REPORT

On the results of the GFATM second round HIV project in the Republic of Kazakhstan

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LIST OF ACORNYMS

AIDS	Acquired immunodeficiency syndrome
ARVT	Antiretroviral therapy
CCM	Country coordination mechanism
DIA	Department for Internal Affairs
ELISA	Enzyme-linked immunosorbent assay
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human immunodeficiency virus
IDU	Injecting Drug User
IEC	Information, Educational and Communication
M&E	Monitoring and evaluation
MIA	Ministry of Internal Affairs
MSM	Men having sex with men
NGO	Non-governmental organization
NCHL	National Center of Health Lifestyles
PIU	Project Implementation Unit
PLHIV	People living with HIV
SSS	Sentinel Surveillance Survey
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Program on HIV and AIDS
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
VCT	Voluntary HIV counseling and testing
WHO	World Health Organization

EXECUTIVE SUMMARY

The first project funded by the grant of the Global Fund to Fight ADS, Tuberculosis and Malaria (GFATM) was implemented in Kazakhstan from December 1, 2003 till November 30, 2008. The main objectives of this project were to support national efforts in strengthening activities to fight HIV-infection and to build capacity of non-governmental organizations in reducing effects of the HIV epidemic. The Republican Center for AIDS Prevention and Control (Republican AIDS Center) was selected as a primary recipient of the grant and was responsible for the overall implementation of the project and coordination of all project's sub-recipients, including local AIDS Center and NGOs, as well as project's partners.

This project was fully in line with the main strategies of the National HIV Program and facilitated its effective implementation. Implementation of this project allowed ensuring access of target groups to HIV-prevention activities, including STI diagnostics and treatment services. This project also stimulated development of a large number of AIDS-servicing NGOs. Introduction of methadone substitution therapy and initiation and scale up of antiretroviral therapy can be considered among the most important achievements of the project. In addition, this project contributed to the improvement of HIV-related legislation and facilitated enabling social environment for prevention and treatment programs.

The project had achieved all of its goals and created a good foundation for the future work in HIV prevention among target groups and treatment, care and support services.

INTRODUCTION

Kazakhstan has completed implementation of the first national HIV Grant of the Global Fund to Fight ADS, Tuberculosis and Malaria (GFATM) (№ KAZ 202-G01–H-00) at the end of 2008. This grant was implemented from December 1, 2003 till November 30, 2008 with the aim to support continuing national efforts to strengthen HIV and AIDS control and prevention activities, while increasing civil involvement in actions to reduce effects of the epidemic.

Main objectives of the GFATM HIV project included prevention of HIV-infection by promoting behavioral changes, reducing vulnerability of target populations, provision of information to increase knowledge about HIV and AIDS, and promotion of healthy lifestyles among young people. The project also included activities to further develop care, treatment and psycho-social support to people living with HIV (PLHIV).

Target groups of the project consisted of:

- Injecting Drug Users (IDUs);
- Sex workers;
- Men having sex with men (MSM);
- Youth;
- People living with HIV.

In order to achieve the stated objectives the following activities were conducted under two phases:

Phase 1 (December 1, 2003 – December 1, 2005; $6,502,000)

1. Prevention of HIV-infection among the most vulnerable groups;
2. Organization of campaigns to improve HIV awareness and knowledge among general population, including youth;
3. Ensuring access to good quality voluntary HIV counseling and testing (VCT) services, and treatment for target groups.

Phase 2 (December 2, 2005 – November 30, 2008; $15,583,999)

1. Support to improve laws and regulations, and create social environment, favorable for prevention and treatment programs;
2. Prevention of HIV-infection among target groups, including young people;
3. Ensuring access of target groups to good quality treatment services.
4. Improvement of monitoring, evaluation, planning, and forecasting of HIV activities.

In order to obtain an independent evaluation of the project implementation results, the Republican Center for AIDS Prevention and Control (Republican AIDS Center), the principal recipient of the GFATM HIV grants in Kazakhstan, conducted an external evaluation (Terms of Reference - Appendix 1).

MATERIALS AND METHODS

Independent evaluation team. The Republican AIDS Center has hired Anna Deryabina and Larissa Bashmakova as consultants to conduct this evaluation. Anna Deryabina, the Deputy Regional Director of the CAPACITY Project/JSI Research & Training Institute, Inc., was appointed as the team leader and was responsible for conducting individual and group interviews with grant recipients, project beneficiaries and partners, as well as for development of the final report in Russian and English. Larissa Bashmakova, independent HIV expert, has contributed by participating in individual and group interviews with grant recipients, project beneficiaries and partners, as well as in preparation and reviewing of the evaluation report.

Evaluation period: Visits to project implementation sites were conducted from April 14 until May 8, 2009. GFATM project activities were evaluated for the period of December 2003 – November 2008.

Site visits: The Republican AIDS Center has identified the following sites for consultants to visit: Almaty, Pavlodar, Karaganda, Astana, and Shymkent. In addition to the cities selected by PIU, consultants have visited several other project implementation sites, including Aksu in Pavlodar *oblast*[1]; Temirtau in Karaganda *oblast*; Turkestan and Sairam in South Kazakhstan *oblast*.

Methodology for collection and analysis of information. Project results were evaluated based on the analysis of information obtained during qualitative assessment: observation of work during site visits and interviews with respondents in the selected sites (Appendix 2), as well as review of reporting documents provided by the PIU and other surveys and reports related to the topic (Appendix 3). Respondents were interviewed using focus group discussions and in-depth interviews, during which open-ended questions were used, and interviewees' responses were recorded verbatim where possible. The objective of the in-depth interviews was to encourage key respondents to say as much as they could about the main achievements and weaknesses of the project. The majority of respondents were selected by the PIU with the help from *oblast* AIDS Centers. Results of the interviews were analyzed and presented in a summarized manner, without any references to specific individuals to ensure confidentiality. To ensure transparency and accuracy of the report its draft version was distributed among all the respondents for comments, which were included in the final report.

Limitations of this evaluation. There are several factors that could, in the authors' opinion, introduce a possible bias into results of this evaluation:

- The project implementation *oblasts*, which were selected by the Republican AIDS Center for consultants to visit, were not necessarily representative of the overall program.
- Due to the short timeframe of the evaluation, even in the selected *oblasts,* it was not feasible for the consultants to visit all the project implementation sites and talk to all the project partners and implementers that were working on the project from the beginning.
- Some recall bias due to the fact that the consultants were collecting information from the beginning of the project, which goes back to 2003.

[1] "Oblast" is defined as a province or region.

RESULTS

I. Support to improve laws and regulations and create social environment, favorable for prevention and treatment programs

Creation of favorable regulatory and social environment

Support of activities to improve national policy related to HIV-infection is one of the most important achievements of the GFATM Project. Thus, the Project assisted in revision of the Law of the Republic of Kazakhstan on Prevention of AIDS by facilitating the multi-stakeholder (multi-sectoral) technical working group involving representatives of PLHIV. As a result of the work, a new version of the law included state guarantees for provision of free medical services, specific treatment of HIV-infection and AIDS, periodic medical examination, as well as social and legal protection and non-discrimination of PLHIV. Additionally, provisions concerning mandatory HIV testing of certain groups of individuals were deleted from the new version of the law. The second (revised) Law of the Republic of Kazakhstan (No.172-III) on Prevention and Treatment of HIV-infection and AIDS (HIV/AIDS Law) was adopted on July 7, 2006.

This project has also supported the development of the third National Program on AIDS epidemic counteraction in the Republic of Kazakhstan for 2006 - 2010[2] (National HIV Program) which was adopted in 2006 in accordance with the HIV/AIDS Law and within the framework of the National Policy to Fight HIV/AIDS in the Republic of Kazakhstan, as well as the midterm plans for social and economic development of the country for 2006-2008 and 2007-2009[3]. *Oblast*-level programs to counteract AIDS epidemics were also adopted for all the regions of Kazakhstan. Implementation of the program is aimed to ensure universal access of target groups to treatment, care and support services. This new program includes actions to improve policy to ensure availability of antiretroviral drugs and drugs necessary to treat opportunistic infections, as well as improvement of adherence of PLHIV to treatment.

