Uzbekistan

Independent Mid-term Review of Implementation of the First Phase of the Global Fund's Project (HIV Component) in Uzbekistan

Final Report

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
CADAP	Central Asia Drug Action Programme
CCM	Country Coordinating Mechanism[1]
ECDC	European Centre for Disease Control and Prevention
EHG	Euro Health Group
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
LFA	Local Fund Agent
M&E	Monitoring and Evaluation
MARP	Most-At-Risk Population
MIS	Management Information System
MSF	Médecins Sans Frontières
MSM	Men who have Sex with Men
NGO	Non-Governmental Organisation
OI	Opportunistic Infection
OST	Opioid Substitution Therapy
PLHIV	People Living With HIV (also PLWHA)
PMTCT	Prevention of Mother-to-Child Transmission
PMU	Project/Programme[2] Management Unit
PR	Principal Recipient
PSM	Procurement and Supply Management
RCC	Rolling Continuation Channel
SDA	Service Delivery Area
SSF	Single Stream of Funding
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
UNAIDS	Joint UN Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

[1] In Uzbekistan, this body is referred to as the Multisectoral Expert Council. However, it is referred to in this report as County Coordinating Mechanism (CCM)

[2] The terms 'project' and 'programme' are used interchangeably in documents to describe Global Fund support to Uzbekistan, e.g. in the terms of reference (see Annex 1, p52). This same approach has been used in this report.

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EXECUTIVE SUMMARY

The Global Fund has been providing a significant level of funding to the HIV response in Uzbekistan since awarding the country its first grant in Round 3 in 2004. This grant focused particularly on scaling up HIV prevention among those populations most affected by HIV. This work was continued through the Rolling Continuation Channel (RCC) and supplemented with a further grant, focused on health systems strengthening, in Round 10. Since January 2012, these two grants were combined into a Single Stream of Funding (SSF) worth $22.7m in the first two years.

In January and February 2013, a team from Euro Health Group conducted a mid-term review of phase 1 activities. This involved reviewing documents, interviewing key informants and visiting programme activities in Bukhara, Fergana, Samarkand and Tashkent.

In order for a country to respond effectively to HIV, it is essential that a country 'knows its epidemic'. This means knowing how HIV transmission is occurring in the country as this allows prevention efforts to be focused effectively. Overall, sufficient epidemiological evidence is available in Uzbekistan for this purpose. The country is experiencing a significant HIV epidemic concentrated among key populations, particularly people who inject drugs and their sexual partners. Sex workers and men who have sex with men (MSM) are also key populations at particular risk. The country has begun to introduce effective HIV prevention measures among these populations. These include provision of sterile injecting equipment and other services to people who inject drugs through a network of trust points and outreach workers; the provision of condoms and other services to sex workers and MSM; and low threshold treatment of sexually-transmitted infections (STIs) through a network of 30 friendly cabinets.

There is some evidence that these measures may be beginning to have an impact on HIV transmission. According to official data, the number of new HIV infections registered annually declined from 4,152 in 2009 to 3,584 in 2011. According to sentinel surveillance data, HIV prevalence among people who inject drugs declined from 13.0% in 2007 to 8.4% in 2011. The Government of Uzbekistan, UNDP and some other local stakeholders consider that this is evidence that HIV transmission among people who inject drugs is declining as a consequence of the programmes implemented. Although this explanation is plausible, there are a number of other possible explanations. As a result, it would be premature to conclude that Uzbekistan's epidemic among people who inject drugs is fully controlled.

The Global Fund has provided considerable financial resources to expand HIV prevention services among key populations, particularly among people who inject drugs, through support to 114 trust points. The introduction of outreach services from these trust points has been a very important development. However, the gains are fragile. Given the relatively low monthly payments made to outreach workers, outreach services rely largely on their individual dedication, commitment and motivation. Turnover is reported to have been high. Services for sex workers have been supported, both through the work of NGOs, and through the work of 30 friendly cabinets, that provide free-of-charge, syndromic management of STIs for members of key populations. Work among MSM has been more limited. Activities are implemented by one NGO in only seven of Uzbekistan's 14 regions. Not only is sex between men criminalised but there are also very strong cultural and social taboos regarding this behaviour. As a result, there is strong resistance to expanding services for this group, including to male sex workers.

Some HIV transmission is occurring in hospital settings. In common with other countries of the region, Uzbekistan has experienced localised outbreaks of such infections among children aged less than 15 years. However, the precise scale of such transmission is unknown. Overall, the number of infections acquired in this way is likely to be relatively small,

compared to the total number of HIV infections, with minimal risk of onward transmission. The allocation of resources to this area within the programme is disproportionate, e.g. when compared to HIV prevention among key populations. In addition, the programme is focused largely on procuring single use instruments as a way of addressing this transmission route, funds available to this activity were reduced to allow more ART procurement and there have been significant problems in quantifying the number of single use instruments to be procured. As a result, there is a significant risk that the quantity of single use instruments procured will prove to be insufficient to pilot this approach in five regions over two years.

The Global Fund has, to date, been the sole direct funder of antiretroviral therapy (ART) in Uzbekistan, although delivery of treatment has relied heavily on a government contribution, in term of staff, infrastructure etc. The Global Fund and UNDP have demonstrated great flexibility and willingness to expand the number of people receiving this treatment through the programme. As a result, more than 6,000 people are now reported to be on treatment. Although this is a major achievement, it is clearly undesirable and unsustainable for this treatment to be financed solely by one external funder. Announcements that both MSF and, in particular, the Government of Uzbekistan are to begin to also finance this therapy are especially welcome.

However, there are clearly some people in Uzbekistan who currently require ART but are not yet receiving this. Reasons vary. People who actively inject drugs may find it difficult to adhere to treatment requirements without access to opioid substitution therapy. In addition, some people may be infected with HIV but have not yet been diagnosed. According to the 2012 report to the Global AIDS Response Progress reporting process, almost one third (31%) of those diagnosed with HIV are diagnosed late, i.e. when their CD4 is <350 and they already require treatment. Clearly, this indicates that there are people in Uzbekistan who require ART but who have not yet been diagnosed with HIV infection. The precise scale of this unmet need is not known. It is likely that these people are found largely among members of key populations, such as people who inject drugs and their sex partners, sex workers and MSM. It is therefore of concern that official statistics show that rates of annual HIV testing among these groups remains low. For example, in 2011, sentinel surveillance data showed that less than one third of people who inject drugs had been tested for HIV in the last 12 months and knew the results.

Activities under the four objectives focused on integration, supply chain management, health systems strengthening and enabling environment currently seem to lack cohesion and a systematic or strategic approach. As a result, there is a risk that significant amounts of resources will be consumed under these objectives and substantial numbers of people may be trained but without tangible results.

Global Fund support to Uzbekistan has resulted in more people on ART. More members of key populations are being reached with essential HIV prevention services. These efforts are clearly effective and are contributing to slowing of the epidemic. However, the epidemic is not yet controlled. More can be done. The review's ten main recommendations are presented in Box 1.

Box 1: Main recommendations of the review

1. There is a need in phase 2 to **increase the focus of programme's activities on those areas where it can make the most difference, in particular, promoting HIV prevention among key populations**. This will involve reducing/stopping activities in some areas, e.g. HIV prevention among young people, in general, and unfocused, ad hoc training activities.

2. **HIV prevention activities among key populations could be strengthened by expanding services in ways identified by clients and service providers, and further strengthening outreach work by increasing the financial and other incentives provided to outreach workers**.

3. There is need to **further increase the capacity of NGOs to provide social services for members of key populations**. NGOs are critical to the provision of such services not only in Uzbekistan but also in other countries. Effective links between NGOs and government services have been developed and these need to be strengthened and developed.

4. The Ministry of Interior, in general, and its health staff, in particular, should be invited to participate in planning for phase 2 with a view to **identifying any areas related to HIV in prisons which could be incorporated into the programme**.

5. Plans need to be made to ensure the sustainability of activities commenced with Global Fund financing. During phase 2, **the Global Fund should taper off its funding to ART and infection control as these areas are increasingly financed by government**.

6. Efforts should be made to **reduce late HIV diagnosis by expanding HIV testing among key populations**, e.g. by supporting introduction of rapid HIV testing in low threshold services, such as trust points and friendly cabinets.

