MIDTERM EVALUATION OF HIV REACT PROJECT
FOR KEY POPULATIONS IN DETENTION CENTERS
AND POST-RELEASE IN THREE COUNTRIES IN
CENTRAL ASIA

March 2017

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March 2017

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ABSTRACT

Evaluation questions: 1) How effectively is HIV React making the transition from general HIV prevention to HIV case identification, linkage to antiretroviral (ARV) treatment and achieving adherence and retention in care in both prisons and the community, post-release? 2) What are the project’s strengths, weaknesses and gaps? and 3) What are the constraints to successful implementation of this project?

Methods: Collection of qualitative data from interviews and focus groups with project implementers, clients and stakeholders; analysis of project indicator data; secondary data analysis; and document review.

Key findings and conclusions: The redesign and implementation of HIV React Phase II has appropriately made the transition from general HIV prevention to HIV case detection and linking HIV-positive prisoners and ex-prisoners to HIV treatment, with adherence and retention support. ART uptake rates among eligible prisoners are generally high. There is qualitative evidence that post-release support has increased adherence rates. However, due to the recent transition in programming, there was insufficient data to determine the effectiveness of this transition. The project is also not collecting a sufficient range of data to measure its progress in achieving the 90-90-90 objectives. New indicators are needed along with a revised monitoring plan for the project. HIV React has facilitated improved collaboration between penal medical departments and AIDS Centers which improved the quality of care within prisons and reduced loss to follow-up on release. The peer model for education and support is operating effectively. There is a need for advocacy to governments on replication of the HIV React model in non-project sites. Key constraints include weak prison health systems which impact negatively on the quality of care; restrictions on the work of NGO implementing partners access to prisons; and the inability of the project to provide post-release treatment support to ex-prisoners who return to regions where the project is not working.
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<tr>
<td>AFEW/KR</td>
<td>AIDS Foundation East West Kyrgyz Republic</td>
</tr>
<tr>
<td>AFEW/KZ</td>
<td>AIDS Foundation East West Kazakhstan</td>
</tr>
<tr>
<td>AFEW/TJ</td>
<td>AIDS Foundation East West Tajikistan</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>AMEP</td>
<td>Activity Monitoring and Evaluation Plan</td>
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<tr>
<td>AOR</td>
<td>Agreement Officer’s Representative</td>
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<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral</td>
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<tr>
<td>CA</td>
<td>Central Asia</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<tr>
<td>DOT</td>
<td>Directly observed therapy</td>
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<tr>
<td>EKO</td>
<td>East Kazakhstan Oblast</td>
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<tr>
<td>FGD</td>
<td>Focus group discussion</td>
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<tr>
<td>FY</td>
<td>Fiscal Year</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender-based violence</td>
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<tr>
<td>GF</td>
<td>Global Fund</td>
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<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<tr>
<td>GHPPro</td>
<td>Global Health Program Cycle Improvement Project</td>
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<tr>
<td>HCV</td>
<td>Hepatitis C Virus</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HRN</td>
<td>Harm Reduction Network</td>
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<tr>
<td>HTC</td>
<td>HIV testing and counseling</td>
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<tr>
<td>HTS</td>
<td>HIV testing services</td>
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<tr>
<td>IBBS</td>
<td>Integrated Biological and Behavioral Survey</td>
</tr>
<tr>
<td>IEM</td>
<td>Information and educational materials</td>
</tr>
<tr>
<td>IP</td>
<td>Implementing partner</td>
</tr>
<tr>
<td>KP</td>
<td>Key populations (at risk for HIV)</td>
</tr>
<tr>
<td>KR</td>
<td>Kyrgyz Republic</td>
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<tr>
<td>KUIS</td>
<td>Committee of the Criminal-Executive System</td>
</tr>
<tr>
<td>KZ</td>
<td>Kazakhstan</td>
</tr>
<tr>
<td>LTFU</td>
<td>Loss to follow-up</td>
</tr>
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</table>
M&E  Monitoring and evaluation
MAT  Medication assisted therapy
MER  Monitoring, Evaluation, and Reporting
MIS  Management Information System
MOH  Ministry of Health
MoU  Memorandum of Understanding
MSM  Men who have sex with men
NGO  Non-governmental organization
NSP  Needle and Syringe Program
OST  Opioid Substitution Therapy
PEPFAR  US President’s Emergency Plan for AIDS Relief
PLHIV  People Living with HIV
PSI  Population Services International
PWID  People who inject drugs
Q  Quarter
RAC  Republican AIDS Center
SI  Strategic information
SRH  Sexual and Reproductive Health
SSPE  State Service on Penalty Execution
STI  Sexually transmitted infection
TA  Technical assistance
TB  Tuberculosis
TJ  Tajikistan
UIC  Unique Identification Code
UNAIDS  United Nations Program on HIV/AIDS
UNDP  United Nations Development Program
UNODC  United Nations Office on Drugs and Crime
USAID  United States Agency for International Development
USG  United States Government
VCCT  Voluntary counseling and testing
VL  Viral load
EXECUTIVE SUMMARY

EVALUATION PURPOSE AND QUESTIONS

This midterm evaluation of the PEPFAR USAID/Central Asia (CA) HIV React Project served four purposes: 1) to assess how well HIV React is making the transition from its first to second phase of programming; 2) to determine the extent to which the project is achieving its goals, objectives, and performance targets/results; 3) to identify implementation gaps and challenges; and 4) to document lessons learned and provide recommendations to inform future programming directions. The evaluation questions were:

1. How effectively is HIV React making the transition from general HIV prevention to HIV case identification, linkage to antiretroviral (ARV) treatment and achieving adherence and retention in care in both prisons and the community, post-release?
2. What are the project’s strengths, weaknesses, and gaps in planning, management, and service delivery?
3. What are the constraints to successful implementation of this project?

EVALUATION DESIGN, METHODS, AND LIMITATIONS

This performance evaluation undertook a wide range of interviews with the project’s implementing agency, all sub-recipient implementing partners, prison medical departments, AIDS Centers, and other stakeholders. Focus group discussions (FGDs) were conducted with prisoner and ex-prisoner clients of the project. The evaluation reviewed project documentation, including performance indicator data. All data were triangulated at analysis.

The evaluation was primarily reliant on qualitative data. The short period of time between the project’s transition from Phase I to Phase II and this evaluation meant there was limited implementation experience and data on which to base conclusions regarding the effectiveness of the transition. There was insufficient data to construct an HIV clinical cascade for people living with HIV (PLHIV) clients of the project. The evaluation team was given permission to visit prisons only in the Kyrgyz Republic. However, interviews with penal health system staff and FGDs with ex-prisoner project clients were conducted in all three countries.

PROJECT BACKGROUND

The five-year (2014-2019), $5.9 million USAID HIV React Project is implemented by the AIDS Foundation East-West Kazakhstan (AFEW/KZ) and six non-governmental organization (NGO) implementing partners (IPs), working in 19 prisons in US President’s Emergency Plan for AIDS Relief (PEPFAR) priority sites in Kazakhstan, the Kyrgyz Republic, and Tajikistan. The project’s objectives are to increase coverage of HIV testing and counseling for prisoners/people who inject drugs (PWID); to create conditions for increasing access of people living with HIV to antiretroviral therapy (ART); and to create conditions for maintaining adherence to ART. HIV React also supports ex-prisoners following their release through the project’s START Plus transitional client management component, with a focus on reintegration support, including
linking PLHIV with AIDS Centers to maintain adherence and retention in care, and linking to the harm reduction programs (Needle-Syringe Exchange Points (NSP) Medication Assisted Therapy (MAT)) for HIV prevention for HIV-negative PWID and drug use relapse prevention and ex-PWID.

**FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS**

**Evaluation Question 1: Effectiveness of transition from Phase I to Phase II**

AFEW/KZ’s Phase II redesign appropriately involved cessation of HIV education for the general prison population, replaced by a focus on PWID, and a stronger emphasis on HIV case finding, linkage of PLHIV to ART, adherence, and retention in care by minimizing loss to follow-up (LTFU). This has been supported by a greater emphasis on improving HIV and ART literacy through education by peers and social workers. Post-release support was similarly re-focused by targeting PLHIV and PWID, focused on linking PLHIV to ongoing treatment. The project’s sites were adjusted to reflect PEPFAR’s priority geographic regions. The reprogramming decisions were appropriately aligned to the project’s transition to the PEPFAR 90-90-90 objectives. Interviews with NGO IPs and review of project documentation indicate that they have reoriented their activities, consistent with the Phase II re-programming. AFEW/KZ has provided support to IPs for the project’s transition. However, as only a quarter of data and implementation experience for Phase II had occurred at the time of the evaluation, there is insufficient data to determine the effectiveness of the project’s transition. In addition, HIV React’s Activity Monitoring and Evaluation Plan (AMEP) is currently not collecting a sufficient range of data to measure its progress in achieving the 90-90-90 objectives. Data collected by the evaluation during interviews (to address the AMEP gaps) show generally quite high ART treatment uptake rates among eligible PLHIV prisoners. Only limited data on viral load (VL) suppression was available. Where such data was available, VL suppression was below community levels of VL suppression, indicating lower adherence or more recent initiation of ART.

**Evaluation Question 2: Project strengths, weaknesses, and gaps**

Interviews with penal medical departments and AIDS Centers demonstrated that the project has established good working relationships and is seen as adding value. This is a key strength given that HIV React’s role is primarily to facilitate and support service delivery by these gatekeepers. Communication between penal medical departments and AIDS Centers has improved. AIDS Centers report that this has improved the quality of care within prisons and reduced loss to follow-up, post-release.

Most of HIV React’s NGO IPs are peer-based (PWID and PLHIV), which gives them credibility and trust among target populations that have a low level of trust for authority figures. The low level of HIV treatment literacy among PLHIV prisoners, and their distrust of penal authorities, including doctors, is reported by React’s IPs to negatively affect ART initiation, adherence, and retention. The project’s introduction of peer navigators has strengthened PWID and PLHIV education in these areas from a trusted source. However, HIV React is currently not collecting data that links project interventions to ART initiation, adherence, and retention. As countries in Central Asia move towards Test and Start, there needs to be greater promotion among prisoners and AIDS Center and prison doctors on the benefits of early initiation of treatment.
The social challenges faced by ex-prisoners post-release are considerable (e.g., finding accommodation and employment, stigma, etc.). IPs commonly reported that this resulted in health dropping to the bottom of ex-prisoners’ priorities, which in turn results in a decrease in adherence. HIV React IPs are providing high levels of post-release support for ex-prisoners, although the challenges of social reintegration can be daunting. NGO IPs reported that by the time they are able to largely meet ex-prisoner social reintegration needs, there is a noticeable increase in ART adherence, highlighting the importance of this aspect of programming. Overall, there is a shortage of post-release transitional housing.

Given the large number of PLHIV ex-prisoners who reside in Almaty, the absence of PEPFAR HIV care and treatment services for post-release prisoners in Almaty is a missed opportunity for maximizing adherence and retention post-release.

The limited geographic footprint of HIV React means that it is essentially a demonstration project, reliant on government replication of project approaches if it is to have a broader and sustainable impact. Advocacy for national level systems improvements has been a feature of HIV React’s work in the Kyrgyz Republic, and in Tajikistan in Phase I, and has resulted in policy and programming changes. In Kazakhstan, which has a less conducive environment for NGO advocacy, work in this area has been confined to the local site level. There is a need for national level advocacy in Kazakhstan and for this to continue in Tajikistan. Advocacy work could be usefully undertaken in collaboration with United Nations Office on Drugs and Crime (UNODC) and LEADER for People Living with HIV project.

Transitional case management program START Plus’ prioritization of post-release support to PLHIV is appropriate, but it appears that, post-release, insufficient priority is accorded by all NGO IPs to HIV prevention for negative PWID and drug use relapse prevention for ex-PWID. In Tajikistan, Hayoti Nav has not been providing any post-release support to negative PWID and ex-PWID. It appears that this is based on a misunderstanding, which AFEW/KZ intends to correct.

The application of PEPFAR’s geographic prioritization in selecting HIV React Phase II sites in Tajikistan resulted in no project presence in a large prison close to a PEPFAR site and also in the country’s only female prison. Site selection needs to be reconsidered based on data and whether cost savings can be found.

The quality of the approved Phase II AMEP is suboptimal as the indicators do not adequately reflect the full scale of HIV React’s work. Additional indicators are recommended to measure the impact of the project’s work in support of treatment initiation, adherence, and retention, both in prisons and post-release. The project’s work with the sexual partners of ex-prisoner PWID and PLHIV is not currently captured by the indicators. Other weaknesses include: the Year 2 Annual Performance Report does not contain data for all indicators; annual indicator targets for the same indicator differ across a number of project documents; there is insufficient disaggregation of data; and indicator reference sheets do not provide clear operational definitions, including the methods of data measurement and collection. Collectively, these are serious weaknesses that need to be addressed by development of a revised AMEP, strengthening the capacity of HIV React’s Monitoring and Evaluation (M&E) Advisor, and a greater level of engagement between USAID/CA and AFEW/KZ on monitoring and evaluation.

NGOs reported good networking between the different NGO IPs across the three countries through regional trainings and study tours. NGO IPs in Kazakhstan and the Kyrgyz Republic reported high levels of satisfaction with project management, technical assistance (TA), and
trainings from AFEW/KZ. IPs in Tajikistan reported either less frequent TA from AFEW/KZ or the need for TA tailored to the local context and their needs.

There are currently poor relations between AFEW/KZ and AFEW/Tajikistan (TJ). While AFEW/TJ is not an IP in Phase II, in the interests of current and future cross-project public health collaboration between AFEW network members, it is important to rebuild a working relationship.

Evaluation Question 3: Project constraints
The weakness of prison health systems has a negative impact on the quality of HIV care and treatment. For example, HIV-negative test results are commonly not communicated to prisoners by penal medical departments, with the result that prevention benefits of post-test counseling are not being realized. In the Kyrgyz Republic, NGOs and ex-prisoners reported instances of prisoners who tested HIV-positive not being informed of their test result, although it was not possible to determine the frequency of this or exactly why this had occurred.

Prison health systems weaknesses have been ameliorated by HIV React’s close collaboration with AIDS Centers and support for AIDS Center provision of treatment in prisons. However, in the Kyrgyz Republic, where AIDS Centers play a lesser role in prisons and the penal medical department provides the bulk of HIV care, the quality of care appears to be lower than in Kazakhstan and Tajikistan (e.g., less frequent CD4 and VL testing). ART adherence in Kyrgyz Republic prisons was reported by IPs and the Republican AIDS Centers (RAC) to be low. This appears to be related to PLHIV enrolling on ART in order to obtain Global Fund food packages, with no intention of adherence.

There are inherent difficulties for NGOs working in secured closed institutions. The regularity and length of prison visits is restricted and educational mini-sessions are conducted in the presence of guards, which inhibits interaction with prisoners. In Khujand, Tajikistan, Hayoti Nav, a new Phase II IP, has not, as yet, been able to obtain a Memorandum of Understanding (MoU) to enable it to work inside prisons. In a number of sites, NGO IP staff who are ex-prisoners are denied access to prisons, limiting the benefits of a peer-led approach.

Large numbers of ex-prisoners, upon their release, return to regions other than their place of imprisonment. Republican AIDS Centers need to establish a system for AIDS Centers and local NGOs to track PLHIV ex-prisoners who are lost to follow-up in these regions, as HIV React can only do this in the sites where it is working. This would significantly improve retention in care and adherence.

Kazakhstan recommendations
1. PEPFAR, USAID/CA, and AFEW Kazakhstan should consider the feasibility of making cost savings within the HIV React Project to allow for provision of START Plus post-release support services in Almaty to maximize adherence and retention in HIV treatment for the large number of ex-prisoners who reside in Almaty.

2. USAID/CA and AFEW Kazakhstan should investigate the possibility of supporting transitional housing for PWID and PLHIV post-release at each project site.

3. USAID and AFEW Kazakhstan should leverage the United Nations Office on Drugs and Crime and LEADER to advocate for HIV and drug treatment-related health systems

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1 Only high priority recommendations are included in the Executive Summary. All recommendations are in the main body of the report and a consolidated list of all recommendations is in Annex 1.
improvements in prisons and for state/municipal funding for replication of HIV prisons programming in regions not covered by HIV React Project.

**Kyrgyz Republic recommendations**

4. HIV React should work through the quarterly expert working group, UNODC and LEADER (as appropriate), in consultation with prisoners, to:
   a. Promote discussion of strategies to increase adherence to ART, both related to the Global Health-funded food packages for PLHIV on ART and initiating different approaches to foster adherence (e.g. Directly Observed Therapy (DOT), peer navigator or PLHIV peer support, etc.);
   b. Include social dormitories in the upcoming Global Fund proposal, including one for women;
   c. Support systems improvement to ensure all HIV-positive and HIV-negative prisoners are informed of their test results; and
   d. Support moving the penal health services under the Ministry of Health.

5. HIV React should work with peer navigators to promote CD4 and viral load testing and communication of results, in collaboration with prison health staff and the RAC.

**Tajikistan recommendations**

6. Obtain a central level MoU to enable Hayoti Nav to work in prisons. The Agreement Officer’s Representative (AOR), in consultation with USAID/Tajikistan, should work with Hayoti Nav and AFEW/Kazakhstan to determine how this can best be done as quickly as possible.

7. Resolve issues between AFEW/KZ and AFEW/TJ through mediation by a third party. The HIV React AOR and USAID/TJ should, in consultation with AFEW/KZ and AFEW/TJ, identify a suitable third party to assist with mediation.

8. Hayoti Nav’s START Plus pre- and post-release programming should include evidence-based interventions on HIV prevention for negative PWID and PWID drug use relapse prevention, in addition to its existing focus on linking PLHIV ex-prisoners to HIV treatment services on release and supporting adherence and retention in treatment.

9. AFEW/KZ should negotiate with USAID to expand HIV React sites to Vagdhat, Yavan, and the third Sugd Oblast prison, provided there are sufficient numbers of PWID/PLHIV prisoners and savings can be found.

**Cross-cutting recommendations**

10. HIV React, in collaboration with Centers for Disease Control and Prevention (CDC), should advocate for RACs to establish national systems for city and Oblast AIDS Centers to initiate follow-up action for PLHIV ex-prisoners who do not enroll in HIV treatment upon release from prison.

11. AFEW/KZ should increase the level of post-release support through START Plus for HIV-negative PWID and ex-PWID, including evidence-based drug use relapse prevention programming.

**Monitoring and evaluation recommendations**
12. AFEW/KZ should hire an independent local consultant with extensive PEPFAR and M&E experience to closely examine and significantly revise the current AMEP. S/he should work in close collaboration with M&E Advisors from AFEW/KZ and USAID/CA during the revision process, and a revised AMEP should be approved and implemented by FY17 Q4. **At minimum**, revisions need to ensure that: a) the Results Framework and indicators adequately represent the populations and full range of activities conducted by HIV React across the clinical cascade. (See Annex 2 for a detailed list of illustrative indicators and disaggregation); b) data that would enable HIV React to construct an HIV cascade for current and post-release prisoners should be included; and c) data collection forms and indicator reference sheets reflect the above changes.

13. M&E Training for all HIV React NGOs by AFEW Kazakhstan should be conducted once the revised AMEP has been approved.

14. The USAID/CA M&E Advisor should have a greater level of engagement in strengthening the capacity of AFEW Kazakhstan’s routine program monitoring, including detailed reviews of all strategic information (SI)-related documents and cross-validations before submission to the AOR. At a minimum, quarterly meetings should be conducted between the M&E and technical Advisors from USAID/CA and AFEW Kazakhstan program and M&E staff, (with more frequent meetings initially), to review project results, identify potential leakage points within the clinical cascade, and thoroughly review the quality of data submitted.

15. The HIV React M&E Advisor should be relocated to AFEW Kazakhstan’s office.

16. Strengthen the AFEW Kazakhstan M&E advisor’s capacity by budgeting and providing relevant professional development opportunities (e.g. online M&E courses, in-person M&E training).

17. Prior to the implementation of React’s Management Information System (MIS), standard operating procedures and protocols on the collection, storage, and management of program data at AFEW Kazakhstan should be developed by HIV React (with support from USAID/CA).

**AFEW/KZ project management recommendations**

18. Increase regular communication regarding technical needs and implementation issues between AFEW/KZ and SPIN Plus and Hayoti Nav in Tajikistan. This includes quarterly in-person discussions and ongoing liaison as needed between AFEW/KZ and the local implementing partners to familiarize AFEW/KZ with the local context, with the agenda determined by the needs of the NGOs, rather than solely from AFEW/KZ, to ensure successful program outcomes are obtained.
1. INTRODUCTION

This was a midterm evaluation of the five-year US President’s Emergency Plan for AIDS Relief (PEPFAR) USAID/Central Asia (CA) HIV React Project, being implemented under a Cooperative Agreement by the AIDS Foundation East West Kazakhstan (AFEW/KZ) and sub-recipient non-governmental organizations (NGOs) in Kazakhstan, the Kyrgyz Republic, and Tajikistan. The total project budget is $5.9 million. The project commenced in June 2014 and is due to end in December 2019. An overview of the project can be found in Section II of this report.

1.1 EVALUATION PURPOSE

The purpose of the evaluation was to:

1. Assess how well HIV React is making the transition from general HIV prevention to case identification, linkage to antiretroviral (ARV) treatment, and adherence and retention at the PEPFAR sub-national unit levels in both prisons and community-based services.

2. Determine the extent to which the project is achieving its goals, objectives, and performance targets/results.

3. Identify implementation gaps and challenges.

4. Document lessons learned and provide recommendations that will inform future programming directions for HIV React project.

The evaluation covered the period from project commencement in June 2014 to end-September 2016. The scope of work for the evaluation is set out in Annex III.

1.2 EVALUATION QUESTIONS

The questions to be answered by the evaluation are:

1. How effectively is HIV React making the transition from general HIV prevention to HIV case identification, linkage to ARV treatment and achieving adherence and retention in care in both prisons and the community, post-release?

2. What are the project’s strengths, weaknesses, and gaps in planning, management, and service delivery?

3. What are the constraints to successful implementation of this project?

1.3 EVALUATION METHODS AND LIMITATIONS

The evaluation was designed to comply with USAID’s Evaluation Policy (2011) and the PEPFAR Evaluation Standards of Practice (2014). The evaluation is consistent with USAID’s definition of a performance evaluation and PEPFAR’s definition of a process evaluation. A full description of the evaluation design and methodology can be found in Annex IV. The evaluation was conducted by a five-member team, consisting of two international consultants specializing in the areas of HIV and key populations (KP), and two HIV technical experts and one evaluation specialist from USAID/Washington. The evaluation was conducted from October 2016 to January 2017, with field work performed from November 7 – 28, 2016.
The key components of the methodology are outlined below.

**Document review:** Key background documents provided by USAID and the HIV React Project were reviewed and analyzed. These included the Cooperative Agreement; the PEPFAR Regional Operational Plan and Strategic Directions Summary; HIV React needs assessments, annual work plans and budgets; and quarterly and annual progress reports. The sources of information for the evaluation are set out in Annex VI.

**Performance data:** The adequacy of the project’s Monitoring and Evaluation (M&E) plan and project database, which is currently under development, were assessed. Indicator data were analyzed to identify achievement of outputs and outcomes relevant to the evaluation questions. Trends in performance indicator data for Phase 1 were examined and compared to targets.

**Qualitative data collection:** Interviews were held with AFEW/KZ and all current and previous NGO implementing partners at each of the project’s implementation sites, plus the NGO implementing partner in the former project site of Almaty, Kazakhstan. Former prisoner clients of the project participated in focus group discussions (FGDs) at each site. FGDs were held with prisoner clients of the project in two prisons in the Kyrgyz Republic. Interviews and discussions were held with staff from USAID and the Centers for Disease Control and Prevention (CDC) in Kazakhstan, the Kyrgyz Republic, and Tajikistan. Stakeholder interviews were conducted with Republican, city, and oblast AIDS Centers, penal medical departments, addiction treatment centers, staff of Global Fund- (GF) financed programs, the United Nations Development Programme (UNDP), and the United Nations Office on Drugs and Crime (UNODC). Interviews were also conducted with Population Services International (PSI), the principal implementer for the USAID/CA Flagship HIV Project, at regional and country levels. All people interviewed and FGD participants provided informed consent. A list of all people and organizations consulted is in Annex VI. Interview and FGD guides are in Annex VII.

**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 was used to substantiate quantitative findings derived from project reports and M&E data, to 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 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, and CDC, as well as the AFEW/KZ, for validation and feedback.

**Limitations:** The key limitations of this evaluation were:

1. From mid-2016, HIV React reoriented project activities from general HIV prevention to case identification and linkage to ARV treatment to support the PEPFAR 90-90-90 targets. The relatively short period of time between the project pivot and this evaluation meant there was limited implementation experience and data on the reoriented project, on which to base conclusions.
2. As the project has only recently transitioned to place greater emphasis on HIV testing and counseling and testing (HTC), antiretroviral therapy (ART) initiation, adherence, and retention, there was insufficient data to construct the HIV clinical cascade.

3. The evaluation team was only given permission to visit prisons in the Kyrgyz Republic, which meant there was no access to prisoner clients of the project in Kazakhstan and Tajikistan. This was anticipated. The evaluation team was, however, able to speak to former prisoner clients and penal health system staff in all three countries.
2. PROJECT BACKGROUND

2.1 OVERVIEW OF REGIONAL AND COUNTRY CONTEXT

2.1.1 Epidemiology
At the end of 2014, there were an estimated 1.3 million–1.8 million people living with HIV (PLHIV) in Eastern Europe and Central Asia, which accounts for 4 percent of the global number of PLHIV. In Kazakhstan, 18,185 adult PLHIV are diagnosed, accounting for 92 percent of the estimated adult PLHIV; in Tajikistan 5,310 adult PLHIV are diagnosed and officially registered, accounting for 35 percent of the estimated adult PLHIV; while in the Kyrgyz Republic 4,339 adult PLHIV are diagnosed, accounting for 49 percent of the estimated adult PLHIV. The HIV epidemic in CA is growing, and is primarily concentrated among people who inject drugs (PWID) and their sexual partners. The number of new HIV infections in Central Asia rose rapidly in the 1990s, remained relatively stable for several years since 2000, and then again began increasing towards the end of the last decade.

Sixty percent of the cumulative HIV cases in this region have been reported among PWID. Heterosexual transmission among PWID is known to be of significant importance, but the proportion of sexual transmission independent of drug use is not known. The estimated population size of PWID in Kazakhstan is 127,800 with a HIV prevalence of 7.95 percent. In Tajikistan, the PWID population size estimate is 23,100 with a HIV prevalence of 13.5 percent, and in the Kyrgyz Republic, it is estimated to be 25,500 with a HIV prevalence of 12.4 percent.