> *"The main achievement of the project is the support of the National HIV Program in Kazakhstan."*
>
> Representative of an international organization

Adoption of the new HIV/AIDS Law and the National HIV Program for 2006-2010 promoted interest and responsibility of the government authorities and facilitated development of the inter-sectoral and interagency cooperation. Local authorities were interested and involved in HIV-infection preventive activities in all the visited *oblasts.* HIV-related issues were discussed at least once a year during regular meetings of coordination council under the local mayor offices (*akimats*). These meetings included

[2] Decree of the Government of the Republic of Kazakhstan No.1216 dated December 15, 2006.

[3] Decree of the Government of the Republic of Kazakhstan No.884 dated August 26, 2005 concerning Middle-term Plan of Social and Economic Development of the Republic of Kazakhstan for 2006-2008; Decree of the Government of the Republic of Kazakhstan No.822 dated August 25, 2006 concerning mid-term Plan of Social and Economic Development of the Republic of Kazakhstan for 2007-2009.

discussion of activities implemented by the local AIDS Centers and health departments, as well as other agencies (departments of education, law enforcement structures, penal system). However, since the HIV/AIDS Law and the National HV Program do not outline duties and responsibilities of various agencies outside of the health sector their active involvement in HIV activities is not promoted. Under the GFATM 2nd round project, capacity building for agencies outside of the health sector was conducted through seminars arranged for various groups of specialists by the AIDS Centers staff. Direct funding of agency-level programs was neither planned nor provided by the GFATM grant. Given the high rate of personnel turnover, as well as the workload of the AIDS Center staff, such policy could not contribute to sustainability of agency-level programs within the National HIV Program and did not promote inter-sector cooperation under the Project.

Effective cooperation with the law enforcement agencies has not been fully achieved. Despite the understanding of harm-reduction programs reached at the level of Departments of Internal Affairs (DIA) and the presence of laws enabling to carry out preventive activities, law enforcement practices were not always consistent with the effective laws. The assumed commitments of law-enforcement structures not to interfere in harm-reduction program were not always fulfilled by the staff, especially at the level of privates and sergeants. For example, police officers detained drug users and project volunteers if the latter were found to carry new or used syringes. As the result, drug users were afraid of going to trust points or buy syringes at the pharmacies. This was also the reason why the used needles are not returned as required by the needle exchange practices. Despite the fact that the voluntary sexual relations between adults are not considered as a violation neither by the criminal nor the administrative codes, sex workers and their clients were sometimes arrested by the police. The practice of regular so-called *"subbotnik"*[4] (day of unpaid work) still exists. Such actions by the law enforcement agencies force sex workers to often change locations, work through pimps and refuse visiting friendly clinics. All of this impedes efficient preventive work.

Republican AIDS Center is trying to actively support activities targeting men, having sex with men (MSM), however to date, MSM remain one of the hardest to reach groups with the minimal level of coverage by preventive activities. Negative and sometimes hostile attitude of the society, including medical personnel and the law enforcement agencies towards MSM, as well as self-stigmatization of this group do not allow developing adequate prevention interventions for this group.

Improvement of knowledge and awareness of employees and representatives of non-governmental organizations

The 2nd Round Grant of the Global Fund gave rise to organization and allowed to substantially increase the numbers of AIDS-servicing organizations in the country. Except for a limited number of NGOs established at the end of 1990-s – beginning of 2000-s with

[4] "*Subbotnik*" (day of unpaid work) - means unlawful actions of police officers using free sex services in exchange for the opportunity to continue working on a certain site.

the assistance of the Soros Foundation and UNDP, the GFATM grant became the first source of funding for a great number of NGOs, and their registration was motivated by the approval of the Grant for the Republican AIDS Center. Creation of a large number of new NGOs resulted in expansion of coverage and access to the target groups. Since some NGOs were founded by the employees of the AIDS centers, it was possible to build more trustworthy relationships of the project beneficiaries and the AIDS centers.

Series of annual trainings to build capacity of project personnel were organized with the help of the National Center of Health Lifestyles (NCHL). However, the project did not implement a systematic approach to building capacity of project implementing partners by providing direct funding for them for organization of trainings for all the staff, including outreach workers. Consequently, a great number of NGOs that received their first grant under the GFATM project failed to remain sustainable, increase leadership capacity of their employees and, accordingly, were not be able to perform quality work among target groups. Most of the capacity building trainings organized on the local level were conducted by the staff of local AIDS Centers, who themselves were not always properly trained and did not have the relevant experience organizing outreach work among target groups, team building and harm-reduction principles. Approaches and curriculum of trainings for project staff working with different target groups did not differ and were largely unified.

> *"The Global Fund project gave rise to establishment of great number of NGOs, but did not support their further development."*
>
> Director of NGOs Association.

The project has established a system of information exchange between sub-recipients and all of them have regularly received project implementation reports. Additionally, by mid-project, the Republican AIDS Center has developed a web-site that had a separate section devoted to the GFATM project implementation. The project has also supported an electronic distribution of HIV related information organized by the "Peer-to-peer" Association for all sub-grantees and project partners. Jointly with other partners the project has supported creation and annual meetings of the NGO Forum that allowed open dialogue between AIDS-servicing organizations, government institutions and international partners.

Strengthening capacity of government healthcare in monitoring and evaluation of HIV-related programs

Coordination of the HIV response is performed by the National Health Coordination Council, which was established under the Ministry of Health by merging several national coordination mechanisms (e.g., National AIDS Council, National TB Council) to simplify the management structure and improve decision-making process.

The Country Coordination Mechanism (CCM) was established to manage the grant of the Global Fund to Fight AIDS, TB and Malaria. In accordance with the UN "Three Ones"

principles[5] this CCM became part of the National Coordination Health Council in 2005. Following GFATM recommendations, CCM operational guidelines, work plan, terms of reference and selection mechanism for CCM members were developed. However, effective functioning of the CCM was compromised by the fact that there were no funds allocated in the GFATM grant for regular meetings of CCM members and operation of the CCM secretariat. As a result, most CCM decisions were discussed via email and on ad hoc basis.

An M&E plan specifying project indicators, its goals and information collection methods and sources was developed as required by the GFATM grant. To build capacity of the state health system in monitoring and evaluation of HIV-infection related programs GFATM project has also organized several regional seminars for the AIDS Center staff. These seminars were mainly focused on reporting forms and indicators related to the National HIV Program; methods of data analysis and data quality control were not discussed. In addition, lack of a systematic information exchange between AIDS Centers and sub-recipients from the NGO sector, as well as different client coding systems used in the project by different sub-recipients often lead to double-counting of clients and uneven territorial distribution of project activities. Poor coordination and lack of information often resulted in an inability of local AIDS Centers to fully account for the activities implemented by local NGOs. All the above often resulted in lack of agreement between government and non-government sectors and prevented implementation of the "Three Ones" Principles at the local level.

> *"An implementer must bear responsibility for the money. In 2004-2006, the donor did not perform special control over the expenditures. Implementers did not report to anyone, no one monitored the performance results."*
>
> *Employee of the oblast AIDS Center, NGO Director.*

II. Prevention of HIV-infection among vulnerable groups[6]

Project work related to prevention of HIV-infection among target groups consisted of two main components[7]:

1. Distribution of free individual means of protection (condoms, syringes, lubricants, disinfectants) through trust posts, including mobile ones, friendly clinics and outreach workers.
2. Educational sessions, including peer-to-peer education, and distribution of IEC materials.

Distribution of individual means of protection

[5] **Three ones principles** aim at enhancing coordination and harmonisation of program efforts in fighting the epidemic. According to them each country should have **One** agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; **One** National AIDS Coordinating Authority, with a broad-based multisectoral mandate; **One** agreed country-level Monitoring and Evaluation System.

