MIDTERM PERFORMANCE EVALUATION OF USAID'S CENTRAL ASIA HIV PROGRAM

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ABSTRACT

This is a midterm evaluation of the five-year (2016-2020), USAID/Central Asia HIV Flagship Project, being implemented by Population Services International (PSI) and its nongovernmental organization (NGO) implementing partners (IPs) in Kazakhstan, Kyrgyz Republic, and Tajikistan. The purpose of the evaluation was to determine: 1) how well the Project components worked; 2) strengths and weaknesses of the Project; and 3) gaps inhibiting project achievements.

The USAID/Central Asia HIV Flagship Project was successful in rolling out a new approach to HIV programming in Central Asia, focused on case detection, treatment initiation, and adherence. Peer-driven rapid HIV testing in community settings has significantly broadened access to testing for people who inject drugs (PWID) and their sexual partners. Large numbers have been tested, although ambitious targets were not met (66,747 HIV tests versus a target of 77,321). The overall HIV-positive, case-detection yield of 1.8 percent is well below expectations given the estimated HIV prevalence among PWID. The Project needs to expand testing to new networks of PWID not currently reached and undertake more testing among former PWID. The Project's case management has made a significant contribution to antiretroviral therapy (ART) initiation, adherence, and retention in care, but there is still a significant gap between the number of new cases detected and the number of people who have initiated ART. Of the 1,192 newly found people living with HIV (PLHIV) through case detection, 735 (61.7 percent) commenced ART. The Project also supports ART re-/initiation by 2,132 loss to follow-up clients and PLHIV referred to the Project by AIDS Centers. While structural barriers play a significant part in limiting ART initiation, factors within the Project's control are improving the quality of pre-test counseling, including treatment education and motivational skills of case managers.

ACKNOWLEDGMENTS

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TABLES

ACRONYMS

AC	AIDS Center (City and Oblast Levels)
ACF	Active Case-finding
AMEP	Activity Monitoring and Evaluation Plan
APN	Assisted-partner notification
ART	Antiretroviral therapy
ARV	Antiretroviral
CD4	Cluster of Differentiation 4
CDC	US Centers for Disease Control and Prevention
COP	Chief of Party
COR	Contract Officer's Representative
FGD	Focus Group Discussion
FY	Fiscal Year
GBV	Gender-based violence
GF	Global Fund
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GH Pro	Global Health Program Cycle Improvement Project
HQ	Headquarters
IBBS	Integrated Biological and Behavioral Survey
ICAP	International Center for AIDS Care and Treatment Programs
IP	Implementing Partner (PSI NGO Implementing Partners)
KP	Key population (at risk for HIV)
KR	Kyrgyz Republic
LINKAGES	Linkages across the Continuum of HIV Services for Key Populations Affected by HIV
LTFU	Loss to follow-up
M&E	Monitoring and evaluation
MAT	Medication-assisted Therapy
MSM	Men who have sex with men
NGO	Nongovernmental organization
OGAC	Office of the US Global AIDS Coordinator
PDI	Peer-driven intervention
PDO	Peer-driven outreach
PEPFAR	US President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PN	Peer Navigator

PSI   Population Services International

PWID   People who inject drugs

RAC   Republican AIDS Center

RCD   Rapid case detection

SI   Strategic Information

TA   Technical Assistance

TB   Tuberculosis

TG   Transgender

ToT   Training of Trainers

UNAIDS   Joint United Nations Program on HIV/AIDS

UNDP   United Nations Development Programme

UNODC   United Nations Office on Drugs and Crime

USAID   United States Agency for International Development

VL   Viral load

WHO   World Health Organization

EXECUTIVE SUMMARY

EVALUATION PURPOSE AND QUESTIONS

The purpose of this midterm performance evaluation of the USAID/Central Asia HIV Flagship Project was to: 1) determine which Project components worked well and why and which components did not work well and why; 2) make recommendations for course correction; and 3) inform the design of future USAID HIV activities and strategy in Central Asia.

The evaluation questions were:

1. How effectively is the Project cohesively supporting the community components of the HIV cascade, including case-finding, linkage to treatment and adherence support for people who inject drugs (PWID), partners, prisoners, and ex-prisoners?

2. What are the Project's strengths, weaknesses, and gaps in planning and management, both internally (subgrantees, across their offices) and externally (e.g., USAID, host governments, US Centers for Disease Control and Prevention (CDC) Partners, other donors, etc.)?

3. What gaps still exist that inhibit the Project from achieving the expected results and how can these be addressed both within the current USAID Project activities and in future activities?

EVALUATION DESIGN, METHODS, AND LIMITATIONS

This performance evaluation undertook a wide range of interviews with the Project contractor's management and staff, nongovernmental organization (NGO) implementing partners (IPs), republican and city/oblast AIDS Centers [Republican AIDS Center (RAC)/AIDS Center (AC), city and oblast levels], USAID's HIV REACT and LEADER Projects, CDC and CDC's International Center for AIDS Care and Treatment Programs (ICAP) Project, and multilateral development partners. In addition, focus group discussions (FGDs) were conducted with clients of the USAID/Central Asia HIV Flagship Project. A thorough review of Project documentation, including performance indicator data, was conducted. All data were triangulated at analysis.

Key limitations of the evaluation were: findings and conclusions based primarily on qualitative data, and quantitative data relied on the Project's monitoring data; possible bias by NGOs in selecting clients for participation in FGDs; and the necessity of conducting some joint interviews with NGOs, given limited time.

PROJECT BACKGROUND

The five-year (2016–2020), $23 million USAID/Central Asia HIV Flagship Project is being implemented under contract by Population Services International (PSI) and 14 NGO IPs in priority sites of the US President's Emergency Plan for AIDS Relief (PEPFAR) in Kazakhstan, the Kyrgyz Republic, and Tajikistan. The two core components of the Project's work are focused on accelerated HIV case-finding and treatment scale-up through:

1. **Case detection** in community settings to find undiagnosed HIV cases and link them to treatment; and

2. **Case management** of people living with HIV (PLHIV) for antiretroviral therapy (ART) initiation, adherence, and retention in care.

Case detection focuses primarily on PWID as well as ex-PWID and their sexual partners. HIV prevalence estimates among PWID range from 9 to 27 percent within the PEPFAR focus subnational units. The USAID/Central Asia HIV Flagship Project has recently extended their case-detection and case-management work to include a 12-month pilot for men who have sex with men (MSM) in Bishkek and Dushanbe. The Project uses three methods of case detection:

1. **Peer-driven outreach** (PDO) uses community members as seeds to recruit peers for HIV testing, based on respondent-driven sampling and peer-driven intervention (PDI) models.

2. **Active case-finding** (ACF) uses Project-employed peer navigators (PNs) to undertake structured community mapping to find new injecting sites and new networks of PWID.

3. **Assisted-partner notification** (APN) assists PLHIV with sexual partner disclosure and offers HIV testing to partners. (APN is the sole case-detection method in Kazakhstan. Where this leads to identification of PWID, testing of PWID also occurs.)

The Project's case-management PNs provide community-based support for PLHIV found through the Project's case-detection work to ensure linkage to care, timely ART initiation, adherence, and retention in care. The Project has also undertaken extensive loss to follow-up (LTFU) work for AC patients (non-Project clients) and in fiscal year (FY) 2018 has been receiving referrals from ACs of their patients (non-Project clients) for community-based case management.

FINDINGS AND CONCLUSIONS

Evaluation questions 1 and 3: Effectiveness of the USAID/Central Asia HIV Flagship Project in cohesively supporting the community components of the HIV cascade and gaps in programming inhibiting achievement of results

Overall, PSI and its NGO IPs have done a good job implementing the Project in a very challenging environment characterized by high levels of HIV and PWID-related stigma and discrimination and a series of structural impediments to accessing health services. The key achievement has been the very significant progress in rolling out a new approach to HIV programming for Central Asia focused on case detection, treatment initiation, and adherence in pursuit of the Joint United Nations Program on HIV/AIDS (UNAIDS) 90-90-90 objectives. Key innovations in the context of Central Asia have been 1) peer-driven rapid HIV testing in community settings, which has significantly broadened access to testing; 2) leveraging the comparative advantage of NGOs in undertaking HIV testing among sexual partners; and 3) linking PLHIV to ART treatment through community-based case management. This represents a paradigm shift from previous HIV-prevention programming conducted through traditional outreach models to known PWID networks.

Case detection: PDO, ACF, and APN are complementary approaches to HIV case-finding and all three — individually and in combination — are a vital part of the Project's efforts to reduce the undiagnosed population. Consequently, having multiple approaches operating simultaneously can help sustain the overall case-finding effort. The Project deserves credit for efforts to improve case-detection rates, including seed selection (positive seeds versus negative seeds), varying the number of PDO waves before stopping, a greater emphasis on ACF to find hidden networks, attention to the appropriate balance between ACF and PDO, and incentives for seeds and those who undertake testing.

In the Kyrgyz Republic, the number of PWID tested for HIV by the Project increased from 8,156 in FY 2017 to 13,227 in the first nine months of FY 2018. However, the yield of HIV-positive results declined year after year from 3.5 percent to 1.1 percent. In Tajikistan over the same period, the number of

PWID tested for HIV increased on a pro-rata basis from 13,787 to 13,128 with yield declining from 2.2 percent to 1.5 percent.

While the USAID/Central Asia HIV Flagship Project has succeeded in testing large numbers of PWID, the total number (66,747 as of June 30, 2018) is well below the ambitious targets (77,321) and the gap between targets and testing has risen due to significant increases in annual targets. The overall yield of HIV-positive cases of 1.8 percent has been well below what was expected, given the relatively high estimated HIV prevalence among PWID. Just as importantly, the decline in yield from testing in FY 2018 indicates that the Project is finding it increasingly difficult to detect new cases. Possible reasons include that most of the HIV-positive PWID in the areas where the Project has been testing have already been diagnosed and that there are significant numbers of undiagnosed PWID in areas where the Project has not been conducting case detection. Alternatively, HIV prevalence and PWID population estimates may be too high.

The yield from sexual partner testing has been significantly higher than for PWIDs. APN yield in FY 2018 (to June) ranged from 5.3 percent in Kazakhstan to 6.3 percent in Kyrgyz Republic to 15.3 percent in Tajikistan. While APN is an important component of the Project's work, case-finding among sexual partners rests on initial case detection among PWID/ex-PWID. This needs to be kept in mind in regard to the relative priorities accorded to case detection among PWID and their sexual partners.

The two highest priorities for the Project over the remaining two and half years need to be improved targeting of PWIDs to increase the yield from testing and enrolling newly detected cases in ART. Success in increasing the yield from testing will primarily rest on identifying currently unreached networks of PWID and ex-PWID.

The recent welcome innovation in Tajikistan using RAC data to map all recent PWID case detections and those over the last three years and comparing these maps with the areas where NGOs are currently undertaking case detection should result in case-finding being undertaken in new areas. This may facilitate access to previously unreached networks of PWID. While it is too early to say, this could result in a significant number of new case detections. Implementation of this work by NGOs needs to be closely monitored by the Project. The RAC-generated maps need to be updated periodically. USAID and CDC, in collaboration with the Project and ICAP, should ask the RAC in the Kyrgyz Republic to generate similar maps so this approach can be replicated, and request the RAC in Tajikistan to regularly update the maps.

Recommended strategies to improve testing uptake and yield include: continuing to learn and adapt how to best implement the different case-detection approaches, including the interaction between the approaches; modifying, scaling down, or stopping case-detection activities in areas with significantly lower yields; incentivizing current PWID involvement in ACF mapping to find new networks of PWID; fostering greater sex, age, and socio-economic diversity among case-detection PNs to assist in finding a broader range of PWID networks; increasing case-finding among ex-PWID; maintaining a core focus on PWID, with a broader sexual/social networking approach; and improving pre-test counseling, with a strong emphasis on the benefits of treatment initiation.

Case management: The USAID/Central Asia HIV Flagship Project has primarily focused on case-detection work in an attempt to meet its very high testing targets, with a correspondingly lower level of effort on case management. The Project's very dedicated case managers, who are highly valued by their PLHIV clients, have, however, made a significant contribution in supporting ART initiation, adherence, and retention in care. There is, nonetheless, still a significant gap between the number of newly confirmed HIV case detections and those who have initiated ART. Of the 1,192 newly found PLHIV through case detection, 735 (61.7 percent) commenced ART as of June 30, 2018. ART initiation among

newly detected cases with a confirmed HIV-positive test ranged from 42 percent in Kazakhstan to 63 percent in Kyrgyz Republic to 68 percent in Tajikistan. In addition, the Project has also supported ART initiation or re-initiation by 2,132 LTFU clients and PLHIV referred to the Project by ACs for case management. Structural and enabling environment barriers relating to access to treatment play a significant part in limiting ART initiation. Other factors more within the Project's control are improving the quality of pre-test counseling, including treatment education, and improving the motivational skills of case managers.

The success of the USAID/Central Asia HIV Flagship Project in finding large numbers of AC LTFU patients has, along with the other work of case managers, demonstrated to RACs and ACs the benefits of community-based case-management work. More recently, with ACs now referring their existing patients (non-Flagship clients) to the Project for case management and APN, caseloads are increasing. While the Project's triage system for case management has been a useful tool for setting priorities, the reality is that few clients are ever fully "graduated." Given that the needs of PLHIV clients can fluctuate significantly over time in the context of Central Asia's highly stigmatized environment, some level of ongoing contact between case managers and their clients is appropriate. Most case managers are already carrying high caseloads, which are likely to increase. The Project will need to develop systems and support to effectively respond. This should be accompanied by efforts to professionalize the existing cadre of case managers.

With the exception of the need for above-site advocacy and support for Project replication, and advocacy to address structural barriers to HIV testing and treatment, the evaluation did not find any significant gaps in programming. Rather, it found a number of areas where the effectiveness of Project implementation can be improved; these are summarized above and set out in more detail in the recommendations below.

Evaluation question 2: Strengths, weaknesses, and gaps in internal and external planning and management

USAID staff reported that management of the USAID/Central Asia HIV Flagship Project has improved significantly under the new chief of party (COP), including better communication with USAID, within PSI, and with NGO IPs and external partners. The Project is seen as responsive and flexible to USAID requests. The regional and Kyrgyz PSI offices have dedicated and capable management teams that have been adaptive in responding to challenges. There has been limited technical support from PSI headquarters (HQ), and technical support staffing in the regional office is under-resourced and stretched thin. The PSI Tajikistan office needs considerable strengthening with regard to management and technical leadership.

There is a strong commitment by PSI and NGOs to collecting and using data to track performance. For example, the Project's three approaches to case-finding — PDO, ACF, and APN — are all data-driven and the USAID/Central Asia HIV Flagship Project uses both input and outcome data to improve the performance of the different approaches. However, the reporting burden on IPs seems excessive and may be taking away from their ability to focus on core Project activities. The focus on targets makes it challenging to develop a more strategic perspective on how a Flagship-type project can best contribute to controlling a concentrated epidemic from prevention through viral suppression. There is a need for PSI to build the skills of NGOs to analyze Project data on case detection and case management, coupled with the use of qualitative data from PNs' field experience in answering difficult "why" questions relating to key challenges, such as increasing case-detection rates, confirmatory testing, and ART uptake. PSI also needs to ensure that their high level of interaction on management support leaves NGO IPs with

sufficient time to implement. There is also an opportunity to expand the sharing of knowledge and experience across different IPs at both the organizational- and individual levels.

There is a high degree of collaboration between the USAID/Central Asia HIV Flagship Project and USAID's HIV REACT prisons project. As needed, ex-prisoners with ongoing case management needs are referred to the USAID/Central Asia HIV Flagship Project and Flagship notifies REACT of clients who are incarcerated to ensure ongoing access to ART and case management. The work of USAID's LEADER Project in reducing stigma and discrimination in health-care settings has been broadly supportive of an improved environment in ACs and some polyclinics for PLHIV seeking treatment.

The effectiveness of collaboration between the USAID/Central Asia HIV Flagship Project and ICAP varies from site to site and country to country. A common factor in strong collaboration is good management by AC directors who understand that the community-focused work of the Project and the facility work of ICAP are complementary, serving common objectives, and who actively manage respective inputs by each project so that the two projects are working as part of one, broader team. Tensions and competition, particularly in the areas of partner testing and case management, have arisen where there is overlap between the work of the USAID/Central Asia HIV Flagship Project and ICAP and confusion on boundaries. There is a need for USAID and CDC to reach clear agreement on role delineation, division of labor, and areas of joint work for the ICAP positions of PNs and Patronage Nurse as well as the USAID/Central Asia HIV Flagship Project position of PNs, including ICAP's role in the community and Flagship's role in facilities.

RECOMMENDATIONS

A. Recommendations for Implementation by PSI/Flagship

Frontline Staff

1. Flagship country offices should re-evaluate the respective roles of frontline staff working on case-finding and case management to ensure the roles and mix of staff are best suited to the specific environment and context, including having greater sex, age, socio-economic, and ethnic diversity among staff. The fundamental concern with the current approach is the limited qualifications of PNs to provide effective support to clients as they progress through the testing continuum, as they are linked to treatment, and as they are retained on treatment. *(Priority recommendation)*

2. The Project should explore further professionalizing its cadre of case managers. Not only will a better prepared, more professional group of case managers provide better support to clients, they are more likely to be retained by Flagship, and be part of a sustainable core of HIV case managers who can continue future work.

Incentives

3. The Project should experiment with its incentive schemes used with clients and staff. There appears to be opportunity and latitude to experiment with the different Flagship incentive schemes. For example, the Project could engage and incentivize current PWID to help find new, hidden, and/or hard-to-reach networks of PWID. The more variable approach used by Flagship with PDO (e.g., positive seeds versus negative seeds) is an example of how variation can shift outcomes and having a more open-minded and flexible approach to incentives could help optimize client engagement and staff performance. *(Priority recommendation)*

Case-finding

4. To strengthen its case-finding activities, Flagship should:

a) Continue to implement all three primary approaches (PDO, ACF, and APN) as these multiple methods, operating simultaneously, can help sustain the overall case-finding effort. Flagship and its partners should continue to learn and adapt ways to best implement the different case-detection approaches, including the interaction between them. ***(Priority recommendation)***

b) Pilot and/or expand the use of innovative/alternative approaches to case-finding; for example, contacting ex-PWID who may have been infected some years ago and who are no longer part of current PWID networks, or using tuberculosis (TB) death registries to offer HIV testing to surviving partners. ***(Priority recommendation)***

c) Expand existing efforts to improve pre-test counseling to increase numbers of PWID to undertake both initial HIV screening and confirmatory testing, with a strong emphasis on the benefits of treatment initiation, dealing with highly exaggerated fears on treatment side effects, and addressing widespread HIV myths and misinformation. ***(Priority recommendation)***

d) Maintain a core focus on PWID, while supplementing current case-detection approaches with a broader sexual/social networking approach, building on the APN approach.

e) Analyze client characteristics, including clients who test positive or negative, and network size to improve targeted testing under the PDO approach.

f) Extend the time frame for the MSM pilots currently being implemented in Bishkek and Dushanbe to give them a better opportunity to test and refine their approaches.

5. The PSI regional and Tajikistan offices should closely monitor the work being done in Tajikistan using geo-maps of recent/new PWID HIV diagnoses to improve case-finding. If the use of these maps continues to show promise, Flagship should continue the use of the approach in Tajikistan and initiate this approach in the Kyrgyz Republic, working as needed with USAID, CDC, and RACs to secure the anonymized data required for creating and maintaining up-to-date maps. In parallel with the use of geo-maps, Flagship should identify local areas where current case-detection activities are resulting in low case-detection yields and consider whether case-detection work in these areas should be modified, scaled down, or stopped. This would allow Project case-detection resources to be redeployed to other areas within the geographic remit of Flagship NGOs, where geo-maps indicate the possibility of previously unreached PWID networks. **(Priority recommendation)**

6. Flagship, USAID, and CDC should advocate for more flexible regulations and practices on where HIV screening and confirmatory testing can be done, who can do it, and how it can be done. In the short term, allowing confirmatory testing to be done outside ACs (i.e., in the community) is likely to have an impact on the loss factor between screening and confirmatory testing. The expanded community use of oral testing should also reduce barriers to HIV screening among the populations served by the Project.

Case Management

7. Flagship should take steps to improve HIV treatment education/knowledge, including:

a) training and mentoring of PNs and case managers on how to motivate PLHIV to initiate treatment, and

b) production of compelling and easily understood information materials for clients and prospective clients. *(Priority recommendation)*

Strategic Information (SI)

8. The Project should redefine its approach to data to emphasize the "strategic" value and utility of the collected and used information. A stronger emphasis on "strategic" information should include steps to strengthen the collection and use of relevant contextual and qualitative data to help Flagship understand why things are happening and what can be done to improve performance; for example, it would be useful to have a better understanding of the factors influencing ART uptake, including reducing the gap between confirmatory testing and ART initiation. As part of this effort, Flagship should also re-evaluate its approach to collecting client information to ensure it is respectful of client confidentiality and is only collecting data it will use. *(Priority recommendation)*

9. Flagship should conduct a pragmatic review of each project indicator used in the different countries to determine its value and utility. Given the central role that indicators play in both monitoring and reporting, it is critical to understand how, why, and whether each indicator contributes to the overall understanding of Project activities and outcomes. Flagship should also conduct a pragmatic review of other data points collected by the Project to determine their value and utility and identify what contextual and qualitative data could be added to the Project's portfolio of strategic information. *(Priority recommendation)*

10. The Project should consult with key stakeholders — including USAID, IPs, and ACs — to better understand which Project data are valuable and useful for the stakeholders and how these data can be presented best so that stakeholders can take full advantage of their value and utility. In addition, USAID should be more specific about what data and analysis it wants from Flagship and how they would like to see them presented. *(Priority recommendation)*

11. Flagship should identify what approaches and existing data sets can be used to triangulate more precise estimates of population sizes in its operational areas. The Project should then use the approaches and data sets to work with IPs to get a better picture of both the size and key characteristics of the populations in their operational areas. Given the influence of PEPFAR targets on Project planning and implementation, a better understanding of local population dynamics would be invaluable for helping shape those targets as well as improving case-finding. *(Priority recommendation)*

PSI Management

12. The PSI regional office should expand its technical assistance (TA) support to country offices, particularly around the use of SI for Project improvements. The regional office, in consultation with USAID, also needs to develop a plan to strengthen the management and technical capacity of the PSI Tajikistan office, including a review of the function of all staff positions. *(Priority recommendation)*

13. PSI HQ should take a more active role in providing technical support to the Project. The focus of this support should be on performance improvement (e.g., sharing of global best practice in HIV case-finding methods among key populations (KPs); better collection, analysis, and uses of quantitative and qualitative data; triangulation of data from different sources; quality improvement/assurance efforts; and management and technical capacity of IPs. *(Priority recommendation)*

14. PSI policies and procedures should be revised to ensure that frontline staff are spending the vast majority of their time doing frontline work (i.e., interactions with clients), not administrative work. On a parallel note, Flagship should streamline its systems to ensure that frontline organizations (e.g., its NGO IPs) have a lower administrative and reporting burden. It should also be clear to both frontline staff and frontline organizations how any required administrative and/or reporting efforts are used by the Project overall. *(Priority recommendation)*

15. PSI policies and procedures related to compensation and travel allowances should be reviewed to ensure that Project staff — at PSI and Flagship IPs — are treated fairly, given heavy demands of the work and the challenges in recruiting and retaining qualified staff members. The issue of travel allowances is especially relevant for outreach staff at Flagship IPs who work in rural areas. *(Priority recommendation)*

B. Recommendations for Implementation by USAID

USAID Management

16. USAID should strengthen its internal capacity to do ongoing data analysis to track and improve program performance as well as ensure USAID and Flagship can respond rapidly and efficiently to Office of the US Global AIDS Coordinator (OGAC) queries and concerns. USAID should also create and enforce a quality control process for data submitted to USAID by Flagship. *(Priority recommendation)*

Collaboration between Flagship and ICAP

17. USAID should encourage CDC and ICAP to undertake advocacy with RACs and ACs on facility-based structural issues that inhibit access to treatment, such as the restriction on where confirmatory tests can be undertaken, the inability of homeless people to access HIV treatment, and current AC practices relating to partner tracing. *(Priority recommendation)*

18. USAID and CDC, in consultation with RACs and ACs, should agree on role delineation, division of labor, and areas for joint work between ICAP and Flagship in each country. This should include consideration of the need to develop a formalized system of referral of AC clients to Flagship for community-based case management. USAID and CDC should liaise on the design of follow-on projects to maximize future collaborative efforts. USAID and CDC should also review how targets for indicators are allocated between Flagship and ICAP. *(Priority recommendation)*

19. In the interest of achieving national-level epidemic control, USAID and CDC should undertake advocacy and provide support to RACs for replication of the PEPFAR programming approaches in non-PEPFAR sites. Other stakeholders [e.g., Global Fund (GF), UNAIDS] who are actively involved in planning and/or implementing the response should also be included in these discussions.

1. INTRODUCTION

1.1 EVALUATION PURPOSE

This is an independent midterm performance evaluation of the five-year, United States Agency for International Development (USAID)/Central Asia HIV Flagship Project, being implemented by Population Services International (PSI) and its nongovernmental organization (NGO) implementing partners (IPs) in Kazakhstan, the Kyrgyz Republic, and Tajikistan, with a budget of $23 million (award number: AID-176-C-16-00001). An overview of the Project can be found in Section 2 of this report.

The purpose of the evaluation was to:

1. Determine which Project components worked well and why and which components did not work well and why.
2. Make recommendations for course correction.
3. Inform the design of future USAID HIV activities and strategy in Central Asia.

It is intended that USAID and its IPs will use the results of this evaluation to decide if changes in the course of the Project are necessary and to guide the design of follow-on Project strategies.

This evaluation of the USAID/Central Asia HIV Flagship Project included an examination of the synergies and collaboration between Flagship and the activities of USAID's two other HIV projects in Central Asia: LEADER for People Living with HIV; and HIV REACT. (See Section 2 for an outline of these projects.)

1.2 EVALUATION QUESTIONS

The questions to be answered by the evaluation of the USAID/Central Asia HIV Flagship Project, as specified in the scope of work (see Annex 1), were:

1. How effectively is the HIV Project cohesively supporting the community components of the HIV cascade, including case-finding, linkage to treatment and adherence support for PWID [people who inject drugs, partners, prisoners, and ex-prisoners?
2. What are the Project's strengths, weaknesses, and gaps in planning and management, both internally (subgrantees, across their offices) and externally (e.g., USAID, host governments, US Centers for Disease Control and Prevention (CDC) Partners, other donors, etc.)?
3. What gaps still exist that inhibit the HIV Project from achieving the expected results, and how can these be addressed both within the current USAID Project activities and in future activities?

2. PROJECT BACKGROUND

2.1 OVERVIEW OF REGIONAL AND COUNTRY CONTEXT

In Central Asia, HIV remains concentrated within key populations (KPs): PWID, prisoners, sex workers, and men who have sex with men (MSM). There is some evidence to suggest that the incidence of sexual transmission is on the rise. However, given that injecting drug use is still estimated to account for most new and prevalent HIV cases, PWID and their sexual partners remain the focus for prevention, case-finding, and treatment efforts by US President's Emergency Plan for AIDS Relief (PEPFAR).

Data from 2016 indicates that in Tajikistan 5,807 adult people living with HIV (PLHIV) are officially registered, accounting for 37 percent of the estimated adult PLHIV; in Kyrgyz Republic, 4,823 adult PLHIV are diagnosed, accounting for 61 percent of the estimated adult PLHIV; and in Kazakhstan, 19,372 adult PLHIV are diagnosed, accounting for 85 percent of the estimated adult PLHIV. The antiretroviral therapy (ART) coverage is 24 percent in Tajikistan, 33 percent in Kyrgyz Republic, and 35 percent of estimated adult PLHIV in Kazakhstan.[1]

Table 1 presents the estimates of PWID and PLHIV in Tajikistan, Kyrgyz Republic, and Kazakhstan derived from PWID population-size estimates and estimates of PWID HIV prevalence. The table also shows the number of PWID diagnosed with HIV in each country. While these data are somewhat out of date they do indicate that a fairly high number of PWID have already been diagnosed with HIV, particularly in relation to the estimated number of PWID PLHIV, especially in Kazakhstan.

Table 1. Estimated PWID populations, HIV prevalence, and PWID PLHIV diagnoses

Country	PWID Population-size estimate	Estimated PWID HIV Prevalence	Estimated number of PWID PLHIV	PWID PLHIV diagnosed (% of estimated PWID PLHIV)
Tajikistan	23,100	13.5%	3,119	2,293 (74%)
Kyrgyz Republic	25,000	12.4%	3,100	2,228 (72%)
Kazakhstan	120,500	9.28%	10,885	8,999 (83%)

Source: PEPFAR CAR Regional Operational Plan 2017

Preliminary data from recent Integrated Biological and Behavioral Surveys (IBBS) indicate that the PWID population-size estimates are likely to increase, while estimated PWID HIV prevalence will be revised downward. In effect, this means the job of finding undiagnosed HIV cases among PWID becomes even more difficult. It is also important to note that there are limited population-size data to triangulate with the IBBS estimates to improve their accuracy, particularly at the local level. Flagship's task of HIV case detection is not confined to current PWID, but also includes ex-PWID and the sexual partners of current and ex-PWID.

In the Kyrgyz Republic and Tajikistan, PEPFAR's key strategy is to intensify site-level case-finding in priority provinces for PWID and their sexual partners to accelerate treatment scale-up. In Kazakhstan, given the high rate of case-finding achieved among PWID, the focus is on case detection among PWID sexual partners and linking loss to follow-up (LTFU) PLHIV to care. PEPFAR's strategy of improved case detection and accelerated ART initiation, adherence, and retention is intended to act as a catalytic model for national scale-up. PEPFAR is also supporting medication-assisted therapy (MAT) as a critical

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[1] PEPFAR, Central Asia Region Regional Operational Plan 2017, Strategic Direction Summary, 2017, p. 4.

component of keeping HIV-negative PWID uninfected, and in supporting HIV-infected PWID to be adherent to HIV treatment and achieving viral suppression.

The reorientation of PEPFAR's Central Asia strategy to case detection and treatment scale-up represented a significant shift for USAID programming, which previously focused on HIV prevention and referral of KPs for HIV testing. The new focus on case detection, coupled with rapid HIV tests administered by trained community peers or by community-based nurses in the Kyrgyz Republic, and the emphasis on ART initiation, adherence, and retention through case management, represented a paradigm shift for the work of NGO partners.