2.1.2 HIV and prisons
Prisons are extremely high-risk environments for transmission of HIV, due to overcrowding, poor nutrition, limited access to health care, continued drug use, unsafe injecting practices, unprotected sex, and tattooing. In addition, incarceration rates in Eastern Europe and Central Asia are among the highest in the world, with many inmates who come from marginalized populations – such as PWID – who already experience an elevated risk of HIV. The interaction of injecting drug use with sex work and imprisonment is further accelerating the spread of HIV in Central Asia. Up to 9 out of 10 people who inject drugs are imprisoned at some stage in their lives. This reflects an incarceration response to illicit drug use rather than an emphasis on treatment, which in turn is reflected in either a lack or paucity of treatment programs. HIV

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3 World Health Organization, Central Asia HIV Profile, 2013
5 Population Size Estimates and integrated bio-behavioral survey (IBBS) among PWID, Republican AIDS Center, 2014
prevalence has been reported to be 8 percent among prisoners, significantly higher than in the general population.\(^9\)

In Kazakhstan, the 2014 integrated bio-behavioral survey (IBBS) found HIV prevalence among prisoners at 3.9 percent.\(^10\) In the Kyrgyz Republic, the 2013 IBBS found HIV prevalence among prisoners to be 7.6 percent.\(^11\) HIV prevalence was twice as high among prisoners who had stayed in prisons for one to three years than those who had stayed in prison less than one year (10 percent versus five percent), possibly indicating high rates of HIV transmission in prisons. In Tajikistan, a 2013 sentinel surveillance survey found HIV prevalence among prisoners to be 8.4 percent.\(^12\)

Based on the latest published available data from October 2015, which include both pre-trial detainees/remand prisoner and those who have been convicted and sentenced, there are 41,333 prisoners in Kazakhstan (234 per 100,000 population), 9,729 in Kyrgyz Republic (166 per 100,000 population), and 9,317 in Tajikistan (121 per 100,000 population).\(^13\) Annex II (Figures 1–3) contains available data on the number of PWID, the number of prisoners with known HIV status, and the number of prisoners with HIV status who are receiving ART in 2016 by region (subject to availability of data). Data on the total prison population covered by the HIV React project in 2016 is in Annex II (Tables 2– 4).\(^14\)

Penal system medical departments are separate from and not under the control of ministries of health. They are under-funded and experience high staff turnover and staff shortages. Most prisons in Central Asia lack personnel who have sufficient knowledge and experience in administering ARV and tuberculosis (TB) treatment and managing side effects. Access to timely viral load (VL) testing in prisons is variable. AIDS Center specialists visit prisons upon request from prison officials and prescribe ARV treatment to prisoners, but they are not able to monitor and supervise treatment adherence regularly.

Prison policy is total eradication of drug use in prisons. As a result, prison authorities deny drug use and the official number of drug users in prison is artificially understated. This is an obstacle for harm reduction interventions (needle exchange and medication assisted treatment (MAT)), and also creates difficulties for HIV prevention programs seeking to identify PWID in prison.

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\(^12\)World Health Organization Regional Office for Europe, HIV Programme Review in Tajikistan. Evaluation Report. 2014. p. 8. The survey was conducted in only four prisons in two cities so may not be representative.


\(^14\)Data provided by AFEW Kazakhstan. Technical and Cost Application, June 2016-December 2019 document. Please note that prison populations are highly dynamic and data presented in Annexes 1 and 2 represent cross-sectional data available in 2016.
2.2 OVERVIEW OF THE HIV REACT PROJECT

The goal of the HIV React Project is to “expand coverage and service provision for key populations (KPs) in prisons and after release in accordance with the PEPFAR 90-90-90 goals.” These goals are that by 2020, 90 percent of all people living with HIV will know their HIV status; 90 percent of all people diagnosed with HIV infection will receive sustained ART; and 90 percent of all people receiving ART will have viral suppression. HIV React’s target groups are male and female PWID, ex-PWID and PLHIV in prisons, and, following their release, the sexual partners of PLHIV and PWID. The objectives of HIV React are, with key activities listed under each objective, are:

1. To increase coverage of PWID by HIV testing and counseling services.
   - Promotion of HTC to PWID in prisons through educational mini-sessions, project peer navigators and information and educational materials (IEM) for prisoners.
   - Organizing HTC testing weeks for PWID in prisons every six months.
   - Promoting HTC to all released PWID and the sexual partners of PWID and PLHIV

2. To create conditions for increasing access of PLHIV to ARV treatment.
   - Promotion by peer navigators, NGOS, and IEM of timely initiation of ART.
   - Provision of information to prison staff, service providers, and NGOs to promote best practice approaches to ART.

3. To create conditions for maintaining adherence to ART.
   - Promotion by peer navigators, NGOs, and penal medical staff of adherence among PLHIV in prisons and for up to six months after release.
   - Provision of counseling, education, support groups, and social support for PLHIV in prison and after release.
   - Ensuring a continuum of care for PLHIV receiving ART in prison and after release.
   - Creation of conditions to improve the quality of life of PLHIV in prisons and after release through reducing HIV-related stigma and discrimination.

HIV React’s START Plus initiative provides transitional client management to PLHIV to help them to reintegrate in society after release from prison and maintain ART enrollment and adherence. START Plus provides six sessions with clients, two prior to release, and four following release, plus one-to-one support post-release. Sessions focus on post-release linkage to ART; re-integration needs (e.g., recovering identity documents, finding accommodation and employment, etc.), HIV and drug use risk behaviors, and criminal relapse risks.

HIV React supports working groups at the local level in project sites to enhance collaboration between NGO implementing partners, prison medical departments, AIDS Centers, and Narcology Centers.

HIV React was initially funded for two years from June 2014 and received a cost and time extension from June 2016 to December 2019, at which time it pivoted to support the 90-90-90 objectives. The project is currently implemented by six NGO sub-awardees in the following PEPFAR sites:

- Kazakhstan: Ust-Kamenogorsk (Answer – 6 prisons) and Pavlodar (Gerlita – 3 prisons)
- Kyrgyz Republic: Bishkek (AFEW Kyrgyz Republic – 4 prisons) and Chui Oblast (Harm Reduction Network – 2 prisons)
- Tajikistan: Dushanbe (SPIN Plus – 2 prisons) and Khujand (Hayeti Nav – 2 prisons).
3. FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

3.1 KAZAKHSTAN

Phase I of HIV React in Kazakhstan was implemented in Almaty Oblast by the NGO Doveriye Plus and in Ust-Kamenogorsk, East Kazakhstan oblast (EKO) by the NGO Answer, from June 2014 to June 2016. The initial scope of activities included HIV prevention among the general prison population and implementation of the START Plus case management model for social reintegration of prisoners after their release.

In Phase II of HIV React, from July 2016, in compliance with PEPFAR’s geographic prioritization, HIV React shifted its activities from Almaty to Pavlodar oblast. This required the selection of a new local NGO implementation partner. In consultation with Pavlodar Oblast AIDS Center, the Penal Department and other stakeholders, the NGO Gerlita was contracted. Although Gerlita does not have prior experience of working in prisons, it has strong expertise in managing prevention programs among PWID, many of whom are former prisoners. In addition to Gerlita’s solid reputation among key partners in the oblast, it has several ex-prisoner employees that are a valuable asset for peer-led education and other interventions.

3.1.1 Achievements

**Reorientation to 90-90-90 programming:** In addition to the geographic shift of activities in Phase II of the project, HIV React re-focused its HIV services to specifically target PLHIV and PWID, as key drivers of the epidemic. Documents reviewed and interviews with implementing partners (IPs) indicated that under Phase II of the project, HIV prevention activities are focused on PWID and PLHIV; there is a greater emphasis on improving HIV and ART literacy through peer education and support for ART adherence; and social reintegration support after release places higher priority on linking PLHIV to the public healthcare system to support ART adherence and retention.

During Phase I of HIV React, 114 PLHIV had been detected in the three prisons in Almaty oblast where Doveriye Plus was working, and 45 of these PLHIV, (39 percent), had commenced on ART. ART eligibility for prisoners was <350 CD4, which may explain the low uptake rate. In Pavlodar, there are currently 58 PLHIV who know their status in the prisons being served by Gerlita, of whom 28 are currently eligible for ART (<500 CD4). Twenty-two are currently on ART (79 percent of those eligible), with six having refused treatment. Gerlita and the Pavlodar AIDS Centre reported that the main reasons for treatment refusal are self-denial of HIV status and fear of side effects. In Ust-Kamenogorsk, 126 PLHIV have been detected in the six prisons where Answer is working and 88 (70 percent) are currently on ART.

**Improved communication between prison authorities and AIDS Centers:** According to staff of AIDS Centers, the lack of timely notification about PLHIVs’ release from prisons was one of the key factors that negatively impacted patient adherence to ART after release. Joint trainings by HIV React for AIDS Centers and penal health department staff has helped to improve communication of prison health authorities with AIDS Centers. As a result, the penal
medical department routinely informs AIDS Centers and NGOs prior to the release of PLHIV from prison, which minimizes loss to follow-up (LTFU) rates.

**Rapid roll-out of activities in prisons**: Although AFEW/KZ had limited engagement with Committee of the Criminal-Executive System (KUIS) due to lack of a signed Memorandum of Understanding (MoU) that is required for starting activities in prisons, Phase I project activities in prisons started soon after AFEW/KZ signed contacts with NGO implementing partners as the latter already had MoUs with local prison authorities.15

**Meeting program targets**: In Phase I of HIV React, Doveriye Plus and Answer were very successful in achieving project targets. The targets of reaching 3,000 prisoners with prevention activities during the first two years were exceeded by nearly 13 percent (3,380 persons reached).16 Although Answer reached 615 prisoners with prevention activities in Year 2, versus a target of 850, this was due to no access to prisons in fiscal year (FY) 2016 Quarter 4 due to delays in renegotiating its MoU with local prison authorities.

**Expanded prison coverage**: In Ust-Kamenogorsk, the number of prisons covered doubled from three in Phase I to six in Phase II. Of those six penitentiary institutions, one is a medical colony for TB treatment and one is a female colony with 295 convicts. Expansion of prisons covered was possible due to Answer’s good relationship with the EKO AIDS Center and local prison authorities.

### 3.1.2 Strengths

**Strong implementing partners**: Gerlita, Answer, and Doveriye Plus are very experienced NGOs with strong reputations among stakeholders interviewed. Answer and Doveriye Plus are peer-led organizations that have been providing a comprehensive set of HIV prevention and social support services for PWID and prison populations for some years. Leaders of Answer and Doveriye Plus have personal experience of drug use and serving prison sentences that gives them considerable trust among the clients they serve. Gerlita comprises a team of health and lay workers, including those with a history of drug use and imprisonment.

**Strong collaboration with oblast AIDS Centers**: Staff of AIDS Centers in Pavlodar and Ust-Kamenogorsk underlined their satisfaction with the level of collaboration with HIV React. Answer and Gerlita regularly meet with the heads of AIDS Centers, engaging them in project planning activities, seeking their advice in setting priorities, and identifying opportunities for joint actions. In both of the oblasts, NGO IPs organize joint visits to prisons to conduct seminars, peer counseling after HIV testing, and prison staff trainings. In addition, both Oblast AIDS Centers were appreciative of HIV React support in addressing LTFU problems among ex-prisoners, following their release.

### 3.1.3 Weaknesses

**Lower viral suppression rates among prisoners**: According to the staff of the AIDS Center in Ust-Kamenogorsk, prisoners have lower VL suppression (>50 percent) compared to

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15 HIV React Project Quarterly Performance Report Year One, Quarter Four.
16 KP_PREV 2014-2016.xlsx file with APR Y1 and APR Y2 data received from Roman Dudnik on 21 November 2016.
general population (~75 percent). NGO and AIDS Center respondents noted that this is associated with low adherence to ART, which in turn is influenced by low levels of HIV treatment literacy, widespread myths about ART, and fears about side effects.

**Lack of directly observed therapy (DOT) for ART:** Both NGO and AIDS Center staff indicated that ARV drugs are given to PLHIV in prisons to take when they choose. Given the low levels of HIV treatment literacy, adherence rates are low, as indicated by the VL data. Administration of ARVs using a DOT approach, along with improved prisoner education, could help to address the problem.

### 3.1.4 Constraints

**Limited time and regularity of visits to prisons by NGOs and AIDS Centers:** Prison rules and the remoteness of some prisons make it difficult to organize more than one or two visits to each prison per month. The time of visits is usually restricted to no more than two and a half hours, which does not allow sufficient time for individual consultations.

**Mini-sessions for prisoners in the presence of guards:** HIV React NGO mini-sessions for prisoners and meant to be interactive. These sessions include content on drug use and sexual behaviors that are illegal in prisons. Due to security rules, prisons guards are always present at these sessions (see photo). Implementing partners reported that prisoners will not ask questions or engage in discussion in the presence of guards, who are not trusted. This results in didactic sessions, which limits their effectiveness.

**Limited access to Medication Assisted Therapy upon release and lack of relapse prevention services:** MAT is currently not available in prisons. Although Kazakhstan is gradually increasing the number of out-of-prison sites offering MAT, current restrictions on the number of patients per site (50-75) seriously limits access. Currently, MAT sites in Pavlodar and Ust-Kamenogorsk are fully enrolled, meaning there is no access to MAT for PWID upon release from prison. Drug users who may be forced to abstain from drugs while in prison very often relapse into drug use soon after their release. The provision of MAT in prisons would help to address this problem and should be on HIV React’s advocacy agenda. In Kazakhstan, there are no low-threshold relapse prevention services for ex-prisoners.\(^{17}\) Nor are there opioid overdose prevention interventions for ex-

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\(^{17}\) Low threshold relapse prevention services include free or very low cost outpatient services run by drug users and other volunteers such as Narcotics Anonymous; SMART Recovery’s INSIDE OUT programs designed specifically for convicted drug users and those who are from penitentiary institutions (http://www.smartrecovery.org/resources/correctional.htm).
prisoners, even though global data indicates that overdose-related mortality among ex-prisoners is higher than for all other opioid drug users.18

**Peer counselors cannot enter prisons in Pavlodar:** Unlike in Ust-Kamenogorsk, peer counselors who have served prior prison sentences are not allowed to enter prisons in Pavlodar oblast. This limits Gerlita’s ability to communicate health-related information through peer education. As a consequence, Gerlita’s peer counselors are restricted to working with ex-prisoners. The issue of NGO staff who are ex-prisoners being denied access to prisons should be addressed through HIV React advocacy, in partnership with organizations such as UNODC and LEADER.

**Decreased funds for ARV procurement:** Due to the devaluation of Kazakh Tenge, Pavlodar Oblast AIDS Center had to limit its procurement of ARVs and set limits for enrollment of new patients. Although ARV eligibility in Kazakhstan is a CD4 count below 500, ARV initiation was restricted to those with a CD4 count below 350 and who were assessed as likely to be adherent. Following provision of additional funds by the Ministry of Health (MOH), the Pavlodar AIDS Center now has sufficient ARV supply and the problem is unlikely to recur with the cheaper procurement of ARVs from 2017 through UNICEF.

**Non-Kazakh prisoners do not have access to free HIV services:** National regulations do not provide for free health care for non-Kazakh citizens in either public or prison settings. This includes HIV testing and treatment. AFEW/KZ facilitated the agreement of the Kyrgyz Republic Republican AIDS Center (RAC) to provide free ARV to a female Kyrgyz citizen who is an inmate of a Kazakhstan prison. This requires the transport of the ARV supplies from Bishkek to Almaty every three months. AFEW/KZ reported that in 2016 there were approximately 87 foreign prisoners in Kazakhstan penal institutions, none of whom would be eligible for ART provided by the Kazakh Government. As this is a significant number of prisoners, HIV React should prioritize this as a regional advocacy issue, in collaboration with UNODC and LEADER.

### 3.1.5 Gaps

**No post-release support services in Almaty:** Provision of post-release support services to PLHIV ex-prisoners aims to ensure their linkage to AIDS Centers and is key to achieving continued adherence and retention. In Phase II, with the closure of HIV React activities in Almaty, START Plus services are no longer available. No other project is providing HIV-related post-release support services in Almaty. As the largest city in Kazakhstan, Almaty attracts large numbers of post-release ex-prisoners from other regions. Doveriye Plus data for Year 2 indicates that 58 (38 percent) of the 153 PLHIV ex-prisoner residents of Almaty receiving START Plus support were from other regions of Kazakhstan. The number of ex-prisoner PLHIV residing in Almaty may be higher as most of these 58 Doveriye Plus START Plus clients would have been serving prison sentences in Almaty and linked into post-release support. It is likely that many other ex-prisoners who were incarcerated in other regions are migrating to Almaty post-release. Given the large number of PLHIV ex-prisoners who reside in Almaty, the absence of START Plus post-release services in Almaty is a missed opportunity for maximizing adherence.

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and retention in care post-release. USAID/CA and AFEW/KZ should examine whether cost savings can be found to allow the re-commencement of START Plus activities in Almaty. This would require PEPFAR approval.

**Transitional housing for post-release clients:** Some ex-prisoners have no housing following their release. HIV React NGO implementing partners reported that temporary transitional housing helps with social reintegration and ART adherence and retention, and reduces criminal recidivism. In Kazakhstan, HIV React does finance transitional housing. In Ust-Kamenogorsk, Answer has been able to source funding from non-HIV React sources to provide transitional housing for up to eight persons. However, by the end of 2016 the funding will cease.

### 3.1.6 Recommendations

1. **PEPFAR, USAID/CA, and AFEW Kazakhstan** should consider the feasibility of making cost savings within the HIV React Project to allow for provision of START Plus post-release support services in Almaty to maximize adherence and retention in HIV treatment for the large number of ex-prisoners who reside in Almaty.

2. **USAID/CA and AFEW Kazakhstan** should investigate the possibility of supporting transitional housing for PWID and PLHIV post release at each project site.

### 3.2 KYRGYZ REPUBLIC

Phases I and II of HIV React in the Kyrgyz Republic (KR) have been implemented by AFEW/KR and the Harm Reduction Network (HRN). In Phase I, AFEW/KR was responsible for all work in prisons and the HRN was responsible for post-release work through implementation of START Plus. The division of labor has changed in Phase II, with AFEW/KR now responsible for implementing HIV React in four prisons and providing START Plus services to inmates from those prisons and HRN implementing HIV React in two prisons, including START Plus activities. It was decided by AFEW/KZ that this was a better division of labor given coordination problems between the two implementing partners during Phase I.

#### 3.2.1 Achievements

A number of HIV React’s most significant achievements in the Kyrgyz Republic were the result of AFEW/KR’s engagement at the policy level to foster coordination across the health and penal systems and institute policy change designed to improve HIV service delivery for prisoners and ex-prisoners following their release.

**Multisectoral engagement in the policy arena:** AFEW/KR worked with the State Service on Penalty Execution (SSPE) (the penal department) to create and institutionalize an expert working group to improve coordination of the work of the penal medical service and the Republican AIDS Center and the Republican Drug Treatment Center. The working group was officially established by an Order of the President’s Office and an Order of the SSPE, with the goal of improving medical services for PLHIV and HIV prevention for PWID in prisons, ensuring

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19 Recommendations which contain bold text in their first line are high priority recommendations. All recommendations are listed in priority order.
HIV-related services for post-release prisoners, and developing solutions to ongoing problems. AFEW/KR serves as the Secretariat of the working group and HRN participates in meetings. Through the working group, AFEW/KR has assisted with developing the draft national law on probation, and national guidelines that addressed gaps in the prison regulatory framework related to HIV.

AFEW/KR identified a gap in policy for transitional support for PLHIV prisoners upon release from detention centers. HIV React supported the working group to draft the law on probation, which provides for prisoners to receive social, medical, and legal support before and after release. This proposed law has passed the second stage of parliamentary approval and AFEW/KR reports that it is likely to become law.

The working group, with AFEW/KR support, also developed an SSPE Instruction on Implementation of Harm Reduction Programs in the Penitentiary Facilities to delineate prison staff responsibilities for prison needle and syringe exchange and MAT programs and an SSPE Instruction on HIV and STI Prevention and Treatment in Detention, which provides clinical updates based on national clinical protocols and international recommendations.

**Improved coordination between government entities:** The RAC and penal medical department stated that HIV React has successfully facilitated their improved coordination, which has resulted in improved monitoring of patient clinical information. Since the project’s inception, HIV React worked with the RAC to monitor the quality of HIV prevention, treatment, and care and support services in project sites, providing recommendations for improving these services. Prison doctors then reported progress related to these recommendations on a quarterly basis. The RAC undertook monitoring visits of project sites in April 2016 and noted that ART clinical management had improved considerably. Most notably, PLHIV who were in need of ART in accordance with clinical criteria were receiving it and viral load testing and CD4 counts were being undertaken on a more regular basis, although there is still considerable room for improvement (see Constraints, below). These achievements have resulted from HIV React’s work in arranging regular prison visits by RAC doctors to the prison facilities to initiate ART and assist prison doctors with clinical management of PLHIV.

**ART prescribed by prison doctors:** In Phase I, HIV React successfully trained more than 120 prison doctors and nurses to enhance their knowledge of HTC, ART, MAT, and sexually transmitted infections (STIs) and to foster their ability to provide related services, particularly prescribing ART to minimize delays in treatment initiation. In Years 1 and 2, 96–97 percent of prison health staff passed the post-training exam, exceeding the target of 75 percent. AFEW/KR reported that of the 160 PLHIV prisoners identified in the four prisons where they are working, 131, or 82 percent, are currently receiving ART. This represents a high ART

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20 HIV React Project, Quarterly Performance Report: Year 2, Quarter 1, 2016.
23 HIV React Project, Annual Performance Report: Year 2, 2016. Viral load testing is currently not reported by HIV React as a Monitoring, Evaluation, and Reporting (MER) indicator.
uptake rate. ART initiation by prison doctors is only being undertaken in the Kyrgyz Republic and not in Kazakhstan or Tajikistan, where ART initiation is undertaken by visiting AIDS Center doctors. Prison doctors in the Kyrgyz Republic also undertake a more significant role in ongoing clinical management of prisoners on ART (with RAC support), compared to Kazakhstan and Tajikistan. This has the advantage of being more sustainable and accessible, as it removes the need to wait for the RAC doctor’s prison visit. The weak state of prison medical services, however, impacts on the quality of care provided to prisoners in the Kyrgyz Republic (see constraints, below).

In the second year of the project, the number of specialists trained in evidence-based and human rights-based service provision far surpassed the target of 392 with 713 trained. In addition, in Phase I, AFEW/KR trained 550 non-medical prison officers on HIV, stigma and discrimination, and HIV prevention. AFEW/KR also trained more than 90 social workers from prisons and NGOs to build their knowledge on HIV, harm reduction, and viral hepatitis.

**Effective transition to Phase II programming:** In the first quarter of Phase II programming (FY 16, Q4), HIV React’s NGO implementing partners reached 575 PWID in prison with individual counseling or small group mini-trainings on HIV prevention and HTC promotion, which was 153 percent of the quarterly target. Some 366 PWID were tested for HIV and know their results, which was 108 percent of the quarterly target. A representative of the Global Fund Principal Recipient (UNDP) informed the evaluation that the number of prisoners having HIV tests is higher in prisons where HIV React is working compared to GF-supported prisons, although data to support this claim was not available during the interview. In addition, 243 PLHIV prisoners received counseling to start ART and/or adherence to treatment. START Plus programming has been particularly strong, with 243 PLHIV ex-prisoners receiving care and support services outside of a health facility, which exceeded the quarterly target by 972 percent.\(^\text{25}\)

**Systems developed to share data across government agencies:** Since the prison medical departments fall under the SSPE and not the MOH, a coordinated effort is needed to share health information on prisoners. Recognizing this need, the expert working group developed a unified reporting form to ensure coordinated information exchange between prisons and the RAC. These forms were approved by the SSPE in February 2015.\(^\text{26}\) As a result, medical departments of all prisons in the Kyrgyz Republic are now required to provide information about prisoners with HIV and prisoners who receive ART to the RAC through these forms. Once data is entered into the e-system, it is available to all AIDS Centers in the country. This facilitates the care and treatment of post-release prisoners, along with tracking HIV cases in the country. It also assists AIDS Centers in planning for ARV commodity provision for the prison health system.\(^\text{27}\) HIV React’s support for this initiative can be regarded as an example of best practice.

\(^{26}\) Penal order ref. #46 February 2, 2015.
\(^{27}\) HIV React Project, Annual Performance Report: Year 2, 2016.
**Post-release social support improved adherence:** Recognizing that post-release prisoners have a range of social support needs, including accommodation, that must be addressed before they focus on their health, HIV React supports the NGO Ranar to provide a social dormitory for up to seven recently released male PLHIV prisoners. (It is estimated that approximately 35 PLHIV are released annually from the six prisons where the project is working in the Kyrgyz Republic.) The Ranar social dormitory provides men with housing for six to eight months, including meals, health assistance, and psychosocial and legal support. Ranar assists PLHIV in registering at local AIDS Centers and supports adherence to ART and MAT. Ranar reported that they have seen an increase in ex-prisoners’ ability to adhere to ART once their immediate needs of housing and employment are met. This is especially important given that a range of key informants reported that post-release prisoners are less likely to be adherent to ART than those in prison.

**3.2.2 Strengths**

**HIV React works directly with prisoners:** The work undertaken by HIV React in Kyrgyz prisons is more comprehensive than other prison programs in the country in that it involves working directly with PWID prisoners in HIV prevention mini-sessions, targeted promotion of HTC, linking PLHIV to treatment, support for adherence and retention in prison, and transitional support for ex-prisoner PLHIV and PWID through START Plus, with an emphasis on linkages to ART treatment post-release. HIV React’s activities are complemented by Global Fund support for MAT, ART, and Needle and Syringe Program (NSP) in prisons and CDC’s support of ART, MAT, and TB in some prisons. UNDP’s Global Fund representative stated that HIV React’s work was the more effective as it involved working directly and closely with prisoners, which was beyond the capacity of the Global Fund project.

**AFEW/KR plays an advocacy role:** AFEW/KR has taken advantage of the more open political environment in the Kyrgyz Republic and played a valuable role in advocacy and in addressing systems problems in prisons. This is evidenced in their extensive work organizing the multisectoral working group to address policy gaps related to HIV issues for prisoners and support provided to produce policy documents.

**HIV React works closely with the Penal System and RAC:** HIV React has been successful in establishing close working relationships with the penal medical department and the RAC. As described under Achievements, AFEW/KR has helped strengthen cooperation between the two entities. As part of this cooperation, HIV React fostered regular monitoring of prison HIV services, in coordination with the penal system and the RAC. Respondents noted that monitoring of patients has improved. Respondents reported that prior to this monitoring, PLHIV were not receiving physical exams, CD4 counts, or VL testing. In addition, doctors in prisons were not prescribing ART without first consulting with the RAC, even though prison doctors are allowed by law to initiate ART. AFEW/KR indicated that training of doctors has facilitated further initiation of ART in prisons, as they are now more confident in their skills. In addition, the prison health staff notify the RAC before starting a patient on ART. Furthermore, the RAC has indicated that HIV React has assisted them in obtaining information on PLHIV in prisons, which was an issue before the project started.
Complementary implementing partners: HIV React’s two main implementing partners in the Kyrgyz Republic, AFEW/KR and HRN, have complementary skill sets. AFEW/KR has a high level of competency in advocacy and policy development and serves as the Secretariat for the working group. This role has facilitated policy advancements and provided HIV React with the opportunity to have a voice as a “watchdog.” The HRN is a strong, peer-based NGO with a history of direct service provision in prisons. HRN has strong relationships with both prisoners and the penal system. As an NGO that is founded and run by PWID, HRN is seen as one that understands PWID/prisoner issues and as noted by PWID focus group discussants, also serves as inspiration to PWID on living positively and sober.

3.2.3 Weaknesses
HIV React weaknesses in the Kyrgyz Republic largely center around complex relationships between the various project actors.

Strained relations between NGOs: Respondents indicated that there is some tension between the two implementing NGOs in the Kyrgyz Republic, AFEW/KR and HRN, that appears to relate to the different organizational cultures. AFEW/KR it is not seen as an NGO from and of the “community” (i.e., PWID and ex-prisoners). Even though AFEW/KR employs peer consultants who are peers to PWID and prisoners, it is seen as more of a professional policy and advocacy organization that may not completely understand the lives of prisoners and post-release prisoners. While the complementary skills of the two HIV React implementing partners are a strength, it can also lead to tensions from time to time.

The new division of labor in Phase II requires a lower level of collaboration between AFEW/KR and HRN. It is too early to determine if this approach has improved project outcomes, especially as indicator data, disaggregated by NGO, were not available to the evaluation team.

HRN has reservations about HIV testing of PWID in prisons: During its evaluation interview, HRN expressed the view that HIV testing targeting PWID, a key objective of the project, should not be conducted in closed prisons. HRN stated that anyone testing HIV positive in prison would be seen as a current injecting drug user and targeted by prison authorities and other prisoners. Instead, HRN argued that prisoners in pre-trial detention centers should be targeted for HIV testing, as it is a population with higher turnover and it would be less likely for PWID to be identified to others. Despite HRN’s stance, AFEW/KZ stated that HRN is undertaking HTC promotion in the two prisons where they work. Unfortunately, the evaluators were not able to access NGO-level results in the Kyrgyz Republic, so there is no basis for assessing the results of HRN’s promotion of HIV testing in these prisons.