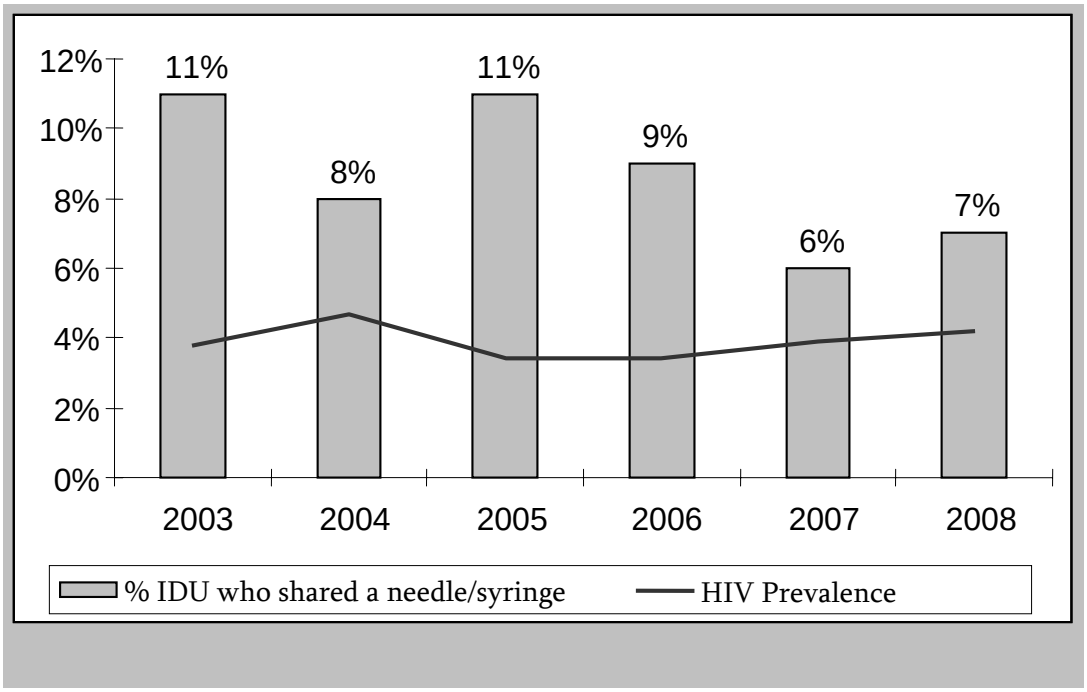
[6] For the purposes of this report - injecting drug users, sex workers and men, who have sex with men.

[7] STI and VCT services provided at the friendly clinics, and the substitution therapy are also important for HIV-prevention and are described in Section IV of this report.

The absolute majority of respondents consider provision of large quantities of syringes and condoms during a long-term period to be one of the main achievements of the project. Free distribution of condoms and syringes was most effective approach for the AIDS Centers to attract sex workers and IDUs to trust posts and friendly clinics for educational sessions, HIV testing and STI services. In addition, distribution of individual protection means, received as part of the project, laid out the foundation for activities of the most AIDS-servicing NGOs, and helped to expand access to the target groups and build trustworthy relationships.

During the project implementation, there was a decline in needle sharing practices among IDUs, and an increase in condom use among sex workers (figures 1 and 2), according to the data of the Sentinel Surveillance Surveys (SSS). Thus, the percentage of IDUs that reported sharing needles decreased from 11% in 2003 to 7% in 2008, and the percentage of sex workers reporting use of condoms during the last sexual intercourse with a client increased from 86% in 2003 to 93% in 2008.

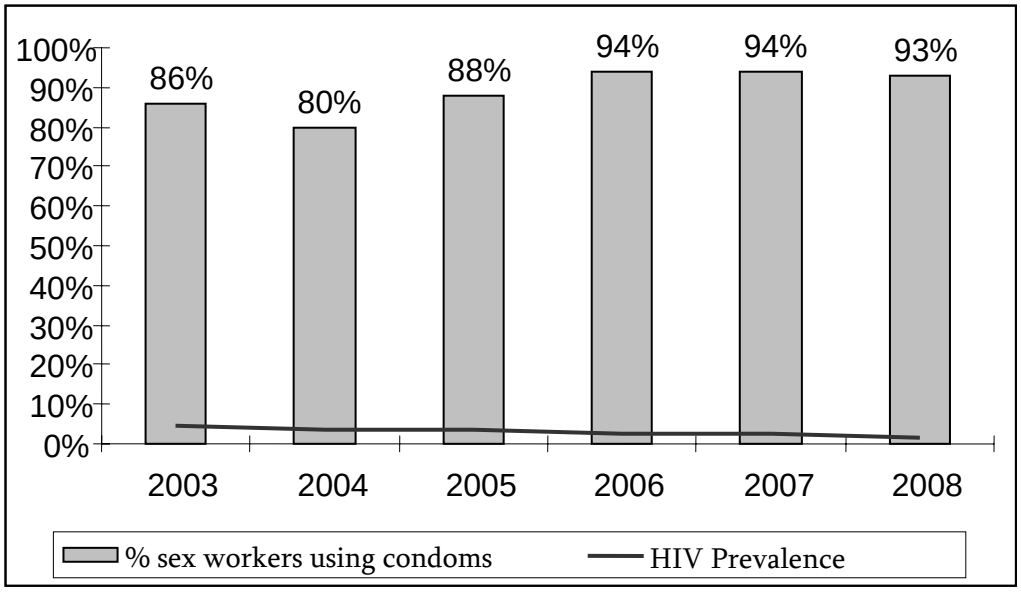
Figure 1. Percentage of IDUs sharing syringes during last injection and prevalence of HIV among IDUs [8,9]



[8] B.I. Bapenova. Results of HIV-infection epidemiological watch among intravenous drug users, Kazakhstan, 2003-2005. Almaty, 2006.

[9] L. Bunina, B. Bapenova. Analysis of HIV-infection situation among intravenous drug users based on data of epidemiological watch in the Republic of Kazakhstan for 2008. Materials from Conference "Results of Epidemiological Control of HIV-infection in the Republic of Kazakhstan for 2008", Almaty, April 27-28, 2009.

Figure 2. Percentage of sex workers reporting using condoms during last sex intercourse with a client.[10,11]



However, despite significant achievements in provision of access to free individual protection means, procurement of them was not always coordinated with target group representatives; assortment and quality did not meet client expectations and demands, especially in the beginning of the project. Although MSM were included as one of the target groups of the project, condoms that would fully meet the requirements of this group were never supplied. In 2007 the project has procured lubricants, but the number of lubricants distributed per client did not meet the actual needs of both MSM and sex workers. Distribution of bad quality syringes and condoms in 2005, as well as untimely supply of materials resulted in partial demotivation of project volunteers and, thus, made the project less attractive for the beneficiaries.

> *"They [IDUs] used to rinse them [syringes] with water and share one syringe in a circle, and now everyone has an opportunity to inject drugs with his/her own syringe. Now people do not want to share [syringe], they use only their own syringes."*
>
> Woman, a volunteer working with IDUs, co-dependent.

Outreach work and distribution of syringes and condoms via volunteers and mobile trust posts were the most appropriate and effective methods, especially with IDUs and MSMs. While sex workers were somehow interested and motivated to attend stationary friendly clinics because of the STI and gynecological services, IDUs and MSM tried to avoid visiting medical institutions due to the fear of being seen by acquaintances or police, inconvenient location and operation hours of friendly clinics and absence of services desired and suitable for them. The services provided by trust posts were not attractive for the majority of target groups.