7. **People who inject drugs should be given maximal support to adhere to ART**. This should involve reintroducing opioid substitution therapy along the lines recommended by Emilis Subata. Key first steps would be for the CCM and Ministry of Health to endorse this report and to establish a working group on OST.

8. Given the reduction in budget for procurement of single use instruments and the problems in generating robust estimates of the quantities needed, **consideration should be given to reducing the scale and length of this pilot of measures to control HIV transmission in hospital settings**, for example, to one region over one year rather than in five regions over two years. This would allow procurement and provision of single use instruments to be done as part of an overall package of measures to reduce HIV transmission in hospital settings rather than as a poorly-planned, stand-alone measure.

9. Consideration should be given to **integrate the four smallest objectives (integration; health systems strengthening; supply chain management and enabling environment) into one objective**. This could be streamlined in order to allow more resources to be focused on prevention among the most affected populations. There should be clarity over the expected results under this objective and a clear strategy through which these will be achieved.

10. Given that there are currently limited opportunities to engage in critical discussion and dialogue about HIV-related data in Uzbekistan, there is **an opportunity for the Global Fund and UNDP to model transparent and open sharing of data, knowledge and information related to the programme**. This is already beginning to happen in some areas. However, more could be done. There is a specific opportunity to engage stakeholders in discussion and dialogue about the findings, conclusions and recommendations of this review as part of the planning process for phase 2 of the programme.

For more detailed explanation of these recommendations, see Section 7 (p512).

1. INTRODUCTION

1.1 Epidemiology of HIV in Uzbekistan

Overall, the prevalence of HIV infection among the general population remains low. In 2011, there were 545,524 registered pregnant women in Uzbekistan. Of these, 98.4% were tested for HIV. Among these, HIV prevalence was very low (0.1%).

However, HIV prevalence is higher among some sub-populations. Since 2005, Uzbekistan has been conducting sentinel surveillance every two years among particular sub-populations including people who inject drugs, sex workers and men who have sex with men (MSM). Table 1 shows HIV prevalence rates among people who inject drugs, sex workers and MSM according to sentinel surveillance conducted from 2007 to 2011.

Table 1: HIV prevalence among key affected populations according to sentinel surveillance: 2007 to 2011

	2007	2009	2011	
People who inject drugs	13.0%	11.0%	8.4%	n=5600
Sex workers	2.2%	1.9%	2.2%	n=3379
MSM	6.6%	6.8%	0.7%	n=150

From 2007 to 2011, HIV prevalence among people who inject drugs fell from 13.0% in 2007 to 8.4% in 2011 and among MSM from 6.6% in 2007 to 0.7% in 2011. HIV prevalence among sex workers remained static at 2.2% in both 2007 and 2011.

However, caution is needed in interpreting this data. Sentinel surveillance among MSM was only conducted in Tashkent and in 2011 the sample size was small (n=150)[3].Particular caution is needed in attributing reductions in prevalence to a reduction in HIV incidence as a result of programmes being implemented. There are other possible explanations for declines in prevalence among a particular group including death or migration of HIV-infected members of a particular population.

Regardless of the trend, national HIV prevalence among people who inject drugs has been high (>5%) in each of the last three rounds of sentinel surveillance. Prevalence rates are considerably higher in some parts of the country, e.g. Termiz, Tashkent and Samarkand.

Similarly, caution is needed in interpreting a reduction in the number of newly-registered cases of HIV infection as evidence that the epidemic is declining as a result of prevention measures that have been put in place. According to official statistics[4], the total number of HIV infections diagnosed and registered in Uzbekistan was 21,542 as of 1st January 2012. New cases of HIV diagnosed declined from 4,152 in 2009 to 3,795 in 2010 and 3,584 in 2011. Although it is possible that the reduction in new diagnoses is occurring because of a decline in HIV transmission, this is based on the assumption that reported new HIV diagnoses is a reliable and accurate proxy of the number of new HIV infections occurring. This will only be the case if all new HIV infections are detected promptly. Official statistics[5] provide evidence that this is unlikely to be the case in Uzbekistan:

[3] Sampling techniques may not have allowed for inclusion of different sub-populations of MSM. HIV programmes among MSM in Tashkent largely reach young, unmarried MSM.
[4] In Uzbekistan's report to Global AIDS Response Progress Reporting 2012
[5] In Uzbekistan's report to Global AIDS Response Progress Reporting 2012

- In 2011, only just over a quarter (29%) of people who inject drugs reported that they had had an HIV test in the last 12 months and knew the results. Given the evidence of a concentrated HIV epidemic among people who inject drugs in Uzbekistan, it is extremely likely that there would be people with HIV infections among the almost three quarters (71%) of people who inject drugs who were not tested for HIV in 2011.

- In 2011, almost one third (31%) of those diagnosed with HIV infection had a CD4 count <350 at the time of diagnosis, i.e. they were diagnosed late[6,7]. These diagnoses probably reflect earlier infections. It is likely that there were infections which occurred in 2011 which will only be diagnosed in later years.

Consequently, although it may be the case that the reduction in new HIV diagnoses in Uzbekistan reflects a reduction in new HIV infections, this may not be the case given particularly the relative low rate of HIV testing among people who inject drugs. Whatever the explanation, the absolute rate of new diagnoses of 12.7 per 100,000 of population remains high. For example, during the same period, the average rate of reported new diagnoses across countries of the European Union/European Economic Area was less than half this level at 5.7 per 100,000 population[8].

Caution is also needed in interpreting data relating to the sex and reported route of transmission[9] based on HIV case reporting data. In an epidemic that is largely driven by injecting drug use, it would be expected that initially most new HIV infections would be detected among men who inject drugs but that, over time, the number of women infected sexually would rise as a result of transmission to the sexual partners of men who inject drugs. This is the pattern being seen in other countries with an HIV epidemic among people who inject drugs, e.g. Estonia[10]. This is also the pattern being seen in Uzbekistan[11]. This does not mean that there is a separate sexually-transmitted epidemic of HIV. Rather, it is the expected transmission pattern seen in an epidemic driven largely by injecting drug use.

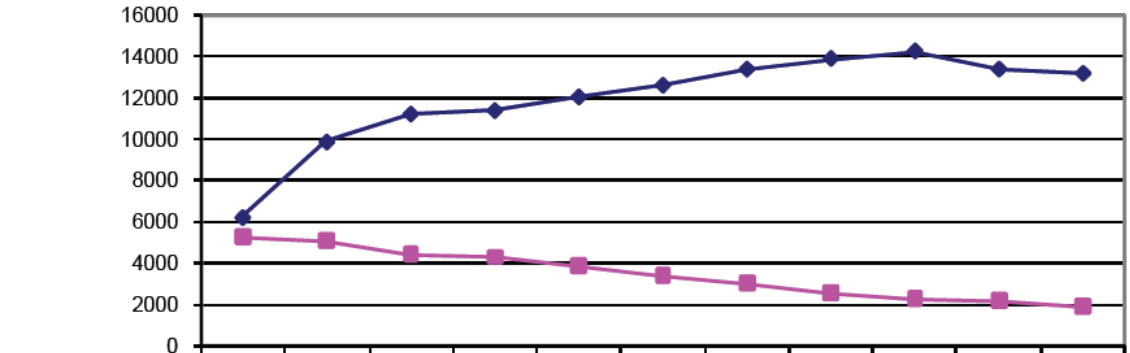
This understanding is correctly reflected in official reports on the HIV epidemic in Uzbekistan. For example, Uzbekistan's 2012 report to the Global AIDS Response Progress reporting process concluded that HIV is spread primarily among vulnerable populations at most risk of infection, including people who inject drugs[12].