3.2.4 Constraints
There are numerous constraints in the Kyrgyz Republic that affect HIV React’s ability to implement project activities, both at the systems level and social level.

Prison HIV services are highly variable: The majority of respondents noted that in the Kyrgyz Republic, the quality of prison HIV services is highly variable. This is largely due to prison health services falling under the penal system, rather than the MOH, and not having sufficient resources for the role they play. According to respondents, prison health staff are usually less
experienced and may be less educated than those in the public health sector. Since there are few specialists, many prison health staff do not have sufficient HIV expertise. Furthermore, there is high staff turnover, resulting in 40 percent of prison health positions being vacant. The penal system explained that these positions carry a heavy workload and have low salaries, resulting in high turnover and vacancies. Several respondents discussed a proposal to move the penal health system under the MOH, but the penal system stated that this is currently on hold.

Overall, it appears that the Kyrgyz Republic has poorer HIV treatment outcomes than is the case for other project countries. For example, VL and CD4 testing is conducted more regularly in Kazakhstan and Tajikistan. The limited available data on VL testing indicates higher rates of VL suppression in Kazakhstan and Tajikistan than is the case in the Kyrgyz Republic. A possible reason for these cross-country differences in standard of care may be that HIV clinical management of prisoners in Kazakhstan and Tajikistan is primarily provided by AIDS Centers, whereas in the Kyrgyz Republic, visiting AIDS Center doctors play a lesser role, with the prison medical department providing the bulk of the care. It may be that the weak state of the prison health system, despite HIV training, is contributing to a lower standard of care in the Kyrgyz Republic.

**Low levels of trust in prison health staff:** Prisoners’ attitudes to prison health staff are influenced by the lack of trust and conspiracy theories that are common in prisons. IPs reported that prison doctors are seen as guards, since they are part of the penal system. The majority of respondents reported that male prisoners do not trust prison doctors, which impacts their willingness to seek medical care. One respondent stated that some prisoners think that prison doctors receive incentive payments for HIV treatment and so falsely diagnose patients with HIV to boost their income. As a result, some prisoners reject an HIV-positive diagnosis. In other cases, some prisoners think that ART is being administered in prisons as an experiment.

HIV React NGOs reported that prisoners understand that prison health staff may have less expertise than outside specialists. RAC doctors are more trusted than prison health staff, as are HIV React peer consultants and social workers. While this is a significant issue for male prisoners, it is worth noting that both the prison health staff in the women’s prison and the female prisoners reported that women have very good relationships with the prison doctors.

**Limited notification of HIV test results:** HIV React NGOs reported that prisoners who test HIV-negative are never informed of their test result by the penal medical department. The opportunity to reinforce the need for safe behaviors in post-test counseling is therefore missed. NGOs and some ex-prisoners also reported instances of prisoners who tested HIV-positive not being informed of their test result. It was not possible to determine the frequency at which this occurs. One ex-prisoner interviewed indicated that he first found about his HIV-positive status when he had an HIV test after being released from prison. At that time he was informed by the RAC that he was already on their HIV-positive database from a test that was conducted in prison.

The reason why some HIV-positive prisoners are not informed of their test results is not clear. Responsibility for communicating HIV-positive test results rests with two epidemiologists employed by the penal medical department. Lack of notification may relate to the limited number of these positions that work across all prisons, and their workload, or logistical issues
like transport to prisons. The RAC stated that the doctor who provides pre-test counseling can also inform the patient of their HIV-positive test result and that on some occasions RAC doctors inform prisoners of their HIV-positive test result. The RAC stated that confirmatory testing previously took two to three weeks and prisoners may have been moved to another prison or released prior to the result being available. It is unclear what the actual standard of practice is regarding who is formally responsible for communicating HIV-positive test results in prisons, but clear that implementation needs to improve.

**Irregular patient monitoring and low ART adherence:** Monitoring data shared by the RAC indicates that around 50–55 percent of HIV-positive prisoners have undetectable VL, which was reported to be 10–15 percent less than for non-prisoner PLHIV. However, according to the penal medical department, around 30 percent of prisoners on ART have undetectable VL. This correlates with prison health staff reports from Prison #31 that 30 percent of PLHIV on ART in that prison have undetectable VL. Respondents in the women’s prison reported that 9 out of 10 women on ART have undetectable VL, so low adherence may be specific to men. This is likely due to the administration of ART in women’s prisons, which is done through DOT. In men’s prisons, PLHIV are given ART to take on their own. While the data on VL vary, it is clear that ART adherence in prisons is a problem.

While CD4 and VL testing is reported to now be undertaken more frequently than was previously the case, most respondents stated that these tests are not performed on a regular basis. A contributing factor is that blood needs to be transported to external laboratories, but no regular pathology transport system exists, which means that staff need to transport samples by public bus or wait until an RAC doctor is visiting the prison. Prison medical staff also reported that some patients don’t have VL tests because their veins are damaged, making it difficult to get blood samples. They stated that it would be easier to use dry blood spot-based VL testing.

**PLHIV enroll in ART to access food packages:** With Global Fund support, HIV-positive prisoners who initiate ART are provided with food packages. AFEW/KR and prison medical staff noted that many prisoners initiate ART specifically to access the food support and then do not take ART. It is likely that this contributes significantly to the low level of viral suppression among PLHIV prisoners. Provision of food packages is a strong incentive as normal prison food was reported to be very poor. The expert working group plans to discuss the issue of food incentives for ART initiation at its next meeting.

**Reduced social support for PWID and PLHIV:** Since donor support for prison programming has decreased in the Kyrgyz Republic, respondents reported that there are fewer social dormitories for post-release ex-prisoners. Respondents cited this as a particular concern for post-release prisoners, especially those who are HIV-positive. Currently, only the HIV React and GF-supported Ranar House is available for post-release prisoners as temporary housing. However, this is only for men and there is no longer any housing support for women post-release.

**3.2.5 Gaps**

**Tracking PLHIV ex-prisoners post-release:** Although HIV React has been effective at providing post-release prisoners with support in Bishkek and Chui oblast, where the project
operates, there are no systems in place to ensure that post-release ex-prisoners reach AIDS Centers and social services outside of the project implementation sites. In the Kyrgyz Republic, most of the prisons are in Bishkek and Chui oblast in the north of the country. Post-release ex-prisoners from the southern part of the country are not tracked and HIV React is not able to assess longer-term client outcomes, such as retention in HIV treatment.

**Lack of data:** Data reported from the Kyrgyz Republic was not disaggregated by NGO, so it is not possible to assess NGO-level results. Since both NGOs are now implementing the same activities in different sites, it will be important to track NGO-level results to assess their achievements. This is discussed further in the M&E Section.

**Penal settlement colonies:** The penal system and AFEW/KR reported that penal settlement colonies do not provide health services to residents. Penal settlement colonies are low security penal institutions where provision of health care is not the responsibility of either the MOH nor the penal medical department. Residents of these colonies are supposed to access health services from local public facilities. AFEW/KR reported that there is no system of communication between closed prisons and settlement colonies, and prisoners’ ART needs may not be taken into account when they are transferred to a colony. HIV React has initiated work related to HIV testing services (HTS) in settlement colonies, but there are no planned activities to address ART in these sites. The Instruction on HIV and STI Prevention and Treatment in Detention address this issue, but the instruction is not being fully implemented.

**Gender Based Violence (GBV) programming:** Current HIV React activities include GBV groups in the women’s prison. While it is important to provide a space for GBV awareness and support for women, it is equally important to work with men on GBV prevention. HIV React is not addressing this issue in the men’s prisons and it does not appear that there are other activities in the Kyrgyz Republic that can be leveraged for this purpose.

### 3.2.6 Recommendations

1. **HIV React should work through the quarterly expert working group,** UNODC, and LEADER (as appropriate), in consultation with prisoners, to:
   a. Promote discussion of strategies to increase adherence to ART, both related to the Global Health funded food packages for PLHIV on ART and initiating different approaches to foster adherence (e.g. DOT, peer navigator or PLHIV peer support, etc.);
   b. Include social dormitories in the upcoming Global Fund proposal, including one for women;
   c. Support systems improvement to ensure all HIV-positive and HIV-negative prisoners are informed of their test results; and
   d. Support moving the penal health services under the Ministry of Health.

2. **HIV React should work with peer navigators to promote CD4 and viral load testing** and communication of results, in collaboration with prison health staff and the RAC.

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28 Recommendations which contain bold text in their first line are high priority recommendations. All recommendations are listed in priority order.
3. HIV React should assess the needs of settlement colony prisoners related to ART, including the number of PLHIV transferred to settlement colonies and the number of people testing HIV-positive at HTS events in settlement colonies. If needed, HIV React should share findings with the working group to discuss possible next steps to address policy and service implementation gaps.

4. USAID Central Asia should support conflict resolution and mediation for NGO implementing partners, in partnership with AFEW/KZ.

5. HIV React should assess opportunities to provide GBV prevention education to male clients or leverage existing opportunities in this area.

### 3.3 Tajikistan

In Phase 1 of the project (October 2014 – May 2016), HIV React implementing partners in Tajikistan were AFEW/Tajikistan, NGO VITA, and Hayoti Nav. These NGOs worked with the general prison population in four areas: Dushanbe, Yovon, Nurek, and Khujand. Yovon and Nurek were dropped from Phase II as they are not PEPFAR priority regions. AFEW/KZ conducted a competitive selection process for Phase II partners. Hayoti Nav was chosen to continue work in Khujand and SPIN Plus was chosen as the new partner for Dushanbe. VITA’s application for Phase II was unsuccessful. AFEW/TJ did not apply. Service delivery for Phase II began toward the end of FY16 Q4.

#### 3.3.1 Achievements

**Reorientation to 90-90-90 programming:** In Phase 1, implementing partners provided 179 transitional prisoners (pre- and post-release) with case management services. The two-year target was 200, resulting in 90 percent of the target being achieved in seven quarters.

During Phase I, NGO Vita served 56 post-release prisoners, which constituted a shortfall against its target. In addition, VITA did not specifically target PWID and PLHIV prisoners during Phase I. In its first two months of operation under Phase II (September-October 2016), SPIN Plus served 16 post-release prisoners, all of whom are PWID and the majority of whom are PLHIV. Clients of SPIN Plus stated in focus group discussions that they appreciated services being delivered by an organization that they consider to be understanding of their situation because it is comprised of and led by peers.

In FY16 Q4, SPIN Plus and Hayoti Nav were able to reach 208 PWID with individual and/or small group HIV prevention interventions in prisons (KP_PREV), representing 55 percent of the quarterly target. In the same quarter, both NGOs reached 202 PWID prisoners with project interventions who subsequently received HTC services (HTC_TST), representing 60 percent of the quarterly target. Although the targets were not met, these were good results given SPIN Plus was at an early stage of implementation, Hayoti Nav’s lack of an MoU with prison authorities which currently precludes their staff from entering prisons (see below), and a temporary reduction in the prisoner population due to a national amnesty in September 2016.

HIV React’s services for PLHIV are intended to motivate PLHIV to initiate timely treatment and to increase adherence to treatment, in accordance with the 90-90-90 strategy. In Dushanbe
In Phase II in Tajikistan, HIV React has made the transition from general prison population HIV prevention activities to HIV case identification among PWID prisoners, linkage to ARV treatment, and achieving adherence and retention in care in both prisons and community-based services. The project now puts less emphasis on training for custodial and prison health staff, has introduced peer navigators in prisons, and made modifications to the START Plus model. START Plus changes include a greater focus on planning post-release transition for PLHIV, including linkages to AIDS Centers to achieve adherence and retention, supported by CD4 and VL testing, and encouraging HIV status disclosure to sexual partners and testing of sexual partners (post-release).

**Timely signing of Phase II MoU by SPIN Plus:** Shortly after being granted its Phase II sub-award in FY16 Q3, SPIN Plus was able to sign a tri-partite agreement with the Republican AIDS Center and the Penitentiary Medical Services to allow access to prisons to implement HIV React activities. Service delivery was initiated immediately thereafter.

**Implementation of HIV testing and counseling by prison medical staff:** During Phase 1, trainings were provided to prison medical staff to help identify high-risk prisoners for HIV testing. This resulted in an innovative approach to provider-initiated counseling and testing by medical staff in Prison #3, who decided to examine medical records for the reasons for incarceration. They looked for a history of drug use or male-to-male sexual behavior, based on conviction codes. As a result, 75 prisoners were tested for HIV, and five HIV cases were detected (three PWID and two sexual transmission cases). HIV React should consider whether this approach to HIV testing can be considered as a best practice approach for increasing yield of HIV testing, for replication in other sites in the three countries.

### 3.3.2 Strengths

**Strong peer-led implementing partners:** The Phase II implementing partners are peer-led organizations that have both expertise and the trust of prisoners, PWID, and PLHIV. SPIN Plus has been working in HIV prevention, care, and treatment for PWID and PWID/PLHIV for almost 10 years. The current agreement with HIV React funds and expands work they have been doing with ex-prisoners. Many clients, staff, volunteers, and outreach workers are former prisoners and PWID/PLHIV. According to clients, SPIN Plus is part of their community. Hayoti Nav was established in 2009 with support from AFEW/TJ to provide support to prisoners and ex-prisoners. Over the course of participating in previous projects and now HIV React, Hayoti Nav has gained expertise in working with PWID and PLHIV. Hayoti Nav clients also stated that they felt a sense of community with the organization. Several clients have become volunteers and outreach workers.
One of the previous sub-awardees, AFEW/TJ, indicated during an interview that they had an ideological problem with peer education in prisons as they believed this work should be done by qualified and certified individuals, despite the fact that there is an extensive international evidence-base for the peer model approach for HIV interventions targeting prisoners and PWID. There had been no dialogue between AFEW/KZ and AFEW/TJ on this issue.

**Strong working relationships with AIDS Centers and prison medical authorities:**
There are excellent working relationships between the HIV React NGOs and the local AIDS Centers and prison medical services. According to the Director of the Republican Penal System Medical Department, the project provides important systemic support by accompanying ex-prisoners to medical appointments and helping them to recover their identity documents post-release from prison. He stated that SPIN Plus had been instrumental in supporting post-release prisoners during the amnesty period, even though they had not commenced full implementation of START Plus at the time. He reported no complications in the shift from VITA in Phase I to SPIN Plus in Phase II.

The Sughd Oblast AIDS Center Director reported a very good relationship with Hayoti Nav and praised them as being the best NGO working in the field of HIV in the oblast. He stated that HIV React had helped to make it possible for the AIDS Center to work in prisons by facilitating the process of an MoU with the Ministry of Justice. He emphasized that two of Hayoti Nav’s biggest contributions are its ability to find ex-prisoners who are LTFU and assisting the AIDS Center with partner contact tracing and testing. In addition, Hayoti Nav informs the AIDS Center of PLHIV known to them who have recently been incarcerated. This enables the AIDS Center and penal medical staff to provide services to them.

### 3.3.3 Weaknesses

**Lack of START Plus post-release support for PWID:** Since the transition from Phase I to Phase II, Hayoti Nav has been exclusively focusing START Plus post-release programming on support for PLHIV ex-prisoners, to the exclusion of HIV-negative PWID ex-prisoners. They provide services to released HIV-negative prisoners by simply referring them to other sources of support (limited) rather than actively assisting. This includes released prisoners who are PWID, who constitute approximately 30-40 percent of released prisoners. AFEW/KZ claims that while START Plus does give priority to post-release support for PLHIV, there should also be post-release support for PWID who are not HIV-infected. AFEW/KZ has indicated that the way Hayoti Nav is implementing START Plus is a misunderstanding and that will be corrected during the next quarterly monitoring visit.

**Lack of promotion for early ART initiation:** Khujand prison medical staff reported that they are moving from prescribing ART for patients with a CD4 count of less than 350, towards Test and Start. They stated that if patients want to begin treatment, ART will be prescribed for them. However, they also reported that since many patients do not feel sick, they do not want to start ART immediately. The doctors stated that they do not advise people to start ART if their CD4 count is still high. Rather, they wait for immunological decline to a CD4 count of 350.

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before actively encouraging patients to start treatment. There appears to be limited promotion about the benefits of early treatment by either doctors or HIV React NGO staff.

**AFEW/TJ and AFEW/KZ relationship:** There continues to be a degree of acrimony between the AFEW/TJ and AFEW/KZ. AFEW/TJ feels that its historical role in the country and USAID HIV prisons programming is being ignored and disrespected by AFEW/KZ. AFEW/KZ feels that AFEW/TJ has been unresponsive to AFEW/KZ as the prime awardee that has responsibilities to USAID. In particular, AFEW/KZ feels that AFEW/TJ was resistant to the 90-90-90 pivot in programming, which was mandated by USAID/CA. There appears to be a failure on the part of both organizations to communicate effectively and move forward to re-establish an effective relationship. Now that the country-based AFEWs are independent organizations, after management was transitioned from AFEW/Amsterdam, there is no mechanism for national AFEWs to mediate and resolve disagreements.

It was beyond the capacity of this evaluation to investigate the history of the relationship between AFEW/KZ and AFEW/TJ in the HIV React Project in sufficient depth to enable conclusions to be drawn. The primary concern of the evaluation team is the negative impact the currently poor relationship will have on future public health cross-project collaboration. For example, USAID/Tajikistan funds AFEW/TJ to conduct TB activities, which includes in-prison work. As both AFEW/TJ and AFEW/KZ are key NGOs in Central Asia, an ongoing healthy relationship is important for public health programming in the region. Efforts need to be made to rebuild the relationship between these organizations. Should this be successful, there may, in time, be a potential technical assistance role for AFEW/TJ in HIV React, given its local knowledge, relationships with implementing partners and geographic proximity.

**Limited engagement with Global Fund:** UNDP is the Global Fund Principal Recipient in Tajikistan for HIV and TB. The Global Fund grant supports activities in prison focusing on prevention and treatment, including assistance for prison medical services. Apart from participation in formal stakeholder meetings, there has been no substantial liaison between UNDP/Tajikistan and HIV React.

### 3.3.4 Constraints

**Access to prisons:** Hayoti Nav has not yet been able to negotiate an MoU to enable its staff to work in Sugd oblast prisons during Phase II of HIV React. During Phase I, VITA and Hayoti Nav staff had access to prisons using the agreement that AFEW/TJ had negotiated with penal authorities. Now that AFEW/TJ is not a Phase II implementing partner, Hayoti Nav staff are not allowed to access prisons, despite the fact that they have worked in prisons in Sugd oblast for many years. AFEW/KZ has stated that they see it as USAID/Tajikistan’s role to support Hayoti Nav to enter into a MoU with the Ministry of Justice as USAID has more influence with the government.

Fortunately, the relationship between Hayoti Nav and the prison medical staff in Khujand is so well established that Hayoti Nav staff are able to undertake some work in prisons on a virtual basis, by having medical staff conduct education sessions with prisoners. Medical staff also provide Hayoti Nav with information on PLHIV and PWID prisoners due for release and provide information to these prisoners on the START Plus post-release program.
Although NGO and AIDS Center staff have a predetermined and approved schedule for their prison visits (with the exception of Hayoti Nav), frequent unscheduled prison lockdowns result in denial of access. Access to transport for visiting prisons is a problem for AIDS Center staff, and this disrupts their clinical monitoring.

**Former prisoners not allowed in prisons:** Another major constraint mentioned by both prison medical staff and implementing partners concerns the refusal of prison officials to allow ex-prisoner NGO staff access to prisons. Prison medical authorities in Khujand felt that it would be helpful if rehabilitated ex-prisoner staff were allowed in to conduct activities in prisons. Two of the three SPIN Plus HIV React ex-prisoner staff have not been granted access to prisons in Dushanbe, although the reason given was not that they are former prisoners.

**Lack of support for harm reduction in prisons:** Despite a government decree providing for sterile needle and syringe exchange in Tajikistan prisons, HIV React ex-prisoner clients said that the only prison NSP was in Dushanbe. They also reported that prison authorities decide whether syringes will be made available or not. None of the former prisoners who participated in focus group discussions reported ever receiving sterile needles and syringes in prison. HIV React clients in Khujand reported that the trust points for accessing sterile needles and syringes did not actually exist in the Sughd oblast prisons. According to the Sugdh Oblast Narcology Center Director, while drug detoxification programs are meant to be available in remand prisons, many PWID prisoners do not receive services.

**Unplanned prisoner amnesties:** Occasional but quite frequent amnesties for prisoners makes post-release planning problematic for HIV React NGOs, especially when a large number of prisoners are being released at one time, with little notice. As a result of a recent amnesty, there may be fewer prisoners being released from prisons for the duration of the HIV React Project. AFEW/KZ may need to revise down START Plus targets for the duration of the project.

### 3.3.5 Gaps

**Geographic gaps:** The selection of priority oblasts for PEPFAR programming did not take account of the fact that many PWID who reside in a particular geographic area both prior to incarceration and post-release are not necessarily incarcerated in a prison in the same area. Strict adherence to PEPFAR geographic prioritization has led to the situation where there is no programming in Vagdhat Prison, which is geographically proximate to Dushanbe (20 kilometers). This prison houses a large number of prisoners (~600). SPIN Plus is already working with former prisoners from Vagdhat who come to them for services post-release. Similarly, there is no programming in Tajikistan’s only female prison because it is not located in a PEPFAR priority oblast.

**Barriers to methadone for post-release PWID:** In Tajikistan, methadone is only available in the community and not in prisons. The policy of the Addiction Center is that people must have a positive urine test for opiates in order to be eligible for MAT. PWID who are coming out of prison and who are at risk of relapse cannot access MAT as a drug relapse prevention intervention. In addition, there are no drug rehabilitation services in Tajikistan, making it difficult for HIV-positive PWID to adhere to ART when they relapse and for HIV-negative PWID to practice safe injecting behaviors. There is a need for drug rehabilitation programming in
Tajikistan. HIV React should leverage advocacy support from UNODC and LEADER to address these gaps at the national level.

**Lack of temporary housing:** There is a lack of post-release temporary housing in Dushanbe. HIV React NGOs and clients reported that ex-prisoners often have insufficient funds to pay for accommodation in the first three months following their release from prison. NGOs reported that many released ex-prisoners feel that it is easier to return to prison where they are provided food and shelter. SPIN Plus will be requesting short-term housing support from local authorities for recently released ex-prisoners.

### 3.3.6 Recommendations

1. **Obtain a central level MoU to enable Hayoti Nav to work in prisons.** The Agreement Officer’s Representative (AOR), in consultation with USAID/Tajikistan, should work with Hayoti Nav and AFEW/Kazakhstan to determine how this can best be done as quickly as possible.

2. **Resolve issues between AFEW/KZ and AFEW/TJ through mediation by a third party.** The HIV React AOR and USAID/TJ should, in consultation with AFEW/KZ and AFEW/TJ, identify a suitable third party to assist with mediation.

3. **Hayoti Nav’s START Plus pre- and post-release programming** should include evidence-based interventions on HIV prevention for negative PWID and PWID drug use relapse prevention, in addition to its existing focus on linking PLHIV ex-prisoners to HIV treatment services on release and supporting adherence and retention in treatment.

4. **AFEW/KZ should negotiate with USAID to expand HIV React sites** to Vagdhat, Yavan, and the third Sugd oblast prison, provided there are sufficient numbers of PWID/PLHIV prisoners and savings can be found.

5. **USAID/Tajikistan and AFEW/KZ should improve coordination between HIV React implementing partners and other Tajikistan stakeholders (UNDP/Global Fund; Bridging the Gap; and the HIV Flagship Project).**

6. **HIV React implementing partners should advocate for the introduction of MAT in prisons and changing MAT eligibility rules in the community to allow access by released prisoners as a relapse prevention intervention.** Advocacy for establishment of community drug rehabilitation services should also be conducted.

7. **AFEW/KZ and HIV React partners in Tajikistan should advocate to the central level Medical Department of the Penal System to change the policy prohibiting former drug users and ex-prisoners who are NGO staff from providing project services in prison.**

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30 Recommendations which contain bold text in their first line are high priority recommendations. All recommendations are listed in priority order.
3.4 CROSS-CUTTING FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

3.4.1 Strengths

Effectiveness of the transition to 90-90-90 programming: The first evaluation question asks “how effectively is HIV React making the transition from general HIV prevention to HIV case identification, linkage to ARV treatment and achieving adherence and retention in care in both prisons and the community, post-release?” In 2016, following USAID/CA’s decision to reorient HIV React programming to reflect the 90-90-90 objectives, AFEW/KZ undertook a redesign for the project’s second phase. Although there are many similarities between the project’s first and second phases, design of the second phase placed stronger emphasis on HIV case finding, linkage of PLHIV to ARV treatment, and adherence and retention in care. This involved cessation of HIV education for the general prisoner population, replaced by an exclusive focus on PWID, as the KP with the highest HIV risk, and PLHIV. This was accompanied by the introduction of prisoner peer navigators to identify PWID and promote HIV testing among this group, and HIV treatment initiation, adherence, and retention.

The START Plus model was also reoriented to a 90-90-90 focus in support for PLHIV ex-prisoners, post-release. This involved a stronger focus on linking PLHIV ex-prisoners with AIDS Centers on release, along with support for adherence and retention in care, accompanied by promotion of CD4 and viral and load testing to measure adherence. A new element of programming is encouragement of disclosure of HIV status to sexual partners on release from prison, and facilitation of partner HIV testing. While START Plus gives priority to supporting PLHIV ex-prisoners, this program component is intended to also provide post-release HIV prevention support to HIV-negative PWID and drug relapse prevention support to all PWID.

In Phase II, HIV React’s geographic scope was re-aligned to match PEPFAR’s high HIV prevalence geographic focus areas. This involved cessation of programming in Almaty, Kazakhstan and Khatlon, Tajikistan and opening new project sites in Pavlodar, Kazakhstan and Dushanbe, Tajikistan. This geographic reorientation was consistent with the project’s transition to 90-90-90 programming.

The reprogramming decisions made by AFEW/KZ in design of Phase II were appropriate and are aligned to the project’s transition to 90-90-90 objectives. Interviews with NGO implementing partners indicate that they have reoriented their activities to be consistent with Phase II programming and that no unanticipated problems are being encountered. However, as Phase II only commenced in the final quarter of Year 2, (July – September 2016), only one-quarter of quantitative data is available, which is insufficient to determine the effectiveness of the project’s transition. More importantly, as detailed in the M&E section below, HIV React is currently not collecting a sufficient range of data to measure its progress in achieving the 90-90-90 objectives. While a full assessment of the effectiveness of the project’s transition is not yet possible, interviews with AFEW/KZ and NGO implementing partners indicate that good progress is being made, albeit within the constraints of weak prison health systems.

HIV React’s service facilitation and support role: The role of HIV React is primarily to facilitate and support service delivery by others. For example, many of the core activities which are key to achieving the 90-90-90 objectives, such as HIV testing, ART treatment initiation, and
clinical case management for PLHIV, are provided by prison medical departments and AIDS Centers. HIV React’s role is to provide essential support by identifying PWID in prisons, educating them about HIV and available treatments, creating demand for HIV testing among PWID, linking them to testing and assisting them to get their results, and providing peer support for PLHIV, with a focus on adherence and retention. Following release from prison, HIV React plays an essential social support role for ex-prisoner’s reintegration to society which, according to key informants, is essential for achieving ART adherence and retention.