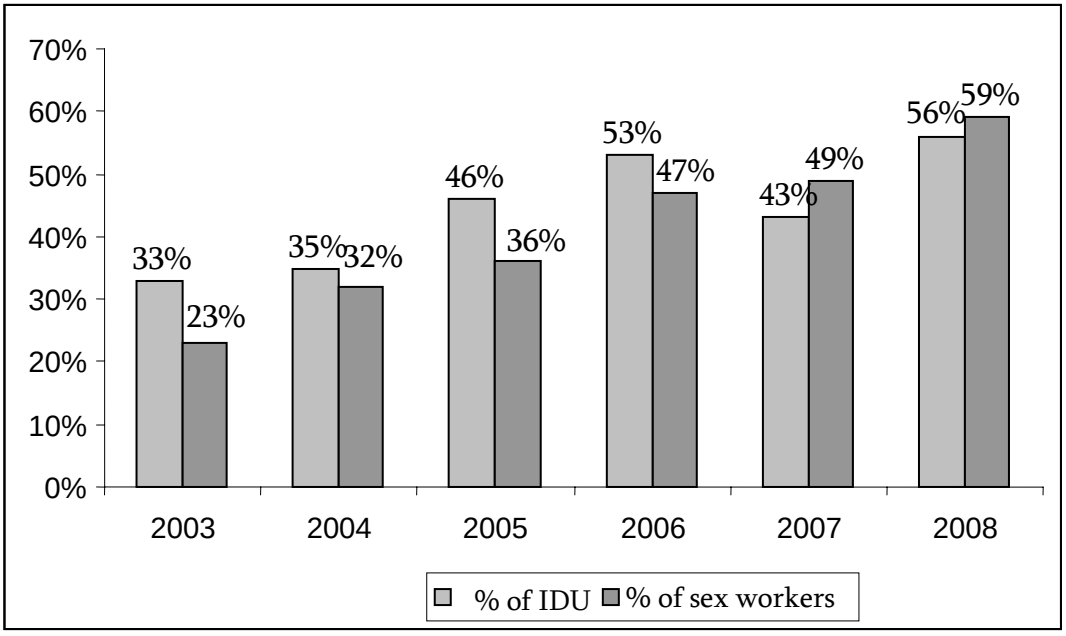
[10] G.Aituganoca, N.Babina. Results of HIV sentinel surveillance survey among Sex Workers, Kazakhstan, 2003-2005. Almaty, 2006.

[11] N.Sakhnova, N.Babina. Analysis of HIV-infection situation among sex workers based on the sentinel surveillance data for 2008. Materials from the Conference "Results of Epidemiological Surveillance of HIV-infection in the Republic of Kazakhstan in 2008", Almaty, April 27-28, 2009.

Educational sessions, including peer-to-peer discussions, and distribution of IEC materials

Increase in knowledge and awareness about HIV among target groups according to the SSS data can also be attributed to the work performed by the AIDS Centers and NGOs under the GFATM project (Figure 3). Thus, during the project implementation percentage of sex workers that can correctly list ways of HIV transmission increased by 23% from 33% in 2003 to 56% in 2008, and has doubled for IDUs from 23% to 59% accordingly.

Figure 3. Knowledge about ways of HIV transmission



Outreach work for the project was conducted through so-called volunteers recruited from medical professionals, target group representatives and co-dependents. At the beginning of the project, outreach workers were planned to work on unpaid voluntary basis, but during the first year of implementation CCM had approved a small budget for compensation of their work. Given the unreasonably high coverage plan per each outreach worker (up to 120 people), extremely low salaries (less than one third of the minimum wage), and inadequate reimbursement of transportation expenses, outreach work was limited to distribution of individual protection means. Low motivation resulted in high outreach workers turnover rates, which complicated capacity building of outreach teams, increased the recruitment and hiring costs, and reduced sustainability and effectiveness of the programs. In addition, only a small number of trainings for outreach workers were budgeted under the project and no additional funds were allocated to conduct motivational trainings for representatives of target groups. No guidelines or manuals for the outreach workers and other project personnel on how to conduct educational sessions among target groups were developed. Thus, due to the specifics of target groups, insufficient capacity and motivation of outreach workers the peer-to-peer education was not used as much as it could have been.

Medical staff of AIDS Centers, friendly clinics and trust points were doing most of the educational work in the project. Due to their excessive workload, lack of proper skills in counseling of target groups, as well as low attendance of medical facilities by representatives of target groups, medical specialists were not able to cover sufficient number of representatives of target groups with individual educational sessions.

Local employment centers allocated different number of paid volunteers for the AIDS Centers almost in all the regions of the country in order to support implementation of the National HIV Program. This helped reduce the coverage plan per volunteer in the project and relieve employees of AIDS Centers of the excessive workload, but the issues with respect to training of such volunteers, their compliance with the peer-to-peer requirement and sustainability of those volunteers were not resolved. As a result, education of target groups about HIV transmission and prevention methods through individual counseling was limited to provision of occasional and very basic information to a limited number of target group representatives.

At the second phase of the project, some NGOs managed to change the situation with outreach work by combining several projects and attracting resources from other donors. Thanks to the GFATM project many organizations managed to recruit outreach workers, establish first contacts with target groups, provide outreach workers with the sufficient number of condoms and syringes, and obtain additional funding for training of volunteers and expansion of activities.

Various information, education and communication (IEC) materials were developed and distributed to improve level of knowledge about HIV among target groups, in addition to individual educational sessions. Most sub-recipients found the centralized development and production of IEC materials to be convenient and appropriate for them. Project sub-recipients from Almaty were actively involved in design and development of brochures, but considering regional differences, sub-recipients from other regions wished they had an opportunity to discuss draft versions of IEC materials with the target groups as well. In general, the content and the design of IEC brochures satisfied information needs of the target groups, however, some of them were overloaded with text and contained not very illustrative pictures, which limited understanding of the materials, especially by less educated beneficiaries.

> *"Under the project, only syringes and condoms were distributed, and that was bad. Experience of harm-reduction programs conducted earlier was not taken into consideration. Unrealistic coverage rates were established for volunteers."*
>
> NGO Director

III. Improvement of HIV information awareness among general population, including youth

Incorporation of HIV/STI and drug addiction prevention topics into the main curriculum of all educational institutions

Currently, students of all education institutions in the country receive at least some information about HIV. Most commonly HIV-infection and AIDS are discussed in healthy lifestyle class, biology or during specially organized events, which are held as part of the International Day against AIDS. In order to improve the quality of teaching of HIV-related topics, practical guidelines and IEC materials for school and college teachers were developed and distributed among with the support of the UNESCO Cluster Bureau, UNICEF and the GFATM project. Additionally, UNICEF has supported a pilot course entitled "Health and Life Skills" in three regions of the country. This course has several sessions on HIV and drug addiction prevention.

> *"Children know about HIV more than teachers and much more than their parents".*
>
> High School Biology Teacher

According to the majority of all respondents, the level of HIV information awareness among organized urban youth is much higher than among population at large. A tendency of decline in the rate of HIV registration among age groups of 15-19 and 20-29 (aged 15-19: 9% - 2002, 2% - 2008; aged 20-29: 52% - 2002, 41% - 2008) [12] as well as "aging" of IDU population and increased length of drug use in 2005 - 2008 [13] can serve as an evidence to that.

Despite of obvious progress, topics on prevention of HIV-infection and drug addiction were not yet included in the standard school curriculum, and thus, no systematic work to develop safer behavior habits among young people is conducted. Healthy lifestyle classes and other extra curricular events are optional, and it is up to each individual educational institution to conduct such classes. Seminars, various education and entertainment events, discussions of HIV prevention during an extra curriculum hours with supervising teacher were mainly aimed at making students aware of the HIV problem, and less at creating the right attitude and safe behavior skills.

> *"At present, it is a slogan plan. One should keep the human factor in mind, because not everybody is capable of communicating information on HIV and to teach a course on healthy life style in the correct format. This subject should not be an extra load to teaching of other subjects. There should be a specially trained teacher for teaching this subject"*
>
> *Representative of Teacher's Professional Improvement Institute*

Certain mentality and insufficient readiness of teachers to discuss prevention of HIV-infection and drug prevention among various age groups of children and young people, result in most of them limiting the discussions about HIV to presentation of epidemiological data and ways of HIV transmission, without talking about evaluation of

[12] L. Ganina. Analysis of HIV-infection epidemiological situation in the Republic of Kazakhstan. Materials from the Conference "Results of Epidemiological Surveillance of HIV-infection in the Republic of Kazakhstan in 2008", Almaty, April 27-28, 2009.

[13] L. Bunina, B. Bapenova. Analysis of HIV-infection situation among IDUs based on the sentinel surveillance data from 2008. Materials from the Conference "Results of Epidemiological Surveillance of HIV-infection in the Republic of Kazakhstan in 2008", Almaty, April 27-28, 2009.

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individual risks and prevention methods. Curriculum of post-graduate institutes for teachers includes only few hours on prevention of HIV-infection and drug addiction.

The fact that all the responsibility for incorporation of topics related to prevention of HIV-infection and drug addiction into the school curriculum and implementation of this component within the GFATM project was assigned to the AIDS Centers also plays a negative role. No funds from the GFATM grant were allocated to departments of education, individual schools, or post-graduate institutes for teachers. Accordingly, actions for institutionalization of HIV prevention topics into the general education curriculum were neither stipulated nor implemented.

