
10.	Description of surveillance/M&E system(s), including organizational charts, staffing, etc. (if available)		
11.	Reporting forms for HIV, syphilis and congenital syphilis, hepatitis (including testing)		
12.	Surveillance/M&E reports over the past 4 years	12.1 The people living with HIV Stigma Index 2.0, 2021.	Mavjigul Azizulloeva
13.	Vaccine administrative coverage data reports (at least for HepB)		
14.	Legal acts describing HIV, STIs, hepatitis testing and transmission	14.1 Procedure for medical examination for HIV.	Alijon Soliev
15.	Legal acts on human rights and gender equity	15.1 Health Code of RT. 15.2 Gender assessment in RT, 2024.	Alijon Soliev

APPENDIX 3. List of variables needed to calculate impact and process indicators

To calculate indicators for HIV, congenital syphilis, and HBV, the following data is needed for each year (2021, 2022, 2023, 2024):

1. Number of pregnant women who had at least one visit during their pregnancy by a health professional for reasons relating to the pregnancy.
2. Number of pregnant women who had at least four visits during their pregnancy by a health professional for reasons relating to the pregnancy.
3. Number of women who have had a live birth or a stillbirth in the given year.
4. Number of women tested for HIV during pregnancy.
5. Number of women with HIV.
6. Number of pregnant women with HIV.
7. Number of women with HIV receiving antiretroviral therapy.
8. Number of pregnant women with HIV receiving antiretroviral therapy.
9. Number of women with HIV who had a live birth or a stillbirth in the given year.
10. Number of births to women living with HIV (includes multiple pregnancies).
11. Number of new HIV infections in children (dates of birth, dates of diagnosis).
12. Number of new HIV infections due to vertical transmission.
13. Number of congenital syphilis cases.
14. Number of live births or fetal deaths at >20 weeks of gestation or >500 g (including stillbirth) born to women with positive syphilis serology and without adequate syphilis treatment (OR Number of live births, stillbirth or child <2 years of age born to a woman with positive syphilis serology, OR with unknown serostatus and with laboratory and/or radiographic and/or clinical evidence of syphilis infection regardless of the timing or adequacy of maternal treatment).
15. Number of pregnant women tested for syphilis during pregnancy.
16. Number of pregnant women who received at least 1 dose of benzathine penicillin 2.4 mln at least 30 days prior to delivery.
17. Hepatitis B surface antigen (HBsAg) prevalence among ≤5-year-old birth cohort (and older children).
18. Depending on Tajikistan's hepatitis B vaccination program for children (HepB3 and/or HepB-BD):
    a) coverage with timely hepatitis B birth dose (HepB-BD); OR
    b) coverage with 3 doses of hepatitis B vaccine (HepB3) in infants.

APPENDIX 4. Work plan agreed with national partners

Time	Events	Venue	Personnel full name	Note
September 14, Sunday				
1:20	Arrival of the consultant in Dushanbe	Rumi Hotel	Justyna Kowalska	
September 15, Monday				
10:30-12:00	Meeting with UNICEF management and the UN security service	UNICEF office	Anthony Asije Azizulloeva Mavjigul	INT
12:00-12:30	**Lunch**			
13:00-14:00	Joint meeting with the leadership of the Ministry of Health and Social Protection of the Population of the Republic of Tajikistan and the responsible secretary of the National Coordination Committee to Combat AIDS, Tuberculosis and Malaria	Ministry of Health and Social Protection of the Republic of Tajikistan, Shevchenko st., 69	Amirzoda Abduholik Amir Abdusamatzoda Zulfiya Avgonov Ziyovuddin Tulforovich Sattorov Safarkhon Saidamirovich Soliev Alijon Azimjonovich Anthony Asije Azizulloeva Mavjigul	NL
14:30-18:00	Meeting with the management and staff of the state institution "Republican Center for the Prevention and Control of AIDS"	State Institution "Republican Center for the Prevention and Control of AIDS"	Sattorov Safarkhon Saidamirovich Soliev Alijon Azimzhonovich Kholnazarov Ramshed Davlatalievich Yokubov Izzatullo Rakhmatulloevich Sidikshoev Akhmadzhon Mirzodzhumaevich Karimova Farzona Makhmadlatifovna Vatanova Saodat Dodovna Madzhitova Tatyana Petrovna	SNL
September 16, Tuesday				
08:00-12:00	Meeting with the management and staff of the state institution "National Center for Reproductive Health"	State Institution "National Center for Reproductive Health"	Saidova Hafiza Ozodovna Nabieva Munira	SNL
12:00-13:00	**Lunch**			