Given that achievement of the 90-90-90 objectives relies on services by prison medical departments, AIDS Centers, and overall cooperation by prison authorities, development of effective working relationships with these gatekeepers is essential. Interviews with prison medical departments and AIDS Centers clearly demonstrated that HIV React has established good working relationships and the project’s work is seen as adding value through its support services. Nonetheless, there are considerable constraints in implementing a prisons HIV project in Central Asia. These constraints fall into two broad categories: firstly, prison health systems weaknesses, which impact on the quality of care; and secondly, the inherent difficulties of working in secured closed institutions, coupled with suspicion by prison authorities regarding the activities of foreign-funded NGOs working in prisons. While the project has been advocating at either the local or national levels (this varies by country) on the need to address health system weaknesses, the core problem appears to lie in chronic under-funding and possibly poor management, which is largely beyond the scope of the project to address. Based on anecdotal evidence provided by HIV React, it would appear that good progress has been made on allaying the suspicions of prison authorities relating to the project, although obstacles to access to prisons are still encountered, with the exception of the Kyrgyz Republic.

**Strong implementing partners:** On the basis of in-depth interviews and document and data review, all of HIV React’s NGO implementing partners appear to have a good understanding of Phase II and the appropriate expertise to effectively implement the project. All were able to speak intelligently to challenges and constraints and how they have responded. Key value added areas for HIV React are the greater levels of trust peer-led NGOs have with prisoners; their role in promoting HIV testing, treatment initiation, and adherence; and the post-release support aimed at retention in treatment.

**3.4.2 Weaknesses**

**Prisoner HIV treatment literacy:** There were consistent reports from NGO implementing partners of the low level of HIV treatment literacy among PLHIV prisoners. This is associated with distrust of penal authority personnel, including doctors. Myths about HIV treatment were reported to be common, including that ART is an experimental therapy being trialed on prisoners. The low level of knowledge among prisoners about HIV treatment can negatively affect treatment initiation, adherence, and retention. The introduction of the peer navigator positions in the project’s second phase has provided an opportunity to strengthen PWID and PLHIV education from a trusted source on the benefits of early ART initiation and the importance of adherence and retention. There is also potential for an informed PLHIV prisoner population to play a role in treatment quality assurance. For example, one prisoner in the Kyrgyz Republic informed the evaluation that despite a significant decline in his CD4 count over
an 18-month period to a low level, it was only “when he started making a noise” that his treatment regimen was changed.

There is evidence of delays in ART initiation. In Khujand, Tajikistan, prison medical staff do not encourage ART initiation for patients with high CD4 counts, waiting for a decline to <350. In the Kyrgyz Republic, although prison doctors have been trained in ART initiation, there were reports of delays in treatment commencement as doctors felt the need to consult with AIDS Center doctors. ART eligibility requirements in each of the three countries are likely to change to Test and Start over the next one to two years. This needs to be accompanied by more training of AIDS Center and prison doctors on the benefits of Test and Start.

**Sexual partners:** There are inherent difficulties in achieving PLHIV self-disclosure of their HIV status to sexual partners upon release from prison. USAID’s Flagship Project is trying to achieve the same objective. This is a new aspect of programming. USAID should encourage cross-project collaboration and sharing of experience and lessons learned.

### 3.4.3 Constraints

**Adherence post-release:** It was commonly reported by NGO implementing partners and some AIDS Centers that ART adherence decreases significantly upon release from prison. For example, in Pavlodar, the AIDS Center reported that a 2014 study of 46 PLHIV ex-prisoners found that only six maintained ART adherence post-release. There was consensus among key informants that the many social challenges faced by ex-prisoners attempting to reintegrate into society, (e.g., finding accommodation and employment, recovering identity documents, stigma against ex-prisoners, etc.), commonly results in health dropping to the bottom of ex-prisoner’s priorities. There was also anecdotal evidence from NGO implementers that by the time ex-prisoner social support needs are largely starting to be met, there is a noticeable increase in their ART adherence. This highlights the importance of the project’s social support for ex-prisoners. The project needs to continue to place a significant emphasis on social support for ex-prisoners through START Plus to achieve good rates of ART adherence. HIV React needs to start monitoring VL testing data post-release to measure adherence.

**Loss to follow-up for ex-prisoners:** HIV React is only funded to provide START Plus post-release support services in the sites where the project is being implemented. It is common for large numbers of ex-prisoners on release to live in different regions to that of their place of imprisonment. Upon release from prison, penal medical departments in the three countries commonly provide PLHIV with two to four weeks’ supply of ART and a letter of referral to the city or oblast AIDS Center in the locality of their intended residence. The referral letter is also sent to the local AIDS Center. While it is the responsibility of the city or oblast AIDS Center to initiate tracking action for ex-prisoners who do not attend the AIDS Center, it is unlikely that this is happening on a consistent basis. This is a significant gap, which can result in loss of retention in care. While it is beyond the capacity of HIV React to follow-up PLHIV ex-prisoners in places the project is not working, RACs in each country should set up a system to ensure local level follow-up. Follow-up could be undertaken by the AIDS Center and/or local NGOs.

**Communication of test results:** A consistent practice across the three countries is that prisoners are not informed of negative HIV test results. It is not clear whether this is because of
under-staffed prison medical services, poor systems, or the information is not seen as important. This practice means that the prevention benefits of post-test counseling cannot be realized.

**Health system weaknesses:** A key constraint to achieving the 90-90-90 objectives is the weak state of prison medical departments in all three countries. Recruitment and retention of prison medical staff is problematic, with a high level of vacancies and staff turnover. For example, 40 percent of prison doctor positions in the Kyrgyz Republic are currently vacant. Prison health system weaknesses have to some extent been ameliorated in Kazakhstan and Tajikistan, where AIDS Centers play an important role in the provision of HIV treatment, albeit limited by the frequency of their prison visits. In Kyrgyz Republic prisons, where the penal medical department has greater responsibilities for provision of HIV care and treatment and AIDS Centers play a lesser role in prisons, the standard of care appears to be of a lower quality compared to Kazakhstan and Tajikistan. A health systems strengthening approach is needed to achieve sustainable improvement in HIV care and treatment in prisons. This is more likely to be achieved if responsibility for provision of prison medical services is transferred to ministries of health.

**Recovery of identity documents after release from prisons:** Due to a lack of systems or poor document management, official government identity documents of prisoners (e.g., passports) are lost when prisoners transition from remand centers to prisons and penal colonies and during their transfer from one prison to another. Upon release, ex-prisoners who do not have personal identity documents experience difficulties in claiming social assistance, health care services, and seeking employment. Seeking replacement identity documents is a time-consuming procedure which commonly occurs only after release from prison. This process can delay other social reintegration priorities, such as seeking health care, accommodation, and employment. START Plus provides assistance to ex-prisoners seeking to recover their identity documents. It would be preferable if governments in the three countries where HIV React is working were able to establish systems for retention of prisoner identity documents during incarceration so that the documents could be made available to prisoners upon their release.

### 3.4.4 Gaps

**Project replication:** Given the funding available, the geographic scope of HIV React’s work is limited. As such, the project is essentially a demonstration project which relies on government adoption of project approaches through replication in non-project sites if it is to have a broader and sustainable impact. The extent to which the project is involved in advocacy related to improving prison health systems and replication of project approaches varies by country. In the Kyrgyz Republic, which has a more open environment to civil society participation, AFEW/KR has been involved in advocating for health systems improvements in prisons. This is occurring at the national level as much of the work of the project is based in Bishkek and key partners are the national prison medical department and the RAC. In contrast, in Kazakhstan, where the project is working at the sub-national level at two sites, advocacy has been confined to the site level. AFEW/KZ has been reluctant to engage in above site or national level advocacy as the political environment in Kazakhstan is not particularly receptive to NGO advocacy in the sensitive areas of prisons and drug use. While this is understandable, advocacy at this level should be seen as essential if broader systems changes are to be achieved. To avoid direct participation by the HIV React Project in national level advocacy work, USAID/CA and
AFEW/KZ could seek to facilitate advocacy work by other agencies to address national health prison systems weaknesses and for replication of project approaches in other regions. This work could, for example, be undertaken by UNODC and LEADER.

In Tajikistan, during Phase 1 of HIV React, AFEW/TJ and the other implementing partners were able to undertake advocacy efforts through their participation in the technical working group on prisoners. They were able to have the HIV React strategy approved by the working group and have the START Plus curriculum adapted to the Tajikistan Ministry of Justice penal medical curriculum to include Sexual and Reproductive Health (SRH), Opioid Substitution Therapy (OST), Sexually Transmitted Infections (STI) and Hepatitis C Virus (HCV), in addition to TB and HIV. With AFEW/TJ no longer participating in HIV React, AFEW/KZ should work with the new implementing partners to determine the optimal manner in which to undertake increased advocacy efforts.

**Ex-prisoner transition to Flagship Project support:** The design of HIV React’s Phase II provides for post-release START Plus support for PLHIV and PWID ex-prisoners for up to eight months, followed by referral to USAID’s Flagship Project for ongoing support. As implementation of Phase II has only recently commenced, the time for referral of clients has not yet been reached. There have been initial discussions between the two projects on client referrals, with both projects acknowledging the need for more detailed planning. The Flagship Project informed the evaluation team that its support will be focused on PLHIV with poor adherence and that it does not have the capacity to provide social support. The Flagship Project also noted that their NGO implementing partners are all experienced in working with PWID since that is their focus population as well, and would be equipped to support post-release clients, if needed. Some HIV React implementers expressed concerns about transfer of ex-prisoners with ongoing social support needs, pointing to the importance of social support for adherence and retention. Current plans for transition could be regarded as representing a gap for social support. More detailed planning on client transition by both projects needs to occur. This should explore the types, level, and length of support that can be provided by Flagship. A flexible, client-centered approach should be taken to client transition, based on client needs and the support capacities of both projects.

START Plus gives a higher level of support to PLHIV ex-prisoners, with less support to ex-PWID and HIV-negative PWID. While prioritization of PLHIV is intended and appropriate, insufficient priority is currently accorded by START Plus to HIV prevention for HIV-negative PWID and drug use relapse prevention for ex-PWID. Specifically, AFEW/KZ should support HIV React project implementing partners to incorporate evidence-based relapse prevention programming for ex-PWID.

**3.4.5 Recommendations**

1. **HIV React, in collaboration with CDC, should advocate for RACs** to establish national systems for city and oblast AIDS Centers to initiate follow-up action for PLHIV ex-prisoners who do not enroll in HIV treatment upon release from prison.

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31 Recommendations which contain bold text in their first line are high priority recommendations. All recommendations are listed in priority order.
2. **AFEW/KZ should increase the level of post-release support through START Plus** for HIV-negative PWID, and ex-PWID, including evidence-based drug use relapse prevention programming.

3. **USAID and AFEW Kazakhstan should leverage UNODC and LEADER** to advocate for HIV- and drug treatment-related health systems improvements in prisons and for state/municipal funding for replication of HIV prisons programming in regions not covered by HIV React Project.

4. **AFEW/KZ and its NGO implementing partners need to better equip peer navigators to strengthen PLHIV education on the benefits of early ART initiation and the importance of adherence and retention.** AFEW/KZ and NGO implementing partners should, in consultation with penal medical departments and AIDS Centers, consider the feasibility of DOT for ART as a means of building adherence in the initial stages of treatment. AFEW/KZ should also advocate for more training of AIDS Center and prison doctors on the benefits of Test and Start.

5. **AFEW/KZ and its NGO implementing partners should advocate to prison medical departments and AIDS Centers for all prisoners to receive their HIV test results, accompanied by post-test counseling.**

6. **AFEW/KZ and its NGO implementing partners should advocate to the Governments of Kazakhstan, the Kyrgyz Republic, and Tajikistan for the establishment of systems for retention of prisoner identity documents during incarceration so that the documents can be made available to prisoners upon their release.**

7. **AFEW/KZ and its NGO implementing partners need to commence detailed planning with USAID’s Flagship Project on transitioning support for post-release ex-prisoners from HIV React to the Flagship.** This should incorporate a flexible, client-centered approach, based on client needs and the comparative advantages of each project to meet those needs, rather than a fixed time frame for client transition.

8. **USAID should encourage HIV React and Flagship to collaborate on sharing experiences and lessons learned on self-disclosure of HIV status to sexual partners and promotion of HIV testing.**

### 3.5 MONITORING AND EVALUATION AND STRATEGIC INFORMATION

As the prime recipient of HIV React, AFEW/KZ is responsible for the development of the project’s Activity Monitoring and Evaluation Plan (AMEP) and quarterly reporting of project performance to USAID/CA. In addition, AFEW/KZ serves as the technical leader in building the capacity of its sub-recipients in the areas of program planning, data collection, analysis and use. Based on the Results Framework (Annex II, Figure 4) in the approved Phase II AMEP, the primary goal of this project is to “Expand coverage and service provisions for KPs in prison and after release in accordance with the PEPFAR 90-90-90 goal.” The three key program objectives are as follows:
1. Increase coverage of PWID by HTC services
2. Create conditions for increasing access for PLHIV to ARV treatment
3. Create conditions for maintaining adherence to ART

The associated indicators to be reported to PEPFAR on a quarterly basis in the Phase II AMEP are:

1. Number of PWID reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required (KP_PREV)
2. Number of PWID reached with the project interventions who received HTC services in the past 12 months and know their results (HTC_TST)
3. Number of PLHIV receiving care and support services outside of the health facility (Customized CARE_COMM)
4. Number of PLHIV who were screened for TB symptoms at reporting period (Customized TB_SCREEN)
5. Number of specialists and service providers trained on issues of modern approaches to ART
6. Number of issued information and educational materials on early initiation of ART, adherence, stigma/discrimination, etc.

3.5.1 Key achievements and strengths

One of the strengths of HIV React is the timely submission of quarterly data and performance reports by NGOs to AFEW/KZ and by AFEW/KZ to USAID/CA. The project also put considerable effort into meeting performance indicator targets in Phase I (June 2014–June 2016), with a majority of indicators exceeding their targets. At the completion of this evaluation, only one quarter (FY16, Q4) of Phase II results were available for assessment. Performance against targets in FY16 Q1 for key indicators are shown in Table 1. Kyrgyz Republic NGOs are on track to exceed their annual targets for KP_PREV, HTC_TST, and most notably for CARE_COMM. Tajikistan NGOs are below target for KP_PREV and HTC_TST and on track to significantly exceed its CARE_COMM annual target. Performance below target for KP_PREV and HTC_TST occurred because one of the Tajikistan NGOs is new to the project and the other currently has no access to prisons. The Kazakhstan NGOs were well below target for all three key indicators, particularly KP_PREV and HTC_TST. This was due to limited access to prisons by NGO implementing partners in this quarter. Gerlita was in the inception phase and Answer encountered delays in renegotiating its MoU with the government for prison access. AFEW/KZ is confident that the achievements of the Kazakhstan NGOs will improve now that Gerlita has moved beyond the inception phase and Answer has renewed government approval to access prisons.
Table 1. Performance against targets for key indicators by country, FY17 Q1

<table>
<thead>
<tr>
<th>Country</th>
<th>KP_PRE FY16 Q4*</th>
<th>KP_PRE V annual target</th>
<th>HTC_TS T FY16 Q4*</th>
<th>HTC_TS T annual target</th>
<th>CARE_COM M FY16 Q4*</th>
<th>CARE_COM M annual target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kazakhstan</td>
<td>26 (10%)</td>
<td>1,000</td>
<td>8 (4%)</td>
<td>900</td>
<td>16 (64%)</td>
<td>100</td>
</tr>
<tr>
<td>Kyrgyz Rep</td>
<td>575 (153%)</td>
<td>1,500</td>
<td>366 (108%)</td>
<td>1,350</td>
<td>243 (972%)</td>
<td>100</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>208 (55%)</td>
<td>1,500</td>
<td>202 (60%)</td>
<td>1,350</td>
<td>60 (240%)</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>809 (81%)</td>
<td>4,000</td>
<td>576 (64%)</td>
<td>3,600</td>
<td>319 (425%)</td>
<td>300</td>
</tr>
</tbody>
</table>

Source: HIV React Annual Performance Report Year Two and AMEP.
* Percentages are the level of achievement against quarterly targets.

The modification of standardized data collection tools for HIV React sub-recipient NGOs was completed shortly after the initiation of Phase II of the project. NGO staff were trained in August 2016 on changes to the indicators and data collection forms, and the revised AMEP was swiftly adopted by all partners for routine reporting. Forms for monitoring visits are in place and quarterly visits by the AFEW/KZ M&E advisor to NGOs are scheduled for FY17, Q1 as part of the Phase II transition.

3.5.2 Weaknesses, gaps, and constraints

The quality of the approved Phase II AMEP is suboptimal, as existing indicators do not adequately represent the full scale of HIV React’s work. Given the increased emphasis in Phase II on tracking the movement and retention of an individual along the HIV clinical cascade, additional indicators should be considered to better reflect the critical support that HIV React is providing in enhancing the linkages of services for prisoners and ex-prisoners post-release. For example, the number and proportion of PLHIV prisoners reached by HIV React through ART literacy mini-sessions, one-on-one sessions with social workers, and/or peer navigators, etc. who subsequently initiate ART in prison, should be documented as a project success in improving treatment uptake. Similarly, the project should be collecting data on the number of PLHIV ex-prisoners who are successfully linked to ART Centers post-release. This should include data on the number of PLHIV who are retained in treatment within the same oblast in which they are released and the number of post-release PLHIV who are retained in treatment in other oblasts (i.e., oblasts where HIV React is working and oblasts where the project is not working). Indicators in these areas would enable the project to track individuals across the continuum of services pre- and post-release. A detailed list of proposed indicators across the continuum of prevention, care, and treatment is in Annex II.

Secondly, program monitoring capacity is limited at AFEW/KZ, alongside limited engagement between the M&E Advisors at AFEW/KZ and USAID/CA. The need to strengthen the capacity of the AFEW/KZ M&E advisor is hampered by this position being based in Bishkek. It is unclear what type of skills-building support the M&E Advisor is receiving from AFEW/KZ in Almaty, and/or from external sources such as professional development opportunities in the area of strategic information (SI). But there seems to be limited mentorship from both AFEW/KZ and USAID/CA. While it was evident that the sub-recipients of HIV React are submitting their
results in a timely matter, it is unclear whether all partners have a comprehensive understanding of Phase II’s data needs and the importance of data use for program improvement. As such, the M&E capacity of these implementing partners may also need to be strengthened, which further underlines the importance and urgency of increasing the capacity of the AFEW/KZ M&E Advisor who is responsible for building the capacity of its sub-recipients.

As discussed in the cross-cutting section of this report, there is not a clear M&E plan or discussion on how post-release PLHIV will be documented across the HIV React and HIV Flagship projects when they transition from HIV React to Flagship, four to eight months after release from prison. At minimum, the two projects should either use the same nomenclature for their Unique Identification Code (UIC) (once HIV React’s Management Information System (MIS) is developed), or have a system in place where HIV React supports PLHIV beneficiaries who are successfully transferred to Flagship can be documented and reported.

Notwithstanding the timely implementation and roll-out of the Phase II AMEP, a number of SI-related inconsistencies and incongruities were found among approved documents. The Phase II AMEP Results Framework and indicators do not capture the project’s work among all target populations. For example, in the HIV React Project (Part 2) Technical and Cost Application, June 2016–December, 2019 document (page 3), the target populations are clearly stated as: “female and male PWID and PLHIV in prison and after release; sexual partners of PWID and PLHIV” and Objective One is to “ensure all released PWID and their sexual partners [receive] HTC.” However, sexual partners of PWID and PLHIV are not included in the AMEP Results Framework (Annex II, Figure 4). Nor does the AMEP include the collection of HTC data for sexual partners of PWID and PLHIV. The current HIV testing indicator is limited to only PWID.

There are also a number of problems in how HIV React is reporting against indicators in Phase II. The Phase II AMEP contains six indicators (listed above), yet HIV React reported against only three indicators in the Year Two Annual Performance Report, namely KP_PREV, HTC_TST, and the customized CARE_COMM. Furthermore, the annual targets (Year 1 of Phase II) listed in the approved Phase II AMEP are different from those set in the AFEW Phase II Workplan 2016-2019 and the HIV React Project progress summary July 1–September 30, 2016 document. For example, KP_PREV annual target for Phase II Year 1 in Kyrgyzstan was 1,500 in the approved AMEP vs. 3,600 in Phase II Workplan vs. 1,000 in HIV React Project progress summary. In addition, test results were not disaggregated as part of routine reporting for HTC_TST, which is a required element of PEPFAR reporting for this indicator.

Furthermore, the primary goal of this project is to expand the coverage of services for KPs in prison and after release, yet disaggregation of whether clients are served inside the prison vs. post-release is not a standard requirement for routine monitoring, as the AMEP indicator reference sheets do not require this type of disaggregation. Opportunities for tracking the transition of prisoners from pre- to post-release are often missed when such disaggregates are not available, especially in the absence of a patient-level monitoring system. In addition, the indicator reference sheets do not currently provide clear operational definitions, including the methods of data measurement and collection. For example, in the KP_PREV indicator reference sheet, there is no mention of how the same individual should be counted and de-duplicated if reached across multiple periods within a fiscal year.
It is conceivable that the transition from Phase I to Phase II of the project in mid-cycle of the United States Government (USG) fiscal year increased the complexity of target calculations and documentation. However, project targets and indicators that were agreed upon by USAID/CA and AFEW/KZ in a clearly defined period should be uniform across all documents and validated by both the AFEW/KZ M&E Advisor, the USAID/CA M&E Advisor, and the project AOR before approval. Moreover, the quality of all M&E documents should be carefully assessed and evaluated by USAID/CA prior to approval to ensure these documents are of an acceptable standard.

While paper-based data collection forms used by the sub-recipients are standardized, AFEW/KZ lacks a centralized data management system to enter and store routine data. This may have contributed to the incongruity in their overall M&E documentation and reporting. HIV React is planning to develop a patient-level MIS with UICs in FY17 Q2, which should improve the documentation of individuals across the continuum of prevention, care, and treatment. However, at present, there is a lack of structure and organization at AFEW/KZ in regards to their data collection and management processes. A number of data-related files were not available for review at the time the evaluation team met with the AFEW/KZ M&E Advisor (e.g., site-level targets and FY16 Q4 results by NGO), and it was unclear where source documents submitted by the NGOs were stored.

### 3.5.3 Recommendations

1. **AFEW/KZ should hire an independent local consultant** with extensive PEPFAR and M&E experience to closely examine and significantly revise the current AMEP. S/he should work in close collaboration with M&E Advisors from AFEW/KZ and USAID/CA during the revision process, and a revised AMEP should be approved and implemented by FY17 Q4. **At minimum,** revisions need to ensure that:
   
   a. The Results Framework and indicators adequately represent the populations and full range of activities conducted by HIV React across the clinical cascade. (See Annex II for a detailed list of illustrative indicators and disaggregation).
   
   b. Data that would enable HIV React to construct a HIV cascade for current and post-release prisoners should be included.
   
   c. Data collection forms and indicator reference sheets reflect the above changes.

2. **M&E Training for all HIV React NGOs by AFEW/KZ should be conducted** once the revised AMEP has been approved.

3. **The USAID/CA M&E Advisor should have a greater level of engagement** in strengthening the capacity of AFEW Kazakhstan’s routine program monitoring, including detailed reviews of all strategic information (SI)-related documents and cross-validations before submission to the AOR. At a minimum, quarterly meetings should be conducted between the M&E and technical Advisors from USAID/CA and AFEW Kazakhstan program and M&E staff, (with more frequent meetings initially), to review project results, identify

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32 Recommendations which contain bold text in their first line are high priority recommendations. All recommendations are listed in priority order.
potential leakage points within the clinical cascade, and thoroughly review the quality of data submitted.

4. **The HIV React M&E Advisor should be relocated to AFEW/KZ’s office.**

5. **Strengthen the AFEW/KZ M&E advisor’s capacity** by budgeting and providing relevant professional development opportunities (e.g., online M&E courses, in-person M&E training).

6. **Prior to the implementation of React’s MIS,** standard operating procedures and protocols on the collection, storage, and management of program data at AFEW Kazakhstan should be developed by HIV React (with support from USAID/CA).

7. USAID/CA should translate all relevant PEPFAR Monitoring and Evaluation Guidance 2.0 (MER 2.0) indicators and MER 1.0 (2015) indicators (i.e., CARE_COMM, TB_SCREEN) into Russian. USAID/CA should then conduct an in-person training for AFEW Kazakhstan on the new PEPFAR 2.0 indicators and a refresher course on relevant MER 1.0 indicators.

8. Development of the patient-level MIS by AFEW Kazakhstan should be undertaken **after the revised Phase II AMEP is finalized and approved.**

9. **As part of the MIS development,** AFEW Kazakhstan should consider including systems interoperability among HIV React’s NGO implementing partners so that ex-prisoners who migrate or return to an oblast different from the prison where s/he was released can be referred, linked, and monitored within the MIS by AFEW Kazakhstan and the respective NGOs (transferred out/transferred in). For example:
   
   a. Post-release PWID can be documented as linked into prevention and testing services from one HIV React NGO implementing partner (pre-release) to another HIV React NGO implementing partner (post-release).
   
   b. A post-release PLHIV who initiated ART in prison (with support from Answer) and was later successfully linked to Pavlodar Oblast AIDS Center (with support from Gerlita) can be documented as a successful post-release ART transfer.

10. **AFEW/KZ and PSI,** in close collaboration with USAID/CA M&E advisor, should develop joint operating procedures for the HIV React and HIV Flagship projects to properly document the transfer of ex-prisoners between the projects.

11. **All M&E-related HIV React documents and indicator reporting requirements need to be reexamined and validated by AFEW Kazakhstan to minimize inconsistencies and incongruities.**

### 3.6 PROJECT MANAGEMENT

#### 3.6.1 AIDS Foundation East West Kazakhstan

HIV React’s NGO implementing partners in Kazakhstan and the Kyrgyz Republic reported high levels of satisfaction with project management and technical assistance from AFEW/KZ. These NGOs reported high levels of support through trainings, frequent day-to-day contact, quarterly
monitoring visits by M&E and finance staff during Phase I, and less frequent visits by technical staff, which also involved meetings with clients. Positive attributes of AFEW’s support included asking about the NGO’s needs, provision of sufficient guidance, and sharing of information in a transparent way. AFEW trainings were reported to be effective, with case studies and role plays that were oriented to solving problems.

One NGO in Tajikistan reported less frequent TA from AFEW/KZ than was the case for Kazakhstan and Kyrgyz Republic NGOs, saying that financial monitoring visits were conducted every six months and technical staff visits only occurred twice over the project’s first two years. While there was frequent Skype contact, this was not always related to technical issues. SPIN Plus in Tajikistan, a new NGO implementing partner under Phase II, requested additional TA for working in prisons. SPIN Plus has extensive experience working with PLHIV and PWID, including ex-prisoners, but the HIV React Project is the first time they have worked in prisons. SPIN Plus indicated a need to adapt START Plus methodologies and workplans to the local context in Tajikistan. This included readjusting targets to take account of the recent amnesty that may reduce the number of prisoners being released in future, and to address scheduling and geographic constraints encountered in Tajikistan.

One NGO Director in Kazakhstan said that AFEW/KZ had, over a number of years, empowered peer-based NGOs made up of PLHIV and PWID ex-prisoners. This had enabled these NGOs to work effectively with their target groups and be role models in relation to treatment adherence and cessation of drug use. Another NGO reported that AFEW/KZ is very beneficiary-oriented – “everything AFEW/KZ does is in favor of the beneficiaries.”

NGOs reported good networking between the different NGO implementing partners, which was achieved through regional trainings that bring all the NGOs together, and regional study tours that were beneficial in opening eyes to different experiences, policies, and practices across the three countries.

In Phase I, a considerable amount of training was provided by NGO implementing partners. In Phase II, AFEW/KZ now conducts all project-related training. The rationale is to ensure the quality of training and to promote a consistent approach to project implementation. While this is a justifiable approach, AFEW/KZ should consider providing joint trainings with its NGO implementing partners in order to develop their capacity. There should also be some capacity for NGO-provided country-based trainings, as needed, to respond to local needs. More broadly, USAID and CDC should identify external trainings provided by the HIV Flagship Project, International Center for AIDS Care and Treatment Programs (ICAP), and others which would be of benefit to AFEW/KZ and its NGO implementing partners.