Provision of education and information about HIV/AIDS and STIs to general population, including youth

The GFATM project has put a lot of efforts to increase knowledge and awareness of general population, aside from working with target populations. To achieve this, the following activities were conducted:

- Creation of outdoor advertisements;
- Work with mass media;
- Development and dissemination of information materials (brochures, posters);
- Organization of public events and information campaigns.

Several different types of billboards with HIV-related information were designed as part of the GFATM project. The placement of billboards in major cities where the project was implemented was funded by local city budgets. This activity potentially allowed covering a great number of people with HIV-related visual information.

Video spots were also designed and aired on the national and local TV channels under the GFATM project. Rotations of these video spots were provided free of charge on the national television channels and with significant discounts on the commercial TV channels according to the agreement with the Ministry of Culture and Information.

It is not possible to assess the actual contribution of the activity to improvement of information awareness of the population since no special study to evaluate the impact of the billboards and video spots was conducted. However, one can make an assumption that such type of information is only capable to provide basic information about HIV and does help neither to obtain sustained knowledge about methods of prevention nor to develop safer behaviors. This can be proved by the fact that in 2006 in Kazakhstan, 98.7% of women aged 15-49 heard of HIV/AIDS; however, only 30.2% could correctly name three main methods to prevent sexual transmission of HIV-infection, and only 22.3% were able to correctly list ways of HIV transmission and identify most common misbelieves[14].

[14] UN Children's Fund (UNICEF), Agency of the Republic of Kazakhstan for Statistics. The 2006 Multi-indicator Cluster Survey. Astana 2007.

Over the last five years, the project supported organization of public events dedicated to the AIDS Candlelight Memorial Day and the World AIDS Day in all the regions. Such actions played an important role in creating demand for HIV-related information, especially among young people. Organization of big public events also facilitated building better working relations between NGOs, government organizations and commercial companies involved in the process.

IV. Improving access of target groups to good quality services for voluntary counseling and testing (VCT) and treatment

Improving access and acceptability of STI treatment services

Opening of friendly clinics (FC) for anonymous treatment of STIs outside of the official dermato-venereologic dispensaries service (DVD) and use of syndromic approach to case management of STI have helped to increase access of target groups, especially sex workers and youth, to STI treatment services. Additionally, existence of the FCs at the AIDS Centers helped to create more trustworthy and open relationships between the AIDS Center staff and target groups, as well as to expand coverage with HIV-testing.

> *"When I got sick I went to consult with a private doctor. They told me so many things and did not explain anything; and I had to pay big money. When I went to AIDS Center clinic, they helped me out and I did not have to pay any money I go there every often for tests, even if I do not feel ill".*
>
> Young female, SW.

The project has organized annual seminars for the staff of the future clinics on how to arrange their work, manage STI using the syndromic approach and work with target groups.

According to the WHO[15], in case of gonorrhea and chlamidiosis, specificity of syndromic approach for vaginal discharge is low; and in case of vaginal discharge in women it is necessary to identify micro-organisms (etiology) that cause specific syndrome (disease) on the site and adapt the treatment schemes accordingly. All of the FCs were taking smears, however, in many cases microscopy of smears was done in the general laboratory, took a long time, clients were reluctant to wait for the results and the treatment was prescribed without microscopy results. Better results can be achieved if the smear microscopy is done by the doctors of the FCs themselves, who were trained at the specialized DVS laboratory. This approach is already practiced and proved to be effective by the FC located at the Pavlodar AIDS Center.

In addition, FC doctors were not always satisfied with the assortment of STI treatment medicines procured by the project. For example, only few drugs for local (topical) administration were provided and antiseptic solutions for post-exposure prophylaxis of STIs in case of sex without a condom or when condom was broken were not purchased. In addition, there were several cases of drug supply irregularity and stock-outs. For more comprehensive examination and treatment, a fairly great number of clients were referred

[15] http://www.who.int/mediacentre/factsheets/fs110/ru/index.html

to dermato-venereological dispensaries (DVD). However, no joint seminars and work plans for FC employees and DVD specialists were initiated within the project. This did not facilitate friendly attitude of DVD specialists towards project clients, and sometimes made clients to loose their confidence in the work of FCs themselves.

Initiation and expansion of substitution therapy for IDUs

This project has implemented a great amount of work on the top governmental level to promote methadone opioid substitution therapy (OST). A state quota for import of methadone was approved by the Decree of the Government of the Republic of Kazakhstan # 960 concerning Norms of Demand for Narcotics, Psychotropic Substances and Precursors in the Republic of Kazakhstan for 2008 dated October 17, 2007. Import of methadone was agreed upon with the Committee for Fight against Drug Addiction and Drug Dealing under the Ministry of Internal Affairs of the Republic of Kazakhstan. Permit of the Pharmaceutical Committee under the Ministry of Health of the Republic of Kazakhstan for non-recurrent import of methadone was obtained. As the result of these efforts, in October 2008 two regions of Kazakhstan[16] had an opportunity to start OST among 50 clients. The start of OST can be considered as the project's great success and an important contribution to common efforts in both HIV prevention among IDUs and in ensuring adherence to ARVT.

It is too early to evaluate the impact of the OST program in Kazakhstan which has started only less than a year ago, however, based on the very positive feedback from both the program participants and the specialists from narcological dispensaries that participate in the OST program, it is possible to say that the initiation of the OST program was successful and promising.

Considering that the OST was introduced in Kazakhstan for the first time, the Republican AIDS Center has made a decision to postpone active mass media campaign until intermediate results are received. This explains, why currently, IDUs that do not participate in the OST program, health care providers and the general population have controversial attitude to substitution therapy. IDUs often use the term "methadone" to define bad quality drug, which does not bring the expected euphoria in regular doses, and often results in the overdose; thus, the group's perception of it is extremely negative. When asked about the future of OST program, many respondents did not respond with much hope and the majority of representatives of local akimats and health care administrations doubt that it will be possible to fund methadone from the local budget.

> *I've been on methadone for six months now and did not inject drugs since then. Before I used to wake up and run to find money for drugs, to steal. Now all the crime is gone from my life and I have restored good relations with my family.*
>
> Male, IDU/PLHIV.

Prior to launching of the OST program, the project organized a study tour to Kyrgyzstan for the managers of the narcological dispensaries from the pilot regions. However,

[16] Temirtau, Karaganda oblast – 25 persons; Pavlodar, Pavlodar oblast – 25 persons.

insufficient attention was given to training of medical personnel, especially to the local AIDS Centers specialists, who were actively involved in the recruitment of OST program participants and management of patients on ARVT+ methadone. Based on the results of several discussions with specialists and clients, the impression is that the OST is viewed, to a greater extent, as an alternative method of drug abuse treatment, and, to a smaller extent, as a method of HIV prevention among IDUs. This is why narcologists are trying to reduce doses relatively fast and no harm reduction activities are systematically conducted among program participants.

Accessibility and quality of voluntary counseling and testing (VCT)

Over the last five years, primarily due to the efforts made by the Republican and oblast AIDS Centers, and the project, HIV testing of the target groups has increased almost ten times (from 32703 tests in 2003 to 229209 tests in 2008[17]).

The GFATM 2nd round HIV project facilitated increase of information about individual risk assessment and importance of HIV testing, as well as improvement of access to VCT services. Collection of blood for HIV testing was done at the friendly clinics, mobile and stationary trust posts. In some trust posts, HIV testing was a mandatory condition for receiving services on a long-term basis. In most *oblasts,* HIV testing was done using both the standard ELISA methods and express tests funded by local budgets, which increased the number of people willing to undergo the test, especially among IDUs. Compared to MSM, which are very hard to reach and have low level of alert regarding HIV, sex workers and IDUs were more willing to undergo HIV testing. However, counseling was provided in a concise version, especially in mobile trust posts, and was often aimed to motivate people to go for testing, rather than to help them assess and evaluate their risks.

> *"Earlier we would suggest IDUs that they undergo HIV testing; nobody would come on their own. Now some of them ask us to send them for testing".*
>
> Female, outreach worker
>
> *"Sex workers know the environment they work in. They often come to take tests, including HIV test"*
>
> Doctor at a friendly clinic.