According to data published by the European Union's Central Asia Drug Action Programme (CADAP)[13], the number of registered drug 'addicts'[14] in Uzbekistan in 2010 was 18,939. Of

[6] In UNDP's comments on the draft report, they point out that, during 2011, Uzbekistan was initiating ART for those with CD4 counts <200. It could be argued that those in need of treatment, at that time, were those with a CD4 count <200. However, the national report to Global AIDS Response Progress Reporting 2012 states quite clearly that this figure is for those with a CD4 <350 at the time of diagnosis. Of course, if this figure were, in fact, for those who had a CD4 count <200, it would mean that the problem of late diagnosis in Uzbekistan is even more severe.
[7] For more information about late diagnosis data in Europe, please see http://ecdc.europa.eu/en/publications/publications/1009_spr_dublin_declaration_progress_report.pdf, pp137-164
[8] See ECDC and WHO (2011) HIV/AIDS Surveillance Report in Europe 2011: Surveillance Report. This surveillance report did not include figures for Uzbekistan for 2011. However, Uzbekistan's official figures for the rate of HIV cases diagnosed was very similar to rates reported by neighbouring countries, i.e. 12.5 per 100,000 population for Kazakhstan, 11.1 for Kyrgyzstan and 13.7 for Tajikistan.
[9] The following is based on information provided to the team by key informants during interviews conducted for the review. Route of transmission data is based on information provided by the person diagnosed. The assumption is made that transmission has occurred heterosexually in the absence of information to the contrary. Some routes of transmission combine very different transmission routes. For example, 'parenteral' transmission includes transmission through injecting drug use and hospital-acquired infections, including through use of blood products. 'Heterosexual' transmission does not distinguish between transmission to the sex partners of people who inject drugs, transmission through commercial sex and transmission in the absence of these factors. Stigmatised routes of transmission such as injecting drug use and sex between men are likely to be under-reported.
[10] See UNODC and WHO (2008) Evaluation of Fighting HIV/AIDS in Estonia
[11] For example, according to official statistics, the proportion of women among all reported HIV infections is 39%. In 2011, the reported percentage among women was 47.6%.
[12] The report also identified MSM and sex workers as groups in Uzbekistan that are particularly vulnerable to HIV.
[13] See CADAP (2011) The Republic of Uzbekistan: Drug-Related Situation in 2010.
[14] The term addict is used here because this is the term used in the CADAP report. In general, the non-pejorative term – person

these, almost all (95.7%) were men and more than three quarters (79.1%) were dependent on opiates, particularly heroin. The number of registered 'addicts' addicted to heroin rose steadily from 2000 to 2008 (see Figure 1). Almost half (48%) of registered drug 'addicts' report injecting drug use. Almost all of them (93.6%) report using heroin.

Figure 1: Number of drug addicts at dispensary registration addicted to opiates (from CADAP (2011) The Republic of Uzbekistan: Drug-Related Situation in 2010)



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Heroin	6199	9832	11174	11342	12000	12564	13337	13853	14213	13337	13135
Other opiates	5223	5036	4378	4244	3849	3350	3006	2502	2236	2123	1861

However, it is widely-understood that not all people who inject drugs in Uzbekistan are officially registered. In its applications to the Global Fund, Uzbekistan indicated that there were between 80-100,000[15] people who inject drugs in the country. However, there is no current, officially-agreed estimate of this figure. It is expected that in 2013, the Government of Uzbekistan will produce estimates of the size of key populations affected by HIV, namely people who inject drugs, sex workers and MSM, with technical support from UNAIDS.

There are concerns about hospital-acquired (nosocomial) HIV infection. However, information about this route of transmission is limited. According to a published study of data from Kazakhstan, Kyrgyzstan and Uzbekistan[16], one reason for this is fear among hospital staff of being blamed or punished if such episodes are reported. Respondents confirmed in interviews with the review team that fear of punishment was one reason why cases of hospital-acquired HIV infection might be under-reported. Although this issue was not specifically highlighted in Uzbekistan's 2012 report to the Global AIDS Response Progress reporting process, it is recognised that such infections form part of the group of HIV infections acquired parenterally[17]. The issue is highlighted in Uzbekistan's national HIV strategy for 2013-2017. Uzbekistan's application to the Global Fund's Round 10 highlighted this issue and this is noted in the grant agreement that resulted from that application (see Box 2). In brief, the evidence for transmission of this nature is:

- Occurrence of HIV infection among children under 15 that cannot be explained on the basis of mother to child transmission.

who injects drugs – is preferred and used throughout this report.

[15] The application for R3 reported the number of people who inject drugs as >100,000, the number of sex workers as >20,000 and the number of MSM as >8,000. The application for RCC reported the number of people who inject drugs as 80,000, the number of sex workers as 40,000 and the number of MSM as 8,000.

[16] See Thorne, C., Ferencic, N., Malyuta, R., Mimica, J. And Niemic, T. (2010) *Central Asia: Hotspot in the Worldwide HIV Epidemic* Lancet Infect Dis 2010; 10: 479-88 – "*The outbreaks of nosocomial HIV among children in Kazakhstan, Kyrgyzstan, and Uzbekistan, with at least 400 infected children identified so far, have shown structural and systemic weaknesses of health-care systems, including fragmented service delivery, limited resources, interrupted medical supplies, outdated infection control and blood use protocols, flawed blood management systems, and limited staff capacities. Ongoing responses have focused on specific measures to address these weaknesses. However, the punitive nature of the system in central Asia, exemplified by the conviction and imprisonment of healthcare workers after the nosocomial outbreaks, generates distrust and hinders constructive approaches to change.*"

[17] See footnote 9.

- The occurrence of a documented outbreak among children in Namangan. Similar outbreaks have occurred in other Central Asian countries, e.g. Shymkent in Kazakhstan and Osh in Kyrgyzstan[18].

Box 2: Extract from R10 grant agreement related to hospital-acquired HIV infections in Uzbekistan

"Since the second half of 2008, Uzbekistan experienced a sharp increase in HIV infections in children under 15. A paediatric HIV outbreak in Namangan affected 147 children. The outbreak alerted medical personnel to the possibility of nosocomial infection and led to increased awareness of communities and population at large; this resulted in an increase in voluntary and provider initiated HIV testing and increased HIV detection rates. As a result, from the end of 2008 through the end of July 2010, the number of HIV infections detected in children under 15 reached 1,405; around 50% of these infections may have been acquired in healthcare settings, through unsafe invasive procedures, including intravenous injections and catheterisations."

Although the number that may have been infected nosocomially is significant e.g. in terms of the number of children infected through this route (see Box 2), it accounts for a relatively small number of total HIV infections reported in Uzbekistan[19]. These infections are related to the HIV epidemics in Uzbekistan and other countries of Central Asia that are being driven primarily by injecting drug use. It has been noted that the places where these outbreaks of hospital-acquired HIV infections have occurred are located along major drug trafficking routes from Afghanistan[18]. Effective measures, that prevent HIV transmission among people who inject drugs and from people who inject drugs to their sexual partners, would also contribute to reducing hospital-acquired HIV infection by limiting the pool from which such infections could occur.

Concerns have been raised about the possible role of labour migration in HIV transmission in Uzbekistan, e.g. in the national HIV strategy for 2013-2017. However, this was not identified as a major factor driving HIV transmission in Uzbekistan's report to the Global AIDS Response Progress reporting process in 2012. Since 2009, sentinel surveillance has been conducted among this group. In 2011, sentinel surveillance was conducted among 5,600 labour migrants. Three quarters of them had migrated for work to the Russian Federation. Almost three quarters (71.9%) were men. Overall, HIV prevalence among this group was low (0.8%). Although almost three quarters (73%) of male labour migrants reported having sex while outside the country, relatively few (4.6%) of these reported commercial sex[20]. A relatively large proportion of migrants (9.6%) reported ever having injected drugs[21].

Numbers of such labour migrants are very large. The national HIV strategy reports expert estimates[22] that at least 600,000 people migrate out of Uzbekistan each year with 70% of them going to Russia. However, it is unlikely that labour migration per se is a major driving force for the HIV epidemic in Uzbekistan or other countries of Central Asia. This is recognised by the national HIV strategy for 2013 to 2017 which states that "leaving to work abroad is not a risk factor". However, concerns are raised about the amount of time migrants are away from their families and the traditional way of life. Nevertheless, HIV prevalence among this group overall remains low. Of course, sub-groups of labour migrants who buy (or sell) sex or inject drugs while outside the country would be at-risk of HIV infection in the same way as would those who engage in such practices in Uzbekistan.

Overall, although there are areas in which data availability and quality could be improved (see p51), the available data is sufficient to conclude that:

[18] See Thorne, C., Ferencic, N., Malyuta, R., Mimica, J. And Niemic, T. (2010) *Central Asia: Hotspot in the Worldwide HIV Epidemic* Lancet Infect Dis 2010; 10: 479-88

[19] Even allowing for the likelihood that nosocomial transmission in adults is under-estimated and included as sexual transmission in official statistics.