Central Asian countries face similar obstacles in achieving epidemic control, including: punitive and discriminatory laws and policies toward KPs; stigma and discrimination from communities, health providers, and law enforcement officials that marginalize PWID and limit access to and uptake of HIV-related services; and limited epidemiological data on the size and location of these populations to help strategically target services. High levels of social stigma and institutional discrimination against KPs affect both the delivery and demand for HIV services. Moreover, there is inadequate political commitment, leadership, and funds for HIV programs serving KPs.

The Kyrgyz Republic and Tajikistan are primarily donor-dependent for HIV financing with 58 percent and 83 percent of funding, respectively, coming from external sources in 2016. The Global Fund (GF) is the largest single donor in both countries. Kazakhstan has transitioned from GF support, with 85 percent of 2016 funding provided by the government.

The primary gaps in ensuring a sustainable HIV response across Central Asia are: 1) low levels of government HIV funding for KP programming; 2) inefficient funding allocations; 3) high personnel turnover resulting in low institutional knowledge on the HIV technical response; and 4) inadequate collaboration between the public health sector and civil society to access vulnerable populations and ensure KPs receive appropriate high-quality HIV prevention and treatment services.[2]

Rapid screening tests can now be conducted in community settings by trained peers in each country, although Flagship primarily uses community-based nurses for screening test administration in the Kyrgyz Republic. All three countries have or are in the process of developing and rolling out new HIV testing algorithms that incorporate rapid screening tests and simplified confirmatory testing. Average cluster of differentiation 4 (CD4) count at ART initiation in the three countries is still below 350, although it has increased over time. Given that immediate initiation of ART after testing HIV positive regardless of CD4 count (test and start) has been largely rolled out, this indicates that most new HIV diagnoses are still occurring at late stage.

2.2 OVERVIEW OF THE USAID/CENTRAL ASIA HIV FLAGSHIP PROJECT
The strategic approach of USAID's Central Asia HIV programming is consistent with the PEPFAR 3.0 impact action agenda on sustainable control of the HIV epidemic, where resources are focused on the core activities of HIV case-finding and treatment scale-up. The Project is designed to contribute toward achieving the Joint United Nations Program on HIV/AIDS (UNAIDS) 90-90-90 goals, which aim to ensure that by 2020, 90 percent of people with HIV are diagnosed, 90 percent of those diagnosed are on ART, and 90 percent of people on ART have achieved viral suppression. Flagship primarily supports

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[2] PEPFAR, Central Asia Region Regional Operational Plan 2017, Strategic Direction Summary, 2017, p. 9.

NGO IPs to strengthen community components of the HIV testing and treatment cascade, while CDC partners are focused on improving components of the cascade in clinical facilities.

The two core components of Flagship work are:

1. Case detection to find undiagnosed HIV cases and link them to treatment
2. Case management for ART initiation, adherence, and retention in care

The Project is being implemented in Kazakhstan (East Kazakhstan and Pavlodar Provinces), Kyrgyz Republic (Bishkek City, Chui Province, Osh City, Osh Province), and Tajikistan (Dushanbe, Districts of Republican Subordination, and Sughd Oblast). Estimated HIV prevalence rates among PWID range from 9 to 27 percent within the PEPFAR focus subnational units. The Project commenced in December 2015 and will close out in December 2020.

Case detection focuses on PWID and ex-PWID and sexual partners of PLHIV PWID/ex-PWID. In fiscal year (FY) 2018, Flagship is also testing the implementation of peer-driven outreach (PDO) case-finding among MSM in Bishkek, Kyrgyz Republic, and Dushanbe, Tajikistan.

The case-detection approaches used by Flagship are:

1. **Peer-driven outreach** (PDO; also referred to as *rapid case detection, RCD*) uses community members to recruit peers for HIV testing, based on respondent-driven sampling and peer-driven intervention (PDI) models. The Project has used different types of seeds (i.e., HIV positive and HIV negative; KPs with risk factors that place them at higher risk of HIV), as well as using LTFU clients as seeds; different numbers of HIV testing coupons each seed can distribute (e.g., more coupons for HIV-positive recruiters or those who have led to new positive cases); and different numbers of waves to implement before stopping recruitment in a location in an attempt to find the most effective means for increasing case-finding.

2. **Active case-finding** (ACF) uses Project-employed peer navigators (PNs) to implement a structured community-mapping methodology that enables PN teams to find new injecting sites and new networks of PWID and to provide HIV testing.

3. **Assisted-partner notification** (APN) assists PLHIV with sexual partner disclosure and offers HIV testing to partners. Three approaches are used in APN:

    a) Contract: The PLHIV client makes a contract with their PN to bring their partner for testing within a specified period of time. If the client fails to do so, the PN will contact the partner to invite them to have an HIV test, without disclosing the client's status to the partner.

    b) Direct contact: With the consent of the PLHIV client, the PN will make contact with the partner and offer HIV testing, without disclosing the client's status to the partner.

    c) Joint contact: The PN and PLHIV client will jointly disclose the HIV status to the partner.

The PDO and ACF approaches are used in tandem. ACF is used to find new injecting sites and PWID networks. Once these have been identified, PDO is used to recruit PWID for testing. ACF is used in rural and other areas when looking for new networks of PWID whereas PDO is used to find new cases in known areas and networks of drug use. APN primarily occurs with the female sexual partners of male PWID who are HIV-positive. However, APN also includes HIV testing of the male partners of female

PLHIV who were referred to Flagship by AIDS Centers (ACs). Most of these male partners are PWID or ex-PWID.

Trained PNs provide pre-test counseling and offer a HIV rapid screening test to those who consent. For those who screen positive, confirmatory testing at ACs is offered and facilitated. Confirmatory testing can only be undertaken for clients who attend and register with an AC.

Flagship's case-management PNs provide community-based support for PLHIV found through Flagship's case-detection work to ensure linkage to care, timely ART initiation, adherence, and retention in care. A triage system is used to determine the level of case-management support needed, with the ultimate aim of graduating treatment adherent clients from case management. A significant component of the work of PNs is to assist ACs with finding LTFU patients (not attending an AC in the last six months), and patients who have missed their most recent appointment. In FY 2018, ACs in all three countries commenced referrals to Flagship of PLHIV who were not diagnosed through Flagship's case-detection work but who would benefit from community-based case management. Flagship works with these AC-referred clients to support ART initiation or re-initiation. PNs also conduct oral screening for tuberculosis (TB) symptoms using a screening protocol and provide assisted referral for TB diagnosis. PNs also refer clients to MAT services and a range of other health and social services, as needed.

2.3 OVERVIEW OF HIV REACT AND LEADER PROJECTS

USAID's HIV REACT Project promotes HIV prevention and access to treatment for prisoners and ex-prisoners in Kazakhstan, Kyrgyz Republic, and Tajikistan. The activity offers a comprehensive package of services to improve access by PWID and PLHIV prisoners to HIV prevention, treatment, and care during incarceration. HIV REACT supports ex-prisoners upon release with an emphasis on linking PLHIV to ART and MAT services and facilitating adherence and retention. Support for post-release rehabilitation is provided for up to six months to promote positive HIV and MAT treatment outcomes. HIV REACT clients who have ongoing case-management needs extending beyond six months post-release are formally referred to Flagship.

The LEADER for PLHIV Project strengthens organizational and leadership capacity of the Secretariat of the Central Asia Association of PLHIV, helps member organizations reduce stigma and discrimination to improve PLHIV access to quality services, strengthens member organizations' advocacy for quality systems that will deliver equitable services for PLHIV, and reduces legal and policy barriers to services. The key intersection between the work of LEADER and Flagship has been stigma and discrimination training in each of the three countries. Training of PLHIV has focused on countering self-stigma, while training of health-care workers in ACs and polyclinics is aimed at promoting service provision that is free from stigma and discrimination, which in turn will have benefits in the areas of treatment initiation, adherence, and retention in care.

3. EVALUATION METHODS AND LIMITATIONS

The evaluation's methods were consistent with USAID's definition of a performance evaluation and PEPFAR's definition of a process evaluation. The evaluation was conducted by a six-member team, consisting of two international consultants: a team leader/HIV specialist and an evaluation and strategic information (SI) specialist; two HIV technical experts from the Office of HIV/AIDS, USAID/Washington, DC; and two national KP specialist consultants. The evaluation was conducted from May to August 2018, with field work performed June 3–25, 2018. The key components of the methodology are outlined below and described more fully in Annex 2.

Document review: Key background documents provided by USAID and the USAID/Central Asia HIV Flagship Project were reviewed and analyzed. These included the contract; the PEPFAR Regional Operational Plan and Strategic Directions Summary; annual work plans and budgets; quarterly and annual progress reports for the Flagship, HIV REACT and LEADER Projects; Flagship training materials; monitoring data; patient treatment readiness assessment reports; and preliminary data from a costing and cost efficiency analysis of case-finding work. The sources of information for the evaluation are set out in Annex 6.

Monitoring data: Indicator data were analyzed to identify achievement of outputs and outcomes relevant to the evaluation questions. Trends in performance indicator data were examined and compared to targets, with a particular focus on HIV testing uptake (screening and confirmatory), testing yield, and ART initiation.

Qualitative data collection: Interviews were held with the USAID/Central Asia HIV Flagship Project Regional Office and country offices in the Kyrgyz Republic and Tajikistan and all current NGO IPs at each of the Project's implementation sites. Clients of the Project participated in focus group discussions (FGDs) at most sites. Interviews were conducted with the regional offices of LEADER and HIV REACT projects (both USAID-funded HIV projects in Central Asia) and their NGO IPs at the country level. Interviews and discussions were held with staff from USAID and the CDC in Kazakhstan, the Kyrgyz Republic, and Tajikistan as well as CDC's International Center for AIDS Care and Treatment Programs (ICAP) Project. Stakeholder interviews were conducted with Republican, city, and oblast ACs, addiction treatment centers, the United Nations Development Programme (UNDP), the United Nations Office on Drugs and Crime (UNODC), and UNAIDS. All people interviewed and FGD participants provided informed consent. A list of all people and organizations consulted can be found in Annex 4. Interview and FGD guides are in Annex 3.

Analysis: A thematic review of qualitative data from interviews and FGDs was performed, connecting the data to the evaluation questions, focusing on relationships, context, interpretation, nuances and homogeneity, and outliers in relation to key informant views. Qualitative data were used to substantiate quantitative findings derived from Project reports and monitoring and evaluation (M&E) data, provide more insights and context than quantitative data could provide, and answer questions where other data did not exist. At the conclusion of data collection, the evaluation team triangulated all sources of information from the document review, the M&E data, and key informant interviews and FGDs to develop preliminary key findings and conclusions. These were presented at debriefing meetings to USAID, PEPFAR, CDC, and the contractors for Flagship, HIV REACT, and LEADER Projects.

Limitations: The key limitations for this evaluation were:

1. The evaluation was a rapid appraisal, which limited its scope and time to validate findings. Rapid appraisals have proven to be very effective in identifying good performance and areas for improvement. The evaluation team was able to validate findings through the debriefing meetings with USAID and Flagship IPs, as well as feedback from them on the draft evaluation report.

2. Within the time and resources available, it was not possible to collect quantitative data. The evaluation was dependent on the Project's monitoring data. This limitation was minimized by comparing the qualitative data collected by the team, where relevant, against Project data.

3. As IPs were responsible for inviting clients to participate in FGDs with the evaluation team, it is possible that clients with a favorable view of the Project were chosen, while those who may be dissatisfied were excluded.

4. In developing the schedule for NGO interviews and site visits, USAID decided to combine some NGOs into joint interviews. This had the advantage of increasing the number of NGOs with staff interviewed by the evaluation team. A possible limitation may be that joint interviews may have inhibited respondents from providing full and frank answers to questions, particularly if there were strained or competitive relationships between NGOs. This issue was raised with USAID who thought this was unlikely to be the case. The evaluation team did not observe such a dynamic in these interviews.

5. The evaluation focused on Flagship's work with PWID and their sexual partners. The Project's work with MSM was examined in less detail due to its recent commencement (approximately one year) and small scale.

4. FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

The following section is organized by country, with answers to the evaluation questions under each country. The country sections have been organized under subheadings related to the first two evaluation questions: Question 1) Effectiveness of the Flagship Project in supporting the HIV cascade; and Question 2) Strengths, weaknesses, and gaps in planning and management. Existing gaps and how they can be addressed (Question 3) are embedded within the findings and recommendations for Questions 1 and 2. This approach provides a more coherent read as gaps and areas for improvement are integrated with the assessment of the effectiveness of the Project in supporting the HIV cascade and the Project's planning and management.

4.1 KYRGYZ REPUBLIC

4.1.1 Effectiveness of the USAID/Central Asia Flagship Project in supporting the HIV cascade

Case-finding

Strengths

Finding HIV cases that would otherwise go undetected: Senior staff in the ACs in the areas of the Kyrgyz Republic where the USAID/Central Asia HIV Flagship is operating, openly acknowledge the Project is finding HIV cases that would otherwise go undetected. These staff members value the community focus of Flagship's approach to working with PWID and their injecting and sexual partners. They recognize this focus helps reduce the barriers to HIV-testing uptake among harder-to-reach individuals who are more reluctant and/or fearful of coming to an AC for HIV screening. In addition, they recognize the value of partnering with community-based organizations to do this type of outreach work.

Finding approximately 25 percent of new HIV cases: Even though Flagship only operates in limited geographic areas of the country, the national government estimates the Project is finding approximately 25 percent of new HIV cases in the Kyrgyz Republic. The AC in Osh reported Flagship detected 34 percent of all new HIV cases (23 of 68) between January and May 2018. This Center also estimates between 80 to 90 percent of all HIV cases among PWID have been detected by Flagship during the time it has been operating in the region. As mentioned above, AC staff appreciate the community focus of Flagship because it enables the Project to find HIV cases that would not have been detected by the facility-driven approach used by the ACs. As case-finding gets increasingly challenging, Flagship and USAID should consider expanding its operational areas so that it can continue to contribute to the overall number of new cases found in the country.

Complementary case-finding approaches: PDO, ACF, and APN are complementary approaches to HIV case-finding and all three — individually and in combination — are a vital part of Flagship's efforts to reduce the undiagnosed population in the Kyrgyz Republic. The approaches also play an important role in identifying previously diagnosed LTFU individuals, including people who did not have a confirmatory test, did not initiate ART, or did not stay on treatment.

Each of the approaches is likely to outperform other approaches at different times and/or different locations, based on a wide range of factors. These include the targeted population; number and quality

of "recruiters" or field staff working on a given approach; the pool of undiagnosed infections in a given area; and the length of time a particular approach has been active, recognizing that yield can decline as cases are found (e.g., seeds run out of contacts, a high percentage of individuals in a hotspot or catchment area are tested, or a high percentage of current and past partners are tested). The constantly shifting dynamics of case-finding in a concentrated epidemic support having multiple approaches in place that can be adjusted as circumstances change (e.g., using positive and/or negative seeds, adding waves, increasing incentives, identifying new hotspots, identifying new index cases).

It can also be difficult to project the trajectory of a specific case-finding approach. In addition, the absolute number of new cases is low, which further complicates the analysis of the data, including variations in the yield. It can be difficult to determine what constitutes a trend, when it will peak, and how yields will change as possible adjustments are identified and implemented. Consequently, having multiple approaches operating simultaneously can help sustain the overall case-finding effort. The variability of the different approaches is apparent even across two quarters of implementation [Year (Y) 3 Quarters (Q) 1 & 2; see Table 2]. Currently, the yield for APN is significantly higher than for PDO and ACF but the focused approach to partner testing is relatively new and, while the yield is high, the total number of new cases is based on all three approaches (see Table 3). In addition, the lower yield approaches are finding significantly more new cases; for example, with only a 1 percent yield ACF is still generating one-third of the new cases.

Table 2. Yield from different case-finding methods in different locations:
Year 3, Quarters 1 & 2

	RCD/PDO		ACF		APN	
Location	**Y3 Q1**	**Y3 Q2**	**Y3 Q1**	**Y3 Q2**	**Y3 Q1**	**Y3 Q2**
Bishkek city	0.5%	0.7%	1.6%	1.8%	0.0%	1.9%
Bishkek city (MSM)	—	3.4%	—	—	—	—
Chui Oblast	4.8%	2.2%	1.5%	0.7%	10.7%	7.5%
Osh City	3.3%	0.0%	0.7%	0.4%	15%	17.2%
Osh Oblast	0.0%	0.0%	0.4%	1.1%	1.2%	4.9%

Source: Flagship Project/PSI

Table 3. Flagship HIV testing in the Kyrgyz Republic by testing approach and yield,
FY 2017–FY 2018

Testing approach	FY 2017			FY 2018 (to end-June)		
	Number tested	**Number HIV positive**	**HIV positive yield**	**Number tested**	**Number HIV positive**	**HIV positive yield**
PDO	4,014	102	2.5%	7,002	114	1.6%
ACF	4,142	80	1.9%	8,896	92	1.0%
APN	497	35	7.0%	1,116	70	6.3%

Source: Flagship Project/PSI

Table 4. Flagship HIV testing in the Kyrgyz Republic by key population, FY 2017–FY 2018

Key Population	FY 2017			FY 2018 (to end-June)		
	Number tested	Number HIV positive	HIV positive yield %	Number tested	Number HIV positive	HIV positive yield %
PWID	8,156	182	3.5%	13,227	148	1.1%
PLHIV Partners	497	35	7.0%	1,116	70	6.3%
MSM	N/A	N/A	N/A	2,671	58	2.1%

Source: Flagship Project/PSI

Working *with* the community *in* the community: Flagship's commitment to working *with* the community *in* the community underpins its ability to find new HIV cases. In the Kyrgyz Republic, there are significant barriers to HIV-testing uptake (see below). Building relationships and building trust with clients is an essential part of overcoming these barriers. However, building relationships and trust hinges on having capable outreach workers who maintain a consistent and credible presence in the community. In most cases, it also requires outreach workers to make multiple contacts with clients — often over extended periods of time — to gain the confidence of their clients and help them understand the value of knowing their HIV status. Staff at ACs recognize the limitations of their facility-centric approach to case-finding and, as mentioned above, appreciate the community focus that Flagship brings to the overall effort.

Innovative approaches to case-finding: The Republican AIDS Center (RAC) sees the combination of Flagship approaches to case-finding as an important innovation and would like to see the different approaches used more broadly by other organizations doing this type of work. The integration and systematic deployment of PDO, ACF, and APN as proactive approaches to case-finding is seen as an improvement over the reactive approaches to case identification historically used in the country. These approaches were largely based on patients presenting at a health facility at a more advanced stage of disease progression, contributing to the long-standing issue with late diagnosis in the Kyrgyz Republic. In communities where outreach work has been done previously, the approach was reported to be generally uncoordinated and unsystematic, relying heavily on personal contacts with limited results.

The RAC's interest in expanding the use of PDO, ACF, and APN is a unique but under-exploited opportunity for Flagship, USAID, and PEPFAR to leverage its expertise and experience to build an effective and sustainable national initiative on HIV case-finding. Enabling and encouraging Flagship to provide technical assistance (TA) outside of the geographic areas where it is currently working would be an important contribution to epidemic control in the country.[3]

Case-finding among MSM and transgender (TG) populations: The launch in February 2018 of a case-finding initiative among MSM and TG populations in Bishkek City was a pivotal point in Flagship operations, given the potential to identify new or LTFU cases in these populations and put them on

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[3] Although the evaluation team did not directly review the past approaches to outreach work, USAID did note the focus in these programs was harm reduction services for HIV prevention among a stable KP. The approach was seen to be largely effective in keeping this population HIV negative; however, it did not reach the KPs who do not access services.

ART. This initiative is highly relevant in light of growing concerns about the HIV prevalence among MSM and TG individuals, limited knowledge about HIV transmission and prevention in these populations, the percentage of bisexual and married MSM, limited services available for these populations, and levels of HIV and MSM/TG-related stigma and discrimination that suppress health-seeking behaviors. The yield of 3.4 percent from a PDO campaign among MSM in Bishkek City in the first full quarter of activities reinforces the contributions of the initiative to the national response. While the Project has only received short-term funding, the dedication of the IPs and the likely outcomes from their work warrant serious consideration of longer-term support for these activities.

Weaknesses

Not meeting case-finding targets: Flagship continues to struggle to meet case-finding targets in the Kyrgyz Republic but there are legitimate concerns the targets may not reflect the situation on the ground, including possible overestimates of the localized size of the PWID population and their sexual partners as well as the number of undiagnosed infections in Flagship operational areas. For example, street knowledge identifies significantly fewer PWID in the local areas where Flagship is active. In addition, the targets do not reflect the level of effort — e.g., the multiple contacts — required to get people to agree to screening and confirmatory tests, given the levels of HIV-related misinformation, disinformation, criminalization, and stigma and discrimination in the country.

Focus on case-finding targets minimizes other critical activities: The focus on case-finding targets minimizes the wider range of recurrent activities required to successfully and sustainably engage with KPs on HIV-related knowledge and behaviors. Case-finding is a critical component of the HIV response in the Kyrgyz Republic, but it is a long-term endeavor requiring a patient and strategic approach. The short-term focus on targets, including the performance-based management model, places undue stress on outreach staff and their managers and it prioritizes case-finding over the long-term interaction and support needed to ensure clients see diagnosis, treatment initiation, and treatment retention as a life-saving continuum.

There is a parallel concern that the aggressive implementation of the APN approach, which is also driven by the focus on case-finding targets, has the potential to jeopardize partner confidentiality and could involve coercive pressure by the PNs. Descriptions by PNs and managers about the different steps taken to implement partner testing suggest a zealousness (e.g., repeated visits to partners' homes, overt "encouragement" to test) that raises questions about ethical boundaries, particularly in a country where HIV-related stigma and discrimination can be so crippling.

Level of knowledge, skills, suitability, and credibility of outreach staff: Not all outreach staff doing case-finding have the minimum level of knowledge, skills, suitability, and credibility to persuade clients to have an HIV screening test and, if that test is positive, to have a confirmatory test at an AC. Based on observations in the field, the capacity of outreach staff varies widely and there are concerns that less qualified and less prepared staff members, including active/relapsing PWID in some settings, are limiting the ability of Flagship to effectively identify and work with clients. In light of the multiple challenges faced by PLHIV in the country — particularly newly diagnosed PLHIV — every Flagship interaction with clients related to HIV screening/testing is both an opportunity and an obligation to provide them with the support and encouragement they need to engage and stay engaged with the people and systems in place to help them. Flagship needs to invest further in the knowledge and skills of its frontline staff whose efforts are fundamental to the Project's results.

Lack of audience- and language-appropriate information materials about HIV: There is an apparent lack of audience- and language-appropriate information materials about HIV, including critical treatment messaging (e.g., Undetectable = Untransmittable). The lack of simple "leave behind" materials in different locally spoken languages and/or a list of credible Web sites that clients and/or prospective clients can use to learn more about HIV and ART weakens the effectiveness and the credibility of the PNs and their argument for HIV screening. (Note: The Conclusions section of Flagship's Y3 Q2 report states, "In order to improve the quality of community-based counselling and to ensure that the PNs provide important information about ART during pre- and post-test counseling, the Project will produce easy-to-use materials with key messages." As tablets become available for use in Flagship's case-detection work in the Kyrgyz Republic, there will be an opportunity to share informational videos with clients; however, it will be critical for them to be in local languages and have messages appropriate and applicable to the client base.)

Limited data on why clients who are screened for HIV don't have a confirmatory test: Flagship appears to have very limited qualitative data on why the gap between clients who have HIV screening and then do not have confirmatory testing is so large. According to Flagship data from October 2017 through May 2018, only 73 percent of their clients in the Kyrgyz Republic who initially screened positive had their diagnosis confirmed at an AC. Given that these clients are known and tracked by Flagship (i.e., Flagship did the HIV screening), the loss factor points to underlying problems with the work being done with clients to get them to and through confirmatory testing. These underlying problems (e.g., personal concerns about disclosure, stigma and discrimination) are also likely contributors to the additional loss of clients between confirmatory testing and ART uptake. Unfortunately, Flagship does not appear to have a robust program in place to collect and analyze data on why the LTFU exists in their cascade, which makes it difficult to develop, test, and implement efforts to address the loss. (Note: The Conclusions section of Flagship's Y3 Q2 report states, "During the quarter, the Project analyzed reasons for clients foregoing confirmatory testing." However, there is no indication of the findings and how they might be used to improve Project performance.)

There is a corresponding lack of qualitative data on client knowledge, attitudes, and behaviors related to HIV, HIV risks and HIV services, including regularly updated client perspectives on critical barriers to the uptake of these services (e.g., overwhelming stigma and discrimination). It appears some Flagship staff, including IPs, have an anecdotal understanding of different client perspectives but the lack of any systematic collection and use of these types of data undermine the ability of the Project to refine its approaches. It should be noted that the March 2018 report on treatment readiness done by the Linkages across the Continuum of HIV Services for Key Populations Affected by HIV Project (LINKAGES) did collect qualitative information from clients on related issues but the recommendations were largely generic and implementing them depends on understanding current concerns of clients and connecting these concerns with specific activities and messages to help address them.

Poorly qualified and/or poorly suited PNs: The current distinction between case-finding and case-management responsibilities can result in poorly qualified and/or poorly suited PNs — who are focused on case-finding — working with clients who would benefit from a relationship with more competent outreach workers (e.g., improved capacity for pre-test counseling and treatment education). The capacity of some PNs is in direct contrast to the better qualified, better suited case managers who work with clients after they have been diagnosed. The multiple barriers to HIV testing — including the initial screening — place additional pressure on the PNs to provide more wide-ranging support to make the case for screening, confirmatory testing, and treatment from the outset of their involvement with

clients. Not only is this pre-test interaction vital for overcoming client concerns about testing directly, it also sets the stage for continued engagement if they are screened HIV-positive. The continued involvement of less capable PNs through confirmatory testing is likely to be a contributing factor to the LTFU between screening and confirmatory testing. In addition, consistently high-quality interaction with clients early in the process can be an effective way to address misinformation and disinformation, which is one of the major barriers to testing uptake. It may be possible to address issues of poor qualifications with improved and/or expanded training, but the issue of suitability depends more on the type and personality of individuals hired to do this work.

Challenges/gaps

Significant and persistent barriers to testing uptake: There are significant and persistent barriers to testing uptake in the Kyrgyz Republic, including stigma and discrimination, misinformation/disinformation about HIV, and limited knowledge about treatment. The barriers, which are related to both initial screening and confirmatory testing, have a significant effect on the efficiency and effectiveness of the Flagship outreach workers. To a large extent, overcoming these barriers is beyond the capacity of the Project. For example, addressing misinformation and disinformation — much of it spread with malevolent intent by "AIDS denialists" in Russian-speaking countries — requires a comprehensive and coordinated approach to communication, including interpersonal, mass media, and online, by a wide range of credible and influential sources in the Kyrgyz Republic.

Hidden and hard-to-reach populations: Flagship believes there are hidden and hard-to-reach populations in their operational areas where there may be undiagnosed infections. The Project has secondhand knowledge that many members of these populations are part of closed religious and/or ethnic communities that are extremely difficult for outsiders to reach. The levels of stigma, discrimination, and misinformation are reported to be very high within these populations/communities, further complicating efforts to gain access to them and to reach them with behavior-changing messages on HIV testing. In addition, there are other subpopulations, such as female PWID and higher social/economic class PWID who are equally difficult to identify and reach. Currently, Flagship has limited data on these populations/communities, so the actual extent of HIV infection is difficult to assess. In addition, Flagship has not developed a practical approach for reaching these populations/communities; for example, they are not recruiting PNs with similar backgrounds who may have better access. It is an ongoing challenge to determine how to access these people.

Recruiting and retaining PNs: Recruiting and retaining effective PNs is increasingly difficult, given the necessary knowledge and skills, the demanding working conditions, the target/performance-based management and compensation system, and the psychosocial stresses of the work. Finding new HIV cases is hard work and it is increasingly apparent that it requires a sophisticated mix of abilities to find and engage with clients and, most importantly, to overcome the multiple barriers to testing. HIV screening is also the vital first step in a continuum of decisions and actions that lead to ART retention for a client who tested positive; consequently, having a constructive interaction around screening — and confirmatory testing — is an essential part of the overall process.

Government restrictions on blood draws: Existing government restrictions in the Kyrgyz Republic limit Flagship's ability to take full advantage of its community-based approach. One of the critical advantages of a community-based approach to HIV testing is to make the overall process as simple and convenient for clients as possible, including the initial screening and the confirmatory testing. Oral HIV testing, which can be done quickly and easily by trained outreach workers, are a good example of an

approach that improves access and reduces objections to the screening. Since oral testing is not widely used by Flagship in the Kyrgyz Republic at this time, the bulk of the Project's HIV screening relies on finger-prick testing, which must be done by a trained nurse. As a result, the PNs must convince clients to come to a Flagship site where the nurse is based for the screening test, which creates another barrier to uptake. In addition, Flagship must employ nurses to perform this task, which raises the cost of service delivery.

An added setback of the nurse-driven approach is that despite their qualifications, these nurses are prohibited by government regulation to do the larger blood draw necessary for a confirmatory test, necessitating a visit to an AC by the client for that blood draw as opposed to the Flagship nurse doing the draw and sending the sample to the AC. Again, the process creates barriers for the client, which contributes to the LTFU between screening and confirmatory testing. (Note: Flagship reports taking steps to improve these processes — e.g., requesting approval from the RAC for Project nurses to draw blood after positive rapid test, especially in remote villages, and transport the samples for confirmatory testing — but progress on these initiatives appears to be slow or stalled. This may be an area where other PEPFAR-supported projects or partners could assist with policy advocacy.)

Case Management

Strengths

Role and contributions of Flagship case managers: ACs place a high value on the work that Flagship case managers do with newly diagnosed clients and in finding LTFU clients (e.g., engagement with services, patient advocacy, psychosocial support). The fact that ACs refer newly diagnosed PLHIV to Flagship for case management, even if the Project was not involved in the case-finding is a powerful indicator of the value of the Flagship case managers. Both the ACs and Flagship see the ongoing community-based case management as complementary to the facility-based services provided by the ACs. The Flagship case managers also work closely with the patronage nurses from the ACs to help them with their specialized patient visits.