Good awareness about HIV testing is important for timely detection of HIV-infection, prevention of its transmission and timely initiation of preventive and other therapy. Interviews with project beneficiaries demonstrated that going for regular HIV testing was viewed by them as a method of HIV prevention. All interviewees were tested for HIV once every three months on average. Such frequent testing was explained by the fact that they often practice risky behaviors and want to protect themselves from HIV by going through the testing. This means that despite of the major increase in the number of tests, counseling remains of a poor quality and risky behaviors, even among permanent clients, are frequent.

V. Provision of treatment, care and psycho-social support services for PLHIV

[17] Data provided by the Republic's AIDS Center based on form №4 for 2003 and 2008. Only number of people who underwent testing under the following codes was considered: 101.2 – contact for join consumption of drugs with PLH-IDU; 102 – IDU; 114 – anonymous testing.

Creation of favorable environment, elimination of discrimination and segregation of people living with HIV

There are almost no laws discriminating people living with HIV in Kazakhstan's legislation, as already mentioned before. With adoption of the latest Law of the Republic of Kazakhstan concerning Prevention and Treatment of HIV-infection and AIDS, the national laws and regulations became compliant with international standards and allow for creation of the system capable of ensuring full enforcement of rights of people living with HIV, their families, and other groups of people vulnerable for HIV-infection. However, it is necessary to change public thinking in order to ensure that the existing laws are followed and rights of all the people are considered accordingly, especially rights of PLHIV. Civil society organizations, including organizations of people living with HIV, and key governmental structures, including Ministry of Internal Affairs, Ministry of Justice and Ministry of Health play the critical role ensuring those changes in mentality and practice.

Epidemiological situation plays the greatest role in reduction of stigma and discrimination of PLHIV in society according to the results of interviews with respondents. For instance, the earlier start of HIV epidemic in Karaganda *oblast* and the outbreak of HIV-infection among in South Kazakhstan, as well as subsequent information campaign funded by the GFATM project and other donor organizations, resulted in more tolerant attitude of health care providers and the general population towards PLHIV.

On average, however, data of the public opinion poll from 2008[18] shows that more than 44% of people in the country think it is necessary to isolate people living with HIV. While this indicator has slightly decreased over the last five years, other indicators about stigmatizing and discriminating opinions in the society have not changed at all.

> *Neither children, nor their parents are ready to be in a situation when a child with HIV would come to their school. More than half of parents said that if an HIV-infected child came to their class, they would take their children out from such class".*
>
> Healthy lifestyle teacher, Astana

Article 116 of the Criminal Code of the Republic of Kazakhstan, which stipulates prosecution for infecting with HIV, still remains. This Article is a "legalized stigma" according to one of the leaders of the PLHIV community, for elimination of which it is proposed to delete article 116, but to retain the criminal responsibility for infecting with HIV under Article 115 of the Code "Causing damage to human health".

Five video spots aimed to reduce discrimination of people living with HIV were designed and demonstrated free of charge in 22 cities around the country. In 2006, in response to the outbreak of HIV-infection in children of South Kazakhstan, the GFATM project has opened a psycho-social support center "Balakai" for the affected families. This center has not only provided different social and medical services to children and their families, but

[18] Report of the Center for Study of Public Opinion (CSPO) on results of the fifth study conducted with adults in relation to AIDS.

has also supported initiation and functioning of five self-support groups around South Kazakhstan and in Chymkent. Main factors influencing the level of stigma and discrimination were identified during implementation of the Balakai work and were laid as a base for development of another successful campaign implemented by the project in Chymkent. This campaign was titled "Wrong information is worse than HIV" and was aimed at reducing stigma and discrimination of PLHIV by increasing knowledge about HIV and included educational seminars with journalists, teachers and directors of educational institutions, including kindergartens, doctors and parents affected by HIV, as well development and distribution of IEC materials and organization of a thematic dancing party.

Development of standards for clinical management of people living with HIV and provision of ARVT

The GFATM 2nd round HIV project increased both the scale and the scope of antiretroviral therapy in the country. To launch the ARVT, the project helped to develop and introduce clinical protocols and to train doctors and nurses on management of and adherence to ARVT at the national level and abroad (St. Petersburg, Russia). Majority of doctors, who are currently working in outpatient departments of the AIDS Centers, have been properly trained and do not experience any difficulties in administration and management of ARVT.

However, problems still exist in making proper diagnostics and treatment of opportunistic diseases, including tuberculosis. The only training for doctors was organized by the CAPACITY Project and Project Hope on management of dual infection and included specialists from Almaty only. As part of the "Access" project, AFEW has also conducted several trainings on TB and HIV management for nurses.

In 2008 the project has supported a seminar on ARV drugs supply planning, forecasting, and management for the heads of the outpatient departments of the local AIDS Centers. However, such seminars were needed right from the beginning of the ARVT program in the country as the lack of special training and skills in drug supply management resulted in stock-outs or overstocks of drugs at the local level. Due to the well-coordinated interaction and mutual assistance of *Oblast* and the Republican AIDS Centers this situation did not affect the quality of treatment services provided to patients.

The project already made the first steps to develop ARVT monitoring and drug management database; however, to the date no such system was introduced. Introduction of such automated database for monitoring of adherence to regular check-up visits and ARVT could facilitate evaluation of the ARVT program. Currently, medical staff spend about 70% of their time at work doing paperwork, and many of the forms duplicate the same information. As the result, doctors do not have sufficient time to spend on counseling their patients regarding adherence and to build trust with the patients. By introducing an automatic user friendly database it would be possible to significantly

decrease the amount of paperwork for the medical personnel and thus improve the quality of services for clients.

Adherence to ARVT remains low and on average does not exceed 60%. And even these low indicators are achieved, to a greater extent, only because of the active position and efforts of the AIDS Center staff to ensure high rates of regular medical check-ups of PLHIV. Sometimes unlawful measures are applied in the struggle for higher indicators; for instance, PLHIV are invited to come to the AIDS Center for the check-up by the police. Of course, such approach does not always facilitate adherence or good relations between PLHIV with the AIDS Centers.

Low level of knowledge and high rates of misconception about different aspects of ARVT found to be the main the main obstacles for better adherence.[19] They can be explained by the absence of good psycho-social counseling and information support for clients. The project organized several trainings for health care providers and representatives of NGOs on ARVT adherence. However, functioning of multi-disciplinary teams (MDT), that include a health care provider and a representative of PLHIV, or specially trained social worker, have started to work only during the last years of the project and only in a limited number of cities. It is also important to notice, that the overall capacity of PLHIV NGOs remains to be low which prevents building more MDTs. There are very few qualified social workers available, so their functions are usually assigned to either NGO representatives or psychologists from the AIDS Centers.

FINDINGS AND CONCLUSION

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) 2nd round HIV project (№ KAZ 202-G01–H-00), which was implemented in the Republic of Kazakhstan from December 1, 2003 until November 30, 2008, significantly contributed to the overall implementation of the National HIV Program. The first large-scale HIV prevention activities and the appropriate selection of target groups and strategies for this project allowed Kazakhstan to maintain the level of epidemics at the concentrated stage over the last five years.

"It is good that there are GFATM grants. I was a witness of how life of many people has changed back to normal. There is an opportunity now to start off again and even to be proud of one's life, to unbend and say: "I have changed my life". On our own, without any outside support, we would not be able to do anything. We change through cooperation".

Director of an NGO.

The main and the most important achievements of the project included initiation of the ARVT program, ensuring access of target groups to free condoms and syringes, and launch of methadone substitution therapy. In addition, the first GFATM project in the country helped to increase the number of AIDS-servicing NGOs and to improve capacity and equipment of local AIDS Centers. If funding and active capacity building of organizations

[19] Waning B., et al. Qualitative assessment of barriers to uptake and adherence to antiretroviral therapy in Temirtau, Kazakhstan. CAPACITY Project. May, 2007.

and their employees continues, these achievements could lay a good base for more comprehensive programs of HIV-prevention and provision of HIV-related treatment, care and support services in the country.