[20] These figures differ markedly from those in the national HIV strategy, where 93% of migrant men were reported as having had commercial sex partners while abroad. The reason for this discrepancy is unclear.

[21] However, according to the national HIV strategy, only 4% of migrants reported ever using drugs. None reported injecting. The reason for this discrepancy is unclear.

[22] See http://mirpal.org/mirpnews45.html

- The HIV epidemic in Uzbekistan remains concentrated among key populations, particularly among people who inject drugs and their sexual partners.

- Relatively high levels of HIV transmission continue to occur. The epidemic is not yet under control.

1.2 Global Fund support to the HIV response in Uzbekistan

In 2010 and 2011, Uzbekistan was awarded two HIV-related grants by the Global Fund to Fight AIDS, Tuberculosis (TB) and Malaria. These were a grant under the Global Fund's Rolling Continuation Channel (RCC) relating to a Round 3 grant and a new grant under Round 10. The RCC grant is expected to further strengthen prevention, care and treatment services, with a focus on key affected populations. It is also expected to facilitate community systems strengthening and the creation of an enabling environment. The Round 10 grant proposal sought to contribute to the national HIV response by complementing the RCC grant. It covers three broad areas:

- Infection control for prevention of HIV transmission
- Procurement and management of necessary health products and consumables for HIV prevention, diagnosis and treatment
- Integration and decentralisation for sustained outreach and improved access

The RCC grant supports services nationwide. The Round 10 grant aims to provide support in five regions, that is, Andijan, Namangan, Fergana, Samarkand and Tashkent.

The United Nations Development Programme (UNDP) acts as Principal Recipient (PR) for these grants.

2. DESCRIPTION OF THE INTERVENTION

In accordance with Global Fund policy, the grants have been consolidated into a single stream of funding (SSF). The consolidated project is implemented by UNDP in close cooperation with governmental and non-governmental organisations (NGOs).

The main goal of the project is to prevent the spread of HIV into the general population by reducing its impact on most vulnerable populations and to strengthen health systems and national capacity for universal access to HIV prevention, diagnosis, treatment and care in Uzbekistan. The project has seven objectives, which are:

- To scale up coverage and increase quality and comprehensiveness of HIV prevention services for most-at-risk populations (MARP)
- To scale up treatment, care and support for people living with HIV (PLHIV)
- To strengthen health systems in Uzbekistan
- To create an enabling environment for the effective scale up of HIV prevention, treatment, care and support services
- To strengthen infection control for prevention of HIV transmission
- To strengthen systems for procurement, supply and management of necessary health products and consumables for HIV prevention, diagnosis and treatment
- To facilitate decentralisation and integration of services for sustained outreach and improved access

Project activities to implement the first five objectives started from July 2011. Work on the remaining two objectives started from 2012.

3. MID-TERM REVIEW: SCOPE AND OBJECTIVES

The approved SSF budget and work plan include provision for an external assessment to review phase 1 activities conducted from 2011 to 2012. Details of this review are provided in the terms of reference (see Annex 1, p57) and in the inception report produced prior to the in-country work of the review. Results of the review are expected to be provided to the Global Fund by March 2013.

3.1 Review goal and objectives

The overall goal was to conduct a mid-term review of the first phase of implementation of the HIV component of Global Fund financing in Uzbekistan.

The objectives of the review were to:

- Assess the relevance of programme design to the HIV epidemic
- Assess the efficiency and effectiveness of programme implementation, its major achievements (or lack thereof)
- Identify major problems and constraints faced by the grants' implementation at all levels
- Assess availability, accessibility, uptake and quality of prevention activities among MARPs; HIV counselling and testing; HIV case follow-up; Opportunistic Infection (OI) prophylaxis; Prevention of Mother-to-Child Transmission (PMTCT), and Antiretroviral Therapy (ART) for those who are in need and identify gaps and opportunities among different services
- Evaluate results and achievements of the first year implementation of the project components including to strengthen infection control for prevention of HIV transmission; to strengthen systems for procurement, supply and management of necessary health products and consumables for HIV prevention, diagnosis and treatment; and to facilitate decentralisation and integration of services for sustained outreach and improved access
- Assess adequacy of the project's contribution into the implementation of the national strategy and provide recommendations on project restructuring if needed
- Conduct analysis of causation and the contribution of the Global Fund and other explanations along the programme results chain from inputs to outcomes

3.2 Scope

Overall, this is a mid-term review of phase 1 activities[23], i.e. it is limited to those activities which started in 2011. However, Global Fund support to Uzbekistan's response to HIV did not only commence in 2012. Support under the original Round 3 agreement started in December 2004. As a result, Uzbekistan has benefited from almost a decade of Global Fund support. Some sections of this report, e.g. consideration of programme outcomes (p48) take a broader view than the contribution of phase 1 activities only.

3.3 Areas of focus

To meet its objectives, the mid-term review had four areas of focus which were:

- Programme design
- Programme implementation
- Coverage with interventions and achievement of targets
- Impact assessment

[23] Phase 1 activities relate to both the Rolling Continuation Channel of the Round 3 grant and the Round 10 grant. From January 2012, these were implemented as a Single Stream of Funding (SSF).

3.4 Mid-term review questions

These areas of focus were used to structure the review questions listed in the terms of reference (see Annex 1, p57).

4. MID-TERM REVIEW APPROACH AND METHODS

The Euro Health Group (EHG) team's approach to the review was structured around four phases:

- Phase 1 – desk review
- Phase 2 – data collection
- Phase 3 – reporting and analysis
- Phase 4 – final review report

Relevant documents were reviewed during phase 1 of the review. Documents were provided largely by UNDP with some documents being downloaded directly from the Global Fund website. Further documents were provided by UNDP and other stakeholders during phase 2 of the review. In general, documents were made freely available to the review team. In some cases, requested information was not available[24]. In the case of the on-site data verification reports of the Local Fund Agent (LFA), focusing on ART and PMTCT, a request to receive these reports was declined by the Global Fund on the grounds that they were confidential and could not be made available to third parties. Details of documents reviewed are provided in Annex 2 (p62).

Most primary data collection was conducted by the team during an in-country mission to Uzbekistan from 20th January to 5th February 2013. Methods used for data collection were described in detail in the inception report. These included semi-structured interviews with individuals and groups and site visits to and direct observation of programme activities. Details of people interviewed for the review are provided in Annex 3 (p66). In general, initial interviews were semi-structured in nature, using open-ended questions, allowing respondents to identify their own priority issues. Later in the mission, additional interviews were requested to cover information gaps, e.g. on integration, health systems strengthening and procurement and supply management, to ensure that all areas and questions of the terms of reference were covered by the review.

A preliminary interview was conducted with staff of the Global Fund secretariat by telephone prior to the mission. This interview identified a number of priority areas for the review from the perspective of the Global Fund secretariat. After discussion with UNDP, the team decided to visit sites in four locations, namely Tashkent, Samarkand, Bukhara[25] and Fergana. The team indicated, in general, the types of interviews and visits that it wished to carry out. The detailed programme was arranged by UNDP and approved by the Ministries of Health and Foreign Affairs. It was possible to make a number of adjustments to the schedule. However, it was not possible to accommodate all the team's aspirations and requests because of time constraints. In particular, it was not possible to meet with the Chief Narcologist or anyone from the Virological Institute or the Ministry of Internal Affairs.

At the initial meeting between the team and UNDP, it was proposed by UNDP that a staff member could accompany the team to Fergana, Bukhara and Samarkand to facilitate the introduction of the team to stakeholders. The team agreed to this suggestion. The UNDP

[24] For example, the team requested a breakdown of registered HIV infections by year and sex from the Republican AIDS Centre but this was not made available.

[25] For logistical reasons, UNDP suggested that the team might visit Bukhara instead of Khorezm as proposed in the terms of reference. The team agreed with this proposal. The team also decided that to maximise time in Bukhara and Samarkand, part of the team (2 people) would visit Samarkand at the same time as part of the team (one person) visited Bukhara.

staff member attended most of the meetings in each of these regions and was also available to the team for detailed discussion of a range of issues related to the review. The team was also accompanied to a number of the interviews conducted in Tashkent for the same reason. Most interviews were conducted in Russian with translation into English. Interviews with international organisations were conducted mostly in English. Some interviews with beneficiaries were conducted in Uzbek or Tajik and translated into English.