It is possible case managers could play a bigger role in case-finding than they do currently. Any expanded involvement in case-finding would use the basic knowledge and skills they have as case managers to provide information, counseling, and psychosocial support to clients. It is also clear that case managers are playing — and should play — an increasingly larger role in ART initiation and retention. (One of the reasons to include case managers in case-finding is to better support ART initiation among new clients.)

The recognition by case managers that they need expanded knowledge and skills to further improve their ability to do their job supports a further professionalization of the cadre. Not only will a better prepared, more professional group of case managers provide better support to clients, they are more likely to be retained by Flagship, and they become part of a sustainable core of HIV case managers who can continue the work in the future.

Ongoing role of case managers in adherence and retention: The Flagship approach to case management emphasizes initial triage and treatment initiation. However, case managers recognize the longer-term value of their relationships with clients. They specifically recognize the vital role a long-term relationship plays in treatment retention. In the language of global health priorities and epidemic control, the case managers are actively contributing to both the second and the third 90 (i.e., ART initiation and ART retention/viral suppression). The downside of the PNs developing longer-term relationships with clients is that Flagship has less capacity and fewer systems in place to manage this sustained work.

Commitment of the Flagship case managers: Interviews with case managers reveal their deep commitment to their work and dedication to their clients. In turn, clients speak highly of the support they receive from their case managers. When there is tension between case managers and clients, it is largely because clients have issues or need assistance that Flagship is not able to address or provide. However, in these challenging situations, Flagship case managers try to refer clients to organizations and/or individuals who can help. The fact that clients continue to call their case managers for assistance long after they have formally "graduated" from the Flagship program speaks directly to the dedication and quality of work of the case managers.

Weaknesses

Loss factor between confirmatory testing and ART initiation: There continues to be significant loss between confirmatory testing and ART initiation. Despite the combined efforts of Flagship case managers and AC staff, ART uptake continues to lag; between June 2016 and March 2018, Flagship reported only 63 percent of "newly found PLHIV" initiated ART. In addition, between October 2017 and March 2018, Flagship reported only 27 percent of LTFU clients identified by the Project had initiated ART. The primary reasons for the low performance appear to mirror the barriers associated with testing uptake, including stigma and discrimination, misinformation/disinformation about HIV, and limited knowledge about the realities and the benefits of treatment. It is important to note that client concerns about stigma and discrimination are so pervasive that they will delay or opt out of ART. For example, little or no respect for HIV-related confidentiality at family medical centers means the status of PLHIV visiting those facilities will likely be disclosed to other patients.

Limited qualitative data: Flagship has limited qualitative data on client perceptions and behaviors related to ART initiation and retention. Within the context of the above-mentioned barriers to testing and ART uptake, the Project does not have qualitative findings on relevant issues, such as why clients delay starting ART, why they stop treatment, and what can be done to get them started and to keep them on treatment. While the treatment readiness report for the Kyrgyz Republic produced by LINKAGES and published in March 2018 is based on qualitative interviews with clients, it includes limited data on specific behaviors and barriers or specific activities to address them. A generic call to "[e]nhance treatment literacy knowledge and motivational counseling skills of PNs and other NGO staff" is a useful first step but that call needs to be linked to specific and effective treatment knowledge and specific counseling skills and approaches based on actual interactions with clients.

As is the case with the LTFU between HIV screening and confirmatory testing, Flagship does not appear to have a robust program in place to collect and analyze data on an ongoing basis about why the LTFU exists in their cascade. Without this qualitative data, it is difficult to develop and adapt approaches that address client concerns and improve ART initiation and retention.

Inadequate extensive knowledge and skills: Individual case managers — and their managers — recognize the need for more extensive knowledge and skills to do what is a very challenging job. Case managers need a wide array of knowledge and skills to do their job well. While they are provided with core training, case managers cited a number of specific areas where they felt underprepared, including counseling skills, psychosocial support, treatment education, and practical ways to deal with stigma and discrimination. In many respects, the recognition that case managers need to be better prepared for their work is an acknowledgement of their increasing professionalization and the added value that a more professional cadre would bring to the work. As mentioned above, there is also a corresponding

lack of audience- and language-appropriate information materials about HIV that case managers could use to supplement their work with clients.

Limited systems and/or structures for continuing work with clients: Beyond the approach in place for initial triage, there are limited systems and/or structures around the continuing work of case managers with their clients. While the client triage tool seems to be an effective way to conduct an initial assessment of client needs and circumstances, its value appears to diminish over time. The Project's intention to "graduate" clients from case management and shift them to group counseling as a replacement for one-on-one support is more theory than practice. Consequently, Flagship case managers in the Kyrgyz Republic maintain contact with clients for longer, even indefinite, periods of time and there are no systems or structures in place to help them manage these interactions.

Challenges/gaps

Factors outside the control of the Project: Multiple factors outside the control of the Project adversely affect ART initiation in the Kyrgyz Republic, including convoluted government-mandated testing algorithms, intrusive epidemiological investigations, labor migration, rejection by family members, substance abuse, and homelessness. While there are steps that Flagship case managers can take to mitigate many of the factors affecting ART initiation, there are limits to what they can do. Some of those limits are due to the structural nature of the problem (e.g., HIV-related stigma and discrimination); others are due to the availability of services (e.g., lack of housing for homeless people); others are driven by economic priorities (e.g., labor migration); while others are due to long-standing government policy (e.g., testing algorithms, epi investigations). In addition, Flagship's focus on PWID and their partners further complicates the situation because key PWID-related issues, including additional stigma and discrimination, criminalization, and substance abuse programs, are outside the Project's remit. Other PEPFAR-supported partners working in the Kyrgyz Republic may be better placed — and could be tasked — to do vital advocacy work related to the factors outside the control of Flagship that negatively affect clients' ART initiation.

Limited credit for contributions to ART initiation and retention: Because Flagship does not formally report on PEPFAR indicators related to case management (e.g., TX_NEW, TX_CURR), the Project does not get credit for its contributions in this area. The value of Flagship's community-based case managers is well-recognized by governments, which is why ACs are willing to refer all newly diagnosed PLHIV to Flagship for support. As mentioned above, the case managers play an important role in both ART initiation and treatment but ICAP, as the facility-based (i.e., AC) partner, takes sole credit for this work when it reports on the relevant PEPFAR indicators.

"Graduation" from case management: Stable clients are technically being "graduated" after six months working with a Flagship case manager. However, realistically — and sensibly — a high percentage of them continue to engage with their Flagship case managers on a regular basis after graduation. The concept of "graduation" is understandable because it can be difficult to justify an ever-increasing client load for individual case managers and for Flagship as a project. But in reality, community-based case management in a country with so many challenges facing PLHIV is an essential component of the national HIV response. The challenge is how to sustain the effort and ensure case managers get the credit and the corresponding support for their contributions to epidemic control.

Late presentation and AIDS deaths: Late presentation (i.e., low CD4 at diagnosis) and AIDS deaths continue to be a problem in the Kyrgyz Republic. Both factors can be linked to the high levels of HIV-related stigma and discrimination in the country, which contribute to delays in health-seeking behavior.

In addition, both factors complicate the work of case managers because they can be seen by other PLHIV as failures of the HIV response. For example, stories circulate in the country about sick patients (i.e., late presenters) who were put on ART but then died, purportedly killed by the ART drugs.

4.1.2 Strengths, weaknesses, and gaps in planning and management

Internal Project Planning and Management

Strengths

Dedicated and capable management team: At the national level, Flagship has a dedicated and capable management team with the knowledge, skills, and experience to oversee the implementation of the Project's activities. In addition to the expertise they bring to their tasks, the management team also maintains generally good relationships with the existing IPs, working collaboratively with them to find ways to improve Project performance and outcomes. The partners also welcome the support from the Flagship core team and recognize its value. The management team had multiple challenges with previous IPs but they seem open and interested in ensuring they have functional and productive relationships with their partners, even if that requires making difficult decisions about a partner's role in the Project.

Adaptive organizational structure: Flagship has adapted its operational structure to work effectively with different partners and in different settings. While the overall approach and objectives are consistent, Flagship has the flexibility to design and implement its activities in ways best suited to the local situation. For example, in Bishkek, the core work with PWID and their partners is split between one NGO that does case-finding (Rans Plus) and another that does case management (Sotsium). Conversely, the NGOs in Bishkek working with MSM handle both case-finding and case management. In Osh, challenges with local partners led PSI to set up a specialized unit to handle case-finding as well as case management.

Commitment to collecting and using data: Across the integrated Flagship organization, including PSI and IP operations, there is a strong commitment to collecting and using data to track performance. The detailed approaches to case-finding (i.e., PDO, ACF, and APN) are a good indication of this commitment to collecting and using data to track performance, as is the consistent use of the "yes-to-test" calculator at Flagship headquarters and in the individual partner offices. However, the focus on data is primarily a focus on *indicator* data — specifically, indicator data as they correlate to targets. While this focus helps Flagship determine where it stands against the targets and where it needs to improve, it limits the Project's ability to understand why certain activities in certain areas yield certain results. The Project appears to routinely ask what has or would influence the performance reflected in the indicator data. But having more of the above-mentioned qualitative data to help understand the "why" behind Project performance would further strengthen Flagship's ability to use data productively.

Weaknesses

Reporting burden: PSI's reporting burden on IPs seems excessive and may be taking away from their ability to focus resources (e.g., time, energy, funding) on core Flagship activities. IPs in different countries and different settings often express concerns about the reporting burden for these projects, even when those concerns are unwarranted. However, in this case, it does appear the burden is excessive, particularly related to tracking the various incentives used in case-finding. In general, if reporting is consuming a disproportionate amount of an IP's time and energy, it should be streamlined in ways that reduce the burden without any major loss of accuracy or accountability in the reporting.

Flagship should streamline its systems to ensure that frontline organizations (e.g., NGO IPs) have a lower administrative and reporting burden. It should also be clear to both frontline staff and frontline organizations how any required administrative and/or reporting efforts are used by the Project overall. Too often administrative/reporting work is a black box with little transparency about how and/or why this work is important, which makes it difficult for implementers to appreciate what can seem like unreasonable demands.

Technical support: While the Flagship regional office in Almaty clearly plays a key role in managing core technical elements of the Project (e.g., the main database), its ability to provide useful, ongoing technical support to the Flagship team in the Kyrgyz Republic appears to be limited. The limits are due to staffing (i.e., the COP seems to be the only person capable of providing targeted TA for improving field operations) and the generally strong capacity of the staff in the Bishkek office (e.g., the Kyrgyz team has developed forms and tools that have been picked up by teams in the other Flagship countries).

Challenges/gaps

Target-centric approach to planning and management: The PEPFAR/USAID focus on targets puts pressure on Flagship to take a very target-centric approach to its planning and management. A month-by-month, quarter-by-quarter target-centric approach makes it challenging to develop a more strategic perspective on how a Flagship-type project can best contribute to controlling a concentrated epidemic from prevention through viral suppression. For example, the significance of the open acknowledgement by ACs that Flagship is finding HIV cases that would otherwise go undetected says a tremendous amount about the value of the persistent community-driven approach implemented by Flagship. Case-finding in a concentrated epidemic — particularly in a country where HIV continues to be so highly stigmatized — is a more intense, more deliberate, and more expensive approach (per case found) than ones used in higher prevalence settings. Learning from the lessons about case-finding and the role of solid community/development approaches to do this work can and should be informing broader health initiatives in the Kyrgyz Republic on issues, including TB and Hepatitis C.

Roles of frontline staff working on case-finding and case management: In the current approach used by Flagship in the Kyrgyz Republic, PNs are responsible for all aspects of case-finding from initial identification and recruitment of new clients through confirmatory testing. While different IPs have different approaches to performance-based compensation for PNs, including the completely incentive-based approach used by Rans Plus, the single largest incentive payment in all cases is for getting a client who initially screens positive for HIV through confirmatory testing, including receipt of their results. In some cases, it appears that PNs and case managers work together to support clients through confirmatory testing, even though the incentive goes solely to the PN. Beyond the provision of any support during the confirmatory testing approach, case managers have responsibility for the ongoing work with clients on ART initiation and retention, including initial triage and the above-mentioned "graduation." Case managers receive a salary for their work; they did not report receiving any performance-based incentives.

The fundamental concern with the current approach is the limited qualifications of PNs to provide effective support to clients as they progress through the testing continuum. This concern is amplified by the importance of providing high-quality information and counseling from the early stages of engagement with clients to ensure critical issues (e.g., misconceptions about HIV and ART and anxieties about stigma and discrimination) are properly addressed in order to build and sustain a good relationship with them.

While there are clearly some well-qualified PNs working in Flagship who have the range of necessary skills, a significant percentage of them do not appear well-suited to the task.

In Tajikistan, Flagship is experimenting with using a more narrowly focused outreach worker whose focus is on identifying new clients for screening. These workers appear to have little involvement with the client other than identifying them and linking them to a more knowledgeable Flagship representative. A similar approach in the Kyrgyz Republic could address concerns about the capacity of many existing PNs as well as the turnover rate among PNs and the associated costs of training replacements. Essentially, the PN would only focus on identifying clients and "navigating" them to a Flagship site for a screening test. The client education and counseling would be done by a more qualified case manager, including the support required to get any clients with a positive screening to an AC for confirmatory testing. Existing PNs who have broader and better skills (e.g., select PNs at Anti-Stigma) could be trained as case managers, given that their skills already align with the job description of the case manager.

There are two other considerations related to the staffing for case-finding and case management: 1) Flagship nurses could be more fully integrated into the case-finding activities, including using them more broadly and more effectively to provide client-appropriate information about HIV and ART and helping to address concerns about stigma and discrimination; and 2) Staff working on case-finding and case management must have the capacity and the commitment to respect the rights and the dignity of clients and potential clients, including women, MSM, and ethnic communities; this was not the case at all of the IPs. In addition, staffing must be done in light of the realities of working with different subpopulations; for example, male PWID may not be the best positioned to identify and work with female PWID.

Changing nature of drug use: There is an underlying presumption that the PWID who are the focus of the Flagship project are opioid injectors. However, while opioid use remains high, multiple informants in the Kyrgyz Republic cited an increase in other types of drugs and drug use, including broader use of oral amphetamines. On a parallel note, the limited availability of MAT in the country — and the limited acceptance of the practice — makes it is a less appealing option for opioid injectors, despite its positive links to ART initiation and retention.

Undervalued approach and achievements: Although Flagship continues to underperform against targets, there are legitimate reasons why it is not reaching them, including possible over-estimated population size in Flagship operational areas (especially in Osh) and under-estimations of the level of effort required to overcome resistance to testing and treatment and the impact of long-standing structural barriers (e.g., entrenched stigma and discrimination) on health-seeking behaviors. Interviews with frontline staff support the arguments that Flagship is doing essential work on the HIV response and that existing indicators may not be the best measures of its different contributions. It is a challenge for the Project to use its understanding of the situation on the ground to make a stronger case to Office of the US Global AIDS Coordinator (OGAC), USAID, the national government, and other key stakeholders (e.g., GF) for the work it is doing and its significant contributions to the national response (e.g., innovative and replicable case-finding approaches; large percentage of HIV diagnoses among PWID in operational areas).

Sharing of knowledge and experience: There is an opportunity to expand the sharing of knowledge and experience across different IPs at both the organizational- and individual levels. Within the frontline operations of Flagship in the Kyrgyz Republic, there is a wealth of expertise that can and should be shared by the organizations, the PNs, and the case managers. This frontline expertise could play a

significant role in refining the Project's performance. In addition, it would be valuable to include other key Flagship stakeholders, including AC staff, in any improved opportunities and approaches to share and learn how to address the many challenges faced by PWID, their partners, and PLHIV in the country.

External Project Planning and Management

Strengths

Relationship with USAID: There is a solid working relationship between the Flagship management team and USAID in the Kyrgyz Republic. The Flagship team generally — and the Project director for the Kyrgyz Republic specifically — are seen as very responsive to USAID. The director is very engaged with Project activities and takes an active role in addressing management and implementation issues when they arise. The Flagship team in Bishkek seems to have an equally positive and productive relationship with key staff in the USAID regional office in Almaty.

Relationship with government: Key government stakeholders (i.e., RAC and local ACs) recognize and appreciate the contributions of Flagship to the HIV response. Despite the fact that the community-based approach used by Flagship is distinctly different than the facility-based approach implemented by the ACs, government stakeholders recognize the value of integrating community and facility approaches to provide better services to PLHIV in the country. They also recognize the advantages that civil society organizations have in doing this type of ongoing community work. To its credit, Flagship has been able to build on this positive relationship with government to strengthen collaboration and coordination in ways that improve services for PLHIV. However, there continues to be significant opportunity for Flagship and government to refine their working relationship (e.g., community-based confirmatory testing, community-based epi investigations).

Relationships with the USAID LEADER and REACT Projects: There is a positive relationship between the LEADER and Flagship Projects. For example, LEADER's work on reducing stigma and discrimination in health-care settings is broadly supportive of an improved environment for PLHIV. (Leader's selection of facilities where it conducts stigma and discrimination training could be more coordinated with Flagship for greater, more direct impact.) Similarly, there is a positive relationship between the REACT and Flagship Projects, and they collaborate when there is an opportunity or a reason. However, there is limited interaction between the two projects because the number of released prisoners is so small. In addition, released prisoners generally want to maintain their relationship with REACT staff as opposed to being referred to a Flagship case manager; this mirrored the behavior of Flagship clients who chose to establish long-term relationships with their case managers as opposed to shifting to other support mechanisms.

Relationships with other stakeholders in the national response: Flagship appears to have good relationships with other stakeholders in the national response, including the GF Country Coordinating Mechanism and UN organizations (e.g., UNAIDS, UNODC, UNDP). Flagship is seen by these stakeholders to play an important service-delivery role in the parts of the country where it is active. In addition, they appreciate Flagship's role as an engaged partner in the national response as both an innovator and a technical leader.

Challenges/gaps

Relationship with ICAP: Flagship and ICAP seem to have a generally positive relationship in the Kyrgyz Republic. ICAP openly acknowledges the central role that Flagship and its community-based IPs play in working with KPs. In fact, ICAP specifically acknowledges that Flagship clients can be easier to

work with at facilities because of the support they receive from the community partners and their outreach workers. The challenge with the relationship is that many of the issues related to ART initiation and retention are linked to issues at facilities, including stigma and discrimination by, and limited HIV knowledge among, health care providers at family medicine centers. In addition, Flagship does a tremendous amount of work with clients to get them to initiate and stay on ART but ICAP gets the full credit with PEPFAR (e.g., TX_NEW).

Replication/scale-up: The community-based approaches used by Flagship have been slow to be replicated and/or scaled up by other stakeholders in the country's HIV response. Despite strong endorsements by the RAC and local ACs, the approaches used by Flagship for case-finding and case management are not being picked up by other stakeholders. Consequently, PLHIV in large swathes of the country do not have the benefit of the community-based, community-driven services being implemented by Flagship in the limited areas where it operates.

4.2 TAJIKISTAN

In Tajikistan, Flagship is currently being implemented by seven NGO IPs in Dushanbe, the Rudaki, and Vahdat areas of the Districts of Republican Subordination, and Sughd Oblast. Most NGO IPs are implementing both the case-detection and case-management components of the Project, although in Khujand, these functions are split between two NGOs. All HIV rapid screening conducted by NGOs is undertaken by PNs using a saliva test kit.

4.2.1 Effectiveness of the USAID/Central Asia Flagship Project in supporting the HIV cascade

Case-finding

Paradigm shift in programming: The Flagship model of finding previously unreached or hidden networks of PWID and conducting case detection using peer-driven rapid HIV screening in community settings, represented a paradigm shift for Tajikistan away from traditional models of prevention-oriented outreach to known PWID networks. Given the reported reluctance of many PWID to attend ACs for HIV testing, the availability of HIV rapid testing in the community has significantly improved access. The initial resistance from some NGOs, government, and development partners has now been overcome, although this took time and significantly delayed Project commencement in Tajikistan. While some NGOs were more open to new ways of working, some had no previous experience in this type of work and initially found the new methods to be challenging. The fact that the model has now been accepted is a very significant achievement, although there are areas for improvement.

PWID HIV testing below target: Table 5 indicates that while Flagship has undertaken HIV testing of a large number of PWID, the ambitious targets have not been met. Although the number of PWID tested in the first three quarters of FY 2018 represents a significant increase over FY 2017, the higher target for FY 2018 means Flagship is falling further behind in meeting targets. NGOs consistently reported that the case-finding targets are too high, saying that they do not believe there are that many PWID in the districts they are covering.

Table 5. Flagship HIV testing and yield in Tajikistan by key population, FY 2017–FY 2018

Key Population	FY 2017				FY 2018 (to end-June)			
	HIV testing target (% met)*	Number tested	Number HIV-positive	HIV-positive yield %	HIV testing target (% met)*	Number tested	Number HIV-positive	HIV-positive yield %
PWID	17,627 (81%)	13,787	301	2.2%	24,056** (60%)	13,128	192	1.5%
PLHIV sex partners		544	77	14.2%		1,205	184	15.3%
MSM	N/A	N/A	N/A	N/A	908** (67%)	605	15	2.5%
Total	17,627	14,331	378		24,964	14,938	391	

Source: Flagship Project/PSI. * The HIV testing target combines PWID and PLHIV partners. ** Target for first 3 quarters.

Low HIV-positive yield: The HIV-positive yield from Flagship's PWID case detection of 2.2 percent and 1.5 percent in FY 2017 and FY 2018, respectively, is significantly below expectations, given the estimated HIV prevalence among PWID of 13.5 percent. Possible reasons include that most of the HIV-positive PWID in the areas where Flagship has been testing have already been diagnosed and that there are significant numbers of undiagnosed PWID in areas where Flagship has not been conducting case detection. Alternatively, HIV prevalence estimates may be too high. Despite the low yield, RAC data indicate that total HIV case-finding among PWID in 2017 increased by 35 percent, and in the PEPFAR sites of Dushanbe and Khujand by 100 percent and 80 percent, respectively.[4] This is most likely attributable, at least in part, to the case-finding work of Flagship.

HIV testing of the sex partners of PWID PLHIV increased significantly in FY 2018 because APN was only introduced midway through FY 2017, the time it takes to get consent to approach partners, progressive development of PN skills in APN, and an increasing prioritization of this approach by Flagship given the relatively high HIV-positive yield. APN primarily occurs with the female sexual partners of male PWID who are HIV-positive. However, APN also includes HIV testing of the male partners of female PLHIV who were referred to Flagship by ACs. Most of these male partners are PWID or ex-PWID. APN case detection has the highest yield and in FY 2018 accounted for 47 percent of all new case detections in Tajikistan. Although APN requires more time and effort, the relative success in this area has led PSI to emphasize this approach with NGO IPs. While APN is an important component of Flagship's work, case-finding among partners rests on initial case detection among PWID/ex-PWID. This needs to be kept in mind in regard to the relative priorities accorded to case detection among PWID and the sexual partners of PWID.

It is possible that supplementing current case-detection approaches with a sexual/social networking approach may be needed to reach the first 90. For example, a newly identified PWID PLHIV in Dushanbe may also indicate that he is married and injecting when he's back in his village. In addition to using APN to test his wife in the village, community mapping using ACF approaches should be conducted to identify other PWID in the village for testing, accompanied by testing of sexual networks.

Complementary case-detection approaches: Table 6 sets out Flagship's HIV testing data by each of the three case-detection approaches. ACF is used to find new networks of PWID, particularly in rural

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[4] Arash Alaei, Recommendations for Flagship, PSI and Trust Points, 2018, p. 1.

areas, where there are initially no identifiable seeds to undertake PDO. The yield from PDO case detection is higher than ACF because a new positive case found through ACF usually becomes a seed and new HIV cases found by the seed are counted as PDO cases. This highlights the complementary nature of these case-detection approaches. However, one NGO IP indicated that they do not believe that all positive cases are capable of being effective seeds, so they first make an assessment of their suitability. The issue of the suitability of newly detected cases working as seeds was not mentioned by other NGO IPs. Flagship could assist USAID in making a convincing argument to the OGAC on the complementary nature of ACF and PDO methods if it provided data on the number of HIV-positive cases detected through ACF who became PDO seeds, and the number of new cases detected through PDO with the help of these seeds.

Table 6. Flagship HIV testing in Tajikistan by case-detection approach and yield, FY 2017–FY 2018

Testing approach	FY 2017			FY 2018 (to end-June)		
	Number tested	Number HIV positive	HIV-positive yield	Number tested	Number HIV positive	HIV-positive yield
PDO	6,950	182	2.6%	4,233	93	2.2%
ACF	6,837	119	1.7%	9,500	114	1.2%
PLHIV sex partners	544	77	14.2%	1,205	184	15.3%
Total	14,331	378		14,938	391	

Source: Flagship Project/PSI

From FY 2017 to FY 2018 there was a significant decline in the number of PWID tested by PDO and a large increase in the number of PWID tested by ACF. The increase in ACF did not result in an increased number of HIV tests by PDO, which suggests difficulty in recruiting seeds and/or a need to strengthen the link between ACF and PDO. However, PNs interviewed understood the interrelated nature of the PDO and ACF approaches. It may be that the limited yield from ACF in FY 2018 of only 1.2 percent has limited opportunities to launch PDO in new sites. While the very large increase in ACF testing in FY 2018 indicates that Flagship is attempting to broaden its case-detection work in new areas and hidden PWID networks, the declining yield may indicate they are looking in the wrong places or there are problems with implementing the approach. As the HIV-positive yield for both ACF and PDO declined, it seems that Flagship may be approaching saturation levels of case detection in existing sites. Flagship's Quarterly Performance Report for FY 2018 acknowledges that one factor is "the majority of available PWID were tested in previous project periods."[5] This highlights the need for Flagship IPs to conduct case-detection activities in new sites and to strengthen their PDO work to enter new PWID social networks.

Table 7 sets out the variability across the first two quarters of FY 2018 in the different case-detection approaches within and between sites for both the number of tests and HIV-positive yield. ACF testing volumes are significantly higher in rural areas over urban areas. Within many areas there is a significant variation between quarters for the number of tests performed for the same case-detection approach. Although yield for the same case-detection approach in the one area is mostly similar from quarter to quarter, there is a significant difference in yield between quarters for almost half the sites. Variations in

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[5] Flagship Quarterly Performance Report, January 1–March 31, 2018, p. 17.

numbers tested and yield are to be expected given the complementary nature of the case-detection approaches, although it could also reflect more or less effective implementation over time.

Table 7. Testing volumes and yield in Tajikistan by site and case-detection approach, FY 2018, Q1–Q2

Location		RCD/PDO		ACF		APN	
		FY 2018 Q1	FY 2018 Q2	FY 2018 Q1	FY 2018 Q2	FY 2018 Q1	FY 2018 Q1
Dushanbe	No. HIV tests	319	49	902	299	48	138
	Yield	2.8%	16.3%	2.0%	1.3%	22.9%	9.4%
DRS: Rudaki and Vahdat	No. HIV tests	208	365	2,095	1,741	137	126
	Yield	1.4%	1.4%	1.0%	0.7%	8.8%	7.9%
Khujand	No. HIV tests	73	46	124	137	61	28
	Yield	5.5%	6.5%	3.2%	2.9%	18.0%	32.1%
Sughd except Khujand	No. HIV tests	631	573	866	732	102	181
	Yield	3.0%	2.3%	1.8%	0.8%	20.6%	23.2%
Tajikistan Total	No. HIV tests	1,231	1,033	3,987	2,909	348	473
	Yield	2.8%	2.8%	1.5%	0.9%	15.8%	15.6%

Source: Flagship Project/PSI

Flagship efforts to improve case-detection rates have included trying out different approaches in areas such as seed selection (i.e., positive seeds versus negative seeds) and varying the number of waves of PDO before stopping. A greater emphasis has been placed on ACF to find hidden networks, with some attention paid to the appropriate balance between ACF and PDO. Incentives (food packages) have been introduced for seeds who successfully recruit for testing and for PWID and partners who undertake testing and are reported to be effective.

Finding new and hidden PWID networks: All Flagship NGO IPs in Tajikistan have received recent USAID-supported TA on geospatial mapping of HIV case detection among PWID. Using RAC data, maps for the coverage area of each IP were produced showing the localities of all recent HIV case detections among PWID and case detections for the last three years, based on residence. This was used to compare areas where NGOs are currently undertaking case-detection work with the localities of residence of new/recent case detections. IPs have been encouraged to use the mapping to broaden the geographic focus of their ACF work. If there is a reasonable degree of geographical correlation between the residence of new/recent case detections and the location of previously unreached PWID networks, this could result in a significant number of new case detections. As the TA has only recently been provided, it is too early to tell whether this method will generate an increase in the rate of case detection. PSI needs to closely monitor the implementation of ACF work by IPs using the geo-maps and the impact on case detection. PSI should complement this by mapping areas where their previous case-

detection activities have resulted in below average yield to identify areas where further case detection is unlikely to be productive.

Case-finding among ex-PWIDs: A key strategy needed to improve case-detection yield is increased HIV testing among ex-PWID. This may require different approaches as ex-PWID may not be reached through existing case-detection approaches focused on current PWID networks.

Engaging current PWID in finding new networks: Most case-detection PNs are ex-PWID. There has been advocacy for NGOs to recruit active PWID who may have greater knowledge of current PWID networks. The evaluation team concluded that problems in managing active PWID PNs mean this is not a viable option. However, NGO IPs should actively engage and incentivize current PWID in ACF mapping to find new networks of PWID.

Diversity needed among case-detection PNs: NGO IPs need to consider providing for gender, age, and socio-economic diversity among their case-detection PNs as this may assist in finding a broader range of PWID networks. Overall, the profile of PNs tends to be middle aged-to-older males from lower socio-economic backgrounds. SPINPlus only has one female case-detection PN out of 13. There is a greater level of gender diversity among case-detection PNs in most other NGOs.

Provision of harm reduction services, such as sterile needles and syringes by Flagship NGOs (using other donor funds) contributes to strong relations with drug users and facilitates reach to PWIDs for case detection. This highlights the importance of comprehensive programming by NGOs in achieving better prevention, case detection, and treatment outcomes.

Quality of pre-test counseling: PSI has recognized the opportunity to increase testing uptake among PWID by improving the quality of pre-test counseling by PNs and is currently addressing it. Interviews with some PNs indicate that simple treatment education messages (i.e., Undetectable = Untransmissible and improved outcomes from early treatment initiation) are not provided to motivate people to test but rather only upon screening positive. This appears to be variable, as some HIV-positive PNs who are on treatment indicated in interviews for this evaluation that they use themselves as healthy examples of the benefits of treatment. The treatment knowledge of some case-detection PNs interviewed for this evaluation is clearly deficient. The development of additional and improved simple, low literacy materials on the benefits of HIV treatment as both a motivation for testing and treatment uptake is needed.