Time	Events	Venue	Personnel full name	Note
13:30-17:00	Meeting with the management and staff of the state institution "Republican Clinical Center for Skin and Venereal Diseases"	State Institution "Republican Clinical Center for Skin and Venereal Diseases"	Ahmadzoda Maruf Ahmad Bobiev Armiyo Zikriyoevich Gulov Khurshed Ortikovich Munisai Kholmurod Kosimov Azizullo Mirzoevich	SNL
September 17, Wednesday				
8:30-12:00	Meeting with the management and staff of the state institution "Tajik Research Institute of Obstetrics, Gynecology and Perinatology"	State Institution "Tver Research Institute of Obstetrics, Gynecology and Perinatology"		SNL
13:30-14:30	Meeting with the management and staff of the state institution "City Clinical Hospital of Infectious Diseases," HIV treatment department	State Institution "City Clinical Hospital of Infectious Diseases," Zarafshon st., 2M11		SDL
12:00-13:00	**Lunch**			
15:30-17:00	"Republican Center for the Prevention and Control of AIDS" hands on database			
September 18, Thursday				
8:30-09:30	Meeting with the management and staff of the state institution "Republican Center for Immunoprophylaxis"	State Institution "Republican Center for Immunoprophylaxis"	Saidzoda Faizali Barot Saimutdinov Turashokh	SNL
10:00-11:30	Center for medical statistics and information (e-health)			
12:00-13:00	**Lunch**			
13:30-15:00	Meeting with the management and staff of the state institution "Institute of Gastroenterology of the Republic of Tajikistan"	State Institution "Institute of Gastroenterology of the Republic of Tajikistan"	Director Ganiev Behruz	SNL
15:30-17:00	"Republican Center for the Prevention and Control of AIDS" hands on database			

Time	Events	Venue	Personnel full name	Note
September 19, Friday				
08:00-18:00	Joint trip to Tursunzade, RRP. Review of the activities of the center for the prevention and control of AIDS, the center for reproductive health, the center for family medicine, the skin and venereology center, the maternity department, the immunocenter, the central polyclinic	Tursunzade city Central District Hospital 60 km	Karimov Fozil Other	SDL
September 20, Saturday				
08:00-14:00	Meeting with representatives of NGOs	State Institution "Republican Center for the Prevention and Control of AIDS," Dekhoti St., 48	Khaidarova Takhmina Komilova Amina Gulova Farishtamokh Djamolov Pulod	SDL
September 22, Monday				
07:00-18:00	Joint trip to the city of Bokhtar, Khatlon region. Review of the activities of the regional center for the prevention and control of AIDS, the center for reproductive health, the center for family medicine, the skin and venereology center, the maternity department, the immunocenter, the central polyclinic	Bokhtar city 90 km		SNL
September 23, Tuesday				
08:00-17:00	Visit to the AIDS prevention and control center, reproductive health center, family medicine center, skin and venereal disease center, maternity ward, immunocenter	Vahdat 25 km		SDL
September 24, Wednesday				
09:00-10:30	Meeting with WHO leadership in the Republic of Tajikistan	Dushanbe, VEFA Center		INT
11:00-12:30	Meeting with the	Dushanbe,		INT

Time	Events	Venue	Personnel full name	Note
	UNAIDS leadership in the Republic of Tajikistan	Business center "Sozidanie"		
12:30-13:30	**Lunch**			
14.00-18.00	Meeting with the management and staff of the state institution "Republican Clinical Center for Narcology"	Dushanbe city		SDL
September 25, Thursday				
08:00-17:00	Continuation of work at the State Institution "Regional Center for AIDS," at the National Center for Reproductive Health	RC AIDS NCHR		NL
September 26, Friday				
09:00-11:00	Debriefing with UNICEF management	UNICEF office		INT
15.00-17.00	Debriefing at the Ministry of Health and Social Protection of the Republic of Tajikistan with the participation of state, international and public organizations	Ministry of Health and Social Protection of the Republic of Tajikistan, Shevchenko st., 69	Amirzoda Abduholik Amir Abdusamatzoda Zulfiya Davlatzoda Said Haydar Nabizoda Zoir Narzullo Sharifzoda Zainullo All members of the working group	NL
September 26, Saturday				
1:20	Departure to Warsaw			
INT – international, NL - national level, SNL - sub-national level, SDL - service delivery level.				

APPENDIX 5. Consultancy plan and deadlines

The following consultancy plan and deadlines were planned within the framework of the technical assistance of UNICEF to governmental partners, UNICEF Health and Nutrition section committed to supporting the Ministry of Health and Social Protection of Population of the Republic of Tajikistan in the elimination of the mother-to-child transmission of HIV, hepatitis, and syphilis.

Tasks and Milestone	Deliverables and Outputs	Anticipated Timeline
1. Submission of executive plan (inception report)	**Del 1.** Preparation of executive plan (inception report) based on the desk review and conducting the consultative meeting with experts and stakeholders. This executive plan will address the methodology to reach the target including field visits, consultative meetings with experts, delivering reports, and explanation of how the deliverables of the contract will be achieved, and other schedules. The document will also specify the contents of the draft national pre-validation report and plan.	15 working days. June–August 2025
2. Pre-validation assessment: a) Conduct pre-validation assessment jointly with national team (in country), including field visits to healthcare facilities and community organizations to observe service delivery and gather firsthand information. b) Facilitate a consultative meeting to discuss the results with stakeholders (on- line). c) Submission of draft pre-validation assessment report and action plan.	**Del. 2.** Draft pre-validation report and action plan are submitted and discussed with national stakeholders.	30 working days if HIV, Hepatitis and Syphilis are covered. One 15-day country visit (15 September–26 September 2025) to review and validate current recording and reporting system for PMTCT activities.
3. Completion of final report and action plan based on feedback and comments provided by national experts, stakeholders and UNICEF.	**Del. 3.** Final report including the barriers, enablers, recommendations, and feasible action plan with time frame regarding EMTCT of HIV, HBV and Syphilis is submitted to UNICEF and MoHSP. Presentation of the findings and recommendations to relevant stakeholders, including the Ministry of Health, international partners, and community organizations.	15 working days. October 2025
Total number of days		**60 days**


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