5. DATA ANALYSIS

The review team's approach to data analysis was described in detail in the inception report. In general, for quantitative data, the team has largely relied on official country data and programme data reported by UNDP. The team has examined such data critically including inspecting source data during site visits. However, this review is not a data audit. It has largely relied, therefore, on available data.

The consultant team analysed all quantitative and qualitative data collected through desk review of key documents; individual and group interviews; and site visits. This involved comparing data from different sources to develop a common interpretation of the main findings, aiming to answer the review questions in each of the four areas of focus of the review (programme design; implementation; coverage and achievement of targets; impact). Preliminary findings were shared directly with the Programme Management Unit of UNDP, the Programme Implementation Unit of the Republican AIDS Centre and a stakeholder meeting that was held in Tashkent on 4th February 2013. Based on comments raised in these meetings, the consultant team reviewed and revised their analysis.

A draft report was shared with UNDP. A number of comments were received and these were discussed by the team with UNDP staff, by telephone, on 20th February 2013. A number of revisions to the draft report were made following that discussion.

6. FINDINGS AND CONCLUSIONS

As specified in the review's terms of reference (see Annex 1, p57), this section of the report contains both the team's findings and its conclusions. Recommendations are in the section that follows (see p52). This section of the report is structured around the four main focus areas of the review – design, implementation, coverage and impact.

6.1 Programme design

Fit to the HIV epidemiological situation

In general, the intention of Global Fund financing is to support national HIV responses. It is therefore of critical importance that the programme design is appropriate for the nature of the HIV epidemic in Uzbekistan (see p7). Given that Uzbekistan has an HIV epidemic that is largely concentrated among key populations, Uzbekistan's national response to HIV, and Global Fund support to it, should prioritise effective measures to prevent HIV transmission within and from key populations, such as people who inject drugs, sex workers and MSM. Such measures will protect not only members of those populations and their sexual partners but they will also prevent spread of HIV beyond these populations, thus protecting the population of Uzbekistan, in general.

Historical development of the programme

As outlined earlier in this report (see p7), this programme was designed as two separate elements. The first was proposed initially to the Global Fund's Round 3 and this was later continued through the RCC. This focused on strengthening prevention, care and treatment

services, with a focus on key affected populations. The second element was proposed to the Global Fund's Round 10 and focused on three main components – infection control; procurement and management of health products; and integration and decentralisation of HIV services. These two elements have been consolidated into one SSF.

Programme goal

The overall goal of the programme is to prevent the spread of HIV into the general population by reducing its impact on the most vulnerable populations, including injecting drug users[26], sex workers and MSM and to strengthen systems and capacity for universal access to HIV prevention, diagnosis, treatment and care in Uzbekistan. Essentially, this goal has two main elements. The first corresponds to the focus of the Round 3/RCC grant with the second corresponding to the focus of the Round 10 grant.

Programme target groups

The grant agreement specifies a number of target groups for the SSF grant. These include:

- People who inject drugs
- Female sex workers
- MSM
- Prisoners
- Young people (including students, school children and working youth)
- PLHIV
- Uniformed services' personnel
- Pregnant women
- General population
- Civil society organisations working in the field of HIV

Based on comments received from UNDP on the draft report, it is clear that this list is not representative of grant activities. Consequently, the review team have approached it as a list of those who might ultimately benefit from the programme. However, it remains unclear how some populations listed here, e.g. prisoners, actually benefit from programme activities. It is also unclear why the list of target populations limits sex workers to females when this is not the case in the goal statement nor in some of the performance indicators for the programme.

Programme strategies

The SSF grant agreement outlines five strategies for the programme:

- Strengthening of the national Monitoring and Evaluation (M&E) system
- HIV prevention, with particular focus on most at risk populations
- Improved access to treatment and care services for PLHIV, including provision of ART
- Creation of supportive environment for service provision and protection of the rights of PLHIV
- Enhancing national capacity and ownership for sustained response.

These strategies are highly appropriate for the programme although their practical usefulness is unclear, e.g. for guiding resource allocation. It is extremely appropriate for the programme to prioritise prevention, particularly among the key populations at most risk from HIV infection and to prioritise treatment and care for PLHIV. It is also particularly important that the programme focuses on building national capacity and ownership of the response to HIV in order that this is sustained after the end of funding from the Global Fund. This is a key

[26] Referred to as people who inject drugs in this report.

issue which the report returns to later. Strengthening the national M&E system is perhaps an element of enhancing national capacity. However, it is an area of particular importance. So, it is appropriate to highlight this as a particular strategy.

Programme objectives

According to the SSF grant agreement, the programme has seven objectives[27]. These are:

- To strengthen infection control for prevention of HIV transmission
- To strengthen systems for procurement, supply and management (PSM) of necessary health products and consumables for HIV prevention, diagnosis and treatment
- To facilitate decentralisation and integration of services for sustained outreach and improved access
- To scale up coverage and increase quality and comprehensiveness of HIV prevention services for MARP
- To scale up treatment, care and support for PLHIV
- To strengthen health system in Uzbekistan
- To create an enabling environment for effective scale up of HIV prevention, treatment, care and support services

The objectives appear to be the primary way in which programme activities and resources are organised. These have been used as the main lens for examining the programme in this review. These objectives vary widely by financial size, from $6.8m over two years for treatment, care and support to $0.2m for the enabling environment.

In terms of the four smallest objectives – PSM systems, decentralisation and integration of services, health systems strengthening and enabling environment:

- There does not appear to be any overall strategic framework for each individual objective or the four objectives as a group

- The expected results of each objective are unclear

- The only indicators which appear to relate to these objectives are number of health staff trained and percentage of health facilities dispensing ART experiencing a stockout (see Figure 5, p43). The programme does not currently have any explicit logical explanations of how activities within these objectives are expected to contribute to programme outcomes or impact.

- Key informants reported to the review team that the activities within these objectives were suggested by various different stakeholders during the design process and that these were not based on an overview of what specific results might be achieved through these objectives.

- There appear to be a large number of stand-alone trainings whose overall purpose and expected results are unclear.

As a result, the activities within these objectives appear somewhat ad hoc and fragmented.

[27] In some project documents, the order of these objectives varies, e.g. in this review's terms of reference (see Annex 1, p17). In other documents, e.g. the year 2 logical framework (see footnote 29), reference is made to eight objectives. The additional objective appears to relate to M&E. In the programme budget, M&E is labelled specifically as objective 5. Objective 6 in the budget appears to combine two objectives in the grant agreement – infection control and strengthening PSM systems. Although activities for integration and decentralisation are included in the programme budget, there is no objective heading for them. Overall, ordering and numbering of objectives is inconsistent across programme documents, particularly in the programme budget. This risks being quite confusing.

Programme service delivery areas

In addition, the grant agreement analyses the budget breakdown by programme activity using a number of service delivery areas. These are considered briefly in analysing the budget allocation[28]. Activities are described in bulleted lists under each objective in the grant agreement. More detail of broad activities and specific actions are contained in the programme budget and the year 2 logical framework[29]. Some activities appear to have no budget allocated to them in either year 1 or 2.

Programme budget

A summary budget is contained in the grant agreement. This includes analysis by expenditure category, programme activity and implementing entity. However, it is reported that there have been some adjustments to the programme budget. In particular:

- In August 2012, a sum of $1.5m was reallocated from the purchase of single use instruments to cover additional costs of providing ART to a higher number of people than originally expected

- In December 2012, a sum of $1.1m was reallocated from the purchase of ART as scale-up had proceeded more slowly than originally expected. $400,000 was reallocated to the purchase of single use instruments and $700,000 was allocated towards laboratory costs related to ART scale-up

An Excel copy of the programme budget was provided to the review team and this has been used for the purpose of the budget analysis that follows[30]. Table 2 compares original and current budget allocations by service delivery area, as specified in the grant agreement. The main differences are the ones highlighted above, i.e. an increased amount ($1.56m) for ART and a reduced amount for safe use and disposal of equipment in hospital settings ($1.76m). However, there are other differences, such as reduced amounts for Behaviour Change Communication (BCC) – community outreach (-$141,522) and integration of systems for prevention, care and support into primary and secondary healthcare services (-$133,988) and an increased amount for creation of a system for safe storage and distribution of health products (+$326,573).