Pre-test counseling messages need to be tailored to the needs of clients. FGDs with Flagship clients indicated the type of issues that may motivate people to be tested, such as safe sexual reproduction. For example, a PWID client who wants to have a family may be motivated to have an HIV test if they know that viral suppression allows them to have children without transmission to a partner or child. Tailoring of messages to motivate clients requires first establishing a relationship to understand their needs and offering testing later. A number of stakeholders indicated that the pressure to meet targets may be resulting in testing being offered prematurely, prior to establishing an understanding of what would motivate the client to agree to testing and treatment.

The very high levels of HIV-related stigma in Central Asia, prevalent myths and conspiracy theories about HIV, highly exaggerated fears on treatment side effects, distrust of government services, and fear of legal repercussions relating to transmission all have a negative effect on both testing and treatment uptake. PNs indicated that clients were afraid of being registered as HIV positive on a government database (i.e., RAC database). All of these issues need to be dealt with more effectively in pre-test counseling.

HIV confirmatory testing: A major challenge is the significant number of clients who do not go to ACs for a confirmatory HIV test. In Tajikistan, of 764 Flagship clients who tested positive on saliva screening, 19 percent have not had a confirmatory test. The most common reason was client refusal (71 percent), followed by migration (14 percent), death (8 percent), lost connection with client (5 percent); and imprisonment (2 percent). PSI has sought to reduce the rate of confirmatory test refusal by using consultations with trained psychologists, monetary incentives for PNs for newly confirmed cases, case-detection and case-management PNs jointly undertaking field work so case manager PNs can start to build relations with clients from the time of the positive screening test. Additionally, PSI has made efforts at improving pre-test counseling. There are, however, additional structural barriers. Patients need to attend and register with an AC for confirmatory testing. ACs will not accept blood for confirmatory testing nor draw blood offsite. In Khujand, the NGO Dina reported that clients are reluctant to register at ACs due to the fear of being registered as HIV positive on a government database and possible fear they may also be registered by the government as a drug user. It is not possible for homeless people without government identity documentation to be registered in an AC. This prevents access to confirmatory testing and ultimately treatment. Dina reported that it had been unable to arrange confirmatory testing for three homeless clients in May 2018. This was not reported by other NGOs in Tajikistan so it is possible workarounds are being used in other places.

A new HIV-testing algorithm has been approved in Tajikistan, which should reduce delays in conducting confirmatory testing, which in turn increases the risk of losing contact with the client.

ICAP is well-placed to advocate for a more flexible approach to where blood for confirmatory testing can be drawn. While patients will need to ultimately attend an AC to commence treatment, liberalization of requirements regarding confirmatory testing would assist in reducing the number of clients who refuse confirmatory testing. In addition, Flagship needs to make a concerted effort to improve pre-test counseling. ICAP could also advocate for the RAC to change the requirement for clients to have government identity documents to access confirmatory testing and treatment in ACs, as this acts as a barrier to these services by homeless people.

Case Management
ART uptake: Based on site visits, test and treat appears to be, in large part, being implemented in place in Tajikistan and NGOs reported that ACs do put active PWID on ART. Of Flagship's 553 cumulative new PLHIV case detections with a confirmed positive result as of June 30, 2018, 488 (88 percent) were linked to AC care and 375 (68 percent) commenced ART (Figure 1). For those who commenced ART, the average time from linkage to care and ART initiation was 15 days, with a median of one day. While ART initiation is 22 percent below the second 90, it represents a reasonably effective result considering the structural barriers and social environment. For the PLHIV linked and retained in care but who have not commenced ART, the average duration in care is 123 days, with a median duration of 117 days. The 22 percent includes recently diagnosed clients, whom PN case managers are trying to convince to initiate treatment. Forty of the clients linked to care who did not commence ART were not retained in care for various reasons: migration (45 percent), death (23 percent), left on their own initiative (15 percent), lost contact with the Project (10 percent), and other reasons (7 percent).

Figure 1. Linkage to care and ART initiation by Flagship/Tajikistan, FY 2017–2018*
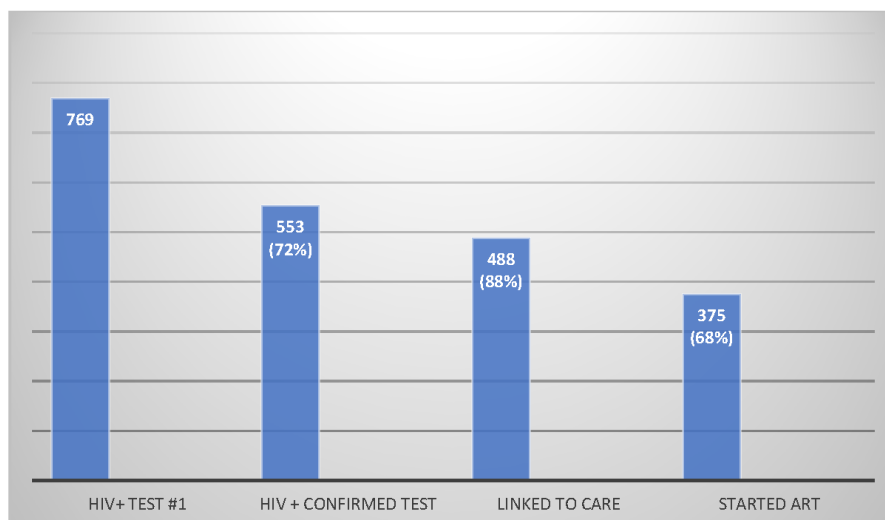
Source: Flagship Project/PSI. *FY 2018 data for the first three quarters only.

Factors limiting ART uptake are largely the same as factors that contribute to refusal to have confirmatory testing (see above). While reducing the impact of some factors, such as stigma, will take time, short-term measures include improved pre-test counseling, with an emphasis on the benefits of treatment, coupled with improved treatment education post-confirmatory testing through simple and effective messages tailored to the needs of clients. Flagship should work with the ACs to determine the factors that result in ART uptake as well as factors that lead to a reduction in time between confirmatory testing and ART initiation. This should be accompanied by measuring progress in reducing the number who do not start ART and also in reducing the treatment initiation interval.

Data extracted from Tajikistan's HIV data management system by local ACs in March 2018 for a cohort of all new HIV diagnoses in PEPFAR subnational units for the previous six months indicated that the number initiating HIV treatment in that period ranged from 90 to 100 percent in different ACs. CDC Tajikistan has concluded that this high level of achievement for test and start can be jointly attributed to the work of both ICAP and Flagship in their support of the RAC and city and oblast ACs.

AC LTFU patients: At the request of ACs, Flagship PNs have made considerable efforts to find AC patients who were LTFU (i.e., non-Flagship case-detection patients). A total of 625 LTFU clients have been found, of whom 577 (92 percent) have been linked with AC care (Figure 2). Three hundred and eighty-one (61 percent) LTFU patients either recommended ART (32 percent) or started ART for the first time (29 percent). PNs reported it takes time to gain the trust of LTFU clients and motivate them to commence treatment. As many of these clients had already dropped out of treatment the uptake rate is high, particularly as there can be a need to overcome the reluctance of some AC doctors to provide ART to LTFU patients for fear they will drop out again. (PEPFAR can help solve this issue through other implementing mechanisms.) Not all of the AC's LTFU patients would be PWID. It may be relatively easier to re-engage non-PWID patients in treatment. Flagship's contribution of 381 LTFU patients restarting or initiating ART represents 44 percent of the total number of PLHIV for whom Flagship has supported ART commencement in Tajikistan.

Figure 2. LTFU PLHIV in Tajikistan, linked to care and ART re-initiation/initiation, FY 2017–2018*
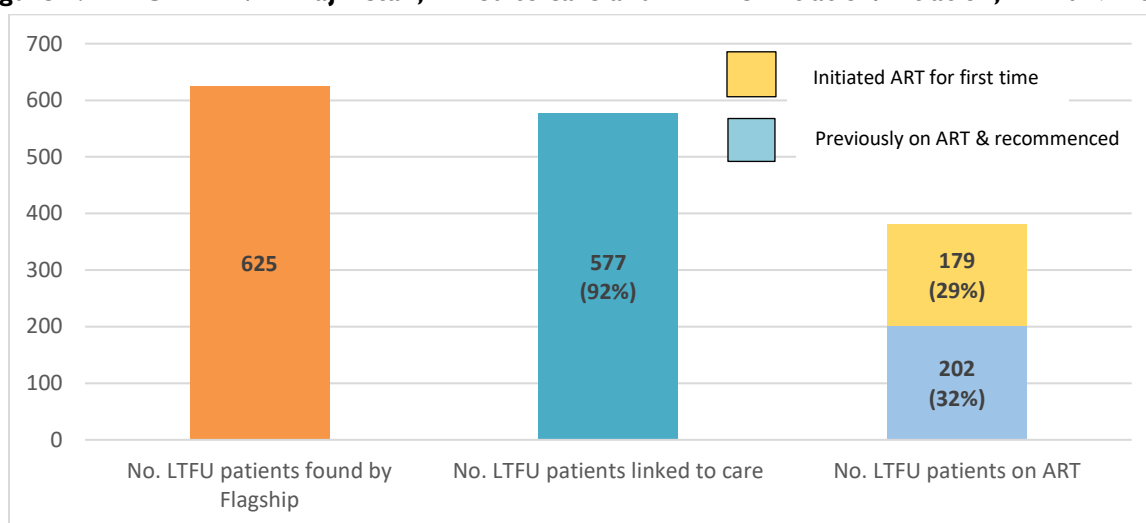
Source: Flagship Project/PSI. * FY 2018 data for the first three quarters only.

AC referrals to Flagship for case management: ACs make referrals to Flagship of PLHIV who would benefit from community-based case management. These patients were not diagnosed through Flagship's case-detection work. Flagship case-management work has resulted in 44 out of 63 (70 percent) referred PLHIV recommencing ART and a further 196 out 364 (54 percent) referred PLHIV starting ART for the first time. This group makes up 24 percent of the total number of PLHIV for whom Flagship has supported ART commencement in Tajikistan. The total number of PLHIV who have commenced or recommenced ART in Tajikistan with Flagship support (i.e., new case detections, LTFU, and AC referred patients) in the 21-month period from October 2016 to June 2018 is 996. This is a significant contribution to the second 90.

Viral suppression: PSI reports that of 996 clients enrolled in treatment, 395 (40 percent) have achieved undetectable viral load (VL). It is not possible to draw a conclusion on the level of adherence as access to VL testing is limited due to stockouts of re-agents and some clients would not have been on treatment long enough to be eligible for a VL test. It is not known how many people were unable to have a VL test due to stockouts.

Case-management PNs interviewed for the evaluation displayed generally high levels of commitment and passion for their work. Many of the PNs are PLHIV and act as role models for clients on the benefits of ART. Clients consistently spoke highly of the work of PNs in helping them with HIV treatment and a range of social problems.

The impact of migration on retention in treatment: High rates of short- to medium-term labor migration to Russia have a significant impact on retention in treatment. While HIV testing is not required for a visa, mandatory testing is enforced for employment, except in the informal economy, and HIV-positive migrants are deported. Migrants to Russia do not register for treatment in Russia for fear of deportation. ACs in Tajikistan give migrants up to six months of ART. After this is exhausted they are reliant on relatives sending ART. The Tajikistan RAC is advocating with Russian authorities to stop deportation and to formalize access to treatment in Russia. While NGOs could place more emphasis on preparing clients for migration and refer them to Russian NGOs, it is unlikely that many would seek treatment services in Russia while the threat of deportation remains.

MAT: Tajikistan has a small, but increasing, number of MAT sites. New sites have been struggling to enroll patients. ICAP has been working with the RAC to increase MAT referrals with mixed success. Key informants reported that factors that are inhibiting utilization and growth of MAT services are the need for patients to go to a MAT site every day as take-away doses are not permitted; negative attitudes to MAT on the part of PWID; the poor location of some MAT sites; a lack of psychosocial support; variations among sites in the quality of service; and a reluctance by the government to allocate funds to MAT due to uncertainty on whether this can be sustained. Registration in MAT automatically results in registration by the government as a drug user, which serves as a strong disincentive. A single window approach is used for MAT, ART, and TB treatment, but if patients stop taking MAT, this may result in discontinuation of HIV and TB treatment. Flagship NGOs provided referral slips to MAT for 494 PWID, of whom 13 percent were HIV positive, from FY 2017 to FY 2018. The self-reported referral uptake rate was 36 percent. The factors inhibiting the utilization of MAT, outlined above, are limiting both referral rates and referral uptake, resulting in rates that are below what could reasonably be expected.

4.2.2 Strengths, weaknesses, and gaps in planning and management

Internal Project Planning and Management

Underperformance in meeting targets has resulted in high levels of NGO support and scrutiny from the PSI country office and multiple sources of international TA, some of which has provided inconsistent advice on ACF methods. One NGO said, "It felt like PSI was living with us last month." While NGOs are not lacking support, consideration needs to be given to whether this is overwhelming and leaves sufficient time for implementation. The director of one NGO said the weekly "control and support" visits by PSI were helpful, but also take the time of PNs away from case-finding.

The PSI country office has a significant focus on monitoring indicator data in relation to the ambitious targets. This includes weekly monitoring of NGO data and identifying weekly priorities for NGOs based on areas of underperformance. For example, if weekly PDO case-detection numbers are low for one NGO, PDO may be identified as that NGO's priority for the week. Problems with this approach are that the performance of different case-detection methods fluctuates over time as part of the "natural" interaction between the PDO and ACF approaches and weekly data analysis may be too short a time frame for determining appropriate priorities.

The focus on meeting targets and following set systems provides no opportunity or motivation for NGOs to propose innovations or new strategies informed by local knowledge and context. There is a need for PSI to build the skills of NGOs to analyze Project data on case detection and case management, coupled with use of qualitative data from PN's field experience in answering difficult "why" questions relating to key challenges, such as increasing case-detection rates, confirmatory testing, and ART uptake. One very simple example of using field experience is that one NGO found that no HIV-positive cases were detected from tests conducted prior to 2 p.m., so they adjusted the time of outreach work accordingly.

NGO management and PNs were positive about PSI trainings and ongoing TA, although a few said PSI was too controlling and visited too frequently. PSI has monthly meetings with directors of all NGOs to discuss coverage, results, effectiveness of different approaches, and future plans. A consistent theme of PN interviews was a desire to be able to exchange experience with PNs from other NGOs. Some NGOs expressed a need for organizational development capacity building to strengthen their sustainability.

A significant gap in HIV programming in Tajikistan is the lack of above-site advocacy from development partners on policy issues. HIV is attracting more political attention, but the response has focused on non-evidence-based policies, such as mandatory screening prior to marriage and proposed testing of all migrants upon return to Tajikistan. Flagship is primarily focused on meeting ambitious case detection and treatment uptake targets and has not addressed policy issues in a significant way. Moreover, an international NGO may not be best placed to undertake domestic policy advocacy functions. Flagship is, however, well-placed, based on its extensive program experience, to inform the policy advocacy agendas of other PEPFAR-supported projects and multilateral organizations, such as UNAIDS and UNDP.

External Project Planning and Management

Flagship NGOs have been able to demonstrate how their comparative advantage at the community level in finding LTFU patients and case detection among PWID and their sexual partners and linking them to treatment, complements health facility-based work. Consultations with government partners indicated that these positive results have, over time, served to build good relations with the RAC and city and oblast ACs. The RAC has indicated that it would like to replicate the PEPFAR model of work in other oblasts in Tajikistan with large KP numbers and low treatment coverage. The RAC's intentions represent a significant achievement.

CDC Tajikistan reported good working relations between ICAP and Flagship, based on a role delineation between ICAP PNs and Flagship PNs. The good relationship was also attributed to cooperation between USAID and CDC in Tajikistan. Most NGOs reported good working relationships with ICAP at the AC level, although one NGO reported some tension over role delineation between Flagship PNs and ICAP PNs and competition for clients.

Leader has conducted trainings of Flagship PNs on self-stigma in Dushanbe and Khujand using a training of trainers (ToT) model. Feedback from PNs interviewed for this evaluation was that the training helped them overcome self-stigma problems in their work. Those trained have undertaken training of other PNs. LEADER also conducted a five-day training on stigma and discrimination for medical staff from the RAC, ACs, and polyclinics, and for PNs, using a ToT model. There was positive feedback, particularly from polyclinic doctors. Stigma and discrimination is more commonly reported from polyclinics. The training has resulted in referrals of PLHIV to SPIN Plus by both ACs and polyclinics and reported improvement in service delivery. Trained PNs and doctors have undertaken one-day trainings for additional doctors from polyclinics. LEADER has identified the need to increase the coverage of medical personnel undertaking stigma and discrimination training and the need to develop a national plan to combat HIV-related stigma and discrimination, including patient monitoring of the quality of health services.

There is a high level of collaboration between HIV REACT and Flagship NGOs in Dushanbe and Khujand. As needed, ex-prisoners with ongoing case-management needs are referred to Flagship and the Project then notifies REACT of clients who are incarcerated to ensure ongoing access to ART and case management. Collaboration in Dushanbe is assisted by the fact that SPIN Plus is the NGO IP for both Flagship and REACT. In Khujand, where different NGOs are implementing Flagship and REACT, it was clear from consultations that there is a high level of collaboration.

Prior to commencement of Flagship, USAID and UNDP went through a lengthy process to ensure there would be no duplication between USAID and GF programming.

4.3 KAZAKHSTAN

4.3.1 Effectiveness of the Flagship Project in supporting the HIV cascade

Case-finding

Strengths

Contribution to identifying new cases: Although case-finding is not a Flagship priority in Kazakhstan, the Project is making an important contribution to identifying new cases in the areas where it is working. In Pavlodar, the local AC feels strongly that they would not be able to find new cases among PWID without Flagship's involvement. In Ust Kamenogorsk, the local AC has a similar perspective on the testing done in remote areas of the oblast; without Flagship, they would not be able to cover these areas for case-finding or case management. The RAC believes Flagship outreach workers have the training required to do effective partner tracing. This training is important because different stakeholders report that partner tracing is difficult in Kazakhstan because people are reluctant to share information on their sexual partners, particularly if a partner is a PWID. However, Flagship is addressing the issue by having outreach workers establish relationships and build trust with clients before doing any contact tracing or assisted-partner testing.

Oral HIV testing: The use of oral HIV tests in the community has been an effective way to test clients because it means they do not have to visit an AC for an initial screening. Given the belief in Kazakhstan that a significant number of undiagnosed HIV cases are in remote communities, the ability to do immediate, on-site screening with an oral test eliminates a key barrier to testing uptake among clients in these communities. In addition, if a proper blood draw (e.g., by a visiting/patronage nurse) can be done on-site after the screening, the client also does not have to travel to an AC for a confirmatory test.

Confirmatory testing: A high percentage of clients who are screened positive for HIV do have a confirmatory test. According to Flagship data from October 2017 through May 2018, 94 percent of clients in Kazakhstan who screened positive for HIV had a confirmatory test. In Pavlodar, the AC directly credits Flagship PNs for their contribution to the high rate of confirmatory testing. The low LTFU is an indication of an effective approach to the testing continuum (i.e., identification, recruitment, screening, confirmatory testing) and the solid collaboration between Flagship and ACs on case-finding). The fact that Flagship focuses on partner testing in Kazakhstan may contribute to the high rate of confirmatory testing but it is unclear from Project data if there is any correlation and, if there is, why partner testing leads to higher confirmatory testing.

Weaknesses

Limited data on why clients who are screened for HIV do have a confirmatory test: In light of the fact that Flagship's case-finding efforts in the Kyrgyz Republic and in Tajikistan have a significant loss factor between screening and confirmatory testing, it would be useful to have a comprehensive understanding of why the loss has been so low in Kazakhstan. It appears Flagship is working on understanding why clients forego confirmatory testing but it would be equally useful to understand who agrees and who doesn't as well as why they agree or don't agree to test.

Knowledge of PNs: To improve their ability to find HIV cases, PNs need more extensive knowledge to help clients overcome their reluctance to test, including better information on treatment. Misconceptions about HIV and ART are widespread in Kazakhstan and addressing these misunderstandings is a critical aspect of getting clients to test and share information about their sexual and/or injecting partners. In addition, there are concerns that some PNs continue to struggle with their

own misconceptions about HIV and ART, which can lead to them sharing inaccurate information with clients.

Challenges/gaps

Barriers to testing uptake: There are significant and persistent barriers to testing uptake in Kazakhstan, including stigma and discrimination, misinformation/disinformation about HIV, and limited knowledge about treatment. The barriers, which are related to both initial screening and confirmatory testing, have a significant effect on the efficiency and effectiveness of the Flagship outreach workers. To a large extent, overcoming these barriers is beyond the capacity of the Project. For example, addressing misinformation and disinformation — much of it spread with malevolent intent by "HIV dissidents" in Russian-speaking countries — requires a comprehensive and coordinated approach to communication, including interpersonal, mass media, and online, by a wide range of credible and influential sources in Kazakhstan.

Testing intervals: ACs would like to see populations at higher risk of infection (e.g., PWID) tested for HIV every three months, which is in line with World Health Organization (WHO) recommendations. However, the PEPFAR indicator only recognizes retesting after six months, regardless of risk profile. While it is unlikely the PEPFAR indicator will change in the short term, it is unfortunate it does not align with WHO recommendations, particularly in a country where there is a highly concentrated epidemic and a willingness to test members of a KP more frequently as part of a national commitment to epidemic control. It is important to note that retesting every three months may not be necessary if clients are not engaged in risk behaviors.

Case Management

Strengths

Positive contributions of Flagship PNs: ACs — and clients — feel strongly about the positive contributions of Flagship PNs to ART initiation and retention, including their work with newly diagnosed clients and finding LTFU clients. Among AC managers, there is a recognition that the community-based work by Flagship PNs is an important part of the overall package of services and support available to PLHIV for ART initiation and retention. For example, in Ust, Flagship PNs are fully integrated into the operations of the AC with each navigator working with a dedicated doctor and patronage nurse with responsibility for their own geographic area. In Pavlodar, patronage nurses rely on the community knowledge and presence of the Flagship navigators to better reach clients. In both Ust and Pavlodar, there is a good relationship between the ACs and the NGOs that field the PNs; if there are operational issues or concerns, they work together to address them.

In both Ust and Pavlodar, clients report being satisfied with and appreciative of the support they receive from the Flagship PNs. They are quick to credit PNs with helping them accept their HIV status, understand the importance of starting treatment, and provide them with the support needed to stay on treatment. However, given the multiple hardships they face as PLHIV and the general lack of services for them, they do say they wish Flagship could do more (e.g., community-based "one-stop shop" for PLHIV, including antiretroviral (ARV) dispensing, VL testing and medical services; job training; food baskets; and housing assistance).

The recognition by PNs that they need expanded knowledge and skills to further improve their ability to do their job also supports a further professionalization of the cadre. Not only will a better prepared, more professional group of case managers provide better support to clients, they are more likely to be

retained by Flagship and they become part of a sustainable core of HIV case managers who can continue the work in the future.

Ongoing role of case managers in adherence and retention: The Flagship approach to case management emphasizes initial triage and treatment initiation. However, case managers recognize the longer-term value of their relationships with clients. They specifically recognize the vital role a long-term relationship plays in treatment retention. In the language of global health priorities and epidemic control, the case managers are actively contributing to both the second and the third 90 (i.e., ART initiation and ART retention/viral suppression). The downside of the PNs developing longer-term relationships with clients is that Flagship has less capacity and fewer systems in place to manage this sustained work.

Weaknesses

Loss factor between confirmatory testing and ART initiation: Between June 2016 and March 2018, Flagship reported only 42 percent of newly found PLHIV-initiated ART. In addition, from Project commencement to June 2018, Flagship reported only 28 percent of LTFU clients found by the Project initiated ART. Given the low loss factor between initial screening and confirmatory testing in Kazakhstan, the poor performance on ART uptake is a significant issue for the Project. The primary reasons for the poor performance appear to mirror the barriers associated with testing uptake, including stigma and discrimination, misinformation/disinformation about HIV, and limited knowledge about the realities and benefits of treatment. There are also concerns about the impact of ARV stockouts, which is a recurrent problem in Pavlodar, and beliefs among doctors that PWID will not adhere to ART regimens. The interplay between the different reasons makes them particularly virulent and difficult to address; for example, rampant stigma and discrimination fueled by misinformation about HIV and ART cannot quickly or easily be overcome by a PN. For patients in remote regions, access to services is an additional barrier to ART initiation.

Limited qualitative data: Flagship has limited qualitative data on client perceptions and behaviors related to ART initiation and retention. Within the context of above-mentioned barriers to testing and ART uptake, the Project does not have qualitative findings on relevant issues such as why clients delay starting ART, why they stop treatment and what can be done to get them started and keep them on treatment. While the treatment readiness reports produced by LINKAGES and published in March 2018 are based on qualitative interviews with clients, it includes limited data on specific behaviors and barriers or specific activities to address them. A generic call to "[e]nhance treatment literacy knowledge and motivational counseling skills of PNs and other NGO staff" is a useful first step but that call needs to be linked to specific and effective treatment knowledge and specific counseling skills and approaches based on actual interactions with clients.

More extensive knowledge and skills: Individual PNs recognize the need for more extensive knowledge and skills to do what is a very challenging job. PNs need a wide array of knowledge and skills to do case management. While they are provided with core training, PNs in Kazakhstan cited a number of specific areas where they felt underprepared, including counseling skills, psychosocial support, mental health, treatment education, and palliative care. There is also a corresponding lack of audience- and language-appropriate information materials about HIV that PNs could use to supplement their continuing work with clients.

Limited systems and/or structures for continuing work with clients: Beyond the approach in place for initial triage, there are limited systems and/or structures around the continuing work of case managers with their clients. While the client triage tool seems to be an effective way to conduct an

initial assessment of client needs and circumstances, its value appears to diminish over time. The Project's intention to "graduate" clients from case management and shift them to group counseling as a replacement for one-on-one support is more theory than practice. Consequently, Flagship case managers in Kazakhstan maintain contact with clients for longer, even indefinite, periods of time and there are no systems or structures in place to help them manage these interactions.

Challenges/gaps

Stigma and discrimination: Flagship struggles to help its clients cope with the high levels of HIV-related stigma and discrimination in its operational areas. As mentioned above, stigma and discrimination fueled by misinformation and disinformation about HIV and ART is a toxic combination that cannot easily be addressed by Flagship staff. An additional concern is the stigma and discrimination that PLHIV face from health care providers, particularly in the polyclinics and particularly by younger staff. For example, in Pavlodar, PNs report that PLHIV are unable to access emergency medical services due to overt stigma and discrimination and female PLHIV are denied services at a local women's crisis center.

"Graduation' from case management: Stable clients are technically being "graduated" after six months working with a PN. However, a high percentage of them continue to engage with their Flagship PN on a regular basis after graduation. The concept of "graduation" is understandable because it can be difficult to justify an ever-increasing client load for individual PNs (e.g., reported to be upwards of 20 clients per PN in Pavlodar) and for Flagship as a project. However, community-based case management in a country with so many challenges facing PLHIV is an essential component of the national HIV response. For example, PNs in Kazakhstan report that PLHIV don't necessarily understand the importance of staying on ART with clients wanting to stop treatment when they feel better or after they are sure their baby is HIV-free. The challenge is how to sustain the case-management effort and ensure PNs get the credit and corresponding support for their ongoing contributions to epidemic control.

Factors outside the control of the Project: Multiple factors outside the control of the Project adversely affect ART initiation in Kazakhstan, including intrusive epi investigations, rejection by family members, substance abuse, homelessness, and ARV shortages. While there are steps that Flagship PNs can take to mitigate factors affecting ART initiation, there are limits to what they can do. Some of those limits are due to the structural nature of the problem (e.g., deep-rooted stigma and discrimination); others are due to the availability of services (e.g., lack of housing for homeless people; in Pavlodar, more than 10 percent of clients are homeless); while others are due to long-standing government policy (e.g., epi investigations) or deficiencies in government systems (e.g., recurrent ARV shortages in Pavlodar and questions about ARV quality).

4.3.2 Strengths, weaknesses, and gaps in planning and management

Internal Project Planning and Management

Strengths

IPs feel well-supported: The Project's IPs feel they are generally well-supported by the Flagship team in Almaty. The partners value the TA provided by Almaty staff as well as their mindfulness of the many challenges faced by both the IPs and their clients. However, the partners do have issues with the limited support for organizational development provided by Flagship and the complexity of some of the Project approaches (e.g., tracking incentive payments).

Commitment to collecting and using data: Across the integrated Flagship organization in Kazakhstan, including PSI and IP operations, there is a strong commitment to collecting and using data to

track performance. Flagship staff across the Project recognize the value of using data to guide their implementation activities. However, the Project focuses primarily on indicator data, which limits its ability to understand why certain activities in certain areas yield certain results. The Project appears to routinely ask what has or would influence the performance reflected in the indicator data. Having more of the above-mentioned qualitative data to help understand the "why" behind Project performance would further strengthen Flagship's ability to use data productively.

New technology: The introduction of tablets for use by PNs is seen as a positive way to improve interactions with clients and streamline the workload for the outreach workers. Implementers believe the ability to show targeted, language-appropriate videos and presentations to clients on the tablet should help with HIV and ART education. For the PNs, the primary attraction is the tablet's ability to reduce the paperwork they are required to do.

Weaknesses

Concerns about client confidentiality: Flagship's "requirement" that clients provide a significant amount of personal data, which has little or no relationship to services provided by the Project, raises concerns about confidentiality, which, in turn, translates into trust issues among clients. In light of the high levels of stigma and discrimination in Kazakhstan, there is a concern among IPs that Flagship requests for personal data are excessive and intrusive. PNs believe the amount of personal data required by Flagship is a disincentive for some clients to engage with the Project. It is unclear if the opportunity cost of collecting these data is a net positive or negative for Flagship but concerns about an intrusive collection of personal data should not be dismissed lightly.

Staff burnout: Burnout among PNs is common and it appears little is being done by Flagship to address it. The work of a PN is highly stressful for various reasons, ranging from the challenges of working with PWID to their on-call availability to clients at whatever day/time they need support to the number of clients they maintain. In addition, the compensation package is low and most PNs have to spend more on transport than their allowances cover, due to the distances they cover in their work and the demands of the job. Implementing programs to address the issues of burnout and to retain effective PNs should be assessed in light of the costs to replace and train new navigators.