Figure 4. Project's Major Achievements and Shortcomings

Achievements	Shortcomings
Support to implementation of the National HIV Program	No funding for regular CCM meetings and functioning of the Secretariat
Creation of large number of AIDS-servicing NGOs	Limited activities to build organizational and technical capacity of sub-recipients
Improved access of AIDS Centers and NGOs to target groups	Low motivation of outreach workers, including low salaries, high coverage plans, absence of trainings and no stimulation of performance
Long-term and large-scale dissemination of free individual means of protection	Non-comprehensive approach to HIV prevention
Improved access of target groups to HIV testing and STI treatment services	Unification of project's events, lack of adaptation to specifics of certain sub-populations and *oblasts*
Increased information awareness of target groups and general population about HIV, ways of transmission and methods of prevention	Weak coordination among sub-recipients working in one city/*oblast;* limited/no accountability of NGOs to coordination councils at local *akimat* level
Initiation of ARVT, including training of health care providers	No electronic database for supply management of ARV drugs and ARVT monitoring
Initiation of methadone substitution therapy	

RECOMMENDATIONS

Assistance in improving laws and regulations and creation of social environment, which would be favorable for preventive and medical activities

1. Given multi-sectoral nature of HIV- related work, efficient functioning of CCM compliant with all the GFATM requirements can facilitate better implementation of future projects. Therefore, GFATM projects should include funding of periodic CCM meetings and operations of its secretariat into the budgets. The CCM secretariat should be responsible for CCM meetings, including preparation and distribution of meeting notes, development of draft regulations and resolutions,

record keeping and correspondence, follow-up to CCM decisions and monitoring of the GFATM grants implementation. This could help to avoid conflict of interests and allow making the process of grant management and monitoring of implementation less biased and more transparent.

2. It is necessary to intensify the work with law enforcement personnel, considering that actions taken by them with regard to the project's target groups on the local level often impedes implementation of prevention activities. To implement this work effectively, it is necessary to ensure that any policies with regard to HIV prevention activities within the departments of the Ministry of Internal Affairs (MIA) are supported by the ministerial order. The funding for any work with law enforcement personnel should come directly to the MIA structures, and it should be their responsibility, not the AIDS Center staff, to implement such activities and monitor performance, especially when it comes to their non-involvement in preventive programs. The role of AIDS Centers should be to provide counseling and technical assistance in development and revision of training materials and programs.

3. It is important to build capacity of people involved in HIV prevention project and programs. Given high rates of staff turnover, continuous capacity building of NGOs to work with target groups should become a mandatory component of all sub-projects. This could include regular and frequent seminars, study tours to other *oblasts* and provision of technical assistance, as well as other activities. The same approach should be used in relation to the AIDS Centers' staff, because having a medical degree and a work experience at the AIDS Centers does not necessarily imply having skills to work with target groups and knowledge of standards and best international practices of prevention work.

Prevention of HIV-infection among target groups

4. Distribution of free-of-charge syringes and condoms was an important step towards building contacts with the target groups and initiating preventive activities. However, in order to ensure increased access of target groups to various services and to form safe behavior and commitment to such behavior, it is important to develop and scale up comprehensive services that include distribution of individual means of protection, good quality peer-to-peer educational discussions, provision of psychosocial and medical services as well as active work with local communities and various services are considered as the most effective methods for HIV prevention among IDUs[20] and sex workers. It is also very important that programs and distribution materials are specifically adapted and adjusted according to the needs of each of the target groups.

[20] UNAIDS. Prevention of HIV-infection among intravenous drug users in high risk countries. 2008

5. Considering that outreach activities are crucially important for effective implementation of HIV prevention programs, it is important to motivate outreach workers and to constantly monitor their work. To do this, it is necessary to bring requirements for outreach workers regarding coverage in compliance with the actual capabilities and to agree the established standards with the sub-recipients (recommended standard of coverage is one outreach worker for 30 people per month, with mandatory contacts with each client once a week or more often). In order to improve motivation of employees, it is necessary to revise the salary level and bring it to at least the minimal salary level in the country. In addition, it is necessary to develop and communicate to each employee a detailed job description and instructions on how to conduct outreach activities among various categories of people. To ensure proper supervision of the outreach team, each sub-project should ensure that at least one full-time outreach coordinator is in place and is properly trained as planned by the project.

6. Trust points, located in medical institutions, for various reasons, do not satisfy the needs of target groups and are considered the least effective method of working with clients. It is recommended to consider opening of alternative trust points outside medical institutions that would have a work schedule more convenient for clients, and to expand the use of mobile trust points. The scope of activities, routes and schedule of mobile trust points should be adapted to IDU group and to sex workers on individual basis. There should also be staff positions allocated to work specifically in mobile trust points.

Improvement of HIV-related information awareness of the general population, including youth

7. Given the important role of educational system in HIV prevention among young people, it is necessary to improve multi-sectoral cooperation and to facilitate development of HIV-related programs within the education sector. The main responsibility for incorporation of HIV-related topics in educational standards as well as organization of informational and educational events in schools should be assigned to the educational sector, not to the AIDS Centers. AIDS Centers should provide technical assistance in development and revision of training materials and programs.

Ensuring access of vulnerable groups to good quality treatment services

8. For the scale-up of methadone substitution therapy, it is necessary to disseminate positive results from two pilot *oblasts* widely and conduct an extensive preliminary work with mass media, public organizations and health care providers. Additionally, it is necessary to organize joint seminars on OST and ARVT for narcologists and doctors working at the outpatient departments of the AIDS Centers and to develop and disseminate IEC materials for program staff and clients.

9. To organize training on management of opportunistic infections, including dual TB and HIV infection, for medical doctors from the AIDS outpatient departments.

10. To introduce an automated database for ARV drug supply management and ARVT monitoring.

Monitoring and evaluation of the project

11. To prevent double counting of clients and to improve project Monitoring and Evaluation (M&E) system, it is necessary to develop a single project database and a single client registration system, preferably using client unique codes. Description of the database, distribution of responsibilities with regard to filling of the database and frequency for data input data should also be described in detail in the M&E manual and discussed with project's sub-recipients.

12. Creation of a transparent mechanism for periodic evaluation of activities of project sub-recipients, using cross monitoring and broad distribution of evaluation results, could facilitate good working relations among NGOs and between NGOs and the AIDS Centers.

13. Given that the GFATM project is the largest and the most significant project in the country, it is very important to ensure that project indicators are fully reflected in progress reports on implementation of the National HIV Program and the UNGASS reports. Given that the responsibility for data collection about HIV-related activities at the *oblast* level is assigned to the local AIDS Centers, it is very important to establish effective mechanism of information exchange between the government and non-government organizations at the local level.

APPENDIX 1 – TERMS OF REFERENCE

Introduction: In 2003 the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has confirmed allocation of a grant to Kazakhstan for implementation of the program "Assistance and Support to Choosing of Safer Behavior among Target Groups of People (injecting drug users, commercial sex workers, youth); Provision of Assistance and Support to People living with HIV" for a period of five years. The Republican AIDS Center was chosen to be a primary recipient of the grant.

Main Goals and Objectives of Project Implementation:

1. Prevention of HIV/AIS among target groups of people.
2. Provision of treatment, care and psychosocial support to people with HIV.

In order to analyze the efficiency of the GF project, final external evaluation is carried out by independent international experts.

Goals: Conduct an independent analysis of GFATM project implementation in Kazakhstan.

Objectives:

1. Evaluate impact of the GFATM project on further development of the national policy, multi-sectoral approach and partnership of government and international organizations, civil sector and private sector, and transparency of HIV program.
2. Identify dynamics in medical and any other assistance to the target groups: sex workers, MSM, IDU, and PLHIV (access to VCT, PMTCT, ARV, STI treatment, TB, etc.), and determine its accessibility and friendliness.
3. Evaluate changes in the level of knowledge, risky behavior and expansion of HIV among project's target groups;
4. Evaluate efficiency of programs for advocacy, extension of participation and capacity building of local organization in working with HIV-infection;
5. Assess performance of project's work plans, achieving of indicators, efficient and effective use of grant funds, and its impact on changes in indices for illnesses, fatalities, changes in quality of life of the key citizens.
6. Evaluate organizational structure of regulatory framework for management of all aspects of the project, and effectiveness of the M&E system of the GF.