[28] The programme budget has two columns labelled SDA. The first column appears to correspond to the SDA categories in the grant agreement while the second column appears to correspond to the SDA categories in the logical framework (see footnote 29).

[29] In commenting on the draft report, UNDP clarified that the grant does not have a logical framework as a formal document, i.e. as part of the signed grant agreement with the Global Fund. Clarification was requested as to which document was being referred to. This is the Excel file supplied by UNDP entitled Logframe_-_Consolidated_g_2013_26%20Nov

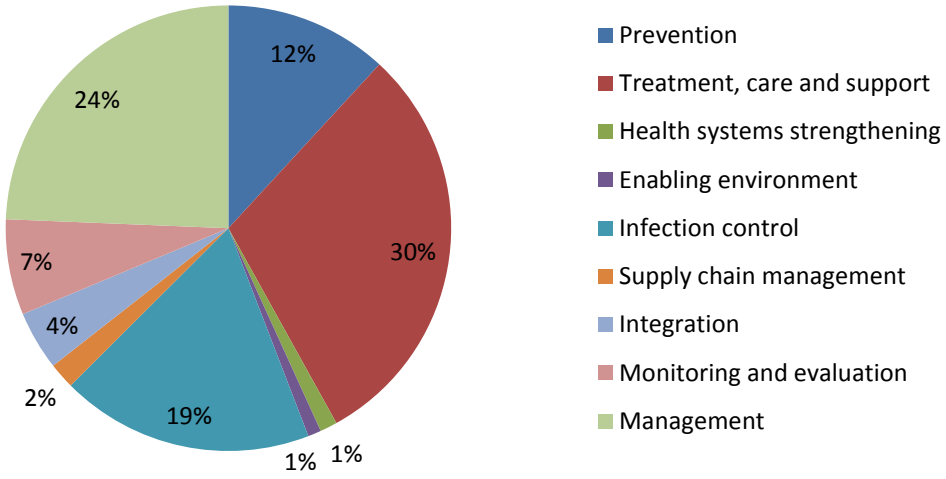
[30] Budget figures are also available in the Y2 logical framework (see footnote 29). For most activities, these are the same as in the programme budget but for some activities they are lower.

Table 2: Budget allocation (over 2 years) by service delivery area: Original and current budget allocations

	Current budget	Original budget	Difference
Prevention			
BCC - community outreach	2,595,028	2,736,550	-141,522
STI diagnosis and treatment	97,347	101,113	-3,766
Testing and counselling	1,036,268	950,268	86,000
PMTCT	676,169	676,763	-594
Treatment	4,788,416	3,231,752	1,556,664
Care and support	335,562	347,226	-11,664
Health system strengthening			
Information system and operational research	285,607	315,346	-29,739
Supportive environment			
Stigma reduction	217,204	197,628	19,576
M&E	1,276,858	1,287,514	-10,656
Sub-recipient capacity development	300,211	254,520	45,691
Safe use and disposal of equipment in hospital settings	3,248,096	5,003,379	-1,755,283
Supply of safe blood and blood products	334,018	313,318	20,700
Creation of a system for safe storage and distribution of health products	1,020,410	693,837	326,573
Integration of systems for prevention, care and support into primary and secondary healthcare services	974,296	1,108,294	-133,998
Management and administration	5,533,355	5,501,336	32,019
Total	**22,718,844**	**22,718,844**	**0**

Figure 2 shows how the current budget is allocated across objectives over the two years of the programme. The financial size of each objective varies. The four main areas of budget allocation are HIV prevention; treatment, care and support; infection control; and management and administration. Together these four elements account for 85% of the programme's budget. Overall, the budget allocation is broadly appropriate for the nature of Uzbekistan's HIV epidemic (see p7). For example, almost all the prevention budget (92%) is focused on key populations. However, spending on some elements of HIV prevention, e.g. infection control and PMTCT, is excluded from this analysis. If these figures are included in the analysis, only one third (33%) of spending on HIV prevention is focused on key affected populations. Under this analysis, more than half (55%) of all prevention spending is allocated to control of HIV transmission in hospital settings. Given the epidemiology of Uzbekistan's HIV epidemic (see p7) this budget allocation is difficult to justify.

Figure 2: Current budget allocation (over 2 years) by objectives ($22.7m)



The largest single objective of the programme by budget is that for treatment, care and support. The bulk of the costs within this objective relate to procurement of ART. Clearly, the provision of ART is of critical importance not only in reducing mortality and morbidity among PLHIV but also in contributing to the prevention of onward transmission of the virus. It is therefore highly appropriate that Global Fund finances are being used to support the provision of ART to PLHIV in Uzbekistan. However, it is of concern that the Global Fund is currently funding the purchase of all ART in the country. This situation is unsustainable and is being addressed. It is welcome that both MSF and, in particular, the Government of Uzbekistan have committed to contribute to the costs of providing ART to PLHIV. This issue is discussed in more detail later in this report (p22).

Within the costs of treatment, care and support, is the sum of just over $1m to support HIV testing in Uzbekistan. The bulk of these funds are for the procurement of HIV tests, including confirmatory tests. Again, it is highly appropriate for the Global Fund to be supporting the provision of HIV testing in Uzbekistan. However, it would be important for this testing to be focused in a way which would identify the highest number of HIV infections as efficiently as possible. Currently, this is unlikely to be the case because HIV testing is focused on relatively low risk populations, such as pregnant women, migrant workers, people planning to marry and uniformed services. According to official figures, rates of HIV testing annually among key populations are relatively low. This issue is discussed in more detail later in this report (p24).

The objectives focused on health systems strengthening; the enabling environment; supply chain management; and integration and decentralisation are relatively small financially compared to other objectives. However, they do account for 8% of the budget overall (almost $2m over two years). It is not completely clear the precise focus of these objectives, the results that are expected to be achieved within them and/or the precise added value of the resources that are allocated to these. These issues are discussed in more detail later in this report (from p35).

The review team was also provided with details as to how the first year's budget had been allocated across sub-recipients (see Annex 4, p71). Overall, just over $1m was allocated[31] across seven governmental organisations (see Figure 3) with a similar amount being allocated across seven NGOs (see Figure 4).

[31] In most cases, these funds are distributed by UNDP to the organisation. In some cases, some of the funds are administered by UNDP on behalf of the organisation.

Figure 3: First year budget allocation to governmental organisations ($1.05m)

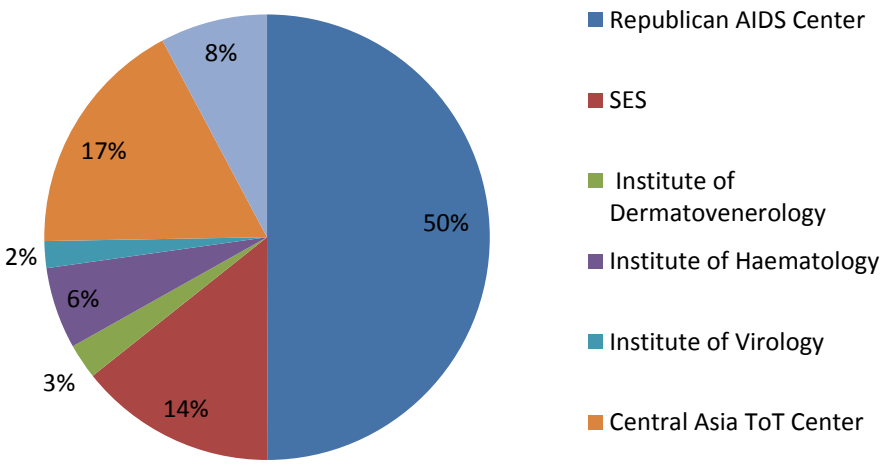
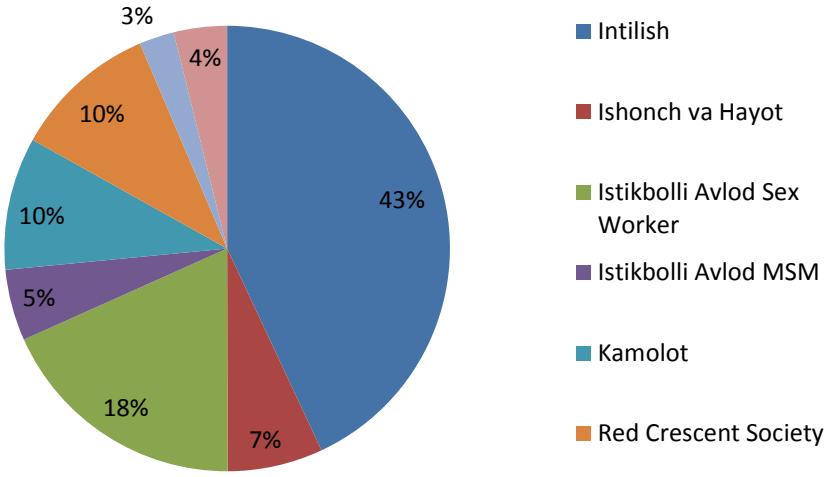