Challenges/gaps

Undervalued approach and achievements: Despite solid support for its work in Kazakhstan, Flagship is not actively demonstrating or documenting how and why its approach is making a difference to a wider group of stakeholders. Although partners in the national and regional governments in Kazakhstan — specifically, the RAC and local ACs — value the contributions of Flagship, broader awareness of the approach, including how and why it is effective and how it could be adapted and expanded to improve the overall HIV response as well as response to other diseases that would benefit from a strong community component, is low. Improving knowledge and awareness of the Flagship approach among other constituents [e.g., other departments in the Ministry of Health, other ministries, private sector partners] would help establish the approach as a proven and effective way to improve client/patient experiences and outcomes. Better awareness of Flagship activities as well as the challenges it faces would also contribute to broader policy discussions that will affect the national response in the future.

External Project Planning and Management

Strengths

Relationship with USAID: There is a solid working relationship between the Flagship management team and USAID staff in Kazakhstan. Given the fact that the Flagship team in Kazakhstan largely functions as both the regional and the country team, it is difficult to separate the quality of the relationship with USAID on the two levels. However, the Flagship COP and the larger Flagship team in Almaty are seen as very knowledgeable about the Project, very engaged with oversight and implementation — and very responsive to USAID on both regional and Kazakhstan issues.

Relationship with government: Key government partners (i.e., RAC and local ACs) recognize and appreciate the contributions of Flagship to the HIV response. Based on their assessment of Flagship's activities and results, government partners recognize the value of integrating community and facility approaches to provide better services to PLHIV in Kazakhstan. They also recognize the advantages that civil society organizations have in doing the necessary community work. Flagship has been able to build on its positive relationship with government to solidify support for its work and strengthen collaboration in ways that improve services for PLHIV.

Relationships with the USAID LEADER and REACT Projects: There is a positive relationship between the LEADER and Flagship Projects in Kazakhstan. For example, LEADER's work on reducing stigma and discrimination in health-care settings is broadly supportive of an improved environment for PLHIV. Similarly, there is a positive relationship between the REACT and Flagship Projects and when they can collaborate to improve services for ex-prisoners, they do. However, there is limited interaction between the two projects because the number of released prisoners is so small.

Weaknesses

Relationship with the Narcology Centers: Flagship has a tenuous link to the HIV-related activities implemented by the government's Narcology Centers. In light of the overlaps in work with the PWID population, it is surprising Flagship does not have a strong(er) relationship with Narcology Centers in Pavlodar and Ust. For example, in Pavlodar, the head of the MAT program at the local Narcology Center knew about Flagship but had never been contacted by anyone from the Project. The tenuous connection is particularly ironic, given that the integrated, "one-stop-shop" approach to the provision of HIV-related services for MAT clients (i.e., ARV dispensing, VL testing and medical services) is often cited by Flagship stakeholders as a preferred model.

Challenges/gaps

Coordination among relevant government partners: Although Flagship has a generally positive and productive relationship with government partners in Kazakhstan, there are issues with internal coordination across the partners, due in part to their diverse geographic locations; for example, the Ministry of Health is based in Astana, the Republican AC is based in Almaty, and the Republican Narcology Center is based in Pavlodar.

Replication/scale-up: The community-based approaches used by Flagship have been slow to be replicated and/or scaled up in the country's wider HIV response. Despite endorsements by the RAC and local ACs, the approaches used by Flagship for case-finding and case management are not being picked up in other parts of Kazakhstan. Consequently, PLHIV in large swaths of the country do not have the benefit of the community-based, community-driven services being implemented by Flagship in the limited

areas where it operates. In addition, it is unclear if the approaches will be continued once the Project ends.

4.4 STRATEGIC INFORMATION

Strengths

Commitment to data collection and data use: Flagship has developed and implemented various tools and systems to ensure that data are collected and used on a routine basis across the Project. For example, the custom-built Project database, which is used in all three Flagship countries, captures a significant amount of data about key components of the Project, including detailed information on individual Flagship clients. Other tools are used on a regular basis to track critical performance data on Project activities; for example, the yes-to-test calculator is an everyday tool for tracking case-finding across the program and within individual sites. In addition, there is a culture of data use in the Project that encourages and supports all Flagship staff — from the COP to PNs — to engage with Project data in their work.

Case-finding approaches are data-driven: The Project's three approaches to case-finding — PDO, ACF, and APN — are all data-driven and Flagship uses both input and outcome data to improve the performance of the different approaches. Each of the approaches uses data in different ways; for example, the effectiveness of ACF hinges on the breadth, depth, and accuracy of input data to map activities in a community and identify where and when PNs should be looking for undiagnosed HIV cases. Similarly, APN works because the Project is collecting input data on partners and their location, using those data to guide outreach activities and then recording outcome data to both track the success of the approach and lay the groundwork for future activities.

Enhanced ACF approach: In Tajikistan, Flagship is working on an enhanced ACF approach using Internet-based geospatial mapping, which has the potential to dramatically improve the effectiveness of ACF in all Flagship countries. The marriage of a traditional, paper-based approach to microplanning with sophisticated mapping technologies will not only improve ACF, it can also be used to plot data points for both PDO and APN to see if any broader patterns emerge. The new approach, which should be evaluated for rapid scale-up across Flagship countries, is likely to have other uses and implications for the Project's work, including community-level data on size estimations of PWID and MSM, the dispersion of PLHIV within Flagship operational areas, and coverage ratios of clients to case managers with distance factors.

Weaknesses

Lack of local population size estimates: Data about population size (e.g., PWID, MSM, partners) and relevant targets is not collected by the Project at the local level. Questions about the coverage of the Project in its operational areas as well as the validity of the targets would be better addressed if the Project did substantive but cost-effective work on quantifying the size of local KPs. In addition, the Project could provide context to its local estimate (e.g., mobility of the population, community and family dynamics, health-seeking behaviors). These findings could also be correlated against the Project's own disaggregated performance data. In many respects, this type of work is an obvious extension of what the Project is doing around ACF, essentially using local intelligence to estimate/map population size within a community. These types of affordable, community-based estimates, which have been proven in various settings around the world, can be used effectively for triangulating with other types of population data [e.g., population-based HIV impact assessment survey data, IBBS findings, national

program data). In general, Flagship should play a more proactive role in analyzing different types of data to come up with a triangulated estimate that is richer and more nuanced.

Over-reliance on indicator and target data: There is an over-reliance on indicator and target data to track, assess, and improve Project performance. Flagship collects and reports data on a wide range of indicators, including PEPFAR indicators and custom indicators. However, the Project has very little data on the underlying factors that explain the "why" behind the indicator data, which means the analysis and decisions are based primarily on the single number captured by an individual indicator on a quarterly basis. In the absence of useful data on the "why," the analysis is largely limited to whether the "number of" being tracked by an indicator went up, went down or remained static and, how it measures up to the target, if there is one for that indicator. As a result — and given the Project's chronic underperformance against the key case-finding indicators, the Flagship analysis tends to lead to an obvious conclusion: "We need to increase our numbers (of people tested and people who test positive)." In the absence of other contextual data, including the qualitative "why" findings, indicator data on its own — even if they are disaggregated by common fields such as sex and age — have very little strategic value.

Custom indicators: The utility and value of many of the custom indicators is unclear. By not critically assessing the specific contributions of the different indicators to the Project and the larger HIV response, Flagship may be wasting limited SI resources on collecting and reporting data that has little or no impact on its work or its objectives. For example, indicators tracking "linked to care" have limited value because linkage on its own does not involve any uptake of a service, which is the critical measure. In the context of test and treat, there is limited value in tracking the "number of newly found PLHIV through case-detection activities who were linked to care" when the "number of newly found PLHIV through case-detection activities who started ART" is also tracked. There are other custom indicators with limited value, including "number of PLHIV provided with minimum of one service to support adherence to ART" and "Number of PWID and PLHIV/PWID referred to MAT." Plus, the multiple LTFU indicators could probably be consolidated in ways that make them more practical. In addition, the definitions of the custom indicators are not as clear or well-articulated as they could/should be. There are also other useful custom metrics that could be added to the activity monitoring and evaluation plan (AMEP), including "the number and percentage of newly found PLHIV identified through a screening test who had a confirmatory test and received their results" or the "number of contacts with clients to get agreement for a screening test, a confirmatory test and ART initiation," that would add more value to the indicator set.

Inconsistencies in how Project indicators and Project data are presented: There are major inconsistencies in how Project indicators and Project data are presented in various Flagship documents, which limits the ability of stakeholders to understand and use data. Ensuring that Project indicators and data are consistently presented in ways that are easy for stakeholders to access and understand should be one of Flagship's main priorities, particularly given the Project's strong commitment to data collection and use. However, the key documents related to indicators and data are not aligned and, consequently, make the overall picture unnecessarily confusing. For example, the AMEP presents indicators in multiple formats with no clear numbering/identification scheme. The indicator annexes in the quarterly reports list the indicators in a different order with different capsule definitions than the AMEP, again with no clear numbering/identification scheme. Published indicator spreadsheets use a different sequence of indicators with different capsule definitions; there is, however, a numbering scheme. In addition, the Flagship indicator documents do not clearly distinguish between the PEPFAR and custom indicators,

which further complicates using these documents for anyone who is not well-versed in PEPFAR terminology and indicators.

The lack of clarity, consistency, and accessibility of data raises questions about the level of Flagship's commitment to data use or potentially the Project's capacity to use it and/or present it in a strategic way. There appears to be more of an information technology (IT) mindset about data as opposed to an SI one that prioritizes the *use* of data over the manipulation of data. For example, in the quarterly reports, there are significant amounts of data — most of it well-presented in different visuals — with short narratives about the specifics of the data but there is very little analysis of the data. Readers get a sense of "what" happened (i.e., people or activities that can be counted) but there is little analysis of "why" it happened.

Use of data by frontline staff: Although Flagship has an organization-wide culture of data use, the frontline staff have a largely reactive relationship with Project data and limited opportunities to provide input on what kinds of data would improve their performance and would impact patient outcomes. Currently, frontline staff focus mainly on their performance against targets — both their individual targets and their organization's targets. The performance of staff doing case-finding also has a direct bearing on their compensation, so they pay attention to those data points. However, it is a missed opportunity for Flagship to not invest in helping frontline staff contribute to the Project's data priorities, particularly any data points that will help these staff members improve their performance.

Challenges/gaps

Lack of qualitative and contextual data: There is a distinct lack of qualitative and contextual data collected, analyzed, and used by the Project. As mentioned above, there is a need for useful data on the "why" behind the core indicator data. Simply knowing performance against targets or if the number of people receiving services is increasing or decreasing is inadequate to do any meaningful work around quality/performance improvement. Addressing the primary challenges faced by the Project — including better case-finding, particularly among hidden and hard-to-reach populations that are not currently accessing HIV-related services, a better understanding of risk behaviors, LTFU between screening and confirmatory testing, LTFU between confirmatory testing and ART initiation, and poor/inconsistent ART retention — all depend on supplementing "hard" data with "soft" and/or "thick" data that provides perspective on the issues driving client decisions and behaviors.

Contextual data can also be effective in demonstrating the necessities and the value of Flagship's approach to its work. For example, it can take multiple contacts by a PN to convince a client to have a screening test (or to have a confirmatory test)

Client data: Flagship requests a significant amount of personal data from clients, which can affect their willingness to engage with the Project. It is unclear if the amount of personal information — particularly information that has little or no relationship to the services provided by Flagship — is required by government or requested by Flagship but, in the context of the high levels of stigma and discrimination in the region, the Project should be doing everything it can to minimize the initial barriers to engaging with clients. For example, if additional data are required (e.g., relevant parts of a client's medical history), they could be collected at a later stage when the PN has established more of a relationship with the client. Similarly, having a less aggressive, longer-term approach on partner tracing — in contrast to the harshness of the epi investigations at the ACs — may involve less overt ways of asking for and recording personal data.

Data quality: Given all the data collected by Flagship, there is very little discussion within the Project about data quality. A pro forma section on data quality assurance is included in the AMEP but the issue does not seem to be a priority. It is worth noting that Flagship tracks the data on incentives very closely; it is possible the high levels of accuracy and accountability attached to these data spill over into other data points collected by the Project. However, it is unclear why data quality has such a low profile in the Project and, if the low profile reflects limited investment in ensuring the quality of the data is sound, Flagship should reassess its priorities in this area.

4.5 CROSS-CUTTING FINDINGS AND CONCLUSIONS

Overall, PSI and its NGO IPs have done a good job in implementing the Project in a very challenging environment characterized by high levels of HIV and PWID-related stigma and discrimination and a series of structural impediments to accessing health services. The key achievement has been the very significant progress in rolling out a new approach to HIV programming in Central Asia focused on case detection, treatment initiation, and adherence in pursuit of the 90-90-90 objectives. Key innovations in the context of Central Asia have been peer-driven rapid HIV testing in community settings, which has significantly broadened access to testing and leveraging the comparative advantage of NGOs in undertaking HIV testing among sexual partners and linking PLHIV to ART treatment through community-based case management. This represents a paradigm shift from previous HIV-prevention programming conducted through traditional outreach models to known PWID networks. While there was initial resistance to Flagship's model from some NGOs, PSI has worked closely with these NGOs and the new approach has now been adopted by all. In addition, a number of NGOs had no previous experience in working with PWID and none of the NGOs had used the case-detection approaches rolled out by Flagship. There has been considerable capacity-building and the confidence of NGOs in case detection and case management has been built over time.

4.5.1 Case-finding

While large numbers of PWID have been tested for HIV, the total number is well below the ambitious targets. A total of 66,747 HIV tests were conducted by Flagship as of June 30, 2018, against a target of 77,321. The number of PWID tested has increased year after year, but the gap between targets and testing has risen due to significant increases in annual targets. Most importantly, the overall yield of HIV-positive cases of 1.8 percent has been well below what was expected given the relatively high estimated HIV prevalence among PWID. Even more importantly, the yield from testing in FY 2018 has declined, indicating that Flagship is finding it increasingly difficult to detect new cases.

The two highest priorities for the Project over the remaining two and a half years needs to be improved targeting of PWIDs to increase the yield from testing, and enrolling newly detected cases in ART. Success in increasing the yield from testing will primarily rest on identifying currently unreached networks of PWID and ex-PWID.

The recent welcome innovation in Tajikistan using RAC data to map all recent PWID case detections and case those over the last three years and comparing these maps with the areas where NGOs are currently undertaking case detection should result in case-finding being undertaken in new areas.

This may facilitate access to previously unreached networks of PWID. While it is too early to say, this could result in a significant number of new case detections. Implementation of this work by NGOs needs to be closely monitored and the RAC-generated maps need to be updated periodically. USAID and CDC, in collaboration with Flagship and ICAP, should be requesting the RAC in the Kyrgyz Republic

to generate similar maps so this approach can be replicated, and in Tajikistan, should be requesting the RAC to update the maps regularly.

Recommended strategies to improve testing uptake and yield include continuing to learn and adapt how to best implement the different case-detection approaches, including the interaction between the approaches; modifying, scaling down or stopping case-detection activities in areas with significantly lower yield; incentivizing current PWID involvement in ACF mapping to find new networks of PWID; fostering greater sex, age, and socio-economic diversity among case-detection PNs to assist in finding a broader range of PWID networks; increasing case-finding among ex-PWID; maintaining a core focus on PWID with a broader sexual/social networking approach; and improving pre-test counseling, with a strong emphasis on the benefits of treatment initiation.

More broadly, PSI needs to build the skills of NGOs to critically analyze Project indicator data on case detection together with qualitative data from the field experience of PNs to improve approaches to case detection and increase the rate of confirmatory testing.

4.5.2 Case management

Flagship has largely focused on case-detection work in an attempt to meet its very high testing and case-finding targets, with a correspondingly lower level of effort on case management. Flagship's very dedicated case managers, who are highly valued by their PLHIV clients, have, however, made a significant contribution in supporting ART initiation, adherence, and retention in care. There is, nonetheless, still a significant gap between the number of newly confirmed HIV case detections and those who have initiated ART. Of the 1,192 newly found PLHIV through case detection, 735 (61.7 percent) commenced ART. Flagship has also supported ART initiation or re-initiation by 2,132 LTFU clients and PLHIV referred to the Project by ACs for case management. Structural and enabling environment barriers (see 4.5.3 below) play a significant part in limiting ART initiation. Other factors that are more within Flagship's control are improving the quality of pre-test counseling, including treatment education, as outlined above, and improving the motivational skills of case managers.

The success of Flagship in finding large numbers of AC LTFU patients has, along with the other work of case managers, demonstrated to ACs the benefits of community-based case-management work. More recently, with ACs now referring their existing patients (non-Flagship clients) to Flagship for case management, caseloads are increasing. While Flagship's triage system for case management has been a useful tool for setting priorities, the reality is that few clients are ever fully "graduated." Given that the needs of PLHIV clients can fluctuate significantly over time in the context of Central Asia's highly stigmatized environment, some level of ongoing contact between case managers and their clients is appropriate. Most case managers are already carrying high caseloads, and this is likely to continue. Flagship will need to develop systems and support to effectively respond. This should be accompanied by efforts to professionalize the existing cadre of case managers.

4.5.3 Structural and enabling environment barriers

In the context of Central Asia's highly stigmatized social environment, Flagship's work has indirectly highlighted a range of structural barriers to accessing HIV treatment that are inhibiting progress in relation to the second and third 90s. These include:

- A reluctance by PWID to attend ACs so as not to be registered on the RAC database (possibly related to the fear of being registered by a government body as a drug user).

- The need to attend an AC for a confirmatory HIV test and the time taken by ACs to complete confirmatory testing (although the latter is likely to be reduced as new HIV-testing algorithms are approved and rolled out).

- The inability of homeless people to access confirmatory testing or ART as they commonly lack government identity documents required for registration.

- A reluctance by PLHIV to attend polyclinics where discriminatory attitudes are more commonly encountered and because of concerns regarding confidentiality.

- The approach of ACs to partner tracing, which is done prior to initiation of patient medical care and shortly after a confirmed positive result, when patients are often in shock or adjusting to their diagnosis, along with provision of punitive information relating to partner transmission.

Given their relationships with RACs and ACs, CDC and ICAP are well-placed to explore solutions and undertake advocacy on these issues.

4.5.4 Collaboration between the USAID/Central Asia HIV Flagship Project and ICAP

Reports by a range of key informants indicate that effectiveness of collaboration between Flagship and ICAP varies from site to site and country to country. A common factor in strong collaboration was reported to be good management by AC directors who understand that the community-focused work of Flagship and the facility work of ICAP are complementary, serving common objectives, and who actively manage respective inputs by each project so that the two projects are working as part of one broad team. Interviews with a range of key informants indicated that tensions and competition, particularly in the areas of partner testing and case management, may arise where there is overlap between the work of Flagship and ICAP and confusion on boundaries. Collaboration between the two projects was not helped by differing commencement dates and a lack of meaningful collaboration between CDC and USAID in the design of their projects. The issue of how to collaborate was, in effect, postponed until the implementation phase. Ambitious targets for each project have also resulted in competition between the two projects for "ownership" of clients.

There is a need for USAID and CDC to reach clear agreement on role delineation, division of labor, and areas of joint work for the ICAP positions of PNs and patronage nurses and the Flagship position of PNs, including ICAP's role in the community and Flagship's role in facilities. There is no formal system for ACs or ICAP staff based in ACs to refer newly diagnosed PLHIV (i.e., those not diagnosed through Flagship) to Flagship for case management, although passive non-formal referrals are being made by some ACs. Some stakeholders indicated that active referrals may be inhibited by health staff concerns over disclosure of patient information and the need for consent. A more formalized system of referral in cases where Flagship may have a comparative advantage in case management should be considered.

Despite regular regional-level partnership meetings involving USAID, CDC, Flagship, and ICAP and similar country-level meetings, the need for improved collaboration remains. USAID, however, reported that collaboration between ICAP and Flagship has improved since the appointment of the new COP for Flagship. There is clearly a need for a better understanding between the two projects on how the "handshake" of collaboration is best operationalized, recognizing this may appropriately vary between sites.

4.5.5 Above-site advocacy issues

The imperative of prioritizing case-finding in response to highly ambitious targets and the need for improved results has resulted in a strong focus by Flagship at the site level, which has impacted the level of effort paid to above-site issues. While the Flagship national offices in Kyrgyz Republic and Tajikistan each have one staff member to undertake advocacy work, in Tajikistan, a significant amount of this positions work is devoted to NGO IP oversight. Nonetheless, Flagship has been undertaking some above-site advocacy, such as promoting the incorporation of test and treat within national strategies (with success in Kyrgyz Republic). In Year 4, Flagship could usefully advocate on adoption of the Project's best practices in case-finding and case management within national government frameworks. A key gap is the need to address financial sustainability of NGO work and enabling environmental issues, which act as Project constraints. While this is unlikely to be a priority for Flagship given competing priorities, USAID needs to consider how work in this area can best be taken forward.

While PEPFAR programming has made significant contributions in relation to the 90-90-90 goals in the subnational units where it is working and demonstrated the efficacy of its programmatic approach to achieve national-level epidemic control, there is a need to advocate for replication in non-PEPFAR sites to RACs. The Kyrgyz and Tajikistan RACs have already expressed the desire to replicate PEPFAR programming in priority districts not covered by PEPFAR. USAID and CDC, in collaboration with other partners, such as the GF and UNAIDS, should consider how best to support RACs in the promotion of the replication agenda.

Stigma and discrimination (self-stigma, by health facilities, and from the community) is the most significant barrier to increasing case detection and treatment initiation and retention. USAID needs to consider what initiatives can be implemented in this area in the context of existing resources and programming.

4.6 PROJECT MANAGEMENT

4.6.1 USAID

Regional and country-level management: The USAID/Central Asia HIV Flagship Project is managed by a contract officer's representative (COR) in the USAID Central Asia Mission in Kazakhstan, with an alternate COR and country-level activity manager in USAID Tajikistan, and a country-level activity manager in USAID Kyrgyz Republic. To facilitate consistent, timely communication, USAID Central Asia (the COR and HIV team lead) holds weekly meetings with the Flagship regional office in Almaty. USAID Central Asia also has biweekly calls with the USAID country activity managers and Flagship country directors, along with a monthly call between all USAID missions, the PSI HQ, and all Flagship field office management staff. Given this level of routine communication, the Flagship regional office noted that there are "no surprises." In addition, the USAID Tajikistan activity manager has weekly meetings with the Flagship Tajikistan country director. In the past, the USAID Kyrgyz Republic activity manager also met frequently with the Flagship Kyrgyz Republic country director, but the meetings are held less often now that the USAID activity manager has changed. Flagship management noted that it is clear that USAID Central Asia is in control, and that there are no conflicting or contradictory messages from USAID.

USAID Central Asia's efforts to improve transparency by expanding involvement of USAID Tajikistan and USAID Kyrgyz Republic staff is highly appreciated. USAID country staff reported on the increased attentiveness of the USAID Regional Mission. As part of this improved coordination, the COR and HIV

team lead from Almaty undertake quarterly Flagship monitoring visits, in addition to other TDYs for Tajikistan and Kyrgyz Republic programs. Flagship country offices noted that they appreciate TDYs from USAID Central Asia, as it is helpful to get their point of view; their questions help Flagship look at things differently. However, Flagship staff indicated that it's also valuable to have monitoring visits by USAID country staff, who know the context a bit better.

In general, respondents noted that USAID communication is working well and is transparent. Previous issues have been resolved, such as USAID Kyrgyz Republic asking the Flagship Kyrgyz Republic office for data without notifying the regional Flagship office of the requests. This was resolved after discussion with the COR; now all requests made at country level must include the COR and Flagship COP. USAID Central Asia should continue to actively engage USAID Kyrgyz Republic and USAID Tajikistan colleagues in planning, implementing, and monitoring Flagship activities to address increased OGAC oversight and inform rapid course adjustments. The COR also worked successfully with Flagship to resolve issues related to the previous COP. USAID respondents are pleased with the new COP and indicated that she is more involved with the country programs, in addition to providing technical input into activity implementation. Nevertheless, at the request of USAID Central Asia, the Project has needed to request additional technical support from PSI HQ in rolling out the new case-finding approaches, such as partner testing, in order to improve target achievement.

Partner collaboration: USAID has also fostered partner communication and collaboration both with USAID partners (e.g., LEADER and REACT) and with the CDC partner (ICAP). USAID holds its partner meetings every few months, which provides partners opportunities to learn about other Project activities and to support coordination and collaboration. As one respondent noted, regular partner meetings are useful because "Partners are focused on their own work plans and monitoring schedules — sometimes they don't have time to stop and look around." Respondents also cited US Government-organized meetings between ICAP and Flagship as facilitating communication but noted that communication can be more effective at the site level.

SI leadership and support: In the past year, USAID has made a concerted effort to better collect and review Flagship data, requesting results against targets on a monthly basis versus reviewing quarterly reports. While USAID has increased access to regular, real-time program data, the extent to which USAID provides direction to Flagship and the NGOs on data quality and analysis for improving programming is unclear.

USAID reports that in response to OGAC requests for program data, Flagship often provides inconsistent and poorly formatted data. Flagship indicated it would be helpful to receive advance notice for OGAC data requests. In addition, Flagship would like to be more involved in setting the different targets for the country programs. However, this can only be successfully undertaken if Flagship and USAID are able to present a data-based justification for negotiating target changes as the current targets for case-finding are mandated by OGAC.

4.6.2 PSI's management of the Flagship Project

USAID staff reported that PSI has demonstrated a high degree of flexibility and responsiveness in exploring new approaches in the context of the programming shift focused on case detection and case management, which has been pioneering work in Central Asia. A strength of PSI and the NGO IPs is that they are mostly open to new ideas and very committed to their work in the face of significant pressure related to targets and the demoralizing effect of not achieving those targets.

USAID staff reported that management of Flagship has improved significantly under the new COP, including better communication within PSI and with NGO IPs and external partners. The COP is encouraging greater input from PSI country offices in setting the vision and priorities for the Project and relations with country offices have improved. NGO IPs have been encouraged to contribute ideas on Project improvement through new quarterly meetings of NGO directors at the country level and new joint NGO meetings to share site-level experiences. Views from other stakeholders on the new COP were universally positive.

At the regional level, responsibility for providing TA to PSI country offices rests largely with the COP, although the regional M&E advisor has somewhat of a broader regional TA role. Given the other management responsibilities of the COP, her capacity to provide regional TA is stretched quite thin. Given the considerable TA needs of a challenging project, the level of TA support from the regional office needs to be enhanced. The key area of TA that needs boosting is support to country offices and NGOs in use of SI data for the purpose of making program improvements.

The PSI regional office indicated a need for USAID Central Asia to share global expertise with the Project. At both regional and country levels, USAID has facilitated broader technical inputs to Flagship through LINKAGES and individual consultants. PSI is part of regular PEPFAR key stakeholder meetings where the PEPFAR team presents on regional operational plan developments and results. Flagship is also part of global regional operational plan briefings with OGAC. The regional PSI management team has also had the opportunity to participate in international HIV conferences. Primary responsibility for sharing global expertise rests with PSI headquarters. USAID has previously identified areas of technical support that PSI HQ needed to provide to Flagship. The fact that Flagship identified the need for greater exposure to global best practices is an indicator of the need for PSI headquarters to increase the level of technical support for this project.

It is evident from a wide range of interviews that all country offices have, over time, effectively facilitated the transition of NGOs to the new model of work focusing on case detection and case management. This is a significant achievement as some NGOs were very resistant.

USAID staff indicated that the PSI office in the Kyrgyz Republic is regarded as technically strong, with good knowledge of all Project sites and indicator data. The office has also been flexible and adaptive in managing NGOs. For example, PSI took on direct implementation in Osh due to performance concerns with the NGO IP and in another instance divided responsibility for case management and case detection between different NGOs when combined responsibility for these functions was not working effectively.

The PSI Tajikistan office needs considerable strengthening with regard to management and technical leadership. Responsibility for supervising and providing TA to the eight NGO IPs is divided among eight PSI staff, but not all staff appear to have the required level of experience and skills to undertake this function effectively. PSI needs to review the current staffing profile and skill set for the Tajikistan office in relation to the priority functions of TA support and management of the work of NGO IPs. The evaluation team observed staff in the Tajikistan office with considerable potential. The PSI regional office needs to prioritize developing the technical skills of these staff.

PSI needs to ensure that their high level of interaction on management support leaves NGO IPs with sufficient time to implement.

PNs consistently complained about the high burden of paperwork, with one PN stating that "every hour of field work results in two hours of paper work." NGOs suggested ways that paperwork could be rationalized. For example, the separate referral note for each service could be combined into one form.

The introduction of tablets for PN data collection may serve to reduce the data entry burden and provide a quick and easy way of mapping hot spots found from ACF work. PNs in SPIN Plus, who are trialing the use of tablets, were very positive about this innovation.

Each NGO IP has a budget for travel expenses for PNs to conduct case-finding and work with clients from remote areas. Although PSI claims budgets are based on geographical coverage for each NGO, a common complaint of PNs in almost all NGOs was the inadequacy of travel budgets, which resulted in use of their personal funds.

4.7 RECOMMENDATIONS

A. Recommendations for implementation by PSI/Flagship

Frontline Staff

1. Flagship country offices should re-evaluate the respective roles of frontline staff working on case-finding and case management to ensure the roles and the mix of staff are best suited to the specific environment and context, including having greater sex, age, socio-economic, and ethnic diversity among staff. The fundamental concern with the current approach is the limited qualifications of PNs to provide effective support to clients as they progress through the testing continuum, as they are linked to treatment and as they are retained on treatment. *(Priority recommendation)*

2. The Project should explore further professionalizing its cadre of case managers. Not only will a better prepared, more professional group of case managers provide better support to clients, they are more likely to be retained by Flagship, and they are part of a sustainable core of HIV case managers who can continue the work in the future.