In 2013, the AFEW transformed into a network of six independent organizations working in countries across eastern Europe and central Asia, including AFEW/KZ, AFEW/KR, and AFEW/TJ. Prior to the HIV React Project, each of these national AIDS Foundations were on an equal footing and independent. The nature of this relationship changed under HIV React, with AFEW/KZ taking on the prime implementing agency role and AFEW/KR and AFEW/TJ becoming sub-recipient implementing partners. While the relationship between AFEW/KZ and AFEW/KR appears to be largely healthy, albeit with some tensions, there are, as outlined in the Tajikistan section of this report, currently very poor relationships between AFEW/KZ and AFEW/TJ.
While the evaluation does not have sufficient information to draw conclusions as to why the relationship between AFEW/KZ and AFEW/TJ has deteriorated, it would appear that the new relationship of prime and sub-recipient was a factor. While AFEW/TJ is not an implementing partner under Phase II of HIV React, it remains a recipient of USAID/TB funding, which includes working with prisoners in the country. In the interest of current and future public health cross-project collaboration between AFEW network members, it is important to rebuild a working relationship between AFEW/KZ and AFEW/TJ, as recommended in the Tajikistan section of this report.

Two NGO implementing partners reported that they would have liked to have had more input into the design of the second phase of the project. One of these partners reported that they had to initiate the request for involvement and that they only had the opportunity to make inputs at a late stage of the design process.

As outlined above, M&E for HIV React needs considerable strengthening. AFEW/KZ needs to place considerably more emphasis on integrating M&E as an integral project component for the purpose of monitoring and improving performance, rather than seeing M&E as a donor-obligated process.

**USAID payment procedures:** AFEW/KZ reported that USAID’s finance practice of paying advances for only 30 days, rather than for a longer time-frame, is resulting in cash flow shortages and disruption to programming. HIV React’s NGO implementing partners, however, did not note any problems in receiving funds on time. USAID Central Asia reported that its Office of Financial Management did discuss the possibility of extending the period of advance payment for AFEW/KZ; however, there were not strong reasons for them to switch to a 90-day period of advances. USAID finance staff met with the AFEW/KZ Finance Manager in July 2016 to discuss how they could better forecast their cash flow. This discussion also included a schedule for submitting advance requests and liquidations to USAID so the project will not be short of funding.

### 3.6.2 Recommendations

1. **Increase regular communication** regarding technical needs and implementation issues between AFEW/KZ and SPIN Plus and Hayoti Nav in Tajikistan. This includes quarterly in-person discussions and ongoing liaison as needed between AFEW/KZ and the local implementing partners to familiarize AFEW/KZ with the local context, with the agenda determined by the needs of the NGOs, rather than solely from AFEW/KZ, to ensure successful program outcomes are obtained.

2. AFEW/KZ should consider providing joint trainings, as appropriate, with its NGO implementing partners in order to develop their capacity. There should also be some capacity for NGO-provided country-based trainings to respond to local needs.

3. USAID and CDC should identify external trainings provided by the Flagship Project, ICAP, and others, which would benefit AFEW/KZ and its NGO implementing partners.

4. USAID/CA should assess whether additional engagement by the USAID Central Asia Financial and Management Office is needed to provide TA to AFEW/KZ in financial planning.

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33 Recommendations which contain bold text in their first line are high priority recommendations. All recommendations are in priority order.
ANNEX I. RECOMMENDATIONS

This annex contains a consolidated list of recommendations contained in the body of the report. The highest priority recommendations are in the Executive Summary. They are also included in this annex. The highest priority recommendations contain bold text in their first line. The recommendations under each of the sub-headings are in priority order.

KAZAKHSTAN

1. **PEPFAR, USAID/CA, and AFEW Kazakhstan** should consider the feasibility of making cost savings within the HIV React Project to allow for provision of START Plus post-release support services in Almaty to maximize adherence and retention in HIV treatment for the large number of ex-prisoners who reside in Almaty.

2. **USAID/CA and AFEW Kazakhstan** should investigate the possibility of supporting transitional housing for PWID and PLHIV post-release at each project site.

KYRGYZ REPUBLIC

3. HIV React should work through the quarterly working group, in consultation with prisoners, to promote discussion of:
   
   a. Strategies to increase adherence to ART, both related to food packages for PLHIV on ART and initiating different approaches to foster adherence (e.g. DOT, peer navigator or PLHIV peer support, etc.)
   
   b. Including social dormitories in the upcoming Global Fund proposal, including one for women;
   
   c. Support systems improvement to ensure all HIV-positive and HIV-negative prisoners are informed of their test results
   
   d. Moving the penal health services under the Ministry of Health

4. HIV React should work with peer navigators to promote CD4 and viral load testing and communication of results, in collaboration with prison health staff and the RAC.

5. HIV React should assess the needs of settlement colony prisoners related to ART, including the number of PLHIV transferred to settlement colonies and the number of people testing HIV positive at HTS events in settlement colonies. If needed, HIV React should share findings with the working group to discuss possible next steps to address policy and service implementation gaps.

6. USAID Central Asia should support conflict resolution and mediation for NGO implementing partners, in partnership with AFEW/KZ.

TAJIKISTAN

1. Obtain a central level MoU to enable Hayoti Nav to work in prisons. The AOR, in consultation with USAID/Tajikistan, should work with Hayoti Nav and AFEW/Kazakhstan to determine how this can best be done as quickly as possible.
2. **Resolve issues between AFEW/KZ and AFEW/TJ through mediation by a third party.** The HIV React AOR and USAID/TJ should, in consultation with AFEW/KZ and AFEW/TJ, identify a suitable third party to assist with mediation.

3. **Hayoti Nav’s START Plus pre- and post-release programming** should include evidence-based interventions on HIV prevention for negative PWID and PWID drug use relapse prevention, in addition to its existing focus on linking PLHIV ex-prisoners to HIV treatment services on release and supporting adherence and retention in treatment.

4. **AFEW/KZ should negotiate with USAID to expand HIV React sites** to Vagdhat, Yavan, and the third Sugd Oblast prison, provided there are sufficient numbers of PWID/PLHIV prisoners and savings can be found.

5. USAID/Tajikistan and AFEW/KZ should improve coordination between HIV React implementing partners and other Tajikistan stakeholders (UNDP/Global Fund; Bridging the Gap; and the HIV Flagship Project).

6. HIV React implementing partners should advocate for the introduction of MAT in prisons and changing MAT eligibility rules in the community to allow access by released prisoners as a relapse prevention intervention. Advocacy for establishment of community drug rehabilitation services should also be conducted.

7. **AFEW/KZ and HIV React partners in Tajikistan should advocate to the central level Medical Department of the Penal System to change the policy prohibiting former drug users and ex-prisoners who are NGO staff from providing project services in prison.**

**CROSS-CUTTING RECOMMENDATIONS**

1. **HIV React, in collaboration with CDC, should advocate for RACs to establish national systems for city and oblast AIDS Centers to initiate follow-up action for PLHIV ex-prisoners who do not enroll in HIV treatment upon release from prison.**

2. **AFEW/KZ should increase the level of post-release support through START Plus for HIV-negative PWID and ex-PWID, including evidence-based drug use relapse prevention programming.**

3. **USAID and AFEW Kazakhstan should leverage UNODC and LEADER to advocate for HIV- and drug treatment-related health systems improvements in prisons and for state/municipal funding for replication of HIV prisons programming in regions not covered by HIV React Project.**

4. **AFEW/KZ and its NGO implementing partners need to better equip peer navigators to strengthen PLHIV education on the benefits of early ART initiation and the importance of adherence and retention. AFEW/KZ and NGO implementing partners should, in consultation with penal medical departments and AIDS Centers, consider the feasibility of directly observed therapy for ART as a means of building adherence in the initial stages of treatment. AFEW/KZ should also advocate for more training of AIDS Center and prison doctors on the benefits of Test and Start.**

5. **AFEW/KZ and its NGO implementing partners should advocate to prison medical departments and AIDS Centers for all prisoners to receive their HIV test result, accompanied by post-test counseling.**
6. AFEW Kazakhstan and its NGO implementing partners should advocate to the Governments of Kazakhstan, the Kyrgyz Republic, and Tajikistan for the establishment of systems for retention of prisoner identity documents during incarceration so that the documents can be made available to prisoners upon their release.

7. AFEW/KZ and its NGO implementing partners need to commence detailed planning with USAID’s Flagship Project on transitioning support for post-release ex-prisoners from HIV React to the Flagship. This should incorporate a flexible, client-centered approach, based on client needs and the comparative advantages of each project to meet those needs, rather than a fixed time frame for client transition.

8. USAID should encourage HIV React and Flagship to collaborate on sharing experiences and lessons learned on self-disclosure of HIV status to sexual partners and promotion of HIV testing.

9. HIV React should assess opportunities to provide GBV prevention education to male clients or leverage existing opportunities in this area.

MONITORING AND EVALUATION

1. **AFEW/KZ should hire an independent local consultant** with extensive PEPFAR and M&E experience to closely examine and significantly revise the current AMEP. S/he should work in close collaboration with M&E Advisors from AFEW/KZ and USAID/CA during the revision process, and a revised AMEP should be approved and implemented by FY17 Q4. **At minimum**, revisions need to ensure that:
   a. The Results Framework and indicators adequately represent the populations and full range of activities conducted by HIV React across the clinical cascade. (See Annex 2 for a detailed list of illustrative indicators and disaggregation)
   b. Data that would enable HIV React to construct a HIV cascade for current and post-release prisoners should be included
   c. Data collection forms and indicator reference sheets reflect the above changes.

2. **M&E Training for all HIV React NGOs by AFEW Kazakhstan** should be conducted once the revised AMEP has been approved.

3. **The USAID/CA M&E Advisor should have a greater level of engagement** in strengthening the capacity of AFEW Kazakhstan’s routine program monitoring, including detailed reviews of all strategic information (SI)-related documents and cross-validations before submission to the AOR. At a minimum, quarterly meetings should be conducted between the M&E and Technical Advisors from USAID/CA and AFEW Kazakhstan program and M&E staff, (with more frequent meetings initially), to review project results, identify potential leakage points within the clinical cascade, and thoroughly review the quality of data submitted.

4. **The HIV React M&E Advisor should be relocated to AFEW Kazakhstan’s office.**
5. **Strengthen the AFEW Kazakhstan M&E advisor's capacity** by budgeting and providing relevant professional development opportunities (e.g. online M&E courses, in-person M&E training).

6. **Prior to the implementation of React’s MIS**, standard operating procedures and protocols on the collection, storage, and management of program data at AFEW Kazakhstan should be developed by HIV React (with support from USAID/CA).

7. USAID/CA should translate all relevant PEPFAR Monitoring and Evaluation Guidance 2.0 (MER 2.0) indicators and MER 1.0 (2015) indicators (i.e. CARE_COMM, TB_SCREEN) into Russian. USAID/CA should then conduct an in-person training for AFEW Kazakhstan on the new PEPFAR 2.0 indicators and a refresher course on relevant MER 1.0 indicators.

8. Development of the patient-level MIS by AFEW Kazakhstan should be undertaken after the revised Phase II AMEP is finalized and approved.

9. As part of the MIS development, AFEW Kazakhstan should consider including systems interoperability among HIV React’s NGO implementing partners so that ex-prisoners who migrate or return to an oblast different from the prison where s/he was released can be referred, linked and monitored within the MIS by AFEW Kazakhstan and the respective NGOs (transferred out/transferred in). For example:
   a. Post-release PWID can be documented as linked into prevention and testing services from one HIV React NGO implementing partner (pre-release) to another HIV React NGO implementing partner (post-release)
   b. A post-release PLHIV who initiated ART in prison (with support from Answer) and was later successfully linked to Pavlodar Oblast AIDS Center (with support from Gerlita) can be documented as a successful post-release ART transfer.

10. AFEW Kazakhstan and PSI, in close collaboration with USAID/CA M&E Advisor, should develop joint operating procedures for the HIV React and HIV Flagship projects to properly document the transfer of ex-prisoners between the projects.

11. All M&E-related HIV React documents and indicator reporting requirements need to be reexamined and validated by AFEW Kazakhstan to minimize inconsistencies and incongruities.

**AFEW/KZ PROJECT MANAGEMENT**

1. Increase regular communication regarding technical needs and implementation issues between AFEW/KZ and SPIN Plus and Hayoti Nav in Tajikistan. This includes quarterly in-person discussions and ongoing liaison as needed between AFEW/KZ and the local implementing partners to familiarize AFEW/KZ with the local context, with the agenda determined by the needs of the NGOs, rather than solely from AFEW/KZ, to ensure successful program outcomes are obtained.

2. AFEW Kazakhstan should consider providing joint trainings, as appropriate, with its NGO implementing partners in order to develop their capacity. There should also be some capacity for NGO-provided country-based trainings to respond to local needs.
3. USAID and CDC should identify external trainings provided by the Flagship Project, ICAP, and others, which would be of benefit to AFEW/KZ and its NGO implementing partners.
4. USAID Central Asia should assess whether additional engagement by the USAID Central Asia Financial and Management Office is needed to provide TA to AFEW/KZ in financial planning.
ANNEX II: ADDITIONAL DATA

Data on HIV cases detected in prisons and number of PLHIV on ART in prisons

Data in Figures 1 – 3 was extracted from the AFEW Kazakhstan Technical and Cost Application, June 2016 – December 2019. Please note that prison populations are highly dynamic and data presented in these figures represents cross-sectional data available in 2016 and may be different from data cited in the main section of the evaluation report.

Figure 1. Number of HIV cases detected and PLHIV on ART in prisons in Pavlodar and Ust-Kamenogorsk, Kazakhstan, 2016
Figure 2. Number of HIV cases detected and PLHIV on ART in prisons in Bishkek and Chui Oblast, Kyrgyz Republic, 2016

DATA ABOUT HIV IN CHUY REGION AND BISHKEK CITY, KYRGYZSTAN
Figure 3. Number of HIV cases detected and PLHIV on ART in prisons in Dushanbe and Sughd Region, Tajikistan, 2016
### Table 2. Cross-sectional data on prison population by region for HIV React sites in Kazakhstan, 2016

<table>
<thead>
<tr>
<th>HIV React NGO implementing partner</th>
<th>Prison</th>
<th>Project Site</th>
<th>Prison population per colony</th>
</tr>
</thead>
<tbody>
<tr>
<td>GERLITA</td>
<td>Colony AP 162/2</td>
<td>Pavlodar city</td>
<td>592</td>
</tr>
<tr>
<td>GERLITA</td>
<td>Colony AP 162/3</td>
<td>Pavlodar city</td>
<td>650</td>
</tr>
<tr>
<td>GERLITA</td>
<td>Colony AP 162/4</td>
<td>Pavlodar city</td>
<td>623</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>1,865</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Pavlodar Oblast</strong>: total prison population 2,475</td>
<td></td>
</tr>
<tr>
<td>ANSWER</td>
<td>Colony 156/3</td>
<td>Ust-Kamenogorsk city</td>
<td>744</td>
</tr>
<tr>
<td>ANSWER</td>
<td>Colony 156/20</td>
<td>Ust-Kamenogorsk city</td>
<td>266</td>
</tr>
<tr>
<td>ANSWER</td>
<td>Colony 156/2</td>
<td>Ust-Kamenogorsk city</td>
<td>508</td>
</tr>
<tr>
<td>ANSWER</td>
<td>Colony 156/18</td>
<td>Zharma</td>
<td>808</td>
</tr>
<tr>
<td>ANSWER</td>
<td>Colony 156/21 (FEMALE)</td>
<td>Zharma</td>
<td>295</td>
</tr>
<tr>
<td>ANSWER</td>
<td>Colony 156/6</td>
<td>Shemonaikha</td>
<td>605</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>3,226</strong></td>
</tr>
<tr>
<td><strong>Source</strong>: AFEW Kazakhstan</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 3. Cross-sectional data on prison population by region for HIV React sites in Kyrgyz Republic, 2016

<table>
<thead>
<tr>
<th>HIV React NGO implementing partner</th>
<th>Prison</th>
<th>Project site</th>
<th>Prison population per colony</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFEW/KR</td>
<td>Colony IK 47</td>
<td>Bishkek city</td>
<td>668</td>
</tr>
<tr>
<td><strong>AFEW/KR</strong></td>
<td>Colony IK 16</td>
<td>Moscow</td>
<td>854</td>
</tr>
<tr>
<td><strong>AFEW/KR</strong></td>
<td>Colony IK 2 (FEMALE)</td>
<td>Alamudun</td>
<td>291</td>
</tr>
<tr>
<td><strong>AFEW/KR</strong></td>
<td>Colony IK 31</td>
<td>Alamudun</td>
<td>396</td>
</tr>
<tr>
<td>Harm Reduction Network</td>
<td>Colony IK 3</td>
<td>Issyk-Ata</td>
<td>985</td>
</tr>
<tr>
<td>Harm Reduction Network</td>
<td>Colony IK 1</td>
<td>Alamudun</td>
<td>1000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>4,194</strong></td>
</tr>
<tr>
<td><strong>Source</strong>: AFEW Kazakhstan</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 4. Cross-sectional data on prison population by region for HIV React sites in Tajikistan, 2016

<table>
<thead>
<tr>
<th>HIV React NGO implementing partner</th>
<th>Prison</th>
<th>Project site</th>
<th>Prison population per colony</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hayoti Nav</td>
<td>Colony YAIS 3/5</td>
<td>Khujand city</td>
<td>912</td>
</tr>
<tr>
<td>Hayoti Nav</td>
<td>Colony YAIS 3/3</td>
<td>Khujand city</td>
<td>1068</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>1,980</strong></td>
</tr>
<tr>
<td>SPIN Plus</td>
<td>Colony YAIS 3/1</td>
<td>Dushanbe</td>
<td>1440</td>
</tr>
<tr>
<td>SPIN Plus</td>
<td>Colony YAIS 3/4</td>
<td>Dushanbe</td>
<td>1949</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>3,389</strong></td>
</tr>
</tbody>
</table>

Source: AFEW Kazakhstan

Figure 4. HIV React Results Framework Phase II

Results Framework

1. Increase coverage of PWID by HTC services
2. To create conditions for increasing access of PLHIV to ARV treatment
3. To create conditions for maintaining adherence to ART

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34 Phase II Activity Monitoring and Evaluation Plan (AMEP): HIV React Project, 2016
List of illustrative proposed indicators recommended for React Phase II

Finalization of revised indicators should be completed by AFEW/KZ, in close collaboration with USAID/CA and the local M&E consultant engaged to revise the HIV React AMEP.

Prevention interventions for all target populations (pre- and post-release prisoners, PLHIV, PWID, and sexual partners of PLHIV and PWID):

1. Number of key populations reached with individual and/or small group-level HIV prevention intervention(s) designed for the target populations (KP_PREV)\(^{35}\)
   a. Disaggregated by: Male PWID; Female PWID; people in prisons (male); and people in prisons (female)
   b. Disaggregated by: known positive, newly tested and/or referred for testing, declined testing or referral

2. Number of the priority populations reached with the standardized, evidence based intervention(s) required that are designed to promote the adoption of HIV prevention behavior and service update (PP_PREV)
   a. Disaggregated by: sexual partners of PWID; sexual partners of PLHIV
   b. Disaggregated by: known positive, newly tested and/or referred for testing, declined testing or referral
   c. Disaggregated by sex and age:
      i. Male: 10-14, 15-19, 20-24, 25-49, 50+
      ii. Female: 10-14, 15-19, 20-24, 25-49, 50+

3. Number of individuals [reached with the project interventions] who received HIV Testing Services and received their results (HTS_TST)\(^{36}\)*
   a. Disaggregated by: Community service delivery modality
   b. Disaggregated by: Facility service delivery modality/results received
   c. Disaggregated by: Service delivery modality/Age/Sex/Results received (coarse age disaggregation)

---

\(^{35}\) PEPFAR MER 2.0 key populations disaggregations are mutually exclusive (an individual cannot be classified as both PWID and prisoner even though s/he is identified as both). Therefore, for the purpose of this project, only those who are post-release PWID should be identified as PWID. PWID who are in prison at the end of the reporting period will be identified as prisoners.

d. Disaggregated by: Key Populations/Test results (female and male PWID, female and male prisoners)\textsuperscript{37}

e. Disaggregated by Priority Populations/Sex/Test results (female and male sexual partners of PWID, female and male sexual partners of PLHIV)\textsuperscript{38}

*All HIV React clients who test HIV positive should be followed by the project in one of the two continuum of care and treatment cascades, as outlined below.

**Continuum of Care and Treatment Cascade for PLHIV in prison**

4. Number of PLHIV who have received ART literacy mini-sessions and/or adherence counseling from peer navigators/social workers (Customized CARE_COMM)
   a. Disaggregated by: female and male prisoners
   b. Disaggregated by: not currently enrolled in care or treatment; newly enrolled in care (pre-ART), newly enrolled on ART, currently enrolled in care (pre-ART and ART), and currently enrolled on ART\textsuperscript{39}

5. Number of PLHIV who were screened for TB symptoms during the reporting period (Customized TB_SCREEN)

6. Number of PLHIV who have received ART adherence counseling from peer navigators/social workers who are retained on ART at 12 months (Customized TX_RET)
   a. Disaggregated by: female and male prisoners

7. Number of PLHIV who have received ART adherence counseling from peer navigators/social workers and are currently on ART with a viral load result documented in the medical record in the past 12 months (Customized TX_PVLS)\textsuperscript{40}
   a. Disaggregated by: suppressed viral load (<1000 copies/ml); viral load not suppressed (>1,000 copies/ml)
   b. Disaggregated by: female and male prisoners

**Continuum of Care and Treatment Cascade for post release PLHIV**

8. Number of individuals who are known to be HIV positive at the time of release from a prison supported by React during the reporting period
   a. Disaggregated by: male and female
   b. Disaggregated by: Currently on ART, not on ART

\textsuperscript{37} PEPFAR MER 2.0 key populations disaggregations are mutually exclusive (an individual cannot be classified as both PWID and prisoner even though s/he is identified as both). Therefore, for the purpose of this project, only those who are post-release PWID should be identified as PWID. PWID who are in prison at the end of the reporting period will be identified as prisoners.

\textsuperscript{38} Disaggregation of priority population/result is not part of PEPFAR MER 2.0, but only specific to React

\textsuperscript{39} Customized CARE_NEW, TX_NEW, CARE_CURR, and TX_CURR

\textsuperscript{40} Contingent upon availability of and access to viral load data
9. Number of individuals who are known to be HIV positive at the time of release and are successfully referred to a NGO serving post-release prisoners within one month upon release
   a. Disaggregated by: male and female
   b. Disaggregated by location: successfully linked to React NGO in same oblast where individual was released; another React NGO in a different oblast from where individual was released; another non-React NGO

10. Number of PLHIV who are enrolled in HIV care and treatment (at Republican or Oblast AIDS Center) within one month upon release from prison
   a. Disaggregated by: male and female
   b. Disaggregated by: Currently on ART, not on ART

11. Number of PLHIV who are retained on ART 6 months post-release
   a. Disaggregated by: male and female

12. Number of PLHIV who are successfully transferred to HIV Flagship project 6-9 months post-release
   a. Disaggregated by: male and female

13. Number of PLHIV who have received ART adherence counseling from peer navigators/social workers and are currently on ART with a viral load result documented in the past 12 months (Customized TX_PVLS)\(^41\)
   a. Disaggregated by: suppressed viral load (<1000 copies/ml); viral load not suppressed (≥1,000 copies/ml)
   b. Disaggregated by: female and male prisoners

**Additional indicator outside of the prevention to care and treatment continuum:**

14. Number of post-release prisoners who are receiving supportive services from React
   a. Disaggregated by: male and female
   b. Disaggregated by services received: e.g. legal services, identification and documentation recovery; transitional housing, social integration counseling, psychosocial support, employment service assistance\(^42\)

\(^41\) Contingent upon availability of and access to viral load data
\(^42\) Services are not mutually exclusive
ANNEX III. SCOPE OF WORK

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

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)

TITLE: Midterm Evaluation of HIV REACT Project for Key Populations in Detention and Post-detention Centers in Three Countries in Central Asia

Requester / Client
☐ USAID Central Asia Mission
Mission/Division: Central Asia / Health and Education Office

Location(s) of Assignment: (Indicate where work will be performed)
Central Asia: Ust-Kamenogorsk and Pavlodar in Kazakhstan, Bishkek and Chui Oblast in Kyrgyzstan, and Dushanbe and Khujand in Tajikistan.

Type of Analytic Activity (Check the box to indicate the type of analytic activity)

EVALUATION:
☐ Performance Evaluation (Check timing of data collection)
  ☐ Midterm ☐ Endline ☐ Other (specify): Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.

☐ 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; impact evaluations 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.

OTHER ANALYTIC ACTIVITIES
☐ Assessment
Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

☐ Costing and/or Economic Analysis
Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

☐ Other Analytic Activity (Specify)

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:

<table>
<thead>
<tr>
<th>Project/Activity Title:</th>
<th>HIV REACT Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Award Number:</td>
<td>Cooperative Agreement # AID-176-A-14-00002</td>
</tr>
<tr>
<td>Award Dates:</td>
<td>June 11, 2014 – December 31, 2019</td>
</tr>
<tr>
<td>Project/Activity Funding:</td>
<td>$5,934,997</td>
</tr>
<tr>
<td>Implementing Organization(s):</td>
<td>AIDS Foundation East West - Kazakhstan</td>
</tr>
<tr>
<td>Project/Activity AOR:</td>
<td>Elmira Imambakiyeva/AOR</td>
</tr>
<tr>
<td>Activity Manager</td>
<td>Marina Kozhevnikova/USAID CAR SPO Evaluation Advisor</td>
</tr>
</tbody>
</table>

Background of project/program/intervention:

At the end of 2013, there were an estimated 1.1 million [0.98 million–1.3 million] PLHIV in Eastern Europe and Central Asia, which accounts for 3% of the global number of PLHIV. In Kazakhstan, official statistics count 18,247 PLHIV; in Tajikistan 5,561 PLHIV are officially registered, with virtually the same number in the Kyrgyz Republic (5,504). 43 although the real population sizes of PLHIV are estimated to be significantly larger due to under-testing of key populations (KPs). The HIV epidemic in the Central Asia Region (CAR) continues to grow, and is primarily concentrated

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43 Kazakhstan, Kyrgyz Republic, and Tajikistan EHCMS, respectively, 2014
among people who inject drugs (PWID) and their sexual partners. The epidemiological data shows that female sex workers (FSW) and men who have sex with men (MSM) are also disproportionately affected by HIV/AIDS. The number of new HIV infections in Central Asia began increasing towards the end of the last decade after having remained relatively stable for several years since 2000. Sixty percent of the cumulative HIV cases in this region have been reported among PWID. Heterosexual transmission among PWID is known to be of significant importance, but the proportion of sexual transmission independent of drug use is not known.

While the HIV prevalence among the general population in the three countries is at or below 0.10%, rates among KPs range from 1.0% to 13.0%. Within each country, the HIV prevalence rate, KP population size, and number of PLHIV vary significantly across oblast (region) and city. In all three countries, the regions and cities that align with international drug trafficking routes have high numbers of PWID and PLHIV. In Tajikistan, over 50% of all reported PLHIV live in five cities (Dushanbe, Vakhdat, Khujand, Penjikent and Kulyab); PWID HIV prevalence rates range from 6.4% in Kulyab to 26.5% in Dushanbe. Countries in this region face several similar obstacles in achieving the targets set out in the UNAIDS "Fast Track – Ending the AIDS Epidemic by 2030" Initiative, including: (1) punitive and discriminatory laws and policies toward KPs; (2) stigma and discrimination from communities, health providers and law enforcement officials that marginalize KPs and limits access to and uptake of HIV related services; (3) incomplete epidemiological data on the size and location of these populations (especially FSW and MSM) to help strategically target services; and (4) limited coverage and quality of an evidence-based HIV continuum of care (including harm reduction for PWID) that will ensure PLHIV achieve long-term viral suppression.