Figure 4: First year budget allocation to non-governmental organisations ($1.03m)



Design of specific interventions: HIV prevention among key populations

The main focus of the design of HIV prevention interventions for key populations, namely people who inject drugs, sex workers and MSM, under this programme appears to have been on scaling up coverage, increasing quality and comprehensiveness of services. The design of these programmes is based on service delivery models with proven effectiveness in international and regional settings, as well as lessons learned in Uzbekistan, including the Round 3 Global Fund grant and other harm reduction programmes[32]. This previous experience has provided evidence that successful harm reduction programmes for key populations require the following key components and characteristics:

- Mapping of key population groups and needs assessments among intended beneficiaries prior to implementation to ensure client-oriented services

[32] E.g., World Vision implemented successful harm-reduction programmes in Tashkent in the context of the DFID-funded Central Asian Regional HIV/AIDS Programme (CARHAP)

- Service packages comprising a range of services, including the distribution of key prevention commodities (syringes, needles and condoms), HIV education materials, syndromic management of STIs, and referral for HIV testing and counselling. Additional services may include legal support, referral to drug treatment and Opioid Substitution Therapy (OST)

- Services should be low-threshold, with easy access to client-friendly services

- Community outreach to clients by professional staff and trained peer outreach workers (peer-driven interventions)

- Partnerships and referral between government services and civil society organisations at national and regional/local levels. Key government facilities include AIDS centres, trust points at AIDS centres and polyclinics, and friendly cabinets at STI clinics. Civil society organisations play a key role in outreach and referral to government services.

- Effective monitoring of service utilisation through a computerised management information system (MIS) and assessments of client satisfaction through focus group discussions.

As mentioned above, the appropriateness of the selected service delivery model for HIV prevention among key populations to local contexts has already been corroborated through previous programmes in Uzbekistan. These experiences have allowed identification of the most appropriate institutional arrangements, including the roles and responsibilities of key institutions to be involved in service delivery, as well as collaboration and coordination mechanisms, specifically the partnerships between government institutions and civil society organisations already mentioned. In addition, collaboration between civil society organisations registered in the national capital with implementing partner organisations at regional level allows effective civil society involvement in the Uzbek context. Further adaptation of models to local contexts is done through needs assessments prior to implementation and through the active involvement of clients through peer outreach work.

Interventions funded through the Global Fund Round 3 were mainly based at government trust points and health facilities without proactive outreach to key populations. As a result, utilisation of these services was limited. Adjustments to the previous service delivery model and a revised programme design have enhanced the availability of key interventions by building on existing facilities, for example, AIDS centres and trust points, while adding new service outlets, such as friendly STI cabinets. In addition, the programme seeks to strengthen referral and collaboration mechanisms between government and civil society organisations. Outreach work and peer-driven interventions strengthen the accessibility and acceptance of key HIV prevention interventions among key populations. An emphasis on low-threshold services and staff training with a strong focus on client friendliness and non-stigmatising attitudes further contribute to the acceptance of services by members of key populations who use the services.

Are there gaps in design?

As mentioned earlier in this report, Global Fund finances are provided to support national responses to HIV. They are not intended to cover every aspect of the national HIV response. They are intended to be additional to other sources of funding, particularly from domestic resources. According to official figures[33], the Government of Uzbekistan provided $11m to the national HIV response in 2011. Without knowing the details of that funding, it is difficult to comment definitively on gaps that may exist in the national HIV response.

[33] In Uzbekistan's report to Global AIDS Response Progress Reporting 2012

However, the team wishes to raise one area, based on their experience of other countries, where gaps often exist. This relates to HIV services in prisons. In countries with HIV epidemics focused among people who inject drugs it is of crucial importance to provide HIV services in prisons because many people who inject drugs spend time within the prison system. It is important to ensure not only that HIV transmission does not occur in the custodial setting but also that services that are available to people who inject drugs and PLHIV in the community are also available in prisons, e.g. the provision of ART. The prison setting also provides an excellent opportunity to reach people who inject drugs with important services, such as HIV testing and counselling. This is important because they may be reluctant to access such services outside the prison setting.

The prison system is mentioned in Uzbekistan's national HIV strategy 2013-2017. This notes that HIV testing is mandatory for those entering the systems. It also comments that preventive measures against HIV infection and the provision of ART and treatment for TB and STIs are available according to the joint order of the ministries of Interior and Health. Prisoners are identified as a target group in the SSF grant agreement. However, there appear to be no services specifically focused on prisoners or prison settings within the programme. The team was not able to access much information on HIV services in Uzbekistan's prisons as the health system is not under the Ministry of Health but is a separate system under the Ministry of Interior. The team was unable to meet with the Ministry of Interior during their visit to Uzbekistan.

UNODC reports that they are in the process of negotiating a memorandum of understanding with the Ministry of Interior. AIDS Centres report that prison health staff are included in their training activities and that ART is available to prisoners, both those receiving it on entering the prison system and those identified as needing this treatment while in prison. Staff of the Republican AIDS Centre reported that there are currently more than 100 people receiving ART in prison. No information was identified on drug treatment services in prisons. There does not appear to be a formal referral system for prisoners on discharge from prison. The review team heard reports of some deaths from overdose among those leaving the prison system. However, official figures on drug overdoses were not provided to the team.

The review team concludes that HIV services in prisons currently represent a significant gap in the programme's activities which could be addressed in phase 2. A recommendation on this is included in section 7 (p512).

6.2 Programme implementation

This section has been organised by programme objectives, arranged by decreasing value, i.e. treatment, care and support ($6.8m); infection control ($4.2m); prevention ($2.7m); integration ($1.0m); supply chain management ($0.4m); health systems strengthening ($0.3m); and enabling environment ($0.2m). It then concludes by considering a number of other issues relevant to programme implementation, such as programme management and M&E.

HIV treatment, care and support

According to programme records, more than 6,000 people are currently receiving ART. Detailed data records are available at local level, for both individual patients and for treatment facilities overall. The Global Fund's LFA conducts annual on-site data verification. The last round of this focused on ART and PMTCT. Although this exercise preceded the latest expansion of numbers on ART, the LFA reported verbally to the review team that this exercise confirmed the overall accuracy of figures reported[34].

[34] However, the review team were not provided with written confirmation of the LFA's report on the grounds that these reports are confidential and are not provided to third parties.

According to official figures[35]:

- Most (81%) adults and children known to need ART receive it
- Retention on ART is 85% at 12 months and 49% at 60 months
- Just under one quarter (24%) of health facilities reported stock-outs of ART in the last 12 months
- Just under one third (31%) of those newly-diagnosed with HIV were diagnosed late, i.e. with a CD4 at the time of diagnosis <350.