Incentives

3. The Project should experiment with its incentive schemes used with clients and staff. There appears to be opportunity and latitude to experiment with the different Flagship incentive schemes. For example, the Project could engage and incentivize current PWID to help find new, hidden, and/or hard-to-reach networks of PWID. The more variable approach used by Flagship with PDO (e.g., positive seeds versus negative seeds) is an example of how variation can shift outcomes and having a more open-minded and flexible approach to incentives could help optimize client engagement and staff performance. *(Priority recommendation)*

Case-finding

4. To strengthen its case-finding activities, Flagship should:

    a) Continue to implement all three primary approaches (PDO, ACF, and APN) as these multiple methods, operating simultaneously, can help to sustain the overall case-finding effort. Flagship and its partners should continue to learn and adapt how to best implement the different case-detection approaches, including the interaction between them. *(Priority recommendation)*

    b) Pilot and/or expand the use of innovative/alternative approaches to case-finding; for example, contacting ex-PWID who may have been infected some years ago and who are no longer part of

current PWID networks or using TB death registries to offer HIV testing to surviving partners. *(Priority recommendation)*

c) Expand existing efforts to improve pre-test counseling to increase numbers of PWID to undertake both initial HIV screening and confirmatory testing, with a strong emphasis on the benefits of treatment initiation, dealing with highly exaggerated fears on treatment side effects, and addressing widespread HIV myths and misinformation. *(Priority recommendation)*

d) Flagship should maintain a core focus on PWID, while supplementing current case-detection approaches with a broader sexual/social networking approach, building on the APN approach.

e) The Project should analyze client characteristics, including clients who test positive or negative, and network size, to improve targeted testing under the PDO approach.

f) Extend the time frame for the MSM pilots that are currently being implemented in Bishkek and Dushanbe to give them a better opportunity to test and refine their approaches.

5. The PSI regional and Tajikistan offices should closely monitor the work being done in Tajikistan using geo-maps of recent/new PWID HIV diagnoses to improve case-finding. If the use of these maps continues to show promise, Flagship should continue the use of the approach in Tajikistan and initiate this approach in the Kyrgyz Republic, working as needed with USAID, CDC, and RACs to secure the anonymized data required for creating and maintaining up-to-date maps. In parallel with the use of geo-maps, Flagship should identify local areas where current case-detection activities are resulting in low case-detection yields and consider whether case-detection work in these areas should be modified, scaled down, or stopped. This would allow Project case-detection resources to be redeployed to other areas within the geographic remit of Flagship NGOs, where geo-maps indicate the possibility of previously unreached PWID networks. *(Priority recommendation)*

6. Flagship, USAID, and CDC should advocate for more flexible regulations and practices on where HIV screening and confirmatory testing can be done, who can do it, and how it can be done. In the short term, allowing confirmatory testing to be done outside of ACs (i.e., in the community) is likely to have an impact on the loss factor between screening and confirmatory testing. The expanded community use of oral testing should also reduce barriers to HIV screening among the populations served by the Project.

Case Management
7. Flagship should take steps to improve HIV-treatment education/knowledge, including:

a) training and mentoring of PNs and case managers on how to motivate PLHIV to initiate treatment; and

b) production of compelling and easily understood information materials for clients and prospective clients. *(Priority recommendation)*

Strategic Information
8. The Project should redefine its approach to data to emphasize the "strategic" value and utility of the collected and used information. A stronger emphasis on "strategic" information should include steps to strengthen the collection and use of relevant contextual and qualitative data to help Flagship understand why things are happening and what can be done to improve performance; for example, it would be useful to have a better understanding of the factors influencing ART uptake, including

reducing the gap between confirmatory testing and ART initiation. As part of this effort, Flagship should also re-evaluate its approach to collecting client information to ensure it is respectful of client confidentiality and is only collecting data it will use. *(Priority recommendation)*

9. Flagship should conduct a pragmatic review of each Project indicator used in the different countries to determine its value and utility. Given the central role that indicators play in both monitoring and reporting, it is critical to understand how, why, and whether each indicator contributes to the overall understanding of Project activities and outcomes. Flagship should also conduct a pragmatic review of other data points collected by the Project to determine their value and utility and identify what contextual and qualitative data could be added to the Project's portfolio of SI. *(Priority recommendation)*

10. The Project should consult with its key stakeholders, including USAID, IPs, and ACs, to better understand what Project data is valuable and useful for them and how it can best be presented for them to take full advantage of its value and utility. In addition, USAID should be more specific about what data and analysis it wants from Flagship and how they would like to see them presented. *(Priority recommendation)*

11. Flagship should identify what approaches and existing data sets can be used to triangulate more precise estimates of population sizes in its operational areas. The Project should then use the approaches and data sets to work with IPs to get a better picture of both the size and key characteristics of the populations in their operational areas. Given the influence of PEPFAR targets on Project planning and implementation, a better understanding of local population dynamics would be invaluable for helping shape those targets as well as improving case-finding. *(Priority recommendation)*

PSI Management

12. The PSI regional office should expand its TA support to country offices, particularly around the use of SI for Project improvements. The regional office, in consultation with USAID, also needs to develop a plan to strengthen the management and technical capacity of the PSI Tajikistan office, including a review of the function of all staff positions. *(Priority recommendation)*

13. PSI HQ should take a more active role in providing technical support to the Project. The focus of this support should be on performance improvement (e.g., sharing of global best practices in HIV case-finding methods among KPs; better collection, analysis, and use of quantitative and qualitative data; triangulation of data from different sources; quality improvement/assurance efforts; and management and technical capacity of IPs). *(Priority recommendation)*

14. PSI policies and procedures should be revised to ensure that frontline staff are spending the vast majority of their time doing frontline work (i.e., interactions with clients), not administrative work. On a parallel note, Flagship should streamline its systems to ensure that frontline organizations (e.g., its NGO IPs) have a lower administrative and reporting burden. It should also be clear to both frontline staff and frontline organizations how any required administrative and/or reporting efforts are used by the Project overall. *(Priority recommendation)*

15. PSI policies and procedures related to compensation and travel allowances should be reviewed to ensure that Project staff — at PSI and Flagship IPs — are treated fairly, given heavy demands of the work and the challenges in recruiting and retaining qualified staff members. The issue of travel

allowances is especially relevant for outreach staff at Flagship IPs who work in rural areas. *(Priority recommendation)*

B. Recommendations for implementation by USAID

USAID Management

16. USAID should strengthen its internal capacity to do ongoing data analysis to track and improve program performance as well as ensure USAID and Flagship can respond rapidly and efficiently to OGAC queries and concerns. USAID should also create and enforce a quality-control process for data submitted to USAID by Flagship. *(Priority recommendation)*

Collaboration between Flagship and ICAP

17. USAID should encourage CDC and ICAP to undertake advocacy with RACs and ACs on facility-based structural issues, which inhibit access to treatment such as the restriction on where confirmatory tests can be undertaken, the inability of homeless people to access HIV treatment, and current AC practices relating to partner tracing. *(Priority recommendation)*

18. USAID and CDC, in consultation with RACs and ACs, should agree on role delineation, division of labor, and areas for joint work between ICAP and Flagship in each country. This should include consideration of the need to develop a formalized system of referral of AC clients to Flagship for community-based case management. USAID and CDC should liaise on the design of follow-on projects to maximize future collaborative efforts. USAID and CDC should also review how targets for indicators are allocated between Flagship and ICAP. *(Priority recommendation)*

19. In the interest of achieving national-level epidemic control, USAID and CDC should undertake advocacy and provide support to RACs for replication of the PEPFAR programming approaches in non-PEPFAR sites. Other stakeholders (e.g., GF, UNAIDS) who are actively involved in planning and/or implementing the response should also be included in these discussions.

ANNEX 1. SCOPE OF WORK

Assignment #: <u>554</u> [*assigned by GH Pro*]

Global Health Program Cycle Improvement Project (GH Pro)
Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)
Date of Submission: <u>03-09-18</u>
Last update: <u>4/30/2018</u>

TITLE: <u>Midterm performance evaluation of Central Asia's HIV program</u>

Requester / Client
■ USAID Country or Regional Mission
Mission/Division: <u>Central Asia</u> / <u>Health and Education Office</u>

Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)
■ 3.1.1 HIV ☐ 3.1.4 PIOET ☐ 3.1.7 FP/RH
☐ 3.1.2 TB ☐ 3.1.5 Other public health threats ☐ 3.1.8 WSSH
☐ 3.1.3 Malaria ☐ 3.1.6 MCH ☐ 3.1.9 Nutrition
☐ 3.2.0 Other (specify):

Cost Estimate: <u>$250,000</u> (Note: GH Pro will provide a cost estimate based on this SOW)

Performance Period
Expected Start Date (on or about): <u>May 3, 2018</u> (Fieldwork to begin in June)
Anticipated End Date (on or about): <u>October 31, 2018</u>

Location(s) of Assignment: (Indicate where work will be performed)

The midterm evaluation will cover Kazakhstan, Kyrgyzstan and Tajikistan.

Type of Analytic Activity (Check the box to indicate the type of analytic activity)
<u>EVALUATION:</u>

■ **Performance Evaluation** (Check timing of data collection)
■ Midterm ☐ Endline ☐ Other (specify):
Performance evaluations encompass a broad range of evaluation methods. They often incorporate before—after comparisons but generally lack a rigorously defined counterfactual. Performance evaluations may address descriptive, normative, and/or cause-and-effect questions. They may focus on what a particular project or program has achieved (at any point during or after implementation); how it was implemented; how it was perceived and valued; and other questions that are pertinent to design, management, and operational decision making

☐ **Impact Evaluation** (*Check timing(s) of data collection*)
☐ Baseline ☐ Midterm ☐ Endline ☐ Other (specify):
Impact evaluations measure the change in a development outcome that is attributable to a defined intervention. They are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

PEPFAR EVALUATIONS *(PEPFAR Evaluation Standards of Practice 2014)*

Note: If PEPFAR-funded, check the box for type of evaluation

■ **Process Evaluation** *(Check timing of data collection)*
    ■ Midterm   □ Endline   □ Other (specify): _____

Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

□ **Outcome Evaluation**

Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

□ **Impact Evaluation** *(Check timing(s) of data collection)*
    □ Baseline   □ Midterm   □ Endline   □ Other (specify): .

Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

□ **Economic Evaluation** (PEPFAR)

Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

BACKGROUND

If an evaluation, Project/Program being evaluated:

Project/Activity Title:	USAID Regional HIV Project
Award/Contract Number:	AID-176-C-00001,
Award/Contract Dates:	FY 2014-2019
Project/Activity Funding:	$55 million
Implementing Organization(s):	Population Services International (PSI), AIDS Foundation East-West, Central Asian Association of PLHIV
Project/Activity AOR/COR:	Joan Woods, HIV Team Lead

Background of project/program/intervention (*Provide a brief background on the country and/or sector context; specific problem or opportunity the intervention addresses; and the development hypothesis.*)

In 2004, the World Bank described the HIV/AIDS situation in Eastern Europe and Central Asia as the fastest growing HIV/AIDS epidemic in the world. Ten years later, national HIV responses are better focused, but the region is one of only two regions in the world where the annual number of people newly infected with HIV is still on the rise.

In particular, HIV remains concentrated within key populations (KP): people who inject drugs (PWID), prisoners, sex workers (SW), and men who have sex with men (MSM). There is some evidence to suggest that the incidence of sexual transmission is on the rise.

Central Asian countries have largely vertical, specialized health care systems that lack the coordination or referral mechanisms needed to facilitate access to a continuum of HIV/AIDS prevention, treatment, and care services. Policies and practices across the region in many instances: 1) fail to address the particular needs of key affected populations; 2) constrain access to services and violate their rights; 3) limit implementation and scale-up of evidence-based prevention, detection, and treatment services; and 4) generally overlook the potential role of non-state actors, including Non-Governmental Organizations (NGOs) and coordinating bodies, communities, and the private sector in the delivery of HIV services.

There are high levels of social stigma and institutional discrimination against KPs, which affect both the delivery and the demand for HIV-related services. Moreover, there is inadequate political commitment, leadership, and funds for HIV programs targeting key affected populations. In addition, many organizations and individuals across the region lack the capacity and systems needed to effectively plan, implement, manage, and monitor HIV programs.

There is also a need to facilitate PLHIV access to treatment services. Immediate initiation on antiretroviral therapy (ART) upon diagnosis is an internationally recognized best practice which needs strengthening in Central Asia. The lack of adherence support for ART and low retention rates among PLHIV remain key gaps to be addressed to ensure the reduction of PLHIV mortality rates and the prevention of onward transmission. Linking sufficient numbers of KP with diagnostic and treatment services is challenging due to the limited availability and accessibility of safe, stigma-free service points. Medication-assisted therapy (MAT) is limited and there are, in some countries, policy and political constraints to implementing or scaling up MAT.

Theory of Change of target project/program/intervention

Activities under this Project broadly follow the UNAIDS ambitious 90-90-90 strategy, which aims to ensure 90% of people with HIV are diagnosed, 90% of those diagnosed are on ART, and 90% of people on ART have HIV that is virally suppressed by 2020. Within this broad strategy, the activity follows the PEPFAR 3.0 Impact Action Agenda on sustainable control of the HIV epidemic where resources are focused on core activities (especially case-finding and treatment) and leveraging additional finances to scale up quality interventions to address the needs of the most vulnerable populations. The HIV Project is implemented primarily through three complementary activities: Central Asia HIV Flagship Activity, HIV REACT, and LEADER for People Living with HIV (Leader).

The Central Asia HIV Flagship activity focuses its efforts on two key components: 1) case detection to find undiagnosed HIV cases and link them to treatment and 2) case management for ART initiation and adherence. The activity primarily supports and strengthens community partners working to improve services along the HIV testing and treatment cascade, while other partners are focused on improving services in the clinical structures that support services along the cascade. Period of performance: December 4, 2015 to December 3, 2020.

HIV REACT provides HIV prevention and access to treatment for prisoners and ex-prisoners in Kazakhstan, Kyrgyz Republic, and Tajikistan. The activity offers comprehensive packages of services to improve prisoner access to HIV prevention, treatment, and care for PWID and people living with HIV (PLHIV) during incarceration. Period of performance: June 11, 2014 to June 10, 2019.

The Leader for PLHIV activity strengthens organizational and leadership capacity of the Secretariat of the Central Asia Association of PLHIV; helps member organizations reduce stigma and discrimination in order to improve PLHIV access to quality services, strengthens member organizations' advocacy

for quality systems that will deliver equitable services for PLHIV, and reduces legal and policy barriers to services. Period of performance: April 25, 2014 to April 24, 2019.

Strategic or Results Framework for the project/program/intervention (*paste framework below*)

The HIV Project directly supports Development Objective (DO) 3: "More accountable and inclusive governance institutions that serve the public good" under the Regional Development Cooperation Strategy. Within DO3, the program supports all three intermediate results (IRs): IR3.1 — "More constructive engagement between representative civil society and governments", IR3.2 — "More accountable and transparent state bodies, and IR3.3 — Increased use of vital health and education services." The evaluation also supports the USAID Kyrgyz Republic CDCS DO 2: "Improved service delivery and policies for all citizens,", and IR 2.2: "Increased utilization of quality health and education services by all citizens."

What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

Activities under this program are being implemented in Kazakhstan (East Kazakhstan and Pavlodar Provinces), Kyrgyz Republic (Bishkek City, Chui Province, Osh City, Osh Province), and Tajikistan (Districts of Republican Subordination, Dushanbe, and Sughd Province). Under this evaluation, implementation of activities among PWID, prisoners and PLHIV will be evaluated in all three countries.

Purpose, Audience & Application
A. **Purpose**: Why is this evaluation/assessment being conducted (purpose of analytic activity)? Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

This performance evaluation will determine which Project components worked well, which did not and why, and make recommendations for course corrections and inform the design of future activities and strategy. An evaluation of the HIV REACT Activity was conducted in FY 2017. Since HIV Flagship is the largest activity, this will be the main focus of the HIV Project evaluation. This is an evaluation of the HIV Flagship, but will include an examination of the synergies, collaborations, and between the activities of LEADER and HIV REACT, with recommendations for strengthening HIV Project strategies.

B. **Audience**: Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

USAID and implementing partners

C. **Applications and use**: How will the findings be used? What future decisions will be made based on these findings?

The findings will help decide if changes in the course of the program are necessary and for the design of follow-on HIV Project strategies.

Evaluation/Analytic Questions & Matrix:

	Evaluation Question	Method & Data Source
1	How effectively is the HIV Project cohesively supporting the community components of the HIV cascade, including case-finding, linkage to treatment and adherence support for PWID, partners, prisoners and ex-prisoners?	Document review, field visit, focus groups discussions with beneficiaries, stakeholders and implementing partners teams in the field.
2	What are the Project's strengths, weaknesses, and gaps in planning and	Interviews with NGO management, Flagship staff, USAID

	management, both internally (sub-grantees, across their offices) and externally (USAID, host governments, CDC Partners, other donors, etc.)?	
3	What gaps still exist that inhibit the HIV Project from achieving the expected results and how can these be addressed both within the current USAID Project activities and in future activities?	Interview with stakeholders, donor community, PEPFAR team in CA

Note: This is an evaluation of the CA HIV Flagship project, but it will include an examination of the synergies, collaborations, and gaps amongst the Flagship, HIV REACT, and LEADER projects. This will be discussed further during the in-brief with USAID.

Other Questions *[OPTIONAL]*
(**Note**: Use this space only if necessary. Too many questions lead to an ineffective evaluation or analysis.)

Methods:

General Comments related to Methods:

■ **Document and Data Review** (*list of documents and data recommended for review*)

This desk review will be used to provide background information on HIV in Central Asia, as well as the CAR HIV Flagship project, and the other HIV projects funded by USAID/CAR (HIV REACT and LEADER), as well as other data for analysis for this evaluation. Documents and data to be reviewed include:
- contractual document
- annual and quarterly reports
- data reports
- training materials
- previous activity evaluations/assessments (mid-term evaluation of HIV React, cost-effectiveness analysis of peer driven models).

The evaluation team will also review PEPFAR related documents, such as, ROP Strategic Direction Summary for FY 2015, FY 2016 and FY 2017, including table 6 and POART call presentations.

☐ **Secondary analysis of existing data** (*This is a re-analysis of existing data, beyond a review of data reports. List the data source and recommended analyses*)

Data Source (existing dataset)	Description of data	Recommended analysis

■ **Key Informant Interviews** (*list categories of key informants, and purpose of inquiry*)

Implementing partners, project peer navigators, social workers, NGO management, government stakeholders, donor community, USAID staff, AIDS Center's, Narcology Center's and Penitentiary service health department's management and staff.

■ **Focus Group Discussions** (*list categories of groups, and purpose of inquiry*)

Project beneficiaries, peer navigators

■ **Group Interviews** *(list categories of groups, and purpose of inquiry)*

Group interviews for donors in a country or for government representatives

HUMAN SUBJECT PROTECTION

The Analytic Team must develop protocols to insure privacy and confidentiality prior to any data collection. Primary data collection must include a consent process that contains the purpose of the *evaluation*, the risk and benefits to the respondents and community, the right to refuse to answer any question, and the right to refuse participation in the *evaluation* at any time without consequences. Only adults can consent as part of this *evaluation*. **Minors cannot be respondents to any interview or survey, and cannot participate in a focus group discussion without going through an IRB**. The only time minors can be observed as part of this *evaluation* is as part of a large community-wide public event, when they are part of family and community in the public setting. During the process of this evaluation, if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information.

An Informed Consent statement included in all data collection interactions must contain:
- Introduction of facilitator/note-taker
- Purpose of the evaluation/assessment
- Purpose of interview/discussion/survey
- Statement that all information provided is confidential and information provided will not be connected to the individual
- Right to refuse to answer questions or participate in interview/discussion/survey
- Request consent prior to initiating data collection (i.e., interview/discussion/survey)

ANALYTIC PLAN

All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will review both qualitative and quantitative data related to the project/program's achievements against its objectives and/or targets.

Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age, and location, whenever feasible. Other statistical test of association (i.e., odds ratio) and correlations will be run as appropriate.

Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist.

Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., project/program performance indicator data, project database, countries' HIV statistics, SPECTRUM data, etc.) will allow the Team to triangulate findings to produce more robust evaluation results.

The Evaluation Report will describe analytic methods and statistical tests employed in this evaluation.

ACTIVITIES

Background reading — Several documents are available for review for this analytic activity. These include HIV Project contract and agreement documents, annual work plans, M&E plans, quarterly progress reports, and routine reports of project performance indicator data, as well as other evaluation, research and/or survey data reports (i.e., DHS and MICS). This desk review will provide

background information for the Evaluation Team, and will also be used as data input and evidence for the evaluation.

Team Planning Meeting (TPM) — This assignment will begin with virtual team planning, prior to the convening of the Team in Almaty. Once most of the plans are in place, the full team will convene in Almaty for a one-day team planning meeting (TPM). The TPM (virtual and in-country) will:
- Review and clarify any questions on the evaluation SOW
- Clarify team members' roles and responsibilities
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
- Review and finalize evaluation questions
- Review and finalize the assignment timeline
- Develop data collection methods, instruments, tools and guidelines
- Review and clarify any logistical and administrative procedures for the assignment
- Develop a data collection plan
- Draft the evaluation work plan for USAID's approval
- Develop a preliminary draft outline of the team's report
- Assign drafting/writing responsibilities for the final report

Briefing and Debriefing Meetings — Throughout the evaluation the Team Lead will provide briefings to USAID. The In-Brief and Debrief are likely to include all Evaluation Team experts, but will be determined in consultation with the Mission. These briefings are:
- Evaluation **launch**, a call/meeting among the USAID, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.
- **In-brief with USAID**, as part of the TPM. At the beginning of the TPM, the Evaluation Team will meet with USAID to discuss expectations, review evaluation questions, and intended plans. The Team will also raise questions that they may have about the project/program and SOW resulting from their background document review. The time and place for this in-brief will be determined between the Team Lead and USAID prior to the TPM.
- **Workplan and methodology review briefing**. At the end of the TPM, the Evaluation Team will meet with USAID to present an outline of the methods/protocols, timeline and data collection tools. Also, the format and content of the Evaluation report(s) will be discussed.
- **In-brief with project** to review the evaluation plans and timeline, and for the project to give an overview of the project to the Evaluation Team.
- The Team Lead (TL) will brief the USAID **weekly** to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email.
- A **final debrief** between the Evaluation Team and USAID will be held at the end of the evaluation to present preliminary findings to USAID. During this meeting a summary of the data will be presented, along with high level findings and draft recommendations. For the debrief, the Evaluation Team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations. The evaluation team shall incorporate comments received from USAID during the debrief in the evaluation report. (***Note****: preliminary findings are not final and as more data sources are developed and analyzed these finding may change.*)

Fieldwork, Site Visits and Data Collection — The evaluation team will conduct site visits for data collection. Selection of sites to be visited will be finalized during TPM in consultation with USAID. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

Evaluation/Analytic Report — The Evaluation/Analytic Team under the leadership of the Team Lead will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

1. Team Lead will submit <u>draft evaluation</u> report to GH Pro for review and formatting.
2. GH Pro will submit the draft report to USAID.
3. USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro.
4. USAID will manage implementing partner(s)'s (IP) review of the report and compile and send their comments and edits to GH Pro. (Note: USAID will decide what draft they want the IP to review.)
5. GH Pro will share USAID's comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH Pro.
6. GH Pro will review and reformat the <u>final Evaluation/Analytic Report</u>, as needed, and resubmit to USAID for approval.
7. Once Evaluation Report is approved, GH Pro will re-format it for 508 compliance and post it to the DEC.

The Evaluation Report **excludes** any **procurement-sensitive** and other sensitive but unclassified (**SBU**) information. This information will be submitted in a memo to USAID separate from the Evaluation Report.

Data Submission — All <u>quantitative</u> data will be submitted to GH Pro in a machine-readable format (CSV or XML). The datasets created as part of this *evaluation* must be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. It is essential that the datasets are stripped of all identifying information, as the data will be public once posted on USAID Development Data Library (DDL).

Where feasible, <u>qualitative</u> data that do not contain identifying information should also be submitted to GH Pro.

DELIVERABLES AND PRODUCTS

Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under "Other" in the table below. Provide timelines and deliverable deadlines for each.

Deliverable / Product	Timelines & Deadlines (estimated)
▉ Launch briefing (call)	May 10 or 14, 2018
▉ In-brief with USAID	May 22, 2018
▉ Workplan and methodology review briefing	May 28, 2018
▉ Workplan submitted to USAID (must include questions, methods, timeline, data analysis plan, and instruments)	May 29, 2018
▉ In-brief with target HIV Flagship project, followed by data collection	KAZ: June1-9, 2018 KGZ: June 11-20, 2018 TJK: June 11-20, 2018 Note: The evaluation team will split up for KGZ and TJK fieldwork
▉ Routine briefings	Weekly
▉ Out-brief with USAID with Power Point presentation	June 25, 2018
▉ IP & stakeholders findings review workshop with PowerPoint presentation	June 25, 2018
▉ Draft report	*Submit to GH Pro*: July 12, 2018 *GH Pro submits to USAID*: July 19, 2018

■ Final report	*Submit to GH Pro*: August 10, 2018 *GH Pro submits to USAID*: August 16, 2018
■ Raw data (cleaned datasets in CSV or XML with codesheet)	August 16, 2018
■ Report Posted to the DEC	October 8, 2018
☐ Other (specify):	

Estimated USAID review time
Average number of business days USAID will need to review the Report? _____10_____
Business days

TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)
Evaluation/Assessment team: Note that **all team members will be required to provide a signed statement attesting that they have no conflict of interest (COI)**, or describing the conflict of interest if applicable.

- Team Qualifications:

Overall Team requirements: Expertise in evaluation of PEPFAR funded programs in the concentrated epidemics, preferably in the Asia region; expertise in strategic information for PEPFAR.

Team Lead/HIV Specialist:
Roles & Responsibilities: The team leader will be responsible for (1) providing team leadership; (2) managing the team's activities, (3) ensuring that all deliverables are met in a timely manner, (4) serving as a liaison between the USAID and the evaluation/assessment team, and (5) leading briefings and presentations. As an HIV Specialist s/he will also provide expertise in the field of HIV, including key populations.
Qualifications:
- Minimum of 10 years of experience in public health, which includes experience in implementation of health activities in developing countries, particularly HIV programs
- Demonstrated experience leading health sector and HIV project/program evaluation/assessments, utilizing both quantitative and qualitative s methods
- Excellent skills in planning, facilitation, and consensus building
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Excellent skills in project management
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience
- Experience working in the region, and experience in *Central Asia* is desirable
- Familiarity with USAID
- Familiarity with USAID & PEPFAR policies and practices
  - Evaluation policies
  - Results frameworks
  - Performance monitoring plans

Key Staff 1 Title: **Evaluation/SI Specialist**
Roles & Responsibilities: Serve as a member of the evaluation team, providing quality assurance on analytic issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will oversee the training of all engaged in data collection, insuring highest level of reliability and validity of data being collected. S/He is the lead analyst, responsible for all data analysis, and will coordinate the analysis of all data, assuring all quantitative and qualitative data analyses are done to meet the needs for this

evaluation. S/He will participate in all aspects of the evaluation, from planning, data collection, data analysis to report writing.

Qualifications:

- At least 10 years of experience in USAID M&E procedures and implementation
- At least 5 years managing M&E, including evaluations and/or assessments
- Experience in design and implementation of evaluations and/or assessments
- Strong knowledge, skills, and experience in qualitative and quantitative analytic tools
- Experience implementing and coordinating others to implement surveys, key informant interviews, focus groups, observations and other evaluation and assessment methods that assure reliability and validity of the data.
- Experience in data management
- Able to analyze quantitative data, which will be primarily descriptive statistics and cross-tabulations
- Able to analyze qualitative data
- Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
- Experience conducting secondary analysis of existing quantitative datasets
- Able to review, interpret and reanalyze as needed existing data pertinent to the evaluation
- Strong data interpretation and presentation skills
- Proficient in written and spoken English and Russian
- Good writing skills, including experience writing evaluation and/or assessment reports
- Familiarity with USAID health programs/projects, particularly in the area of HIV
- Familiarity with USAID and PEPFAR M&E policies and practices
    - Evaluation policies
    - Results frameworks
    - Performance monitoring plans

Key Staff 2 Title: **Local Key Population Specialists (2: one from Kyrgyzstan and one from Tajikistan)**

Roles & Responsibilities: Serve as a member of the evaluation team, providing expertise in HIV programs. S/He will participate in planning and briefing meetings, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report. Each will work in their country of origin, as well as Kazakhstan. Additionally, they may be asked to assist with logistics in the country of their origin, if needed.

Qualifications:

- At least 8 years' experience with HIV projects; USAID project implementation experience preferred
- Expertise in supply and demand for HIV services at the community level with key populations
- Familiarity with HIV integration is desirable
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Proficient in English and Russian or any local language (Tajik, Kyrgyz) is desirable.
- Good writing skills, including experience writing evaluation and/or assessment reports
- Experience in conducting USAID evaluations of health programs/activities

Other Staff Titles with Roles & Responsibilities (include number of individuals needed):

Local **Evaluation Logistics /Program Assistant** (1 local consultant based in Almaty) will support the Evaluation Team with all logistics and administration to allow them to carry out this evaluation.

The Logistics/Program Assistant will have a good command of English and Russian. Ability to speak Kazakh, Kyrgyz and/or Tajik is desirable. To support the Team, s/he will be able to efficiently liaise with hotel staff, arrange regional and in-country transportation (ground and air), arrange meeting and workspace as needed, and insure business center support, e.g. copying, internet, and printing. S/he will work under the guidance of the Team Leader, and coordinate with GH Pro as needed, to make preparations, arrange meetings and appointments. S/he will conduct programmatic administrative and support tasks as assigned and ensure the processes moves forward smoothly. S/He may also be asked to assist in translation of data collection tools and transcripts, if needed.

Translators (1 per country, as needed) will be hired to accompany the evaluation teams. Where possible, translators will be hired at the site to minimize transportation cost. The translators will provide consecutive translation during the meetings with stakeholders and with the NGO staff and beneficiaries. S/He may be asked to assist in translation of data collection tools and transcripts, if needed. S/He may also be asked to assist with local logistic needs, when coordination from Almaty is not feasible.