According to the European Center for Disease Prevention and Control, overall low coverage and limited access to HIV-related services among KPs and high rates of late diagnosis limits governments’ ability to achieve epidemic control in this region. All three countries experience challenges in reaching KPs living with HIV/AIDS and ensuring they are linked to and supported through the continuum of care.

The national HIV/AIDS programs in CAR countries are designed to ensure maximum coverage of KPs by HIV testing and to ensure ARV treatment is available for all people living with HIV. The number of HIV tested KPs and those on ARV therapy in the region is increasing, but some important activities in the cascade of services are still missing. Either HIV testing is not accompanied by pre- and post-test counseling or the counseling is low quality. People living with HIV do not receive quality counseling in preparation for ARV treatment and maintaining adherence. The majority of PLHIV do not receive any psycho-social support. This is due to the lack of counselors and social workers in AIDS centers and primary health care facilities. KPs, including PWID, who test negative often continue with risky behavior due to stigma in society, myths about HIV infection and ARV treatment, and the lack of reliable information about HIV. A significant number of PLHIV who start ARV treatment often stop taking their medication because they are not receiving treatment adherence support.

45 World Health Organization, Central Asia HIV Profile, 2013
The situation in the penal system is direr. Only a small percentage of infected prisoners are currently receiving HIV treatment. In KG, for example, an estimated 800 prisoners are HIV positive and only 360 of them (45%) are currently receiving ARV treatment. Of those receiving treatment, a high percentage default. Most prisons in Central Asia lack personnel who have sufficient knowledge and experience in administering ARV and TB treatment and managing side effects. Prisons also have limited or no access to timely viral load testing services. AIDS Center specialists visit prisons upon request from prison officials and prescribe ARV treatment to prisoners, but they are not able to monitor and supervise treatment adherence regularly. Penal system medical departments are separate from and not under the control of Ministries of Health. Penal system medical departments required adhering to MoH guidelines and protocols; however, there is no formal oversight role to ensure this is taking place. However, once the patients on ARV treatment released from prison they are linked to AIDS Centers and Family Medicine Centers.

Prison policy is total eradication of drug use in prisons. As a result, prison authorities deny drug use and the official number of drug users in prison is artificially understated. This trend is an obstacle not only for harm reduction program interventions (needle exchange and medication assisted treatment [MAT]), but also makes prisons less accessible for HIV prevention programs.

The primary objective of the HIV REACT Project is to reduce HIV transmission in Tajikistan, Kyrgyz Republic, and Kazakhstan, among key populations (PWID) and PLHIV in prisons and after release.

Currently implemented in Kazakhstan, Kyrgyz Republic, and Tajikistan, the HIV REACT Project has received a cost and time extension for three years from June 11, 2016 to December 31, 2019. During the extended period, the Project will continue to support outreach activities to PWID and PLHIV who have already been enrolled in the program, and at the same time, will expand coverage and service provision for PWID and PLHIV. The project is moving beyond HIV prevention among general prison population to HIV case identification, linkage to treatment and provision of support for improved adherence to ARV treatment. Activities will include individual and group education mini-sessions for risk assessment purposes, referrals to HIV testing, linking PLHIV to ART, and provision of community support for PLHIV during treatment in accordance with UNAIDS 90-90-90 goals. The HIV REACT Project will also support coordination mechanisms in the form of existing Working Groups at the local level in project sites to enhance collaboration between NGOs, AIDS centers, Narcology Centers and the penal system; the project will conduct regular joint monitoring visits to prison settings with representatives from the Departments of Penal System, AIDS centers, Narcology Centers, TB dispensaries, and NGOs to monitor the quality and accessibility of medical services inside the prison; the project will provide transitional client management to PLHIV to help them to reintegrate in the society after release; organize self-help groups inside the prisons for PWID and for PLHIV with a special focus on those who are going to start ART, or have already started, in order to improve adherence to ART and prevent treatment interruption. Also, the project plans to develop and launch a mobile application for imprisoned and released PLHIV who are on ART for improving adherence to treatment, providing information about treatment and contacting doctors in case of emergency. The project is working through its sub-awardees – NGO “Answer” in Ust-Kamenogorsk (KZ), NGO “Gerlita” in Pavlodar (KZ), NGO “AFEW-Kyrgyzstan” (Bishkek, KG) and NGO “Harm Reduction Network – Kyrgyzstan” (KG, Chui Oblast), NGO “Spin Plus” in Dushanbe (TJ) and NGO “Hayeti Nav” in Khujand (TJ).

48 Power Point Presentation by Kyrgyz Republic Republican AIDS Center at the meeting on June 7, 2016
Strategic or Results Framework for the project/program/intervention

The program objectives are outlined in the HIV REACT Project Results Framework:

Figure 1: HIV REACT Project Results Framework

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

- The geographic coverage of the HIV REACT Project is: Ust- Kamenogorsk and Pavlodar in Kazakhstan, Bishkek and Chui Oblast in Kyrgyzstan, and Dushanbe and Khujand in Tajikistan.
- The project’s target groups are PWID and PWID PLHIV in prisons and PLHIV after release in these locations.

SCOPE OF WORK

A. Purpose: Why is this evaluation or analysis 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.

The main purpose of the program evaluation is to:

1) To assess how well REACT is making the transition from general HIV prevention to case identification, linkage to ARV treatment and forming adherence at the PEPFAR sub-national unit (SNU) level, prisons, and community-based service levels; identify implementation gaps/challenges; determine how well the project is achieving its goals, objectives, and performance targets/results.

2) To document lessons learned and provide recommendations that will inform future programming directions for HIV REACT project.

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

(listed in order of importance)
- USAID/CAR Health and Education Office
- USAID/Kyrgyz Republic
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C. Applications and use: How will the findings be used? What future decisions will be made based on these findings?

- Findings and recommendations from this program evaluation will be used for further improvement and direction for the remaining activity period.
- The evaluation will be used to decide whether or not the USG should continue investing in this area and if so, how (i.e., should there be a follow on and if so, how should it be designed).

D. Evaluation/Analytic Questions & Matrix:
   a) Questions should be: a) aligned with the evaluation/analytic purpose and the expected use of findings; b) clearly defined to produce needed evidence and results; and c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation/analytic questions. **USAID policy suggests 3 to 5 evaluation questions.**
   b) List the recommended methods that will be used to collect data to be used to answer each question.
   c) State the application or use of the data elements towards answering the evaluation questions; for example, i) ratings of quality of services, ii) magnitude of a problem, iii) number of events/occurrences, iv) gender differentiation, v) etc.

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Evaluation Methods</th>
<th>Application or Data Use</th>
</tr>
</thead>
</table>
| 1 How well REACT is making the transition from general HIV prevention to case identification, linkage to ARV treatment and forming adherence? | ● Document & data review  
● Key informant interviews  
● Secondary data analysis  
● Focus Group Discussions | ● Feedback for course correction  
● Recommendations for project improvement and future project(s) |
| 2 What are the project’s strengths, weaknesses, and gaps in planning, management, and service delivery? | ● Document & data review  
● Key informant interviews  
● Secondary data analysis  
● Focus Group Discussions  
● Survey | ● Feedback for course correction  
● Recommendations for project improvement and future project(s) |
| 3 What are the constraints to successful implementation of this program? | ● Document & data review  
● Key informant interviews  
● Secondary data analysis  
● Survey | ● Feedback for course correction  
● Recommendations for project improvement and future project(s) |

At the conclusion of the evaluation, it is expected that the following recommendations will be provided to USAID/CAR:
   1) Recommendations to build on strengths, correct weaknesses and improve implementation to enable USAID and implementing agency staff to develop a course of action for the remainder of the activity.

E. Methods: Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation/analytic questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.
The evaluation team can decide what method they think would work best to address the evaluation questions.

This evaluation will collect information about the success of AIDS Foundation East West - Kazakhstan in shifting the HIV REACT Project implementation from general HIV prevention among prisoners to HIV case identification, linkage to ARV treatment and forming adherence. Whenever possible, the evaluation should mention gaps in programming as well as innovations and successes, both of which will inform the design of any follow-on activities by USAID CAR.

Data Quality
The qualitative and quantitative data used in this evaluation should meet the following five data quality standards in accordance to USAID’s Automated Directive System (ADS) 203: 1) Validity; 2) Integrity; 3) Precision; 4) Reliability; and 5) Timeliness.

Limitations
This is a midterm performance evaluation of a USAID-funded project; it is not intended to be a rigorous quasi-experimental or experimental design outcome or impact evaluation with predetermined counterfactual groups. Access to the prisons/detention settings and data regarding prisoners may be limited.

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

This desk review will be used to provide background information on the project/program, and will also provide data for analysis for this evaluation. Documents and data to be reviewed include:

- AIDS Foundation East West - Kazakhstan Cooperative Agreement, including modification documents
- Annual Reports
- Quarterly Reports
- Work plans
- AIDS Foundation East West - Kazakhstan monitoring and other internal reports
- AIDS Foundation East West - Kazakhstan AMEP (Monitoring and Evaluation Plan) and data
- National HIV/AIDS Country Strategies
- Central Asia PEPFAR Regional Operational Plan (ROP) 2015 and 2016 Strategic Direction Summary
- PEPFAR 3.0 “Controlling the Epidemic: Delivering on the Promise of an AIDS-free Generation”
- Reports of GOVK partners (prison system, RAC, RCN) within the PEPFAR projects in prisons
- National policies/guidelines on prisoners in Central Asia (if available)
- USAID Evaluation Policy (January 2011)
- WHO Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations (July 2014)
- UNAIDS and regional reports on HIV and prisons
Information from the Annual Reports can provide useful data and is disaggregated by sex, age and geographic location in accordance with PEPFAR Monitoring, Evaluation, and Reporting (MER).

- **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)*

A thorough review of existing data, and descriptive statistical analysis (including the construction of the clinical cascade from AIDS Foundation East West - Kazakhstan program data). Possible datasets for re-analysis are listed below.

<table>
<thead>
<tr>
<th>Data Source (existing dataset)</th>
<th>Description of data</th>
<th>Recommended analysis</th>
</tr>
</thead>
</table>
| Key Populations project monitoring data routinely collected by AIDS Foundation East West - Kazakhstan | Data routinely collected as part of the project, primarily for indicator reporting and management purposes. | ● Confirm findings as reported in Quarterly and Annual reports.  
● Trends over time since the beginning of the project  
● Sub-analyses of routine data (e.g., by location/site, sex, age, PWID PLHIV vs. non-PWID PLHIV, duration of prison terms) |

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

Interviews will be conducted using a semi-structured question guide. Key informants will include, but not limited to:
- USAID Mission staff, including relevant members from the Health and Education Office in three countries
- USG staff members, including CDC in addition to USAID staff
- HIV REACT Project staff and sub-partners’ staff (six local NGOs: “Answer” in Ust-Kamenogorsk and “Gerlita” in Pavlodar in Kazakhstan,” AFEW Kyrgyzstan” and “HRN” in Kyrgyzstan, and “SPIN Plus” in Dushanbe and “Hayeti Nav “in Khujand in Tajikistan)
- Government of CAR representatives – Medical Departments of Penal System, Narcology Centers, Republican AIDS Centers, District/City AIDS Centers, Country Coordination Committees (CCM), etc.
- Beneficiaries (prison medical staff, social workers, peer navigators, PLHIV, prisoners, ex-prisoners, etc.)
- Other donor and implementing partners (PSI, GFATM, UNODC, UNAIDS etc.)
- Representatives of CSOs, especially those that advocate for PWID, prisoners, and PLHIV.

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

To investigate strengths, weaknesses, successes and challenges as seen by the beneficiaries of the HIV REACT project. It should be possible to hold focus group discussion (FGD) in Kyrgyzstan prisons, but very unlikely in Tajikistan. The Mission will investigate the possibility of a FGD in Kazakhstan.

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

Some Key Informants (see above) can be clustered into groups for their interview. The Evaluation Team will be cognizant to avoid any power differentials within a group, to insure that all participants in a group feel comfortable sharing their opinions.
☐ Client/Participant Satisfaction or Exit Interviews (list who is to be interviewed, and purpose of inquiry)

☐ Survey (list and describe files or documents that contain information of interest, and purpose of inquiry)

The Evaluation Team may want to consider a mini-survey as one of the methods to collection standard information across a range of respondents.

☐ Data Abstraction (list and describe files or documents that contain information of interest, and purpose of inquiry)

☐ Case Study (describe the case, and issue of interest to be explored)

☐ Verbal Autopsy (list the type of mortality being investigated (i.e., maternal deaths), any cause of death and the target population)

☐ Rapid Appraisal Methods (ethnographic / participatory) (list and describe methods, target participants, and purpose of inquiry)

☐ Other (list and describe other methods recommended for this evaluation/analytic, and purpose of inquiry)

If impact evaluation –

Is technical assistance needed to develop full protocol and/or IRB submission?

☐ Yes  ☐ No

List or describe case and counterfactual

<table>
<thead>
<tr>
<th>Case</th>
<th>Counterfactual</th>
</tr>
</thead>
</table>

**HUMAN SUBJECT PROTECTION**

The Evaluation 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 attendance. 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**

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data it to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

The evaluation will:

1. Review information related to the relevant HIV/AIDS and health issues being addressed and determine the effectiveness of current initiatives of HIV REACT Project.
2. See if current indicators are appropriate and provide recommendations if not.
3. Make recommendations for a follow-on the activity design to USAID/CAR.

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, site and country, whenever feasible. Other statistical test of association (i.e., odds ratio) and correlations will be run as appropriate.

Data triangulation and the use of analysis methods that are both quantitative and qualitative, will allow the Team to produce more robust evaluation results.

The Evaluation Report will describe analytic methods and statistical tests employed (if relevant) in this evaluation.

**ACTIVITIES**

List the expected activities, such as Team Planning Meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and Deliverables may overlap. Give as much detail as possible.

**Background reading** – Several documents are available for review for this analytic activity. These include HIV REACT Project proposal, annual work plans, M&E plans, quarterly progress reports, and routine reports of project performance indicator data, government data, UNAIDS report, policy briefs, as well as survey reports. 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)** – The TPM be initiated remotely before the Team convenes in Almaty, and then will completed following the in-brief with USAID/CAR once the Team arrived in-country, before the data collection begins. During the TPM the team will finalize:

- 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
Midterm Evaluation of HIV REACT Project for Key Populations in Three Countries in Central Asia

- Review and finalize evaluation questions
- Review and finalize the assignment timeline
- Develop and finalize data collection methods, instruments, tools and guidelines
- Review and clarify any logistical and administrative procedures for the assignment

**Briefing and Debriefing Meetings** – Throughout the evaluation the Team Lead will provide briefings to USAID. The In-Brief and Debrief are likely to include the 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**. This briefing will take place at the beginning of the TPM, so the Evaluation Team and USAID can discuss expectations and review Evaluation Questions, as well as a review or the Evaluation Workplan, Methods and data collection tools. The time and place for this in-brief will be determined between the Team Lead and USAID prior to the TPM.

- **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. This in-brief with REACT can be conducted as an introduction, followed by key informant interviews.

- **In-brief with USAID country offices in Tajikistan and Kyrgyzstan**. As the Team arrives in each country, they will brief the USAID staff in that country about the Evaluation and activities in the country.

- 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. USAID provides the selection of sites in this SOW, on page 17 (Travel Anticipated). 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 Report** – The evaluation 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 draft evaluation 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. 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
5. GH Pro will review and reformat the final Evaluation Report, as needed, and resubmit to USAID for approval.
6. Once Evaluation Report is approved, GH Pro will re-format it for 508 compliance and post it to the DEC.
7. Conduct an official briefing to all stakeholders outside of USAID and GH Pro to disseminate evaluation results.

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 quantitative 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, qualitative 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. AOR would like to set these deadlines with the selected team lead.

<table>
<thead>
<tr>
<th>Deliverable / Product</th>
<th>Timelines &amp; Deadlines (estimated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Launch briefing</td>
<td>October 17, 2016</td>
</tr>
<tr>
<td>[ ] Virtual Team Planning Meeting (TPM)</td>
<td>October 24 - November 2, 2016</td>
</tr>
<tr>
<td>[ ] In-brief with Mission</td>
<td>November 7, 2016</td>
</tr>
<tr>
<td>[ ] Team Planning Meeting (TPM)</td>
<td>November 8-9, 2016</td>
</tr>
<tr>
<td>[ ] Workplan with timeline</td>
<td>November 9, 2016</td>
</tr>
<tr>
<td>[ ] Evaluation protocol with data collection tools</td>
<td>November 9, 2016</td>
</tr>
<tr>
<td>[ ] In-brief with AIDS Foundation East West - Kazakhstan HIV REACT project</td>
<td>November 10, 2016</td>
</tr>
<tr>
<td>[ ] Routine briefings</td>
<td>Weekly</td>
</tr>
<tr>
<td>[ ] Debrief with Mission with Power Point presentation</td>
<td>December 2, 2016</td>
</tr>
<tr>
<td>[ ] Debrief with AIDS Foundation East West - Kazakhstan HIV REACT project &amp; stakeholders??</td>
<td>December 5, 2016</td>
</tr>
</tbody>
</table>
| [ ] Draft report | Submit to GH Pro: December 22, 2017  
GH Pro submits to USAID: December 29, 2017 |
| [ ] Final report | Submit to GH Pro: January 25, 2017  
GH Pro submits to USAID: January 30, 2017 |
| [ ] Raw data | January 25, 2017                  |
| [ ] Report Posted to the DEC | March 8, 2017                   |
Estimated USAID review time
Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? 10 Business days

TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

Evaluation/Analytic team: When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations/analytics must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an Evaluation Specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise related to the analytical skills needed for this activity.
- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

Team Qualifications: Please list technical areas of expertise required for this activities

List the key staff needed for this analytic activity and their roles. You may wish to list desired qualifications for the team as a whole, as well as for the individual team members.

All Evaluation Team Members will:

- Work with Team Lead to finalize and negotiate the team work plan for the assignment;
- Collectively establish assignment roles, responsibilities, and tasks for each team member;
- Work with Team Lead to ensure that the logistics arrangements in the field are complete;
- Participate in Team Planning Meetings to set the agenda and other elements of the program evaluation;
- Responsible for preparing specific sections of report, providing input, developing sections of presentation, and revising the assignment report;
- Contribute to the process of report writing;
- Assist Team Lead with the workflow and tasks in order to ensure that the evaluation adheres to schedule; and
- Assist Team Lead with any supporting logistics, i.e., ensure that team field logistics are arranged (e.g., administrative/clerical support is engaged, ensuring that payment is made for services, car/driver hire or other travel and transport is arranged, etc.).

Members of the evaluation team should be thoroughly familiar with the document entitled “PEPFAR 3.0 Controlling the Epidemic: Delivering on the Promise of an AIDS-free Generation” and UNAIDS 90-90-90 goal and PEPFAR “Test and Treat” model.
**Team Lead (David Lowe):** This person will be selected from among the key staff, and will meet the requirements of both this and the other position. The team lead will have extensive experience conducting health project evaluations, including evaluation of HIV/AIDS projects.

**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/analytic team, and (5) leading briefings and presentations.

**Qualifications:**
- Advanced degree in Public Health, Public Policy/Administration, or a related field
- Minimum of 10 years of experience in public health, which includes experience in implementation of health activities in resource limiting settings
- Demonstrated experience leading health sector project/program evaluation/analytics, utilizing both quantitative and qualitative methods
- Demonstrated ability in designing and implementing development programs on a nation-wide or region-wide basis.
- 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, leadership, teamwork and teambuilding
- 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
- Experience working with KP, PWID, prisoners, and PLHIV
- Familiarity with USAID and PEPFAR project implementation
- Familiarity with USAID and PEPFAR policies and practices
  - Evaluation policies
  - Results frameworks
  - Performance monitoring plans

**Key Staff (1 and 2) Title: HIV Specialists: (Britt Herstad, USAID/Washington and Billy Pick, USAID/Washington)**

**Roles & Responsibilities:** Serve as a member of the evaluation team, providing expertise in HIV, in prevention, treatment, care and support services, particularly for high risk groups. S/He will participate in planning and briefing meetings, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report.

**Qualifications:**
- At least 8 years’ experience with HIV/AIDS projects/programming; USAID project implementation experience preferred
- Expertise in supply and demand for HIV services at the community and clinical level among key populations
- Knowledgeable about HIV/AIDS prevention, clinical services, health systems strengthening, policy, and other issues related to targeted interventions for HIV service delivery for high-risk groups
- Firm understanding of working with HIV high risk groups, including dealing with stigma and discrimination
- Clinical experience would be considered a plus
- Familiar with PEPFAR guidelines and policies, including
  - PEPFAR 1.0 Monitoring, Evaluation, and Reporting Guidance
  - PEPFAR Evaluation Standards of Practice
  - Capacity Building and Strengthening Framework
  - Country Operational Plans (COP)
Site Improvement through Monitoring System (SIMS)

- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Proficient in English
- Good writing skills, specifically technical and evaluation report writing experience
- Experience in conducting USAID evaluations of health programs/activities

**Key Staff**

**3 Title:** Evaluation Specialist (Maria Au, USAID/Washington)

**Roles & Responsibilities:** Serve as a member of the evaluation team, providing quality assurance on evaluation 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
- Experience in design and implementation of evaluations
- Strong knowledge, skills, and experience in qualitative and quantitative evaluation tools
- Experience implementing and coordinating other to implements surveys, key informant interviews, focus groups, observations and other evaluation methods that assure reliability and validity of the data.
- Experience in data management
- Able to analyze quantitative data, which will be primarily descriptive statistics
- Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
- Able to review, interpret and reanalyze as needed existing data pertinent to the evaluation
- Strong data interpretation and presentation skills
- Significant experience in developing and implementing monitoring systems and conducting evaluations for HIV/AIDS prevention and/or impact mitigation and service delivery programs
- An advanced degree in public health, evaluation or research or related field
- Good writing skills, including extensive report writing experience
- Familiarity with USAID health programs/projects, primary health care or health systems strengthening preferred
- Familiarity with USAID and PEPFAR M&E policies and practices
  - USAID Evaluation policy
  - Results frameworks
  - Performance monitoring plans
  - PEPFAR 1.0 Monitoring, Evaluation, and Reporting Guidance
  - PEPFAR 2.0 Monitoring, Evaluation, and Reporting Guidance
  - PEPFAR Evaluation Standards of Practice
Key Staff 4 Title: HIV Key Populations Specialist (Azizbek Boltaev, Regional Consultant)

Roles & Responsibilities: Serve as a member of the evaluation team, providing expertise on HIV, including key populations such as prisoners and people who inject drugs. S/He will participate in planning and briefing meetings, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report.

Qualifications:
- Minimum of 10 years of experience in international development and key populations
- Experience working on health programs/projects, including HIV projects/programs
- Knowledgeable of approaches to improved access to and quality of health care, participation in decision-making, definition of priorities and allocation of resources
- Expertise in analysis and understanding of key populations and HIV in Central Asia, especially prisoners and people who inject drugs
- Demonstrated skills in program mainstreaming
- Experience in project/program implementation focused on HIV prevention, care, and treatment among PWID and prisoners
- Excellent interpersonal skills, including experience successfully interacting with USAID, implementing partners, host government officials, civil society partners, and other stakeholders
- Strong understanding of contextual constraints, health systems, and policies towards key populations, especially PWID and prisoners, in Central Asia
- Proficient in English
- Good writing skills in English, with extensive report writing experience
- Knowledge of UNAIDS and PEPFAR 90-90-90 goal and strategies
- Knowledge of USAID and PEPFAR gender policies and strategies

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

USAID/CAR will provide Evaluation Logistics /Program Assistant support the Evaluation Team. They will arrange local transportation (air & car) as needed throughout the region, as well as assist with arranging appointments, as needed.

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 analytic activity.

☐ Yes – If yes, specify who: USAID/Washington, DC and USAID/CAR will be involved in this evaluation. USAID/W will provide 3 Team members: 2 HIV Technical experts, and 1 Evaluation Specialists. USAID/CAR will provide Logistic/Admin support and Translation/Interpretation support during data collection.
☐ Significant Involvement anticipated – If yes, specify who:
☐ No

Staffing Level of Effort (LOE) Matrix:
This LOE Matrix estimates the LOE needed to implement this analytic activity.
a) Immediately below each staff title enter the anticipated number of people for each titled position.
b) Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.
c) Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.

d) At the bottom of the table total the LOE days for each consultant title in the 'Sub-Total' cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

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

<table>
<thead>
<tr>
<th>Activity / Deliverable</th>
<th>Evaluation Team</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Team Lead (D Lowe)</td>
</tr>
<tr>
<td>Number of persons</td>
<td>1</td>
</tr>
<tr>
<td>Launch Call</td>
<td>0.5</td>
</tr>
<tr>
<td>Desk review</td>
<td>5</td>
</tr>
<tr>
<td>Virtual Team Planning (pre- arrival in Almaty)</td>
<td>3</td>
</tr>
<tr>
<td>Preparation for Team convening in-country</td>
<td></td>
</tr>
<tr>
<td>Travel to country</td>
<td>1.5</td>
</tr>
<tr>
<td>In-brief with Mission w/ prep</td>
<td>1</td>
</tr>
<tr>
<td>Team Planning Meeting (in Almaty)</td>
<td>2</td>
</tr>
<tr>
<td>In-brief with project</td>
<td>0.5</td>
</tr>
<tr>
<td>Data Collection DQA Workshop (protocol orientation for all involved in data collection)</td>
<td>1</td>
</tr>
<tr>
<td>Prep/Logistics for Site Visits</td>
<td></td>
</tr>
<tr>
<td>Data collection / Site Visits (including travel to sites)</td>
<td>12</td>
</tr>
<tr>
<td>Data analysis</td>
<td>6</td>
</tr>
<tr>
<td>Debrief with Mission with prep</td>
<td>1</td>
</tr>
<tr>
<td>Project &amp; Stakeholder debrief with prep</td>
<td>1</td>
</tr>
<tr>
<td>Depart country</td>
<td>1.5</td>
</tr>
<tr>
<td>Draft report(s)</td>
<td>5</td>
</tr>
<tr>
<td>GH Pro Report QC Review &amp; Formatting</td>
<td></td>
</tr>
<tr>
<td>Submission of draft report(s) to Mission</td>
<td></td>
</tr>
<tr>
<td>USAID Report Review</td>
<td></td>
</tr>
<tr>
<td>Revise report(s) per USAID comments</td>
<td>2</td>
</tr>
<tr>
<td>Finalize and submit report to USAID</td>
<td></td>
</tr>
<tr>
<td>508 Compliance Review</td>
<td></td>
</tr>
<tr>
<td>Upload Eval Report(s) to the DEC</td>
<td></td>
</tr>
<tr>
<td>Total LOE per person</td>
<td>43</td>
</tr>
<tr>
<td>Total LOE</td>
<td>43</td>
</tr>
</tbody>
</table>

If overseas, is a 6-day workweek permitted  □ Yes  □ No
Travel anticipated: List international and local travel anticipated by what team members.

It’s preferable to divide the Evaluation Team into two teams. The Evaluation Team decides what team conducts evaluation in what sites. The team(s) will need to travel to HIV REACT Project in Ust-Kamenogorsk and Pavlodar in Kazakhstan (flights from Almaty), Bishkek city and Chui Oblast in the Kyrgyz Republic (flight from Almaty to Bishkek and drive to Chui Oblast), and Dushanbe city in Tajikistan (flight from Almaty) and Khujand city in Tajikistan (flight from Dushanbe).

LOGISTICS

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

GH Pro will send copies of all consultants’ passports to the CAR Mission as soon as the consultants are contracted.

- Consultants should be able to get Tajikistan visa upon entry, but GH Pro will verify if it is better to get prior to travel.
- Consultants with a US or Australian passport do not need a visa for Kyrgyzstan. GH Pro will verify if Kyrgyz visa is needed for consultants with passports from other countries, as needed.
- Consultants with a US or Australian passport can stay in Kazakhstan for up to 15 days without a visa. GH Pro will verify if Kazakh visa is needed for consultants with passports from other countries, as needed.