Expected Deliverables

Upon completion of the work, analytical report, which is compiled on the basis of data from five regions in Kazakhstan (Almaty, Astana, Karaganda *oblast*, Pavlodar *oblast*, and South Kazakhstan *oblast*), will be presented in Russian and English.

APPENDIX 2 – LIST OF RESPONDENTS

Organization	Name	Position
Republican Center for AIDS Prevention and Control	Mariam Khassanova Saltanat Surtaeva Makhabbat Espenova	General Director GFATM project manager GFATM project M&E coordinator
Almaty, April 14-17, 2009.		
PSI	Leila Kushenova Mira Saurynbaeva	Regional Director Deputy Director
Kazakh Union of PLHIV	Nurali Amanzholov	President
Almaty Center for AIDS Prevention and Control	Gulsara Suleimenova Gulzhahan Karimova Gulzhahan Akhmetova	Chief doctor Deputy chief doctor Head of outpatient department
NGO «Fakel»	Svetlana Ausheva Pavel Ivanov Oxana Vinnik Alfira Kirrilova Anna Saprykina	Director Staff member Staff member Staff member Staff member
NGO «Adali»	Sergei Skakunov Rustam Shirbayev Olga Sazonova Vitalyi Vinogradov	President Staff member Staff member Consultant
Department of Internal Affairs, Almaty	Ashat Idrissov	Head of the public security department
NGO «Pravovaya initiativa»	Andrei Andreev	CCM member
Almaty Health care department	Elnara Kurmangalieva	Deputy head of the department
AFEW	Roman Dudnik Linara Ahmedzyanova	Regional Director Kazakhstan Representative
Trust point	Kulbeinet Umirzakova	Nurse
Pavlodar city and *oblast,* April 19-22, 2009		
Oblast AIDS Center	Marina Sorokina Bakhyt Zhanakhmetova	Head of outpatient department Head of organizational department
Pavlodar oblast Health Care Department	Gulfas Aubanova Murat Suleimenov	Chief of the department Deputy chief of the department
Pavlodar oblast Akimat	Ryspy Zhumabekova	Deputy for social issues
Post graduate institute for teachers	Nagima Shakrova Svetlana Safronova	Deputy director Specialist
Pavlodar oblast Department of	Maksat Ishmuratov	Deputy chief

Internal Affairs		
NGO «Victory»	Irina Mosakovskaya	Director
	Tatyana Stupak	Staff member
	Anton Ksunin	Staff member
	Dina Galieva	Staff member
	Aidos Abduganiev	Staff member
	Dmitryi Lehoncev	Staff member
	Alla Polushenko	Staff member
NGO «Zhardem»	Anar Aidarkhanova	Director
	Zhibek	Staff member
	Ainagul	Staff member
	Sasha	Staff member
	Oxana	Staff member
	Nastya	Staff member
	Zhibek	Staff member
	Bulat	Staff member
	Denis	Staff member
	Aigul	Staff member
	Sasha	Client
	Sasha	Client
	Vlad	Client
Trust point	Asem	Nurse
	Igor	Client
Friendly clinic	Leila Osmanova	Doctor
	Violetta Kostonaeva	Nurse
NGO «Turan»	Fedor Fisenko	Director
	Oleg Gordeev	Staff member
NGO «Gerlita»	Galiya Khasenova	Director
	Valeryi	Staff member
	Aliya	Staff member
	Elena	Staff member
	Zarema	Staff member
	Misha	Staff member
	Sasha	Staff member
NGO «Anti-SPID»	Saltanat Ardabaeva	Director
	Sasha	Staff member
	Maxim	Staff member
	Lesha	Staff member
	Kurmanbek	Staff member
	Vitya	Staff member
	Erzhan	Staff member
	Dima	Staff member
Astana, April 22-26, 2009		
Astana AIDS Center	Alexander Lebedev	Chief doctor
	Gulnar Aituganova	Deputy chief
	Saltanat Esenbaeva	Head of epidemiological department
	Vera Barsukova	Head of organizational department
	Gulnar Myrzagalieva	Head of outpatient department
	Inzhu Aimagombetova	Head of M&E department

	Karlygash Kuzembaeva Zhanna Bayandinova Lyazzat Sensembaeva Ludmila Abilova	Epidemiologist Epidemiologist Epidemiologist Doctor
Friendly clinic	Tatyana Zimulkina Tatyana Balgazarova Limziya Kabyldina	STI doctor Gynecologist Nurse
Polyclinic of the MIA	Daurek Dautov Galina Tsumanets	Chief doctor Head of epidemiological department
NGO «Saktan»	Aliay Azmuhatova Balsiya Kotbaeva Olga Orlovskaya Gulsun Ishanova Lida Malevskaya	Director Consultant Psychologist Staff member Staff member
NGO «Gender-quire»	Oleg	Director
Astana health care department	Serik Zhandaev	Chief of the department
Astana department of education	Zhanna Kulushbaeva 11 teachers of healthy lifestyle and biology	Specialist
Karaganda city and *oblast,* April 26-29, 2009		
Oblast AIDS Center	Nikolay Kuznetsov Alla Vasilyeva Raisa Bektemirova Amina Nurzhanova Lubov Serduyk Zhanna Mustafina Ludmila Reznikova Kolya	Chief doctor Head of organizational department Epidemiologist Epidemiologist Epidemiologist Head of outpatient department Assistant epidemiologist Volunteer
Friendly clinic	Elena Nidens	Doctor
Karaganda oblast health care department	Tulegan Sadykov	Deputy chief of the department
Akimat of Karaganda oblast	Ravila Mukhamedzhanova	Public health coordinator
Branch of the Oblast AIDS Center in Temirtau	Erkinbek Momynbaev Svetlana Krukovskaya	Head of epidemiological department Head of outpatient department
Narcological dispensary in Temirtau	Almagul Orumbekova Asiya Sadykova Valera Konstantin Igor Sasha	Director OST program manager Client Client Client Client
NGO «Sau-Urpak»	Elena Nosyreva	Director

NGO «GALA»	Andrei Igor	Director Staff member
OO «Umit»	Gulmira Ismailova Razima Kinzyabaeva Kairzhan Karibaev Nazgul Turgambaeva	Director Staff member Staff member Staff member
Chymkent and South Kazakhstan, May 3-8, 2009		
Oblast AIDS Center	Artur Abdrazakov Kozhahmet Mashirov Erbol Esirkepov Nurzhamal Irsimbetova Akbulpi Altinbekova Gulbaram Ibraimova Sharipa Bilibaeva	Chief doctor Deputy chief doctor Head of epidemiological department Epidemiologist Head of organizational department Head of outpatient department Teacher
Friendly clinic	Gulmaral Seitkalieva	STI doctor
Trust point	Gulnar Elemesova Zhora Valera Sveta Elvira Zana Zhazira Sabina Khaltai Madina	Nurse Volunteer (IDU) Volunteer (IDU) Volunteer (IDU) Volunteer (IDU) Volunteer (SW) Volunteer (SW) Volunteer (SW) Volunteer (SW) Volunteer (SW)
Department of education	Marina Zhanabaeva	Specialist
Center of new technologies in education, post-graduate institute for teachers	Shynar Ergeshbaeva Zhanat Raimkulova	Deputy director Biology teacher
Kashkarata saunas	11 sex workers and 3 pimps	
NGO «Ai-ana»	Dusenbek Eltenbaev	Director
NGO «Zhan Zholdas» and Association «Zholdas»: NGO «Nazym-Chymkent», NGO «Kuat Chymkent», NGO «Bota-Turkestan»	Bolatbek Turgunbaev Oxana Neiman Sergei Borisov Artem Mukhachev Nidira Otzhanova E, Bobileva R. Nasibov Z. Doskieva F. Khassanova D. Narbaev Dzhamilya Auezova Andrei Shkorupa Sergey Shiryaev Zh. Muslimova E. Shaimardanov	NGO representatives

	Taukel Kenzhebaev Madina Sultant	
NGO «Trek»	Kelesbai Dzhumagulov	Director
NGO «Nadezhnaya Opora»	Valentina Skryabina Tamara Oxana Dima Bakhtiyar Elvira Valera Lena Igor	Director Staff member Staff member Client Client Client Client Client Client
NGO «Senim»	Tatyana Rodina	Director

APPENDIX 3 – LIST OF REFERENCES

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