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or assessment activity.
   ■ Full member of the Evaluation Team (including planning, data collection, analysis and report development) –– If yes, specify who: **Billy Pick**, **Britt Herstad**, Office of HIV/AIDS, Washington
   ☐ Some Involvement anticipated – If yes, specify who:
   ☐ No

Staffing Level of Effort (LOE) Matrix:

Level of Effort in **days** for each Evaluation/Analytic Team member

	Activity / Deliverable	Evaluation team				
		Team Lead / HIV Spec	Local KP Spec	Eval/SI Spec	Translators	HIV Spec (USAID/W)
	Number of persons →	1	2 (1 KGZ; 1TJK)	1	4 (1 per KG & TJ, 2 for KZ)	2
1	Launch Call	0.5				0.5
2	Desk review	6	3	6		3
3	Virtual Team Planning (pre- arrival in Almaty)	5	1	3		3
4	Preparation for Team convening in-country					
5	Travel to country	1	0.5	2		2
6	In-brief with Mission w/ prep	0.5	0.5	0.5		1
7	Team Planning Meeting (in Almaty)	1	1	1		3
8	In-brief with HIV Flagship Project	0.5	0.5	0.5		0.5
9	Prep / Logistics for Site Visits	1	4	1		
10	Data collection / Site Visits (including travel to sites)	12	12	12	4.5	17
11	Data analysis	5	3	4		5
12	Debrief with Mission with prep	0.5	0.5			0.5
13	Activity & Stakeholder debrief with prep	0.5				0.5
14	Depart country	1	0.5	2		2
15	Draft report(s)	8	2.5	7		7
16	GH Pro Report QC Review & Formatting					
17	Submission of draft report(s) to Mission					
18	USAID Report Review					
19	Revise report(s) per USAID comments	4		2		3
20	Finalize and submit report to USAID					
21	508 Compliance Review					
22	Upload Eval Report(s) to the DEC					
	Total LOE per person	46.5	29	41	4.5	48
	Total LOE	46.5	58	41	18	96

If overseas, is a 6-day workweek permitted   ■ Yes   ☐ No

Travel anticipated: List international and local travel anticipated by what team members.

> The team will travel to sites in Kazakhstan (Ust-Kamenogorsk City and Pavlodar City and Provinces), Kyrgyz Republic (Bishkek City, Chui Province, Osh City, Osh Province), and Tajikistan (Districts of Republican Subordination, Dushanbe, and Sughd Province).

LOGISTICS

Visa Requirements

List any specific Visa requirements or considerations for entry to countries that will be visited by consultant(s):

> Kazakhstan and Kyrgyzstan do not require visas for visits up to 30 days. Tajik visa is required.

List recommended/required type of Visa for entry into counties where consultant(s) will work

Name of Country	Type of Visa		
Tajikistan	☐ Tourist	■ Business	☐ No preference

Clearances & Other Requirements

Note: Most Evaluation/Analytic Teams arrange their own work space, often in conference rooms at their hotels. However, if a Security Clearance or Facility Access is preferred, GH Pro can submit an application for it on the consultant's behalf.

GH Pro can obtain **Facility Access (FA)** and transfer existing **Secret Security Clearance** for our consultants, but please note these requests, processed through AMS at USAID/GH (Washington, DC), can take 4-6 months to be granted. If you are in a Mission and the RSO is able to grant a temporary FA locally, this can expedite the process. FAs for non-US citizens or Green Card holders must be obtained through the RSO. If FA or Security Clearance is granted through Washington, DC, the consultant must pick up his/her badge in person at the Office of Security in Washington, DC, regardless of where the consultant resides or will work.

If **Electronic Country Clearance (eCC)** is required prior to the consultant's travel, the consultant is also required to complete the **High Threat Security Overseas Seminar (HTSOS).** HTSOS is an interactive e-Learning (online) course designed to provide participants with threat and situational awareness training against criminal and terrorist attacks while working in high threat regions. There is a small fee required to register for this course. [*Note: The course is not required for employees who have taken FACT training within the past five years or have taken HTSOS within the same calendar year.*]

If eCC is required, and the consultant is expected to work in country more than 45 consecutive days, the consultant may be required to complete the one week **Foreign Affairs Counter Threat (FACT) course** offered by FSI in West Virginia. This course provides participants with the knowledge and skills to better prepare themselves for living and working in critical and high threat overseas environments. Registration for this course is complicated by high demand (consultants must register approximately 3-4 months in advance). Additionally, there will be the cost for additional lodging and M&IE to take this course.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

☐ USAID Facility Access (FA)
    Specify who will require Facility Access: _____
    _____

☑ Electronic County Clearance (eCC) (International travelers only)
    ☑ High Threat Security Overseas Seminar (HTSOS) (*required in most countries with ECC*)
    ☐ Foreign Affairs Counter Threat (FACT) (for consultants working on country more than 45 consecutive days)
☐ GH Pro workspace
    Specify who will require workspace at GH Pro: _____
    _____

☐ Travel -other than posting (specify): _____
    _____

☐ Other (specify): _____
    _____

Specify any country-specific **security concerns and/or requirements**

GH PRO ROLES AND RESPONSIBILITIES

GH Pro will coordinate and manage the evaluation/assessment team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation/assessment team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)
- Review methods, workplan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production — If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

USAID ROLES AND RESPONSIBILITIES

Below is the standard list of USAID's roles and responsibilities. Add other roles and responsibilities as appropriate.

USAID Roles and Responsibilities

USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:

Before Field Work
- SOW.
  - Develop SOW.
  - Peer Review SOW.
  - Respond to queries about the SOW and/or the assignment at large.
- Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.
- Documents. Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.
- Local Consultants. Assist with identification of potential local consultants, including contact information.
- Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.
- Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

During Field Work
- Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.
- Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e., USAID space if available, or other known office/hotel meeting space).
- Meeting Arrangements. Assist the team in arranging and coordinating meetings with stakeholders.
- Facilitate Contact with Implementing Partners. Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After Field Work
- Timely Reviews. Provide timely review of draft/final reports and approval of deliverables.

ANALYTIC REPORT

Provide any desired guidance or specifications for Final Report. (See How-To Note: Preparing Evaluation Reports)

The **Evaluation/Analytic Final Report** must follow USAID's Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the USAID Evaluation Policy).

- The report should not exceed **30 pages** (excluding executive summary, table of contents, acronym list and annexes).
- The structure of the report should follow the Evaluation Report template, including branding found here or here.
- Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.
- For additional Guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found here.

USAID Criteria to Ensure the Quality of the Evaluation Report (USAID ADS 201):
- Evaluation reports should be readily understood and should identify key points clearly, distinctly, and succinctly.
- The Executive Summary of an evaluation report should present a concise and accurate statement of the most critical elements of the report.
- Evaluation reports should adequately address all evaluation questions included in the SOW, or the evaluation questions subsequently revised and documented in consultation and agreement with USAID.
- Evaluation methodology should be explained in detail and sources of information properly identified.
- Limitations to the evaluation should be adequately disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Evaluation findings should be presented as analyzed facts, evidence, and data and not based on anecdotes, hearsay, or simply the compilation of people's opinions.
- Findings and conclusions should be specific, concise, and supported by strong quantitative or qualitative evidence.
- If evaluation findings assess person-level outcomes or impact, they should also be separately assessed for both males and females.
- If recommendations are included, they should be supported by a specific set of findings and should be action-oriented, practical, and specific.

Reporting Guidelines: The draft report should be a comprehensive analytical evidence-based evaluation/assessment report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. ***The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.***

The findings from the evaluation/assessment will be presented in a draft report at a full briefing with USAID and at a follow-up meeting with key stakeholders. The report should use the following format:
- Abstract: briefly describing what was evaluated, evaluation questions, methods, and key findings or conclusions (not more than 250 words)
- Executive Summary: summarizes key points, including the purpose, background, evaluation questions, methods, limitations, findings, conclusions, and most salient recommendations (2-5 pages)
- Table of Contents (1 page)
- Acronyms
- Evaluation/Analytic Purpose and Evaluation/Analytic Questions: state purpose of, audience for, and anticipated use(s) of the evaluation/assessment (1-2 pages)
- Project [or Program] Background: describe the project/program and the background, including country and sector context, and how the project/program addresses a problem or opportunity (1-3 pages)

- Evaluation/Analytic Methods and Limitations: data collection, sampling, data analysis and limitations (1-3 pages)
- Findings (organized by Evaluation/Analytic Questions): substantiate findings with evidence/data
- Conclusions
- Recommendations
- Annexes
  - Annex I: Evaluation/Analytic Statement of Work
  - Annex II: Evaluation/Analytic Methods and Limitations (if not described in full in the main body of the evaluation report)
  - Annex III: Data Collection Instruments
  - Annex IV: Sources of Information
    - List of Persons Interviewed
    - Bibliography of Documents Reviewed
    - Databases
    - [etc.]
  - Annex V: Statement of Differences (if applicable)
  - Annex VI: Disclosure of Any Conflicts of Interest
  - Annex VII: Summary information about evaluation team members, including qualifications, experience, and role on the team.

The evaluation methodology and report will be compliant with the USAID Evaluation Policy and Checklist for Assessing USAID Evaluation Reports

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The Evaluation Report should **exclude** any **potentially procurement-sensitive information**. As needed, any procurement-sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USAID separate from the Evaluation Report.

All data instruments, datasets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be submitted electronically to the GH Pro Program Manager. All datasets developed as part of this evaluation activity will be submitted to GH Pro in an unlocked machine-readable format (CSV or XML). The datasets must not include any identifying or confidential information. The datasets must also be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. Qualitative data included in this submission should not contain identifying or confidential information. Category of respondent is acceptable, but names, addresses and other confidential information that can easily lead to identifying the respondent should not be included in any quantitative or qualitative data submitted.

USAID CONTACTS

	Primary Contact	**Alternate Contact 1**	**Alternate Contact 2**
Name:	Josh Karnes	Joan Woods	Khorlan Izmailova
Title:	Director	HIV Team Lead	COR of HIV Flagship
USAID Mission	HEO	HEO	HEO
Email:	jkarnes@usaid.gov	jowoods@usaid.gov	kizmailova@usaid.gov
Telephone:	+77272507612 x6234	+77272507612 x6234	+77272507612 x6327
Cell Phone:			+77717790937

List other contacts who will be supporting the Requesting Team with technical support, such as reviewing SOW and Report (such as USAID/W GH Pro management team staff)

	Technical Support Contact 1	Technical Support Contact 2	Technical Support Contact 3
Name:	Britt Herstad	Billy Pick	Lily Asrat
Title:	Senior Advisor	Senior Advisor	Senior Evaluation Advisor
USAID Office:	USAID/W	USAID/W	GH/OHA/SIEI
Email:	bherstad@usaid.gov	bpick@usaid.gov	aasrat@usaid.gov
Telephone:			571-551-7192
Cell Phone:			571-451-6079

OTHER REFERENCE MATERIALS

Documents and materials needed and/or useful for consultant assignment, that are not listed above

In addition to the documents listed in XI, the evaluation team may review ICAP monthly and quarterly reports.

ADJUSTMENTS MADE IN CARRYING OUT THIS SOW AFTER APPROVAL OF THE SOW (*To be completed after Assignment Implementation by GH Pro*)

ANNEX 2. EVALUATION METHODS AND LIMITATIONS

The key components of the methodology for the evaluation were as follows:

A. Data review and collection

1. Document review

Evaluation team members reviewed key background documents provided by USAID in the following categories:

- Contractual documents for each project
- Annual and quarterly progress reports for each project
- Performance indicator data reports for each project and Activity Monitoring and Evaluation Plans
- Training materials for the HIV Flagship Project
- Patient readiness assessment reports
- Previous activity evaluations and assessments: the mid-term evaluation of REACT and the cost effectiveness analysis of peer driven models
- The PEPFAR Regional Operational Plan Strategic Directions Summary for FY 2015 – FY 2017, including a review of the epidemiological information contained in the ROPs.
- POART call presentations.

2. Review of performance related data

Indicator data for the project were analyzed to identify achievement of key outputs and outcomes relevant to the evaluation questions. Trends in data were examined and performance indicator data were compared to targets with a particular focus on HIV testing uptake (screening and confirmatory), testing yield, and ART initiation.

3. Qualitative data collection:

The evaluation team collected qualitative data from interviews and site visits with:

i. USAID/Central Asia, USAID/Kyrgyz Republic and USAID/Tajikistan
ii. Other US Government HIV partners: CDC and ICAP
iii. Government partners: Republican and City/Oblast AIDS Centers and Narcology Centers
iv. The management and staff of the Flagship Project and LEADER and HIV REACT
v. NGO implementing partners for the three projects
vi. Focus Group Discussions with Flagship Project clients
vii. Multilateral agencies: UNAIDS, UNDP and UNODC
viii. Follow up information from Flagship by way of written questions put to the Flagship Project to clarify key issues that arose in the course of field work.

Key informant and site selection were undertaken by USAID/Central Asia in collaboration with USAID/Kyrgyz Republic and USAID/Tajikistan.

Qualitative data collection will occur in the following places:

- Almaty, Kazakhstan: regional and Kazakhstan specific interviews
- Ust-Kamenogorsk, Kazakhstan: Government partners, NGO sub-grantees and clients

- Pavlodar, Kazakhstan: Government partners, NGO sub-grantees and clients
- Bishkek: Kyrgyz Republic: USAID Mission, Management and staff of the three HIV Projects, Government and multilateral partners, NGO sub-grantees and clients
- Chui Oblast, Kyrgyz Republic: NGO sub-grantees and clients
- Osh Oblast, Kyrgyz Republic: Government partners, NGO sub-grantees and clients
- Dushanbe, Tajikistan: USAID Mission, Management and staff of the three HIV Projects, Government and multilateral partners, NGO sub-grantees and clients
- Rudaki and Vahdat, Tajikistan: NGO sub-grantees and clients
- Soghd Oblast, Tajikistan: Government partners, NGO sub-grantees and clients

Focus group discussions with Flagship Project clients occurred in the absence of NGO staff in an effort to limit bias in responses and to ensure the confidentiality of responses. Interviews with beneficiaries were on an anonymous basis to protect client confidentiality.

Data collection instruments: Interviews with project implementing agencies and stakeholders were semi-structured, using interview guides developed by the evaluation team. The interview guides contained questions on key areas to be explored, based on the evaluation questions, and ensured a consistency in approach across the two sub-teams and between interviews with the same category of stakeholders. They were, however, not used as a rigid list of questions as there was a need to shape interviews in response to the information respondents were providing. GH Pro conducted a QA review of the interview guides prior to field work and the guides were submitted to USAID/Central Asia for review, feedback and approval.

Informed consent: The purpose of the evaluation was explained to all those interviewed and participating in focus group discussions. The evaluators also explained that they would not be using information collected in a way that would disclose the source, and that responses would be aggregated when reported. All persons were informed that they had the right to decline to answer any questions and to end their participation in evaluation activities at any point, without adverse consequence. Oral consent for participation in interviews and focus group discussions was sought and obtained.

B. Analysis

The evaluation collected predominantly qualitative data through interviews with stakeholders and during site visits. A thematic review of qualitative data was performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what was happening and the perception of those involved. Qualitative data were used to substantiate quantitative findings derived from project reports and the project's monitoring indicators to provide more insights and context than quantitative data could provide and answer questions where other data did not exist.

The evaluation team was involved in an ongoing analysis of all data through periodic team and sub-team meetings. This iterative process allowed for emerging issues to be explored and potential conclusions to be tested as the evaluation progressed.

After completing data collection, the evaluation team met in Almaty to conduct a thorough analysis of all data and develop preliminary key findings, conclusions and recommendations related to the evaluation questions. This analysis included triangulation of information from document review, monitoring data, and qualitative data collected from interviews and site visits. This analysis formed the basis upon which

the evaluation report was written, with some additional time allowed for desk work analysis by team members, concurrent with the report writing phase.

The team's analysis was based on the key evaluation questions, evaluation methods and application or data use, as set out in the table below.

	Evaluation Question	Methods and data source	Application or Data Use
1	How effectively is the HIV Project cohesively supporting the community components of the HIV cascade, including case-finding, linkage to treatment and adherence support for PWID, partners, prisoners and ex-prisoners?	• Document & data review • Secondary data analysis • Key informant interviews with stakeholders and implementing partners • Focus Group Discussions with beneficiaries	• Feedback for course correction • Recommendations for project improvement and future project(s)
2	What are the Project's strengths, weaknesses, and gaps in planning and management, both internally (sub-grantees, across their offices) and externally (USAID, host governments, CDC Partners, other donors, etc.)?	• Document review • Key informant interviews with USAID, CDC, government partners, multilateral agencies, implementing agency staff and NGO management	• Feedback for course correction
3	What gaps still exist that inhibit the HIV Project from achieving the expected results and how can these be addressed both within the current USAID Project activities and in future activities?	• Document & data review • Key informant interviews with USAID, implementing partners, NGOs, clients, government partners and multilateral agencies	• Feedback for course correction • Recommendations for project improvement and future project(s)

C. Limitations

Key limitations for this evaluation are:

1. The evaluation was a rapid appraisal, which limited its scope and time to validate findings. Rapid appraisals have proven to be very effective in identifying good performance and areas for improvement. The evaluation team was able to validate findings through the debriefing meetings and USAID and partner feedback on the draft evaluation report.

2. Within the time and resources available it was not possible to collect quantitative data. The evaluation was dependent on the project's monitoring data. This limitation was minimized by comparing the qualitative data collected by the team, where relevant, against project data.

3. As implementing partners were responsible for inviting clients to participate in focus group discussions with the evaluation team, it is possible that clients with a favorable view of the project were chosen, while those who may be dissatisfied were excluded.

4. In developing the schedule for NGO interviews and site visits, USAID decided to combine some NGOs into joint interviews. This had the advantage of increasing the number of NGOs that were interviewed by the evaluation team. A possible limitation may be that joint interviews may have inhibited respondents from providing full and frank answers to questions, particularly if there were strained or competitive relationships between NGOs. This issue was raised with USAID who thought this was unlikely to be the case. The evaluation team did not observe such a dynamic in these interviews.

5. The evaluation focused on Flagship's work with people who inject drugs (PWID) and their sexual partners. The project's work with men who have sex with men (MSM) was examined in less detail due to its recent commencement (approximately one year) and small scale.

D. In-briefs and de-briefs

The evaluation team met with USAID/Central Asia for an In-Brief at the commencement of field work. This covered an outline of the operating environment for the project, identification of key issues to be addressed by the evaluation, clarification on the Scope of Work, and identification of key parameters for a follow-on project(s). The evaluation team also had in-briefs with the USAID Mission in the Kyrgyz Republic and the USAID Office in Tajikistan and at the commencement of field work in those countries. In addition to the in-briefs, interviews were held with the HIV Teams in USAID/Central Asia, USAID/Kyrgyz Republic and USAID/Tajikistan to get their inputs to the evaluation questions. A de-brief with USAID Office in Tajikistan was conducted at the conclusion of field work.

At the conclusion of the field work and following the team analysis meeting, the evaluation team conducted four debrief meetings with:

1. USAID/Central Asia, Kyrgyz Republic and Tajikistan (in Almaty, with the Kyrgyz and Tajikistan joining by video conference)
2. USAID/Central Asia Mission Director
3. PEPFAR/Central Asia
4. The management and senior staff of each of the three USAID HIV projects (joint meeting).

The purpose of these de-briefs was to share the evaluation team's preliminary key findings, conclusions and recommendations (PowerPoint presentation), and to receive feedback, validation and further input that could be considered by the team in the report writing phase.

ANNEX 3. DATA COLLECTION INSTRUMENTS

At the start of all interviews and FGDs the evaluation team provided an overview of the purpose of the evaluation and sought the informed consent from all participants. The text of the overview and informed consent information is below.

The evaluation team developed interview guides for the different categories of stakeholders who were interviewed and participated in FGDs. The interview and FGD guides are reproduced in this annex.

Introduction and informed consent for all interviews, focus groups and site visits

We are conducting an independent mid-term evaluation of the USAID/Central Asia HIV Flagship Project.

The purpose of the evaluation is:

1. Determine which project components are working well and why and which project components are not working well and why.
2. To make recommendations on how the project could be improved.
3. To make recommendations on how USAID can best contribute to control of the HIV epidemic in Central Asia in any future HIV projects.

The information we collect from you today will be used by the evaluation team in developing our findings, conclusions and recommendations.

The evaluation report will not name any individuals as the source of information. The report will describe the sources of information in more general ways which will protect your confidentiality.

[Additional information for Focus Group Discussion participants:] The attendance sheet we have asked you to fill out uses the project's unique client identification code which does not reveal your name. This information is for financial accounting purposes only as we have to account for meeting costs. This information will be kept confidential.

You have the right to decline to answer any question and to end the interview at any time without adverse consequence.

Do you have any questions about the purpose of the evaluation or this interview?

Is it OK to proceed with the interview?

Interview guides

1. USAID staff responsible for management of HIV Flagship

(For interviews with USAID Central Asia HIV Team Lead, COR for Flagship and USAID Health/HIV staff in the Kyrgyz Republic and Tajikistan)

1. How effective are the Flagship Project's strategies in each of the following areas/What are the key strengths and weaknesses of their strategies?:
   a. Case finding among key populations
   b. Case finding among sexual and injecting partners of PLHIV
   c. Linkages to treatment
   d. Treatment retention and adherence

    e.   HIV prevention activities

    f.   Advocacy

2. Flagship's strategies for case finding, linkages to treatment and retention and adherence have been modified over the course of the project.

    a.   How effective have these changes in strategy been?

    b.   What is being done/needs to be done to address any weaknesses and gaps?

    c.   What further changes to strategies in these areas may be needed and why? (e.g., to deal with saturation in case finding using existing approaches).

3. Looking at Flagship overall, what gaps or weaknesses exist that inhibit the Flagship Project from achieving its expected results?

    a.   What needs to be done to address these gaps or weaknesses?

4. What are the project's strengths, weaknesses and gaps in planning and management with their national offices in KG and TJ and NGO sub-grantees?

    a.   What is being done/needs to be done to address any weaknesses and gaps?

    b.   How effective has TA from Flagships regional and country offices been in building the capacity of sub-grantee NGOs?

    c.   Are there any key under-addressed TA needs?

    d.   How effective is communication between NGO sub-grantees and governments?

5. What are the Flagship's strengths, weaknesses and gaps in synergies and collaboration with LEADER and REACT?

    a.   What is being done/needs to be done by Flagship, LEADER and REACT to address the weaknesses and gaps?

6. What are the Flagship's strengths, weaknesses and gaps in synergies and collaboration with CDC and ICAP, particularly in relation to collaborative work with Republican AIDS Centers?

    a.   What is being done/needs to be done by Flagship, CDC and ICAP to address the weaknesses and gaps?

7. What are the Flagship's strengths, weaknesses and gaps in their relationship with USAID/CAR, USAID/KG and USAID/TJ in the areas of planning and management?

    a.   What is being done/needs to be done to address the weaknesses and gaps?

8. What are the strengths, weaknesses and gaps in USAID's management of the Flagship Project?

    a.   What have been the advantages, disadvantages and challenges of having three USAID Missions involved in management of this project?

    b.   What is being done/has been done to address any issues related to multiple Mission oversight?

9. What are the strengths, weaknesses and gaps in Flagship's relationships with host governments in each country?

    a.   What is being done/needs to be done to address the weaknesses and gaps?

    b.   Is there a need for any new government counterparts or new issues to be addressed with governments (e.g., sustainable financing)?

10. What are the strengths, weaknesses and gaps in Flagship's relationships with Global Fund programming and multilateral organizations (UNAIDS, UNODC, etc.) in each country?

    a.   What is being done/needs to be done to address the weaknesses and gaps?

11. Looking ahead to 2020 and the design of future USAID HIV programming in Central Asia:

    a.   What changes will be needed in the programmatic response to HIV in Central Asia?

b. What are the key components you would like to see in any follow-on project?

c. What would be the key similarities and differences to the existing Flagship project?

d. What are your views on the effectiveness, advantages, and disadvantages of separate but collaborating HIV projects or one consolidated HIV project?

2. USAID AORs for LEADER and HIV REACT

1. In what ways does LEADER/REACT work with the Flagship Project at regional, national and local levels?

2. How effective is the working relationship between Flagship and LEADER/REACT?

   a. What achievements you can identify from collaborative work? (Probe for specifics and any data.)

   b. In what ways could synergies and collaboration between Flagship and LEADER/REACT be improved? (effectiveness of joint planning?)

3. Are there any key gaps in collaboration between Flagship and LEADER/REACT which are holding things back?

   a. What needs to be done to address these gaps?

4. What are the key strengths and achievements of the Flagship Project?

5. What are the key weaknesses of Flagship Project?

   a. What has been done or needs to be done to address these weaknesses?

   b. Can improved collaboration between Flagship and LEADER/REACT help to address these weaknesses?

6. Looking ahead to 2020 and the design of future USAID HIV programming in Central Asia:

   a. What changes will be needed in the programmatic response to HIV in Central Asia?

   b. What are the key components you would like to see in any follow-on projects?

   c. What would be the key similarities and differences to the existing Flagship project and other projects?

   d. What are your views on the effectiveness, advantages, and disadvantages of separate but collaborating HIV projects or one consolidated HIV project?

3. USAID/CAR Strategic Information Advisor

Flagship M&E

1. In general:

   a. Tell us what <u>is</u> working with the Flagship HIV Project.

   b. Tell us what is <u>not</u> working with the Flagship HIV Project.

2. More specifically:

   a. Tell us what is and is not working with the project's M&E.

   b. What is your level of engagement with the Flagship Project? (How often do you meet with PSI at the regional and country levels? How often do you conduct site visits?)

   c. Should USAID be presenting more data from Flagship to OGAC on a regular basis or presenting it in a more compelling way? How can USAID better tell the Flagship story?

Pending responses to the above questions

3. Very specifically, tell us what is and is not working with:

   a. Performance monitoring

b. Project indicators

c. Target setting

d. Other sources of data

e. Data collection

f. Data quality

g. Data analysis

h. Data use

    i. Performance improvements

    ii. Shared learning platforms/opportunities

    iii. Project presentations

i. Reporting

3. If something is not working, tell us what could be done to improve the situation.

4. Flagship Project Regional Office and Country Offices in Kyrgyz Republic and Tajikistan

1. How effective are project strategies in each of the following areas/What are the key strengths and weaknesses of your strategies?:

   a. Case finding among key populations

   b. Case finding among sexual and injecting partners of PLHIV

   c. Linkages to treatment

   d. Treatment retention and adherence

   e. HIV prevention activities

   f. Advocacy

2. Your strategies for case finding, linkages to treatment and retention and adherence have changed over the course of the project.

   a. How effective have these changes in strategy been?

   b. What is being done/needs to be done to address any weaknesses and gaps?

   c. What further changes to strategies in these areas may be needed and why? (e.g., to deal with saturation in case finding using existing approaches).

3. What gaps or weaknesses exist that inhibit the Flagship Project from achieving its expected results?

   a. What needs to be done to address these gaps or weaknesses?

   b. What are the strengths, weaknesses and gaps of gender programming by Flagship?

4. What are the project's strengths, weaknesses and gaps in planning and management with your NGO sub-grantees?

   a. What is being done/needs to be done to address the weaknesses and gaps?

   b. What are the key lessons you have learned in how to provide effective TA to your sub-grantees and what changes have resulted from those lessons?

   c. Are there any key under-addressed TA needs?

   d. Check for issues related to incentive payments for Peer Navigators and Case Managers, including differences in incentive payments between NGOs.

5. What are the project's strengths, weaknesses and gaps in planning and management with your **country offices** in KG and TJ (for TJ and KG offices: with Flagship's regional office?)

6. What are the Project's strengths, weaknesses and gaps in synergies and collaboration with LEADER?

   a. What is being done/needs to be done to address the weaknesses and gaps?

7. What are the Project's strengths, weaknesses and gaps in synergies and collaboration with HIV REACT?

   a. What is being done/needs to be done to address the weaknesses and gaps?

8. What are the Project's strengths, weaknesses and gaps in synergies and collaboration with CDC and ICAP, especially in relation to collaborative work in support of Republican AIDS Centers?

   a. What is being done/needs to be done to address the weaknesses and gaps?

9. What are the Project's strengths, weaknesses and gaps in synergies and collaboration with Global Fund programming?

   a. What is being done/needs to be done to address the weaknesses and gaps?

10. What are the Project's strengths, weaknesses and gaps in synergies and collaboration with UNAIDS, UNODC and other UN organizations?

    a. What is being done/needs to be done to address the weaknesses and gaps?

11. What are the strengths, weaknesses and gaps in the Project's relationships with host governments in each country?

    a. What is being done/needs to be done to address the weaknesses and gaps?

    b. Who are your government counterparts? Is there a need for any new government counterparts?

12. What are the project's strengths, weaknesses and gaps in the Project's relationship with USAID/CAR, USAID/KG and USAID/TJ in the areas of planning and management?

    a. What is being done/needs to be done to address the weaknesses and gaps?

    b. What have been the advantages, disadvantages and challenges of having three USAID Missions involved in management of this project?

    c. What is being done/has been done to address any issues related to multiple Mission oversight?

13. Looking ahead to 2020 and the design of future USAID HIV programming in Central Asia:

    a. What changes will be needed in the programmatic response to HIV in Central Asia?

    b. What are the key components you would like to see in any follow-on project?

    c. What would be the key similarities and differences to the existing Flagship project?

    d. What are your views on the effectiveness, advantages, and disadvantages of separate but collaborating HIV projects or one consolidated HIV project?

5. Flagship Regional Office and Country Offices M&E staff

Flagship M&E

1. In general:

   a. Tell us what is working with the Flagship HIV Project.

   b. Tell us what is not working with the Flagship HIV Project.

2. More specifically:

   a. Tell us what is and is not working with the project's M&E.

Pending responses to the above questions

3. Very specifically, tell us what is and is not working with:

   a. Performance monitoring

   b. Project indicators

   c. Target setting

   d. Other sources of data

     e. Data collection

     f. Data quality

     g. Data analysis

     h. Data use

   iv. Performance improvements

   v. Shared learning platforms/opportunities

   vi. Project presentations

     i. Reporting

4. If something is not working, tell us what could be done to improve the situation.

6. Flagship NGO Sub-grantees: NGO management

1. Please provide an overview of your NGOs work in implementing the Flagship Project, including your staffing and peer involvement.

2. In general:

     a. Tell us what *is* working with the Flagship HIV Project.

     b. Tell us what is *not* working with the Flagship HIV Project.

3. More specifically, tell us what is and is not working with:

     a. The project's (PSI's) relationships with its NGO partners.

     b. The project's support and strengthening activities for its NGO partners.

     c. Design of the project's approach (case finding strategies, linkages to treatment, retention and adherence in treatment, advocacy)

     d. Effectiveness of the project's activities/interventions

     e. Collaboration with LEADER and REACT

     f. Relationships with other key stakeholders (e.g., AIDS Center, Narcology Center, ICAP, Global Fund projects, etc.)