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

<table>
<thead>
<tr>
<th>Name of Country</th>
<th>Type of Visa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kazakhstan</td>
<td>☐ Tourist</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>☐ Tourist</td>
</tr>
<tr>
<td>Tajikistan</td>
<td>☐ Tourist</td>
</tr>
</tbody>
</table>

Clearances & Other Requirements

Note: Most Evaluation/Analytic Teams arrange their own work space, often in their hotels. However, if Facility Access is preferred GH Pro can request it.

GH Pro does not provide Security Clearances, but can request Facility Access. Please note that Facility Access (FA) requests processed by USAID/GH (Washington, DC) can take 4-6 months to be granted. If you are in a Mission and the RSO can grant a temporary FA, this can expedite the process. If FA is granted through Washington, DC, the consultant must pick up his/her FA badge in person in Washington, DC, regardless of where the consultant resides or will work.

If Electronic Country Clearance (eCC) is required, 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 must 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 (must register approximately 3-4 months in advance). Additionally, there will be the cost for one week’s 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
  Specify who will require Facility Access: All Evaluation Team will require USAID CAR Office access

- Electronic County Clearance (ECC) (International travelers only)
  - High Threat Security Overseas Seminar
  - 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): 

**GH PRO ROLES AND RESPONSIBILITIES**

GH Pro will coordinate and manage the evaluation/analytic 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/analytic 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.

<table>
<thead>
<tr>
<th>USAID Roles and Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Before Field Work</strong></td>
</tr>
<tr>
<td>- SOW</td>
</tr>
<tr>
<td>o Develop SOW</td>
</tr>
<tr>
<td>o Peer Review SOW</td>
</tr>
<tr>
<td>o Respond to queries about the SOW and/or the assignment at large.</td>
</tr>
<tr>
<td>- 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.</td>
</tr>
<tr>
<td>- 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.</td>
</tr>
<tr>
<td>- Local Consultants - Assist with identification of potential local consultants, including contact information.</td>
</tr>
<tr>
<td>- 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.</td>
</tr>
<tr>
<td>- 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).</td>
</tr>
</tbody>
</table>
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.

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**ANALYTIC REPORT**

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

The product of this evaluation will be a final report that evaluates the successes, shortcomings, and lessons learned of HIV REACT project activities that will inform USAID CAR and USG PEPFAR CAR Team.

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

a. The report must not exceed 30 pages (excluding executive summary, table of contents, acronym list and annexes).

b. The structure of the report should follow the Evaluation Report template, including branding found [here](#) or [here](#).

c. Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.

d. For additional Guidance, please see the How-To Note on preparing Evaluation Draft Reports found [here](#).

**Reporting Guidelines:** The draft report should be a comprehensive evidence-based evaluation 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 will be presented as a draft report at a full briefing with USAID. The report should use the following format:

- **Executive Summary:** concisely state the most salient findings, conclusions, and recommendations (not more than 4 pages);
- **Table of Contents** (1 page);
- **Acronyms**
- **Evaluation Purpose and Evaluation Questions** (1-2 pages)
- **Project [or Program] Background** (1-3 pages)
- **Evaluation Methods and Limitations** (1-3 pages)
- **Findings**
- **Conclusions**
- **Recommendations**
- **Annexes**
  - Annex I: Evaluation Statement of Work
  - Annex II: Evaluation Methods and Limitations
- Annex III: Data Collection Instruments
- Annex IV: Sources of Information
  - List of Persons Interviews
  - Bibliography of Documents Reviewed
  - Databases
  - [etc]
- Annex V: Disclosure of Any Conflicts of Interest
- Annex VI: Statement of Differences (if applicable)

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

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, data sets (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 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.
Annex A: Interview guide questions

In order to answer the five main evaluation questions and to provide the appropriate recommendations at the conclusion of the evaluation, the following list provides a set of sample questions under four major themes that the evaluation team must consider: Program Management, Program Accomplishments and Results, Monitoring and Evaluation, and Lessons Learned. However, additional questions can be added during the course of the evaluation when deemed appropriate.

1. Program Management
   
   - Has the project established constructive working relationships with key stakeholders to improve program outcomes (partners, government, NGOs, others)?
   - How have the sub-contractors of AIDS Foundation East West - Kazakhstan adapted to the continuously changing demands and new data collecting initiatives coming from PEPFAR?
   - Is USAID satisfied with communications with project staff, both that of AIDS Foundation East West - Kazakhstan and those of their sub-partners? Are the staff of AIDS Foundation East West - Kazakhstan and their sub-partners satisfied with USAID? What improvements could be made for more effective communication?
   - Do work plans and budgets reflect project priorities? How are they used as project management tools?
   - Have the staff in the prisons and in NGOs received supportive supervision throughout the life of the project? What are their main points of satisfaction and main grievances with the project?
   - Were members of the evaluation team given an opportunity to assess the quality of care provided in the prisons and after release? If yes, what are their impressions?

2. Program Accomplishments and Results:
   
   - Does the project have well-reasoned strategies to achieve its goals, objectives and indicators within the life of project? Is the vision and direction still valid or should there be changes or new approaches?
   - Is the project truly reaching the populations they are targeting? Are the target populations reached effectively?
   - Is there a progress in shifting the program from general HIV prevention to HIV case identification, linking to treatment, and provision of adherence?
   - What has been the effectiveness and quality of program inputs (training, systems developed, guidelines, services, etc.)? Are they timely and appropriate to achieving program goals and objectives? Is adequate technical leadership available among local project staff or from partner HQ staff, consultants, etc.? Are HQ staff or consultants used appropriately and judiciously?
   - How the REACT management works/communicates with USAID CAR?
   - How effective is AIDS Foundation East West - Kazakhstan approach to capacity building for local organizations? Has the program achieved its goals and objectives in this area?
   - Is the project creating parallel service delivery systems from the government’s established system? Are the services implemented or supported by the project well integrated into the government’s established system? What has the project done to build health systems and human resources capacity at different levels within the CAR Governments or other local partners? Are the activities implemented by AIDS
Midterm Evaluation of HIV REACT Project for Key Populations in Three Countries in Central Asia

Foundation East West - Kazakhstan in alignment with the National HIV/AIDS strategy? Have the project’s collaborations and partnerships been successful? Does the project work to effectively use available skills of all partners? How successful has the project been in leveraging resources from other donors and partners to maximize impact? How has this project complemented work done under other PEPFAR projects and avoided duplication?

- To what degree are CAR Governments and other partner’s replicating/scaling-up project best practices and models?
- Is there evidence that AIDS Foundation East West - Kazakhstan approach has:
  - Introduced and improved the quality and availability of care and treatment services for prisoners and ex-prisoners?
  - Improved referral linkages specific to PLHIV and PWID between community and facility level and within the facility level.
- Is the REACT project’s referral system effective? What are the gaps in service provision of quality comprehensive HIV/AIDS services (voluntary counseling and testing, ART, TB and TB/HIV, adult care and support, STI prevention and treatment?)

1. Monitoring and Evaluation (M&E)

- Is the M&E plan being implemented and kept up to date? How are data being used by project management to make strategic and management decisions? With whom are the data shared? How are project achievements reported to the national government systematically and on a regular basis?
- How might M&E systems be improved?
- Is the project creating a parallel reporting system? How is their routine program monitoring aligned with the existing government reporting system?
- What M&E systems are in place to monitor and follow the progress and trends of their achievements?
- How successful has AIDS Foundation East West - Kazakhstan been in providing valid and reliable strategic information? Are data collected by AIDS Foundation East West - Kazakhstan disseminated-widely, regularly, and utilized by key stakeholders?

2. Lessons Learned

- Does the service delivery model used by AIDS Foundation East West - Kazakhstan meet the needs of the PWID and PLHIV in obtaining HIV treatment and being retained in treatment?
- What are the lessons learned from successful interventions that merit continuation or replication, better practices, significant products and tools for possible dissemination and replication?
- What are the gaps in services and how can this be corrected or mitigated for the remaining lifespan of this project or in the follow-on activity?
- Is current focus and methodology used by AIDS Foundation East West - Kazakhstan appropriate for the CAR HIV epidemic? If not, what adjustments need to be made in the follow-on activity?
- How REACT can better coordinate/align with the other PEPFAR activities?
ANNEX IV. 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 in the following categories:

- **PEPFAR documents**: the Regional Operational Plan and Strategic Directions Summary.
- **USAID documents**: The Cooperative Agreement between USAID/CAR and the AIDS Foundation East West Kazakhstan for the HIV React Project, including modifications.
- **HIV React Project documents**: Including needs assessments, annual work plans and budgets, quarterly and annual progress reports, M&E plans and related project performance data.

2. Review of performance related data

The adequacy of the project’s Monitoring and Evaluation Plan was assessed, including the project database, which was under development at the time of the evaluation. Indicator data for the project was analysed 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. The evaluation team explored how targets were set and assessed the appropriateness of the targets.

The SOW proposed the evaluation team construct an HIV cascade for project clients. Separate cascades would have been needed for current inmates of detention centers and those who had been released, as the factors that affect adherence and retention in care and treatment would vary between prison and community settings. It was not feasible to construct either cascade for the following reasons:

1. The Project’s M&E Plan does not currently collect the data needed, with the exception of the number of PWID who have had an HIV test in the last 12 months and know their result.
2. Obtaining relevant data needed for construction of the cascade from the prison systems was not possible.
3. The project supports PLHIV for only six months post-release, prior to transitioning support to the Flagship Project. This limited time span makes it difficult to measure the cascade for post-release PLHIV.

Some data on HIV testing, ART enrolment, adherence and retention was available from interviews and was used by the evaluation team to develop findings and conclusions. The evaluation team has made recommendations on the data required to measure the HIV cascade, but notes that limitations on the availability of data from the prison system may need to be taken into account.

3. Qualitative data collection:
The evaluation team collected qualitative data from interviews with:

i. USAID/CAR, USAID/Kyrgyz Republic and USAID/Tajikistan
ii. AFEW Kazakhstan management and staff
iii. AFEW's NGO implementing partners
iv. Focus Group Discussions with ex-prisoner clients of the project
v. Focus Group Discussions with current prisoners and on-site interviews with prison health staff
vi. Off-site interviews with prison medical staff
vii. Key stakeholders nominated by USAID/CAR
viii. AFEW Kazakhstan and USAID/CAR follow-up interviews at the conclusion of data collection

I. USAID Missions

The evaluation team met with USAID/CAR for an In-Brief. This covered an outline of the operating environment for the project, identification of key issues to be addressed by the evaluation, and clarifications on the Scope of Work. The evaluation team also received in-briefs with the USAID Mission Kyrgyz Republic and the USAID Office in Tajikistan at the commencement of field work in those countries. The evaluation team received inputs from the USAID HIV Teams in CAR, the Kyrgyz Republic and Tajikistan on the evaluation questions.

(Note: the SOW for the evaluation asked the evaluation team to provide advice on whether there should there be a follow-on HIV prisons project and, if so, how should it be designed. After discussion with USAID/CAR, and in light of the fact that HIV React has three years more years of implementation before close-out, it was decided that it was premature to address this question.)

II. AFEW Kazakhstan management and staff

At the commencement of data collection, the evaluation team met with AFEW Kazakhstan management and staff for an in-brief on the project, followed by an in-depth interview. The evaluation team’s Evaluation Specialist met separately with the project’s M&E Officer to discuss M&E issues in-depth.

III. HIV React Project site visits

The evaluation team held consultations with each of HIV React’s NGO implementing partners in Pavlodar and Ust-Kamenogorsk, Kazakhstan; Bishkek and Chui Oblast, Kyrgyz Republic; and Dushanbe and Khujand, Tajikistan. Due to limited access to prisons, these interviews and FGDs with the project’s ex-prisoner, post-release clients were the evaluation team’s primary opportunity to develop an understanding of programming in detention centers. The evaluation team also interviewed those NGO implementing agencies that were involved only in the first phase of the project.

IV. Focus group discussions with ex-prisoner, post-release clients

Focus group discussions were held with PLHIV and PWID ex-prisoner, post-release clients of the Project’s NGO implementing partners. FGDs were held in the absence of NGO staff to ensure confidentiality of responses. Interviews were on an anonymous basis. NGO
implementing partners were asked to select clients for the FGDs, with the stipulation that participation in FGDs should be entirely voluntary. There may have been some bias in NGO selection of FGD participants. This was unavoidable as the evaluation team did not have the time nor resources to independently recruit clients.

V. Prison visits

It was not possible to obtain permission for prison visits in Kazakhstan and Tajikistan. The evaluation team was permitted to visit two prisons in the Kyrgyz Republic; one male prison and one female prison. In these prisons, interviews and focus group discussions were held with the project’s peer navigators, inmate beneficiaries (PLHIV and PWID), prison health staff and social workers.

VI. Off-site interviews with prison medical staff

Interviews with prison medical staff were conducted in areas where the project is being implemented. Due to limited access to prisons, interviews with prison medical staff usually took place outside of detention centers.

VII. Key stakeholders

The evaluation team conducted consultations with the following categories of key stakeholders:

- AIDS Center staff who provide HIV medical services to prisoners and ex-prisoners.
- Addiction Treatment Center and Narcology Center staff.
- Other United States Government development partners: PEPFAR and CDC staff and USAID Flagship Project implementing agencies.
- Other international development partners: Global Fund supported projects and UNODC.

VIII. Follow-up discussions with AFEW Kazakhstan and USAID/CAR

After the completion of site visits and stakeholder consultations, the evaluation team held follow-up interviews with AFEW Kazakhstan and USAID/CAR to further explore issues that had arisen during the field work.

Two teams: The evaluation team split into two sub-teams for the consultations listed above. The teams visited the following sites:

- Team 1: Ust-Kamenogorsk, Kazakhstan; Dushanbe and Khujand, Tajikistan; and sharing Kyrgyz Republic consultations with Team 2 (Billy Pick, Maria Au and Azizbek Boltaev)
- Team 2: Almaty and Pavlodar, Kazakhstan; and most interviews/site visits in the Kyrgyz Republic. (David Lowe and Britt Herstad, joined by Arman Dairov from USAID/CAR for Pavlodar and the Kyrgyz Republic).

Data collection instruments: Interviews with project implementing agencies and stakeholders were semi-structured, using interview guides developed by the evaluation team to ensure a consistency in approach across the two teams. The interview guides are in Annex VI.

Informed consent: Oral informed consent was obtained from all interviewees and FGD participants at the commencement of the session. The evaluators explained the purpose of the evaluation and that information collected would be aggregated when reported and not used in a way that would disclose the source. All persons were informed that they had the right to
decline to answer any questions and to end their participation in the interview or FGD at any point, without adverse consequence. In the case of prisoner and ex-prisoner clients of the project, particular care was taken to explain that participation in FGDs was entirely voluntary and that if participants chose not to answer particular questions or end their participation in the FGD, this would not affect their ability to access project services in future.

**B. Analysis**

The evaluation collected predominantly qualitative data through interviews with implementers and stakeholders and FGDs with clients. During the field work, the evaluation team conducted progressive analysis of 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.

At the conclusion of the field work, a thematic review of qualitative data was undertaken, 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 was 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. This analysis included triangulation of information from document review, monitoring data, and qualitative data collected from interviews and site visits.

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

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Evaluation Methods</th>
<th>Application or Data Use</th>
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</thead>
</table>
| 1 How effectively is HIV React making the transition from general HIV prevention to case identification, linkage to ARV treatment and achieving adherence and retention in care in both prisons and the community, post-release? | ● Document & data review  
● Key informant interviews  
● Secondary data analysis  
● Focus Group Discussions                                      | ● Feedback for course correction  
● Recommendations for project improvement |
| 2 What are the project’s strengths, weaknesses, and gaps in planning, management, and service delivery? | ● Document & data review  
● Key informant interviews  
● Secondary data analysis  
● Focus Group Discussions                                      | ● Feedback for course correction  
● Recommendations for project improvement |
| 3 What are the constraints to successful implementation of this program?          | ● Document & data review  
● Key informant interviews  
● Focus Group Discussions  
● Secondary data analysis                                      | ● Feedback for course correction  
● Recommendations for project improvement |

**Recommendations to build on strengths, correct weaknesses and improve implementation to enable USAID and implementing agency staff to develop a course of action for the remainder of the activity.**
C. De-briefs

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

1. USAID/CAR, Kyrgyz Republic and Tajikistan (in Almaty, with the Kyrgyz Mission and Tajikistan Office joining by teleconference); and
2. AFEW Kazakhstan management and staff of the HIV React Project.

The purpose of these de-briefs was to share the evaluation team's preliminary key findings, conclusions and recommendations and to receive feedback, validation and further input.

E. Limitations

Key limitations for this evaluation were:

1. From mid-2016, HIV React significantly reoriented project activities from general HIV prevention to HIV case identification and linkage to ARV treatment to support the 90-90-90 targets. The relatively short period of time between the project pivot and this evaluation meant that there was limited implementation experience and data for the reoriented project on which to base findings and conclusions.

2. The evaluation team was given permission to visit prisons only in the Kyrgyz Republic, which limited access to key informants, particularly prisoners, in Kazakhstan and Tajikistan. The evaluation team was, however, able to speak to penal health system staff in Kazakhstan and Tajikistan and former prisoners in all three countries.

3. Construction of the HIV clinical cascade for current inmates and post-release clients was not possible as the project did not have the data needed for this exercise.

4. Within the time and resources available it was not possible for the evaluation team to collect quantitative data. The evaluation was reliant on the quantitative data provided by the project.

5. The evaluation was a rapid appraisal, which limited its depth and time to validate findings. Rapid appraisals have proven to be very effective in identifying good performance and areas for improvement. The team sought to validate findings through ongoing dialogue with USAID/CAR and AFEW Kazakhstan during the field work; at the debriefing meetings; and through USAID feedback on the draft evaluation report.

6. Implementing partners selected clients for participation in FGDs. There may have been some bias in client selection.
## ANNEX V. PERSONS INTERVIEWED

Table 5. List of persons interviewed by the evaluation team

<table>
<thead>
<tr>
<th>NAME</th>
<th>POSITION</th>
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<tbody>
<tr>
<td><strong>USAID/CENTRAL ASIA REPUBLICS, ALMATY, KAZAKHSTAN</strong></td>
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</tr>
<tr>
<td>Kayt Erdhal</td>
<td>Acting Director, Health and Education Office</td>
</tr>
<tr>
<td>Joan Woods</td>
<td>HIV Prevention Advisor, Office of Health and Education</td>
</tr>
<tr>
<td>Elmira Imambakiyeva</td>
<td>Health Specialist and HIV React AOR</td>
</tr>
<tr>
<td>Arman Dairov</td>
<td>Regional SI Advisor, Office of Health and Education</td>
</tr>
<tr>
<td>Lidiya Beisembayeva</td>
<td>Program Assistant, Office of Health and Education</td>
</tr>
<tr>
<td>Stephen Scott</td>
<td>Program Officer, Program Office</td>
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<tr>
<td>Nailya Janabayeva</td>
<td>Budget Officer, Program Office</td>
</tr>
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<td><strong>CDC, ALMATY, KAZAKHSTAN</strong></td>
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<tr>
<td>Indira Aitmugambetova</td>
<td>Associate Director, HIV Program</td>
</tr>
<tr>
<td><strong>PEPFAR, ALMATY, KAZAKHSTAN</strong></td>
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<tr>
<td>Alison Lynch</td>
<td>PEPFAR Coordinator, Central Asia Republics</td>
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<tr>
<td><strong>AIDS Foundation East West Kazakhstan</strong></td>
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<tr>
<td>Roman Dudnik</td>
<td>Chief of Party</td>
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<tr>
<td>Yagdar Turekhanov</td>
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<tr>
<td>Dmitriy Kim</td>
<td>Project Manager</td>
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<td><strong>DOVERIYE PLUS, ALMATY, KAZAKHSTAN</strong></td>
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<tr>
<td>Roza Oleynikova</td>
<td>President</td>
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<tr>
<td>Alla Issateva</td>
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<td>Anna Vatulina</td>
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<tr>
<td>Boris Issayev</td>
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<tr>
<td><strong>ALMATY CITY AIDS CENTER, ALMATY, KAZAKHSTAN</strong></td>
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<tr>
<td>Gulzhakhan Akhmetova</td>
<td>Head, Dispensary Department</td>
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<tr>
<td>Dariga Temirkhanova</td>
<td>Senior Medical Specialist</td>
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<tr>
<td>Dr Marina Sorokina</td>
<td>Head, Treatment Department</td>
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<tr>
<td>Galiya Khasenova</td>
<td>Epidemiology Department</td>
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<td><strong>PAVLODAR PENAL DEPARTMENT, KAZAKHSTAN</strong></td>
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<tr>
<td>Dr Asem Baizhumanova</td>
<td>Doctor/Epidemiologist</td>
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<td><strong>GERLITA, PAVLODAR, KAZAKHSTAN</strong></td>
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<td>Gulsiya Turdinova</td>
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<td>Natalya Rudokvas</td>
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<td>Damira Bibosunova</td>
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<td>Samantha Huffman</td>
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<tr>
<td>Maryzyna Burkhanova</td>
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<tr>
<td>Dr Saidqul Sharipov</td>
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<td><strong>PENAL HEALTH DEPARTMENT, KHUJAND, TAJIKISTAN</strong></td>
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<tr>
<td>Dr Khayrullo Salimov</td>
<td>Physician</td>
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<tr>
<td>Dr Dilovarshoh Niyozov</td>
<td>Head of Medical division in Prison #3/5</td>
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<tr>
<td>Akram</td>
<td>Social worker</td>
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</table>

**Table 6. HIV React Project clients who participated in focus group discussions**

<table>
<thead>
<tr>
<th>Clients of HIV React NGO</th>
<th>Type of clients</th>
<th>Number of client participants in the FGD</th>
<th>Location of FGD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harm Reduction Network</td>
<td>PLHIV/PWID ex-prisoners</td>
<td>5</td>
<td>Bishkek, Kyrgyz Republic</td>
</tr>
<tr>
<td>Ranar (social dormitory for released prisoners)</td>
<td>PLHIV ex-prisoners</td>
<td>7</td>
<td>Bishkek, Kyrgyz Republic</td>
</tr>
<tr>
<td>AFEW KG</td>
<td>Male PLHIV prisoners</td>
<td>10</td>
<td>Prison #31, Bishkek, Kyrgyz Republic</td>
</tr>
<tr>
<td>AFEW KG</td>
<td>Female prisoners</td>
<td>3</td>
<td>Prison #2, Bishkek, Kyrgyz Republic</td>
</tr>
<tr>
<td>Gerlita</td>
<td>Ex-prisoners</td>
<td>2</td>
<td>Pavlodar, Kazakhstan</td>
</tr>
<tr>
<td>Answer</td>
<td>PWID ex-prisoners</td>
<td>11</td>
<td>Ust-Kamenogorsk, Kazakhstan</td>
</tr>
<tr>
<td>Khayoti Nav</td>
<td>PLHIV/PWID ex-prisoners</td>
<td>9</td>
<td>Khuajand, Tajikistan</td>
</tr>
<tr>
<td>Spin Plus</td>
<td>PLHIV/PWID ex-prisoners</td>
<td>9</td>
<td>Khuajand, Tajikistan</td>
</tr>
</tbody>
</table>
ANNEX VI. SOURCES OF INFORMATION

Documents reviewed

AIDSTAR-One, Mapping of key HIV services, assessment of their quality, and analysis of gaps and needs of most-at-risk populations in Chui Oblast and Bishkek City, Kyrgyzstan. 2011.

AIDSTAR-Two, Mapping of key HIV services, assessment of their quality, and analysis of gaps and needs of most-at-risk populations in selected cities of Kazakhstan. 2011.

AIDSTAR-Two, Mapping of key HIV services, assessment of their quality, and analysis of gaps and needs of most-at-risk populations in selected cities of Tajikistan. 2011.


AFEW KZ, Scope of work for database development. 2016.

AFEW KZ, HIV React Project Quarterly Performance Report, Year 1, Quarter Three. 2015.

AFEW KZ, HIV React Project Quarterly Performance Report, Year 1, Quarter Four. 2015.

AFEW KZ, HIV React Project Quarterly Performance Report, Year 2, Quarter One. 2016.

AFEW KZ, HIV React Project Quarterly Performance Report, Year 2, Quarter Two. 2016.

AFEW KZ, HIV React Project Quarterly Performance Report, Year 2, Quarter Three. 2016.


AFEW KZ, Work Plan Year 2 October 2015 – May 2016 Updated. 2015.

Categories of people interviewed

1. United States Government staff: PEPFAR, CDC and USAID
2. Prime project implementer: AIDS Foundation East West Kazakhstan
3. HIV React NGO implementing partners
4. Prisoners in two detention centers in the Kyrgyz Republic
5. Prison health staff in two detention centers in the Kyrgyz Republic
6. Ex-prisoner clients of the HIV React Project
7. Penal medical departments
8. Republican, City and Oblast AIDS Centers
9. Addiction Treatment Centers and Narcolgy Centers
10. Prime project implementer for the USAID HIV Flagship Project
11. Global Fund principal recipients in the Kyrgyz Republic and Tajikistan
12. UNODC staff in the Kyrgyz Republic
Sites visited

- Offices of HIV React NGO implementing partners
- NGO Ranar, a social dormitory for PLHIV ex-prisoners in Bishkek, Kyrgyzstan (part funded by HIV React)
- Prison #2, Bishkek, Kyrgyz Republic.
- Prison #31, Bishkek, Kyrgyz Republic.
ANNEX VII. DATA COLLECTION INSTRUMENTS

Introduction and informed consent for all interviews

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

The purpose of the evaluation is:

a) Assess how well HIV React is making the transition from general HIV prevention to case identification, linkage to ARV treatment and adherence and retention at the PEPFAR sub-national unit levels in both prisons and community-based services.

b) Determine the extent to which the project is achieving its goals, objectives, and performance targets/results.

c) Identify project strengths, implementation gaps and challenges.

d) Document lessons learned and provide recommendations that will inform future programming directions for HIV React project.

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 individuals as the source of information. The report will describe the sources of information in more general ways which will protect your confidentiality.

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?

AIDS Foundation East West Kazakhstan

At the commencement of the field work the evaluation team conducted an in-depth interview with AFEW Kazakhstan. Note: AFEW was asked to answer question 1 in writing to save time.

Overview of HIV-related prison health services by country and other funding for AFEW

1. What is the situation in prisons in each country regarding the availability of the following health services, including any barriers to access or problems with service delivery that are commonly encountered:

   a. HIV testing and counseling. Please indicated if this is voluntary or compulsory and whether there is any established policy on practice on the frequency of testing.

   b. Availability of HIV testing: every day or only at certain times (e.g. testing weeks, etc.) and/or on a routine basis at certain times like admission to prison and prior to release?

   c. What do penal health services do when a prisoner tests HIV-positive?

   d. CD4 and viral load testing availability?

   e. ART, including eligibility requirements? (Any data on adherence and retention?)
f. What is the usual time between an HIV positive diagnosis and commencement on ART, if the prisoner is eligible for ART?
g. OST, including eligibility requirements?
h. Needle and syringe exchange?
i. Condoms and lubricant
j. TB testing and treatment?
k. What arrangements exist in each country for regarding referral of prisoners to ART and OST services upon their release from prison?
l. Are there any initiatives in any of the countries to reform how prison health services are provided (e.g., transferring responsibility to Ministries of Health)?

2. Please provide a brief summary of other donor funding of AFEW and the projects/activities supported by this funding.

Generic questions

3. What are the key achievements and strengths of HIV React?

4. What are the key areas where the performance of the project has been less than what you hoped to achieve? What is being done to do address this?

5. What are the key challenges and constraints to successful implementation of the project (internal to the project and in the external environment)? What are you doing to address these constraints? (Prompts: restriction on access to prisons for the project; stock outs, etc.)