Pending responses to the above questions

4. Very specifically, tell us what is and is not working with:

     a. Activities to support and strengthen:

        i. management and operational capacity? (financial, human resources, planning, etc.)

        ii. technical capacity? (activity design & implementation)

        iii. SI and M&E capacity? (data collection, data use, etc.)

        iv. Sustainability

5. Are there any key gaps that are holding the Flagship project back from what it needs to achieve?

6. If something is not working, tell us what could be done to improve the situation

7. Flagship NGO Sub-grantees: Peer Navigators and Case Managers

1. In general:

     a. Tell us what is working with the Flagship HIV Project.

     b. Tell us what is not working with the Flagship HIV Project.

2. More specifically, tell us what is and is not working with:

     a. Case detection

     b. Linkage to treatment

    c.   Case management

    d.   For ART initiation

    e.   For adherence and retention

3.   In what ways do you work with the LEADER and REACT Projects?

    a.   Is this collaboration with LEADER and REACT effective?

    b.   How could it be improved?

Pending responses to the above questions

4.   Explore adequacy of training and support to do the job of peer navigator / case manager

5.   Explore management/operational expectations and support for peer navigators / case managers

6.   If something is not working, tell us what could be done to improve the situation.

7.   Are there any things the Flagship Project needs to be doing that it currently isn't doing?

8. Flagship NGO Sub-grantees: Clients FGDs

1.   Please tell what support or services you have been receiving from [name of NGO] as part of the Flagship Project and any other involvement you have with this NGO's work as part of the Flagship Project.

2.   In general:

    a.   Tell us what is working with the Flagship HIV Project.

    b.   Tell us what is not working with the Flagship HIV Project.

3.   More specifically, tell us what is and is not working with:

    a.   HIV testing services (including partner testing)

    b.   ART services (e.g., treatment preparedness, adherence, retention)

    c.   Other services (e.g., TB screening, referrals for STI, MAT and GBV services)

    d.   Psychosocial support

    e.   Peer navigators / case managers

Pending responses to the above questions

4.   Very specifically, tell us what is and is not working with:

    a.   Range of services/support

    b.   Quality of services/support

    c.   Availability of and access to services/support

    d.   Addressing stigma and discrimination

5.   If something is not working, tell us what could be done to improve the situation.

9. Interviews with NGOs implementing the LEADER and HIV REACT Projects

1.   In what ways does your project work with the Flagship Project?

2.   How effective is your working relationship with Flagship?

    a.   Are there specific achievements that you can point to from collaboration with Flagship?

    b.   In what ways could synergies and collaboration between your project and Flagship be improved? (any gaps, effectiveness of joint planning?)

3.   What are the key strengths and achievements of the Flagship Project?

4.   What are the key weaknesses of Flagship Project?

    a.   What has been done or needs to be done to address these weaknesses?

5. Are there any key gaps in the work of the Flagship Project which are holding it back from what it needs to achieve?

   a. What needs to be done to address these gaps?

6. What are the key constraints to successful implementation of the Flagship Project (constraints internal to the project and in the external environment)?

   a. What is USAID and Flagship doing to address these constraints?

7. Looking ahead to 2020 and the design of future USAID HIV programming in Central Asia:

   a. What changes will be needed in the programmatic response to HIV in Central Asia?
   b. What are the key components you would like to see in any follow-on projects?
   c. What would be the key similarities and differences to the existing Flagship project and other projects?
   d. What are your views on the effectiveness, advantages, and disadvantages of separate but collaborating HIV projects or one consolidated HIV project?

10. Republican AIDS Centers (national level)

1. Please describe how the HIV Flagship collaborates with the RAC and the City and Oblast AIDS Centers and tell us how effective this collaboration is.

   a. Key achievements, success stories especially regarding case finding, linkages to treatment, adherence and retention/LTFU.
   b. Have there been any challenges in the collaboration between Flagship and the RAC or City and Oblast AIDS Centers. If so, how have these been addressed?
   c. How effective are Peer Navigators and case managers?
   d. Project strengths?
   e. Project weaknesses and gaps?

2. What do you see as the main barriers or problems encountered in HIV case finding, enrolling PLHIV in treatment, retention in treatment and adherence?

   a. Are there any additional things Flagship could be doing to overcome these barriers or problems?

3. What type of support and technical assistance is the RAC and City and Oblast AIDS Centers receiving from other donor projects (e.g. ICAP, Global Fund)?

   a. How effectively does the Flagship Project coordinate with other donor projects to the RAC?
   b. In what ways could coordination between donor projects be improved?

4. What opportunities are there for NGOs that are working in the Flagship Project to in time receive government funding to support the type of work they are doing?

5. If USAID has a follow-on HIV project after Flagship finishes (in 2020), what are the key components that you would like to see included in that project?

   a. Which current project components need to be continued?
   b. What new areas of work need to be included?

11. City and Oblast AIDS Centers

1. Please describe your collaboration with NGO [INDICATE NGO's NAME. MAY BE MORE THAN ONE] in the USAID HIV Flagship Project?

   a. Key achievements, success stories and challenges, especially regarding case finding, linkages to treatment, adherence and retention/LTFU.
   b. How effective are Flagship Peer Navigators and case managers?

    c. Project strengths?

    d. Project weaknesses and gaps?

    e. How could this collaboration be improved?

2. What do you see as the main barriers or problems encountered in enrolling PLHIV in treatment, retention in treatment and adherence?

    a. Are there any additional things the NGO/Flagship could be doing to overcome these barriers or problems?

3. Does your Center share any data with the NGO/Flagship to help Peer Navigators and case managers in their work?

4. What type of support and technical assistance is your AIDS Center receiving from other donor projects (e.g. ICAP, Global Fund)?

    a. How effectively does the Flagship Project coordinate with other donor projects supporting your AIDS Center?

    b. In what ways could coordination between donor projects be improved?

5. Do active PWID in this area get easy access to MAT?

    a. Does your Center work with the local Narcology Center?

    b. What could be done to improve PWID access and retention in MAT?

6. If USAID has a follow-on HIV project after Flagship finishes (in 2020), what are the key components that you would like to see included in that project?

    a. Which current project components need to be continued?

    b. What new areas of work need to be included?

12. Narcology Centers

1. Please describe your collaboration with NGO [INDICATE NGO's NAME. MAY BE MORE THAN ONE] in the USAID HIV Flagship Project?

    a. Key achievements, success stories and challenges.

    b. How effective are Peer Navigators and case managers?

    c. Project strengths?

    d. Project weaknesses and gaps?

    e. How could this collaboration be improved?

2. Does your Narcology Center collaborate with the Republican AIDS Center in relation to HIV positive PWID? How?

    a. Has this collaboration been effectively supported by the HIV React Project?

3. How do you enrol new patients to MAT? What are the procedures for enrolment?

    a. What are the main barriers or problems encountered in enrolling PWID in MAT?

    b. Are there any additional things the NGO/Flagship could be doing to overcome these barriers or problems?

4. Does your Center share any data with the NGO/Flagship to help Peer Navigators and case managers in their work?

5. What type of support and technical assistance is your Narcology Center receiving from other donor projects (e.g. ICAP, Global Fund)?

    a. How effectively does the Flagship Project coordinate with other donor projects supporting your AIDS Center?

    b.   In what ways could coordination between donor projects be improved?

6.   If you had enough resources, what would you change in order to better address drug dependence related needs of PWID?

7.   If USAID has a follow-on HIV project after Flagship finishes (in 2020), what are the key components that you would like to see included in that project?

    a.   Which current project components need to be continued?

    b.   What new areas of work need to be included?

13. Other stakeholders: CDC/ICAP, Global Fund projects, UNAIDS, UNODC

1.   In what ways does your project/organization work with the USAID Central Asia Flagship Project?

2.   How effective is your working relationship and any joint activities or collaboration and what have been the outcomes?

3.   What are the key strengths and achievements of the Flagship Project?

4.   What are the key weaknesses of the Flagship Project?

    a.   What has been done or needs to be done to address these weaknesses?

5.   Are there any key gaps in the work of the Flagship Project that are holding it back from what it needs to achieve?

    a.   What needs to be done to address these gaps?

6.   What are the key constraints to successful implementation of the project (constraints internal to the project and in the external environment)?

    a.   What is USAID and Flagship doing to address these constraints?

7.   Looking ahead to 2020 and the design of future USAID HIV programming in Central Asia:

    a.   What changes will be needed in the programmatic response to HIV in Central Asia?

    b.   What are the key components you would like to see in any follow-on projects?

    c.   What would be the key similarities and differences to the existing Flagship project and other projects?

    d.   What are your views on the effectiveness, advantages, and disadvantages of separate but collaborating HIV projects or one consolidated HIV project?

ANNEX 4. SOURCES OF INFORMATION

PERSONS INTERVIEWED

Name	Organization	Position
Regional and Kazakhstan		
Joan Woods	USAID Central Asia Mission	HIV Team Lead
Khorlan Izmailova	USAID Central Asia Mission	COR for Flagship
Sholpan Makhmudova	USAID Central Asia Mission	AOR for HIV and REACT
Arman Dairov	USAID Central Asia Office	SI Advisor and AOR for Leader
Indira Aitmagambetova	CDC	Associate Director
Marissa Courey	CDC	Scientist
Olga Samoilova	Flagship Project	Regional Chief of Party
Altynay Rsaldinova	Flagship Project	Project Coordinator, Kazakhstan
Maxim Kan	Flagship Project	Regional M&E Advisor
Ekaterina Lee	Flagship Project	M&E Officer
Zamzagul Jumagulova	Flagship Project	Case Management Advisor
Anna Deryabina	ICAP	Regional Chief of Party
Alexander Goliusov	UNAIDS	Country Director
Aliya Bokazhanova	UNAIDS	National Coordinator
Tatyana Davletgalieva	GFATM	National Coordinator on HIV
Galia Tazhibayeva	Republican AIDS Center	Head of the Diagnostic Laboratory
Lolita Ganina	Republican AIDS Center	Head of the Department of Epidemiological Monitoring
Zhannat Mussina	Republican AIDS Center	Head of HIV prevention department
Nurali Amanzholov	Leader Project	Chief of Party
Zhanara Akhmedova	Leader Project	Project Director, Kazakhstan
Ainur Ismailova	Leader Project	Regional Finance Director
Zarina Kaystarova	Leader Project	Regional M&E specialist
Vahtang Djangireev	Leader Project	Office Manager/Procurement Specialist/Translator
Marina Maksimova	Leader Project	Regional Communication Specialist
Roman Dudnik	HIV REACT Project	Regional Chief of Party
Dmitry Kim	HIV REACT Project	Project Manager
Zhamilya Remhof	HIV REACT Project	Grant Manager
Yagdar Turekhanov	HIV REACT Project	Program Advisor
Marina Zhegolko	East Kazakhstan Oblast AIDS Center	Director
Natalia Oralbaeva	East Kazakhstan Oblast AIDS Center	Head of Treatment Department

Name	Organization	Position
Yurii Bauer	East Kazakhstan Oblast Narcology Center	Deputy Director
Andrey Chernishov	NGO Kuat	Director
Svetlana Chernishova	NGO Kuat	Project Coordinator
Natalia Rudokvas	NGO Answer	Director
Tatyana Lutovskaya	NGO Answer	Project Coordinator
Oksana Bashkatova	NGO Ti ne odin, Pavlodar	Coordinator
Sagunova N.L	NGO Ti ne odin, Pavlodar	Data base specialist
Galia Khasenova	NGO Gerlitta	Director of NGO
Madina Zhumataeva	NGO Gerlitta	Coordinator
Asilkhanova D.M.	NGO Gerlitta	Data base specialist
Kyrgyz Republic		
Elmira Imambakieva	USAID	Public Health Specialist
Damira Bibosunova	CDC	Prevention Adviser
Ainagul Isakova	ICAP	Country Director
Meerim Sarybaeva	UNAIDS	Country Manager
Kubanychbek Ormushev	UNODC	Program Specialist
Oksana Katkalova	GFATM	HIV component manager
Ulan Kadyrbekov	Republican AIDS Center	Director
Aida Estebesova	Flagship Project Country Office	Country Director
Daniiar Saliev	Flagship Project Country Office	Project Coordinator
Talgat Mambetov	Flagship Project Country Office	Program Officer
Ainura Moldokmatova	Flagship Project Country Office	M&E Advisor
Maksat Kasymov	Flagship Project Country Office	Database Specialist
Manas Tokombaev	Flagship Project Country Office	MSM component coordinator
Marat Dzhaparov	Flagship Project Country Office	HIV Cascade Advisor
Mahabat Niyazbekova	Flagship Project Country Office	HIV Cascade Advisor
Venera Maitieva	Flagship Project Country Office	Advocacy Technical Manager
Ibragim Lebuzov	NGO Rans Plus	Director
Salkynay Sultanbekova	NGO Rans Plus	Project Coordinator
Mira Karipova	NGO Rans Plus	Project Coordinator, Alamedin Rayon
Aisuluu Bagyshova	NGO Rans Plus	Data base specialist
Batma Estebesova	NGO Sotsium	Executive Director
Erkinay Kalakulova	NGO Sotsium	Data base specialist
Kymbat Duishebaeva	NGO Sotsium	Project Coordinator
Balkabek Israilov	NGO Anti-Stigma	Director
Maria Kisten	NGO Anti-Stigma	Project Coordinator
Nazgul Tukeshova	NGO Anti-Stigma	Data base specialist
Daniyar Orsekov	NGO Kyrgyz Indigo	Director
Jumushbek uulu Kan	NGO Kyrgyz Indigo	Project Coordinator

Name	Organization	Position
Dastan Mambetaliev	NGO Kyrgyz Indigo	Data base specialist
Elmira Narmatova	Osh Oblast AIDS Center	Director
Aichurok Keldibekova	Osh Oblast AIDS Center	Deputy Director
Ulukbek Motorov	Osh Oblast AIDS Center	Head of Treatment Department
Asan Durusbekov	Osh Oblast AIDS Center	Head of Epidemiological Department
Maksat Toyaliev	Flagship Osh Office	Osh Oblast Coordinator
Zamirbek kyzy Aizada	Flagship Osh Office	Program Specialist
Dmitry Emelyanov	Flagship Osh Office	Data base specialist
Aiperi Bojubaeva	Flagship Karasuu Office	Data base specialist
Akim Barakov	Flagship Karasuu Office	Program Specialist
Evgeniya Kalinichenko	Leader Project	Country Director
Galina Vasileva	Leader Project	Program Coordinator
Liliya Maltseva	Leader Project	Procurement specialist
Jakut Orazalieva	Republican Infectious Diseases Hospital	Nurse, trainee under Leader Project
Aizada Muratalieva	National Surgery Center	Head of laboratory, trainee under Leader Project
Nataliya Shumskaya	REACT Project	Country Director
Dina Masalimova	REACT Project	Project Coordinator
Tajikistan		
Katherine Crawford	USAID, Tajikistan	Country Director
Samantha Huffman	USAID, Tajikistan	Health Team Lead
Lola Yuldasheva	USAID, Tajikistan	Health Specialist
Vohidov Suhrob Davlatovich	Ministry of Health and Social Protection of Republic of Tajikistan	Head of the Department of Sanitary Epidemiological Safety, Emergency Situations and Emergency Medical Care
Aziz Nabidzhanov	CDC, Tajikistan	Team Lead/HIV Treatment Advisor
Saifuddin Karimov	Republican AIDS Center	Director
Dilshdod Saidi	Republican AIDS Center	Deputy Director
Arash Alaei	Consultant	USAID Consultant
Ulugbek Aminov	UNAIDS, Tajikistan	Country Coordinator
Signe Rotberga,	UNODC	Regional Coordinator
Mutabbara Vokhidova	UNODC	Country Officer
Firdavs Sheraliev	UNDP/GF HIV Program	Senior Program Officer
Huvaido Shoinbekov	UNDP/GF HIV Program	M&E Specialist
Khursheda Rakhmatova	Flagship Project Country Office	Director
Mavzuna Yaminova	Flagship Project Country Office	Project Coordinator
Iskandar Akhmedov	Flagship Project Country Office	Data base Specialist
Faridun Iskhokov	Flagship Project Country Office	M&E Advisor

Name	Organization	Position
Firuza Nazarova	Flagship Project Country Office	MSM Coordinator
Shodiya Mirhaydarova	Flagship Project Country Office	HIV Cascade Advisor
Firuza Kurbonova	Flagship Project Country Office	HIV Cascade Advisor
Artyom Bdoyan	Flagship Project Country Office	Program Officer
Mirzoev A.S.	Flagship Project Country Office	Advocacy Technical Manager
Firuza Jamolova	Flagship Project Country Office	Project Assistant
Pulod Jamolov	NGO Spin Plus	Director
Alisher Ismoilov	NGO Spin Plus	Coordinator
Vyacheslav Tcoy	NGO Spin Plus	Data base Specialist
Uktam Akilov	NGO Spin Plus	Coordinator, Needle & Syringes
Inoyat Mirzoeva	NGO Spin Plus	Coordinator on PLHIV
Ashurova Rukhshona	NGO Spin Plus/LEADER	Coordinator of LEADER
Liliya Islamova	NGO Guli Surkh	Coordinator of Flagship
Matyuba Rahmanova	NGO Guli Surkh	Psychologist
Suhrob Rafiev	NGO Guli Surkh	Data base Specialist
Rano Kaharova	NGO Marvorid	Director
Nargis	NGO Marvorid	Psychologist
Takhmina Khaidarova	NGO Tajik Network of PLHIV	Director
Zarrina	NGO Tajik Network of PLHIV	Coordinator/Flagship
Karimov Sino	NGO Dina	Director
Albina Ishkuatova	NGO Dina	Program Officer
Ilhom Negmatov	NGO Dina	Coordinator/Flagship
Gulandom Bobojanova	NGO Dina	Manager of Needle and Syringes Point
Ochilov I.V.	NGO Dina	Data base Specialist
Nargis Mirzokhonova	NGO Dina	Psychologist
Dmitry Son	NGO Nasli Javoni Tojikiston	HIV Flagship Coordinator
Abdukholik Abdurakhmonov	NGO Amali Nek/ HIV React	Director
Marina Vishnyakova	NGO Amali Nek/ HIV React	Social Worker
Shahnoza Sharipova	NGO Amali Nek/ HIV React	Social Worker
Akram Sanginov	NGO Amali Nek/ HIV React	Social Worker

PEER NAVIGATOR INTERVIEWS

The evaluation team did not collect the names of Peer Navigators to protect their confidentiality as most are ex-PWID and/or PLHIV.

NGO	Number of Peer Navigator participants	Sex of participants	Type of Peer Navigator
Kazakhstan			
NGO Kuat	1	1 female	1 PN case detection
NGO Answer	7	4 females, 3 males	2 Senior PN, 3 PN case detection, 2 case management
Ti ne odin and Gerlita	15	13 females, 2 males	15 case managers
Kyrgyz Republic			
NGO Rans Plus	5	5 males	5 PN case detection
NGO Sotsium	7	3 females, 4 males	1 Senior PN, 6 PN case management
NGO Anti-Stigma	5	1 female, 4 males	1 Senior PN, 3 PN case detection, 1 PN case management
NGO Kyrgyz Indigo	6	4 males, 1 transgender man	4 PN case detection, 2 PN case management
Flagship Osh	5	2 females, 3 males	1 Senior PN, 2 PN case detection, 2 PN case management
Flagship Karasuu	6	4 females, 2 males	1 Senior PN, 3 PN case detection, 2 PN case management
Tajikistan			
Guli Surkh and Tajik Network of Women with HIV	17	10 females, 7 males	9 PN case detection, 8 PN case management
Marvorid	10	4 females, 6 males	5 PN case detection, 5 PN case management
Spin+	23	7 females, 16 males	12 PN case detection, 11 PN case management
Dina	7	2 females, 5 males	4 PN case detection, 3 PN case management
Nasli Javoni Tojikiston	7	5 females, 2 males	7 PN case management

FLAGSHIP CLIENTS FOCUS GROUP DISCUSSIONS

The evaluation team did not collect the names of the clients of Flagship NGO IPs to protect their confidentiality.

NGO	Number of client participants	Gender of participants#
Kazakhstan		
NGO Answer	6	1 female, 5 males
Ti ne odin, Pavlodar	8	7 females; 1 male
Kyrgyzstan		
NGO Sotsium	8	3 females, 5 males
NGO Anti-Stigma	5	1 female, 4 males
NGO Kyrgyz Indigo	7	1 female, 6 males
Flagship Osh	4	3 females, 1 male
Flagship Karasuu	4	1 female, 3 males
Tajikistan		
Marvorid, Vahdat, Tajikistan	7	3 females, 4 males
Spin+, Dushanbe, Tajikistan	9	4 females, 5 males
Dina and Nasli Javoni Tojikiston, Khujand	10	6 females, 4 males
Amali Nek (HIV REACT clients), Khujand	5	2 females, 3 males

DOCUMENTS REVIEWED

Health Policy Plus, Costing and Cost Efficiency Analysis: Kyrgyz Republic and Tajikistan. TDY De-Brief. 2018. (PowerPoint presentation).

Health Policy Plus, Costing Workbook and Summary Points and Guidance for Navigating the Cost Efficiency Workbook, Kyrgyz Republic, 2018.

Health Policy Plus, Costing Workbook and Summary Points and Guidance for Navigating the Cost Efficiency Workbook, Kyrgyz Republic, 2018.

HIV Flagship Project, Activity Monitoring and Evaluation Plan: Year 3. 2017.

HIV Flagship Project, In-Brief presentation by the Central Asia Regional Office. 2018. (PowerPoint presentation)

HIV Flagship Project, Annual Performance Reports, Years 1 and 2.

HIV Flagship Project, Quarterly Performance Reports, Years 2 and 3.

HIV Flagship Project, Flagship Activity Indicators (including targets and value achieved) from project commencement to 30 June, 2018.

HIV Flagship Project, A guide for the management and delivery of HIV case finding and linking to care services. 2017.

HIV Flagship Project, HIV community case management – A model of practice

HIV Flagship Project training materials:
- Partner Index Case Testing. Standard Operating Procedure
- Job aids: Steps for Index Partner Testing Services
- Various Flagship data collection forms
- Talking Points for Introducing Partner Testing Services to Index Clients
- Tips and Scripts for Telling Your Partner about HIV Testing

HIV Flagship Project, Organizational Chart.

HIV REACT Project, Activity Monitoring and Evaluation Plan. 2017.

HIV REACT Project, Annual Performance Reports, Year 3.

HIV REACT Project, Quarterly Performance Reports, Years 3 and 4.

HIV REACT Project, Annual Work Plan, Year 4.

Leader for People Living with HIV, Annual Performance Reports, Years 1 and 2.

Leader for People Living with HIV, Quarterly Performance Reports, Year 3.

LINKAGES, Social Media Landscape Analysis for HIV Programming for Men who have Sex with Men and Lesbian, Gay, Bisexual and Transgender Individuals in Kyrgyzstan. 2018.

LINKAGES, Social Media Landscape Analysis for HIV Programming for Men who have Sex with Men and Lesbian, Gay, Bisexual and Transgender Individuals in Tajikistan. 2018.

LINKAGES, Understanding patient attitudes about antiretroviral therapy to improve patient readiness for rapid treatment initiation: Kyrgyz Republic. 2018.

LINKAGES, Understanding patient attitudes about antiretroviral therapy to improve patient readiness for rapid treatment initiation: Tajikistan. 2018.

Lowe, D, Au M and Boltaev, A, Midterm Evaluation of the HIV REACT Project for Key Populations in Detention Centers and Post-Release in Three Countries in Central Asia. 2017.

PEPFAR Central Asia, PEPFAR Central Asia Region Regional Operational Plan 2015. Strategic Direction Summary. 2015.

PEPFAR Central Asia, PEPFAR Central Asia Region Regional Operational Plan 2016. Strategic Direction Summary. 2016.

PEPFAR Central Asia, Strategic Technical Assignment for Results Process. Central Asia Region PEPFAR Regional Operational Plan 2016. Strategic Direction Summary. 2017.

PEPFAR Central Asia, COP16/FY17 Q4 POART (PowerPoint Presentation).

USAID, Contract for the Flagship Activity Contract #AID-176-C-16-00001-00 and amendments. 2015.

ANNEX 5. DISCLOSURE OF ANY CONFLICTS OF INTEREST

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

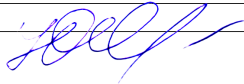| USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project |
| --- |
| As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID's mission.

 Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:
 1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.
 2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.
 3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.
 4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.
 5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.
 6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.
 7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to $5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).
 8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to |

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Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature _____   Date   03/14/2018

Name   DAVID LOWE   Title   MR

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature _____   Date 11 May 2018

Name Larisa Akhmadeeva   Title Interpreter
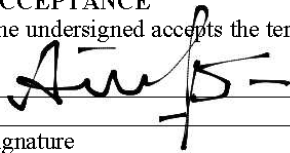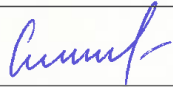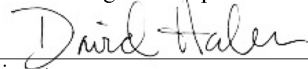
Page **114** of **131**

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

[signature]	04/04/2018
Signature	Date
Shahrigul Amirjanova	translator/interpreter
Name	Title

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Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature	Date 4/4/2018
Name Aisuluu Bolotbaeva	Title

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Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

David Hales (signature)	April 10, 2018
Signature	Date
David Hales	Consultant
Name	Title

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that require access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data tha (i) is or becomes generally available to the public other than as a result of an unauthorized disclosur by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (ii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature _____   Date 04/03/2018
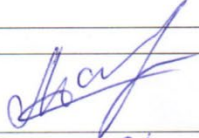
Name Jonboboeva G.S   Title Mls.

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature _____ Date May 22, 2018

Name Maya Shapitova Title Interpreter

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ANNEX 6. SHORT BIOS OF TEAM MEMBERS

David Lowe was the **Team Leader** for this midterm evaluation of USAID's Central Asia HIV Flagship Project. He has an extensive background in health policy and strategy development, program design, health services management, and M&E. Mr. Lowe worked in senior management and health policy positions in the Australian health system from the mid-1980s to mid-1990s and had a key role in shaping Australia's response to HIV. Since the mid-1990s, he has worked as an independent consultant in Australia and internationally, with a primary focus on Asia. He has a broad range of HIV-related technical expertise and has also undertaken assignments in maternal and child health and donor health sector financing. Mr. Lowe has worked in partnership with a wide range of Asian governments, bilateral and multilateral development partners, and community-based organizations to build and consolidate national and regional responses to HIV within a health and community systems strengthening framework. For the evaluation of the Flagship Project, he participated in meetings, interviews and site visits in Kazakhstan and Tajikistan.

Billy Pick, who served as an **HIV Specialist**, is currently the Senior Technical Advisor for Key Populations in the Office of HIV/AIDS Global Health Bureau at USAID. He is the expert on HIV interventions for people who inject drugs and prisoners for the Office. Mr. Pick has a Juris Doctor Degree from Hastings College of the Law in San Francisco, California, and a Master's Degree in Social Work from San Francisco State University. Mr. Pick has been detailed to the Office of the Global AIDS Coordinator at the Department of State where he served as the Senior Advisor for Key Populations. He is also a serving member and HIV Focal Point for the Global Fund for AIDS, Tuberculosis and Malaria's Technical Review Panel. Mr. Pick was a full member of the Flagship Evaluation Team who participated in all aspects of the work including planning, data collection (in Tajikistan), data analysis, and writing the evaluation report.

David Hales served as the **Evaluation/Strategic Information Specialist** on the midterm evaluation of the HIV Flagship project. He drew on his extensive experience of global, regional, national, and subnational M&E, including wide-ranging work on M&E of USAID projects around the world. He was also able to take advantage of his experience and expertise working with key populations and the different challenges they face in accessing HIV-related services. In general, he has a very practical approach to evaluation, focusing on identifying and understanding data and findings that explain the different outcomes of the initiative being assessed as well as those that can be used to improve the quality and effectiveness of ongoing and future programming. For the evaluation of the Flagship project, he participated in meetings, interviews, and site visits in Kazakhstan and the Kyrgyz Republic.

Aisuluu Bolotbaeva, was the **Key Populations Advisor in Kyrgyzstan** for this midterm evaluation of USAID's Central Asia HIV Flagship Project. Ms. Bolotbaeva holds a Master of Arts in Public Policy and has more than 15 years of successful work experience in areas such as HIV, mental health, human rights, and drug policy. She held senior managerial positions from 2005 till 2014 and since 2011, has been providing technical and expert support in improving access to health-care services for key populations and gender mainstreaming in Central Asian countries. Ms. Bolotbaeva served as steering committee member of two pan-European networks — AIDS Action Europe and Eurasian Harm Reduction Network — from 2008 to 2011 and contributed technically to health and human rights programs in the WHO Europe region. She was involved in the design and evaluation of a variety of health programs in Kyrgyzstan and the Kyrgyz Republic. For the evaluation of the Flagship Project, she participated in meetings, interviews, and site visits in Kazakhstan and the Kyrgyz Republic.

Britt Herstad, who served as an **HIV Specialist** is as a Senior HIV/AIDS Regional Advisor for the Central Asia region in the Office of HIV/AIDS, Global Health Bureau, at USAID/Washington, DC. She has worked at USAID for seven years, providing country-specific technical assistance for HIV programs across a range of countries. Ms. Herstad has worked in international development for 20 years, previously working on a series of health policy programs at Palladium Group and with the Population Reference Bureau. Drawing upon her expertise of the region and people who inject drugs HIV programming, Ms. Herstad participated as a full team member in this evaluation, participating in all aspects of the work, including planning, data collection (in Kazakhstan and the Kyrgyz Republic), data analysis, development of debrief presentations, and writing of the evaluation report.

Gulgun Jonboboeva was the **Key Populations Advisor in Tajikistan** for this midterm evaluation of USAID's Central Asia HIV Flagship Project. She has worked in the public health field for more than six years. Her work has included both resident and short-term technical assistance to international programs in areas such as epidemiology, social sciences, evidence-based medicine, HIV/AIDS, and primary health care. Ms. Jonboboeva is currently working at the IntraHealth Organization as a Nutrition Advisor for Tajikistan Health and Nutrition Activity funded by USAID. She has contributed technically to several health programs and has participated in design or evaluation of a variety of health programs in Tajikistan and has participated in a range of national and international conferences. She has a Master's of Health Sciences from the Hamburg University of Applied Sciences. For the evaluation of the Flagship Project, she participated in meetings, interviews, and site visits in Kazakhstan and Tajikistan.

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