6. What are the challenges of implementing a three country project, with three different sets of government counterparts and three USAID Missions? How have you responded to these challenges?

7. Are there any key gaps in the activities that HIV React is undertaking? How could these gaps be best addressed?

8. How were the prisons you are working in selected? (Prompt: PEPFAR requirements, HIV prevalence, etc.)

9. How has the project’s transition positively or negatively affected the project? (e.g., goals, performance, staffing, etc.)

10. What impact has the project’s withdrawal from Almaty had? Were any transition arrangements put in place to minimize negative impacts?

Specific questions

Project transition

11. The project has transitioned away from general HIV prevention to HIV case identification, linkage to ART and achieving adherence and retention in care. Can you tell us:

   a. What has the project stopped doing?
   b. What activities have been modified as part of the transition?
   c. What new things is the project now doing?
12. What data did you have to set targets for the new phase of the project?

13. What challenges or difficulties have you faced in making the transition? How have you responded to these challenges?

14. Why did you change some of your NGO partners in the second phase of the project?

15. Under the new phase of the project, what activities is the project undertaking with prisoners who are not going to be released for the time being?

16. Most of the project’s work with beneficiaries appears to be focused on preparing inmates for release and supporting them post-release. Is that correct?

**Targeting and case detection**

17. Is there any reliable data on what proportion of the total prison population is made up of current/active PWID in the prisons where the project is working?

18. How do the social workers from your NGO implementing partners identify PWID and PLHIV for participation in mini-sessions?
   a. What difficulties do they encounter in identifying PWID and PLHIV?
   b. How successful are they in identifying PWID and PLHIV?

19. What is the role of the peer navigators in prisons? (Check for targeting of HIV testing of those at highest risk.)

20. How effectively is the peer navigator system working in terms of identifying PWID and PLHIV in prisons and promoting HIV case detection? What are the challenges? How have they been addressed?

21. How are the peer navigators selected, trained and supported?

22. How does the performance based incentive system for peer navigators work?

**START Plus**

23. What are the key adaptations or modifications to the START Plus model to address the 90-90-90 objectives?

24. Is START Plus targeting all prisoners prior to their release or is it targeting only PWID and PLHIV?

25. When is HIV testing offered to prisoners being released (prior to release or post-release)? Uptake rates and yield?

26. For prisoners who are part of START Plus, do you know their HIV status? Who tells you prisoners are HIV positive? What is the referral process to the project?

27. What has been the experience of the project with HIV testing of the sexual partners of ex-prisoners, post-release? Uptake rate, challenges, project response, results, any MSM partners?

28. Are there any plans for the local NGOs to conduct HIV testing of post-release prisoners and their sexual partners?
29. How effectively are your NGOs managing adherence and retention in care of PLHIV on ART after their release from prison? Challenges/response? LTFU rates?
   a. What does the project do if the ex-prisoner who has been released lives in an area where your NGO is not working? How frequently is this an issue?

30. What social services are being provided post release?

31. Is START Plus sufficiently flexible to offer more intensive support or support tailored to client needs? (the timing of the six counseling sessions, especially post-release appears to be somewhat inflexible and possibly insufficient to meet needs).

32. How do you measure the effectiveness of START Plus? Are there any milestones you have for measurement of achievement, apart from your existing indicators?

33. Has the Flagship Project commenced its support role for PLHIV, post release from prison? Is the Flagship Project capable of providing the types and level of support to meet the special needs of prisoners?
   a. Are there any systems in place between HIV React and Flagship to jointly measure the HIV cascade for post-release clients?

34. Is any other joint work with the USAID Flagship Project occurring or planned?

**NGO implementing partner capacity**

35. What are the areas of capacity development for your sub-recipient NGOs that AFEW has supported? (Check for development of guidelines, manuals, systems, etc.) What have been the results?

36. What are the highest priority existing and future capacity building needs of your sub-recipient NGOs? What plans do you have to address these needs?

37. To what extent is there variance in the capacity of your sub-recipient NGOs? What are the key areas in which their capacity varies?
   a. In what ways are variance in capacity levels reflected in the performance of your NGO implementing partners?
   b. How many of your NGO implementing partners have worked in prisons and/or with PWID prior to their work for HIV React?

**AIDS Centers and Narcology Centers**

38. In what ways does the project work with AIDS Centers and Narcology Centers?
   a. What data is the project getting from AIDS Centers or Narcology Centers on PLHIV or PWID prisoners and ex-prisoners?

39. What have been the challenges in building links between AIDS Centers and Narcology Centers? How have you addressed these challenges? Results? (Check for outcomes from quarterly local Technical Working Group meetings.)
40. Why doesn’t the project work with Narcology Centers in Kyrgyzstan?

41. Who is responsible for developing the technical capacity of penal medical and other HCWs to improve the quality of services in areas such as HTC, ART, MAT, TB, STIs etc. How is this done (trainings, mentoring, etc.)? Probe for HIV React’s role. Results?

42. What are the highest priority capacity building needs for penal medical and other health staff?

43. How has the project assisted in strengthening policies, regulations, strategic planning and prisons health services reform to support government authorities to improve and expand HIV and drug dependence programs in prisons and what have been the results?

44. Is there a need for new or revised policies or regulations to improve the access of PLHIV prisoners to HIV and drug dependence treatment? If so, in which areas?

**Collaboration**

45. Since the commencement of the project and currently what other donor financed HIV programming in prisons is being undertaken in the three countries?
   
   a. How does HIV React collaborate and coordinate with other donor financed HIV programming in prisons?
   
   b. Is ICAP and Flagship providing any TA to service providers for prisoners or ex-prisoners?

46. What is your level of satisfaction with USAID’s oversight of HIV React and communications with USAID (for all three Missions)?
   
   a. What improvements could USAID make for more effective oversight and communication with AFEW?
   
   b. Has USAID provided sufficient support to AFEW on M&E and changes to PEPFAR indicators?

47. How effectively has AFEW and your NGO implementing partners adapted to the changing requirements and data collection needs of PEPFAR?

**Future directions**

48. What activities is the project undertaking to advocate for replication or scale up of programming approaches being used by HIV React?

49. If there were enough resources available, what would be the key changes you would like to see in prisons and post release programming to better address HIV and drug dependence needs of PLHIV and PWID?
   
   a. Priority geographic areas/prisons?
   
   b. Priority areas for prison health service reform?
   
   c. New areas of work?

50. What do you see as the advantages and disadvantages of a dedicated HIV prisons project versus integrating the project with other USAID supported HIV programming?
51. What are the key elements you would like to see in a follow-on USAID HIV programming in prisons?
   a. Any role for ongoing direct support delivery or transition to a TA only model?
   b. Working in which geographic areas?

**Data requests**

55. In prisons where compulsory testing occurs, is data available on case detection rates by prison?

56. For voluntary HTC promoted by the project, is there data on the total number offered HIV testing, uptake rates, and case detection rates, by prison?

57. Data on the % of prisoners tested for HIV at the project commencement and now for prisons where the project is working, including HIV positive yield?

58. Data on the % of PLHIV prisoners receiving ART at project commencement and now for the prisons where the project is working?

59. Data on the number of PLHIV and PWID successfully referred at time of release to AIDS Centers and Narcology Centers at commencement of project and currently for the prisons where the project is working?

60. How are you going to measure the % of PWID and their sexual partners who received HTC if you don’t have reliable information on the number of PWID in prisons? (refer to indicator definitions)

**AFEW’s HIV React NGO implementing partners**

1. Can you please provide a summary of the work your NGO is undertaking in prisons and outside of prisons for ex-prisoners after their release.

2. What have been your organizations key achievements in implementation of the HIV React Project?

3. What are the key areas where you have not achieved what you hoped to achieve in HIV React? What is being done to do address this?

4. What are the key challenges and constraints to successful implementation of the project (internal to the project and in the external environment)? What are you doing to address these constraints?
   a. Check for access to HTC, ART, TB, CD4, VL, NSP, MAT services in prisons.

5. Are there any key gaps in the activities that HIV React is undertaking? How could these gaps be best addressed?

6. The project has transitioned away from general HIV prevention to HIV case identification, linkage to ART and achieving adherence and retention in care. Can you tell us, as part of this transition:
   a. What have you stopped doing?
   b. What activities have been modified as part of the transition?
   c. What new things are you now doing?

7. What challenges or difficulties have you faced in making the transition? How have you responded to these challenges? What assistance have you received from AFEW in making the transition?
8. How does your social worker identify PWID and PLHIV for participation in mini-sessions?
   a. What difficulties do you encounter in identifying PWID and PLHIV?
   b. How successful are you in identifying PWID and PLHIV?
9. What is the role of the peer navigators in prisons? (Check for targeting of HIV testing of those at highest risk.)
10. How effectively is the peer navigator system working in terms of identifying PWID and PLHIV in prisons and promoting HIV case detection? What are the challenges? How have they been addressed?
11. How are the peer navigators selected, trained and supported?
12. How does the performance based incentive system for peer navigators work?
13. What are the key adaptations or modifications to the START Plus model to address the 90-90-90 objectives?
14. Is START Plus targeting all prisoners prior to their release or is it targeting only PWID and PLHIV?
15. When is HIV testing offered to prisoners being released (prior to release or post-release)?
    Uptake rates and yield?
16. For prisoners who are part of START Plus, do you know their HIV status?
17. What has been the experience of the project with HIV testing of the sexual partners of ex-prisoners, post-release? Uptake rate, challenges, project response, results?
18. Would you like your NGO to be able to undertake the HIV testing of post-release prisoners and their sexual partners? Would this have any advantages and disadvantages?
19. What activities are you undertaking to promote treatment adherence and retention in care of PLHIV on ART after their release from prison? Challenges/response? LTFU rates?
20. What social services are being provided by your NGO or other organizations to ex-prisoners after their release?
21. If some clients part of the START Plus model need more intensive support or support tailored to their particular needs are you able to offer this?
22. What evidence do you have to indicate the effectiveness of START Plus?
23. Has the Flagship Project commenced its support role for PLHIV, post release from prison? Is the Flagship Project capable of providing the types and level of support to meet the special needs of prisoners?
24. Is any other joint work with the USAID Flagship Project occurring or planned in this area?
25. What technical assistance and capacity building support has your NGO received from HIV React to help you implement the HIV React Project more effectively? Check for guidelines, manuals, systems, etc.
26. How satisfied are you with the technical assistance and capacity building support you have received from HIV React? Strengths and weaknesses? Results?
27. In what ways have you been working with local AIDS Centers and Narcology Centers?
28. What have been the challenges in building links between AIDS Centers and Narcology Centers? How have you addressed these challenges? Results? (Check for outcomes from quarterly local Technical Working Group meetings.)
29. In what ways are you working with other HIV programs that are addressing the HIV and drug dependence needs of prisoners and post release?
30. If there were enough resources available, what would be the key changes you would like to see in prisons and post release to better address HIV and drug dependence needs of PLHIV and PWID?
31. What improvements could be made to the HIV React Project?

**Focus Group Discussion with current prisoners**

**Introduction and informed consent**
We are conducting an independent evaluation of the USAID/Central Asia Region HIV React Project. The services provided by [name of NGO implementing partner] are part of the HIV React Project.

We would like to talk with you about the work of [name of NGO implementing partner] in this prison. We want to hear your views on what you think about the work being done by [name of NGO implementing partner]. We especially want to hear about whether or not their services meet your needs. We would also like to hear your ideas on how the services could be improved.

Your participation in this meeting is 100% voluntary. If you agree to participate in this meeting, we would like to ask you some questions about what you like about the work of [insert name of NGO], what you dislike, and whether their services have helped you.

We will take notes of what you tell us, but no names will be recorded. Our notes will not be given to anyone who is not part of the evaluation team. When we write the evaluation report, no one will be able to identify who said what or know who participated in this meeting. We will not be telling anyone else what you said in a way that would identify you.

If there are some questions you do not want to answer that's OK. You can also decide to leave the meeting at any time without any adverse consequence or problem.

We ask all of you to keep everything we talk about today private. Please do not tell anyone who is not in the meeting what anyone said.

Do you have any questions about our work or this meeting?
Is it OK to start asking you questions?

Questions

1. Over the last two years, have you ever received any information or education about HIV prevention and treatment and drug dependence treatment while you have been in this prison?
2. Who provided this information and how was it provided (IEC, mini-session, etc.)?
3. Was the information you received easy to understand and useful or not so useful? How was it useful? Why was it not useful or helpful?
4. Did you receive any information on the benefits of HIV testing and treatment? What?
5. Do you have any suggestions on how HIV and drug dependence education for prisoners could be improved?
6. Is it possible to get sterile needles and syringes in this prison?
7. How easy or difficult is it to get sterile needles and syringes?
8. Do you have any suggestions for how to make it easier to get sterile needles and syringes in prisons?
9. Is it possible to get methadone treatment in this prison?
10. Are there any difficulties or problems in getting methadone treatment in this prison?
11. Do you have any suggestions for how to make it easier to get methadone?
12. Is it possible to get an HIV test in this prison?
13. Are there any difficulties or problems in getting an HIV test in this prison? (check for voluntary or compulsory)
14. Who should have an HIV test and what are the benefits of having an HIV test?
15. Do you think there are any disadvantages for prisoners having an HIV test? (check for confidentiality and stigma and discrimination)
16. For prisoners who test HIV-positive, can they start on treatment for HIV while they are in prison?
17. Are there any difficulties in getting access to HIV treatment?
18. What is the quality of HIV treatment like for HIV-positive prisoners in this prison? How could it be improved?
19. Do you think it is easy or difficult for HIV-positive prisoners to take their medicine every day and to stay on treatment in prison?
20. How do prison doctors and health staff behave toward prisoners who are HIV-positive or who use drugs?
21. How do prison wardens behave toward prisoners who are HIV-positive or who use drugs?
22. What could be done to improve the life of HIV-positive prisoners?
23. Do you have any suggestions for how [insert name of NGO] or the prison health service could improve their services?

**HIV React NGO Implementing Partners: Focus Groups with ex-prisoner clients**

**Introduction and informed consent**

We are conducting an independent evaluation of the USAID/Central Asia Region HIV React Project. The services provided by [name of NGO implementing partner] are part of the HIV React Project.

You are being asked to take part in this meeting because you have used the services provided by [name of NGO implementing partner]. We want to hear your views on what you think about the services being provided by [name of NGO implementing partner]. We especially want to hear about whether or not these services meet your needs. We would also like to hear your ideas on how the services could be improved.

Your participation in this meeting is 100% voluntary. If you agree to participate in this meeting, we would like to ask you some questions about what you like about this service, what you dislike, and whether their services have helped you.

We will take notes of what you tell us, but no names will be recorded. Our notes will not be given to anyone who is not part of the evaluation team. When we write the evaluation report, no one will be able to identify who said what or know who participated in this meeting. We will not be telling anyone else what you said in a way that would identify you.

If there are some questions you do not want to answer that's OK. You can also decide to leave the meeting at any time without any adverse consequence or problem.

We ask all of you to keep everything we talk about today private. Please do not tell anyone who is not in the meeting what anyone said.

Do you have any questions about our work or this meeting?

Is it OK to start asking you questions?

**Questions**
1. How many months ago were you released from prison? (Go around whole group).
2. In what ways has [INSERT NAME OF NGO] supported you when you were in prison and since you were released from prison? (Probe for different types of support.)
   a. Has this support been helpful or not? How has it been helpful? Why was it not helpful?
3. What are the biggest difficulties in your life since being released from prison?
4. Are there any additional types of support you would like to receive from [INSERT NAME OF NGO] or any other organization?
5. How satisfied or dissatisfied are you with the services provided by [INSERT NAME OF NGO]? Why?
6. In what ways could [INSERT NAME OF NGO] improve the services they provide to ex-prisoners?
7. Did you receive any support for making the adjustment to life outside prison before you were released? What type of support, and who provided it?
8. Was this support helpful to you or not? How was it helpful? Why was it not helpful?
9. Did you receive any information or education about HIV prevention and treatment and/or drug dependence treatment when you were in prison? Who provided this information?
   a. Was the information you received easy to understand and useful or not? How was it useful? Why was it not useful or helpful?
10. Do you have any suggestions on how HIV education for prisoners could be improved?
11. Was it possible to get sterile needles and syringes and condoms in the prison you were in? How easy or difficult was it to get sterile needles and syringes?
   a. Do you have any suggestions for how to improve the availability of sterile needles and syringes and condoms in prisons?
12. Did you receive MAT (methadone) while you were in prison?
   a. What difficulties or problems did you have with receiving MAT in prison?
13. Have you been enrolled for MAT (methadone) since your release from prison?
   a. Did anyone help you get enrolled for MAT after you were released from prison?
      Who?
   b. What difficulties or problems did you have with enrolling for MAT since leaving prison and staying on MAT?
We want to ask you some questions about HIV testing, but we don’t need to know your test result.
14. Did you ever have an HIV test while you were in prison?
   a. How many tests did you have and when (e.g., on admission to prison, annually, prior to release, etc.)
   b. Was the test compulsory or voluntary?
   c. Did you receive any information about HIV and the HIV test before having the test?
      Who provided this? Was the information easy to understand and useful or not?
15. For prisoners who test HIV-positive, can they easily start on ARV treatment for HIV while they are in prison? Are there any difficulties in getting access to treatment?
16. What is the quality of care like for HIV-positive prisoners in detention centers? How could it be improved?
17. How common was injecting drug use in the prison where you were in detention? Probe for quantitative estimate.
18. How are HIV-positive prisoners treated by wardens, prison medical staff and other prisoners?
19. What could be done to improve life for HIV-positive prisoners?
20. After release from prison, how easy or difficult is it for ex-prisoners to continue on HIV treatment (if they already started in prison) or start on HIV treatment? What assistance is available for HIV-positive prisoners to get on treatment outside prison? Who provides this assistance?
21. How are HIV-positive ex-prisoners treated by doctors and other health workers at AIDS Centers?
22. Since your release from prison, has anyone suggested to you that your wife/partner should be tested for HIV or STIs? If yes, who suggested this? Do you think this is a good idea or not? Did your partner have a test?
23. Do you have any suggestions for how ex-prisoners could be better supported in health care and their life generally after release from prison?
24. If HIV React/[name of local NGO] was not doing the work they are doing in prisons and with ex-prisoners what would be the situation?
25. Is there anything else you would like to tell us about?
Do you have any questions you would like to ask us?

USAID/Missions HIV Team questions

1. How effective has HIV React been in making the transition from general HIV prevention to HIV case detection, and linkage and retention in treatment?
   a. What have been the challenges HIV React has faced in making this transition? How effectively have they responded to these challenges?
   b. Does AFEW have the right staffing profile to support the transition?
2. What are the key strengths of HIV React?
3. What are the key weaknesses of HIV React?
   a. What is being done to do address these weaknesses?
4. Are there any gaps in the activities that HIV React is undertaking?
   a. How could these gaps be best addressed?
5. What are the key constraints to successful implementation of the project (constraints internal to the project and in the external environment)?
   a. What is AFEW and USAID doing to address these constraints?
6. How effectively has the project been with working with other donor projects, including PEPFAR projects, to maximize impact?
   a. What joint work is HIV React and Flagship undertaking currently and what joint work is planned for the future?
7. Is there adequate technical leadership by AFEW? Do they have staff with the required mix of technical knowledge and other skills to provide leadership to implementing partners?
8. How effectively is AFEW managing the HIV React Project? (Strengths, weaknesses).
   a. What is AFEW doing to address any weaknesses in management?
9. Is USAID satisfied with communications with project staff, both that of AIDS Foundation East West and those of their sub-partners?
   a. What improvements could be made for more effective communication?
10. What challenges have there been in implementing a three-country project, involving three USAID Missions?
    a. How effectively have these challenges been addressed?

Follow on project

11. What do you see as the advantages and disadvantages of a dedicated HIV prisons project versus integrating the project with other USAID supported HIV programming?
    a. Does the Mission have a preference for maintaining an HIV prisons project or integration?
12. What are the key elements you would like to see in a follow-on USAID HIV programming in prisons?
   a. Any role for ongoing direct support delivery or transition to a TA only model?
   b. Working in which geographic areas?
   c. Programmatic priority areas: same as current or any new areas or changes of emphasis, approach or priority accorded to existing program components?

**Prison medical services staff**

1. How is HIV testing and counseling (HTC) made available to inmates in prisons in this area?
   a. Is HTC conducted on a voluntary or on a compulsory basis?
   b. Is HIV testing conducted on a routine basis at certain times like on admission to prison and prior to release?
   c. Frequency of testing; Is HTC available every day or only at certain times (e.g. Testing Weeks, monthly, six-monthly, etc.)?
   d. What HIV testing algorithm is used?

2. How many prisoners were tested for HIV in the past 12 months? How many were HIV-positive?

3. What happens when a prisoner tests HIV-positive?
   a. Is CD4 and viral load testing available in prisons in this area? Are there any difficulties in accessing CD4 and viral load testing?

4. Is ART available to prisoners in this area? What are the eligibility requirements for ART?

5. Currently, how many PLHIV are there in prisons in this area? How many of these prisoners are currently on ART?

6. What percentage of prisoners adhere to ART regimens? What are the difficulties encountered in prisons with adherence? How do you deal with these difficulties?

7. What percentage of prisoners are retained in ART while they are in prison? What are the difficulties encountered in retaining prisoners on treatment? How do you deal with these difficulties?

8. What other difficulties and constraints do you have in providing HIV testing and treatment in prisons? How do you deal with these problems?
   a. Who purchases and supplies ART to the prison system in this country? How is procurement and SCM undertaken? Any problems?

9. When a prisoner on ART is due to be released from prison, are you able to make arrangements for their care to be transferred to a Republican AIDS Centre or other treatment center on release? How effectively does this transfer or referral process work? What difficulties do you encounter?

10. Do prisoners have ready access to sterile needles and syringes and condoms in prisons? Are there any restrictions or problems for prisoners in accessing sterile needles and syringes and condoms?

11. Do prisoners have ready access to opioid substitution therapy in prisons? Are there any restrictions or problems for prisoners in accessing OST?

12. What happens when you diagnose a prisoner with TB?

13. When a prisoner on OST is due to be released from prison, are you able to make arrangements for those prisoners to be transferred to a Narcology Center on their release? How effectively does this transfer or referral process work? What difficulties do you encounter?

14. What training and technical assistance do medical and other penal health staff receive in the area of HIV, STIs, TB and OST? Who provides this?
a. How useful or not is this training and other technical support?
b. What are your priority areas for additional training and technical support.

15. What support do medical and other penal health staff receive from AIDS Centers and Narcology Centers? How useful or not is this?

16. What support do medical and other penal health staff receive from the HIV React Project, including [name of local HIV React NGOs]? How useful or not is this support? What are your priority areas for additional support?

a. Do you have any suggestions for how the HIV React Project could be improved?

17. Have penal health staff been involved in quarterly local Technical Working Group meetings to improve coordination between penal system and external health providers such as AIDS and Narcology Centers? If yes, have these meetings been useful and in what ways?

18. Is there a need for new or revised policies or regulations or reforms to prison health services to improve the access of PLHIV prisoners to HIV and drug dependence treatment? If so, in which areas?

19. If HIV React was not working in this area how would things be different?

20. If you had enough resources, what would you change in order to better address HIV and drug dependence needs for PLHIV and PWID in prisons?

**Republican, City and Oblast AIDS Centers**

1. Please describe your collaboration with NGO [INDICATE NGO’s NAME] on working with PLHIV released from prisons?
   a. Probe: success stories and challenges, especially re adherence and retention.
   b. How could this collaboration be improved?

2. Are there any other ways your AIDS Center has worked with the USAID HIV React Project (e.g., with AFEW which is running the Project)?
   a. What have been the results of this joint work between your AIDS Center and the HIV React Project?

3. What data do you collect on prisoners and ex-prisoners following their release? Is this data shared with the HIV React project?

4. How many persons newly released from prisons you have enrolled in HIV care and treatment, including ART since beginning of 2016? How did those persons came into contact with your program?

5. Does your AIDS Center collaborate with the Narcology Center in any ways in relation to prisoners and ex-prisoners after release? How?
   a. Has this collaboration been supported by the HIV React Project?
   b. How effective are these linkages? Challenges/areas for improvement?

6. How readily available is ART in prisons in this country? Do you have any information on the strengths and weaknesses of ART provision in prisons in this country?

7. Has your AIDS Center been involved in providing any services, support or coordination with penal medical services? In what ways? Who facilitated this?
   a. Do you have problems in getting access to prisons?
   b. Can you track your patients after they have been sent to prison to ensure ongoing treatment?

8. Is your Narcology Center involved in quarterly local Technical Working Group meetings to improve coordination between penal system and health providers? If yes, have these meetings been useful and in what ways?

9. What type of support and technical assistance is your AIDS Center receiving from other donor projects?
   a. Has this support and technical assistance helped you in providing ART for newly released prisoners? How?
10. If you had enough resources, what would you change in order to better address HIV and
drug dependence needs for PLHIV PWID newly released from prisons?
11. Is there a need for new or revised policies or regulations to improve the access of PLHIV
prisoners to HIV care and treatment? If so, in which areas?

**Addiction Treatment Center and Narcology Center questions**

1. How has your Narcology Center worked with the USAID HIV React Project?
   a. Please describe your collaboration with NGO [INDICATE NGO’s NAME] on
      working with persons released from prisons? Probe: success stories, challenges.
      How could this collaboration be improved?
2. What have been the results of any joint work between your Narcology Center and the HIV
   React Project?
3. How do you enrol new patients to OST? What are the procedures for enrolment?
4. Often persons newly released from prisons lack passports and address registration. Do the
   rules of your program allow for accepting these patients?
5. How many persons newly released from prisons you have enrolled to OST since beginning
   of 2016? How did those persons came into contact with your program?
6. Does your Narcology Center collaborate with the Republican AIDS Center in any ways in
   relation to prisoners and ex-prisoners after release? How
   a. Has this collaboration been supported by the HIV React Project?
7. Is OST available in prisons in this country? Do you have any information on the strengths
   and weaknesses of OST provision in prisons in this country?
8. Has your Narcology Center been involved in providing any support or coordination with
   penal medical services? In what ways? Who facilitated this?
9. Is your Narcology Center involved in quarterly local Technical Working Group meetings to
   improve coordination between penal system and health providers? If yes, have these
   meetings been useful and in what ways?
10. What type of support and technical assistance is your Narcology Center receiving from
    other donor projects?
    a. Has this support and technical assistance helped you in providing OST for newly
       released prisoners? How?
11. If you had enough resources, what would you change in order to better address drug
    dependence related needs of PWID newly released from prisons?
12. Is there a need for new or revised policies or regulations to improve the access and
    retention of PWID prisoners and ex-prisoners to drug dependence treatment? If so, in
    which areas?

**Other stakeholders: CDC/ICAP, Global Fund supported projects, UNODC, Flagship Project**

1. What joint activities or collaboration is there between your organization/project and the
   USAID HIV React Project?
2. How effective are these joint activities or collaboration and what have been the outcomes?
3. How effectively has the HIV React project been with working with donor funded projects,
   other than yours, to maximize impact?
4. What are the key strengths and achievements of HIV React?
5. What are the key weaknesses of HIV React?
a. What is being done to address these weaknesses?

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 AFEW and USAID doing to address these constraints?

7. Are there any gaps in the activities that HIV React is undertaking?
   a. How could these gaps be best addressed?
   b. What other improvements could be made to the HIV React Project?

Flagship Project additional question

8. What joint planning has Flagship undertaken with HIV React on support for prisoners post-release?

9. What plans do you have for any other collaboration with HIV React over the next three years?

10. What data are you collecting on current prisoners and post-release prisoners in Flagship sites. Are there plans to share this data with HIV React (for monitoring and cascade measurement purposes.)
ANNEX VIII. DISCLOSURE OF ANY CONFLICT OF INTEREST

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
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

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 09/21/2016

Name  DAVID LOWE  Title MR
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

| 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. |

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**ACCEPTANCE**

The undersigned accepts the terms and conditions of this Agreement.

**September 21, 2016**

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