Significant achievements related to ART that have been supported by the programme include:

- Adopting in 2012 the revised WHO protocol which stipulates provision of treatment for those with a CD4 count <350

- Establishing a working group on treatment under the Country Coordinating Mechanism (CCM)

- The establishment of multidisciplinary teams in some AIDS centres. In Fergana AIDS centre, for example, the review team met an initiative group of PLHIV that is involved in providing peer support to those receiving ART. The role of multidisciplinary teams is particularly key for people recently been diagnosed with HIV. Medical staff and volunteers drawn from PLHIV provide psychological and social support, which is essential to enable new patients to successfully enter care and treatment. In order to ensure continued functioning of these groups, and to avoid turnover, support for volunteers could be strengthened by providing reimbursement of transport costs and small motivational packages

- Making important treatment decisions through a group of doctors rather than by an individual clinician. The aim of this approach is to ensure more consistent decision making, e.g. on which regimens to use

- Regular patient follow-up including clinical assessment, CD4 and viral load

- Regimens including tenofovir have been introduced

Nevertheless, concerns have been raised about relying solely on the Global Fund to finance ART. This situation is neither desirable nor sustainable. It is therefore welcome that MSF are now beginning to implement plans which will see them provide treatment to up to 1,000 people. In addition, in January 2013, it was announced that the Government of Uzbekistan would allocate funds for this purpose from 2014. Although the precise amount has not been finally agreed, it is expected that it will be of the order of $1.6-1.8m. There are a number of practical issues which will need to be resolved related to additional actors financing ART. MSF has indicated that it will procure its own drugs and then provide treatment to patients through their own doctors operating in government AIDS centres. Their intention is to do this in Tashkent but the precise details have not yet been agreed. It is currently unclear/undecided as to whether government and UNDP will use the same systems for procurement and delivery of ART. There are clearly many practical and logistical arrangements which need to be made on an ongoing basis. It may be helpful for the government to establish a working group involving itself, MSF and UNDP to ensure that these matters and discussed and decided so that ART can be provided to all who need it. A specific recommendation on this point is included in section 7 (see p52).

[35] In Uzbekistan's report to Global AIDS Response Progress Reporting 2012

It is clear that expanding provision of ART involves more than just making more antiretroviral medicines available. It will also require expanded laboratory capacity, more training of staff and more provision of psychosocial support to PLHIV. Although the programme is providing for some of these elements, some are lagging behind the expanded treatment provision, for example, the provision of psychosocial support.

Despite the expanded provision of ART, it is unlikely that all who need treatment currently receive it. There is currently no agreed estimate of the number of people requiring treatment in Uzbekistan. However, in interviews, respondents commented that active drug users may not receive treatment, either because health professionals believe it would be difficult for them to adhere or they either refuse treatment themselves or fail to attend for follow-up. Evidence for this being the case is provided by the higher proportion of children among people receiving ART than among those diagnosed with HIV[36]. This is likely to be because some adults diagnosed with HIV are not receiving ART despite needing it.

In Bukhara, it was reported that almost one third (32%) of those receiving ART were people who inject drugs. In interviews, respondents commented that adherence of people who inject drugs to ART appeared to be good. Factors identified for this included social workers reminding them of appointments and careful pre-selection of 'suitable' patients by a panel of doctors.

There may also be people who would need treatment but they have not yet been diagnosed with HIV. Although there are methods for estimating such numbers, no agreed figure exists for this in Uzbekistan. However, according to official statistics[37], almost one third (31%) of those diagnosed with HIV in 2011 already had a CD4 <350, i.e. they were diagnosed late already needing treatment, The occurrence of such late diagnoses is evidence that there are people requiring ART who have not yet been diagnosed with HIV[38].

In addition, there are some areas that could be further improved. The review team observed that personal medical records are, on occasions, stored in unsecured locations. In addition, the team also heard reports that consultations sometimes take place in locations where they can be overheard by other people. It is clear that medical confidentiality within the health system in Uzbekistan could be improved. Lack of confidentiality was reported as a reason why some members of key populations were reluctant to access medical services. Issues of medical confidentiality are also relevant to any electronic databases used to store personal data. In Bukhara, it was reported that a patient management information system was introduced in April 2012. Training was provided and equipment installed in April and May. The system became operational in June 2012. However, this patient management system has not yet been finalised and established nationally.

Access to HIV testing is important as a gateway to access to ART. In recent years, there has been a significant increase in the number of HIV tests carried out in Uzbekistan. The Global Fund has provided considerable support to this process, particularly through the purchase of test kits. However, most testing is focused on groups with low HIV prevalence, such as blood donors, pregnant women, labour migrants, the military and people who are getting married. Some of this testing is mandatory/obligatory in nature. In addition, there is some duplication with one person being tested in more than one group. Given the low rate of return of such testing in terms of HIV infections detected, there are serious questions about the efficiency of this approach and whether or not this investment represents value for money for the Global Fund.

[36] In Fergana, of 573 people receiving treatment, 269 were adults and 304 were children. Staff of the AIDS centre explained that the reason for the higher number of children was that this is because HIV is 'more virulent' in children than in adults. UNDP staff explained that this could be unique to Fergana and other regions where there was nosocomial transmission to children. However, in Samarkand – 10% of all HIV diagnoses were among children but children accounted for 30% of those on treatment.

[37] In Uzbekistan's report to Global AIDS Response Progress Reporting 2012

[38] Please see footnote 7

There is also the risk that this approach could divert attention away from testing those key populations most affected by HIV. Although it is reported to be possible to access HIV testing through trust points, rapid HIV testing has not yet been approved for use at trust points. In Bukhara, it was reported that less than one third (31%) of people who inject drugs who attended a trust point in 2012 were tested for HIV. According to aggregated data provided by UNDP for supported trust points in Bukhara, Fergana, Samarkand and Tashkent in 2012, a total of 3,711 people who inject drugs were referred for HIV counselling and testing out of a total of 12,809, i.e. 29%. Relatively few people who inject drugs are being referred from trust points for HIV testing. It is unknown how many of these are actually tested. Having rapid HIV testing available at trust points would be likely to increase both the numbers offered testing and the uptake of testing. A specific recommendation on this point is included in section 7 (see p52).

There are also reports of key populations experiencing stigma and discrimination when attending for HIV testing. According to official statistics[39] only around one third of key populations, in 2011, reported having received an HIV test in the last 12 months to which they knew the results (see Table 4, p49).

There is evidence that people who are actively injecting drugs can adhere to ART, particularly when they are supported with OST. In 2012, an external review of substitution therapy in Uzbekistan was conducted by Emilis Subata. This report concluded that OST is a critical service for ART adherence among people who inject drugs. A pilot OST project was implemented in Tashkent but this was stopped by the government on the grounds that it had not been as effective as expected. Nevertheless, the review team were told by former clients that they had valued and benefitted from the services provided. The Subata report includes ten recommendations for moving forward on OST in Uzbekistan. The review team concludes that these recommendations provide a sound basis for moving forward on this topic. These include:

- Establishing a working group on OST
- Arranging study tours to relevant countries
- Focusing on OST for ART adherence
- Piloting OST for ART adherence in two to three regional AIDS centres
- International partners providing technical and financial support to the process
- Developing an advocacy plan for harm reduction including OST

The team have included a specific recommendation concerning implementation of the Subata recommendations in section 7 (see p52).

<u>Infection control</u>

The programme has allocated $4.2m over two years to the prevention of HIV transmission in hospital settings. The main elements are the safe use and disposal of equipment ($3.2m), laboratory strengthening ($0.6m) and ensuring a safe blood supply ($0.3m). The main costs relate to procurement of single use instruments ($$2.6m), laboratory supplies ($558k[40]), disposables for medical waste management ($306k) and incinerators ($150k).

[39] In Uzbekistan's report to Global AIDS Response Progress Reporting 2012
[40] Of this, $453k is in the first year's budget. From the detailed notes in the budget document, it appears that these funds are in fact part of the funds available to procure single use instruments. The remainder of this report assumes this is the case.

There have been significant challenges in quantifying the need for single use instruments for the five regions to be supported under this part of the programme – Andijan, Fergana, Namangan, Samarkand and Tashkent. An international consultant (Marc Bonnel) visited Uzbekistan in July 2012 to carry out this work as part of a broader assessment of infectious safety of patients and medical specialists in medical establishments. He submitted a report in September 2012. This mission involved a number of tasks within a relatively short period of time. The consultant was expected to:

- Conduct a rapid assessment of infectious safety of patients and medical specialists in medical establishments
- Develop recommendations on the revision of the respective normative documentation at the Ministry of Health level targeted to health care facilities and an improvement of existing health education strategies aimed at safe behaviour of health care workers and patients
- Estimate the availability of equipment and supplies, including development of list of health products and other medical equipment as well as definition of their quantity, managing waste safely and appropriately in accordance with the normative acts in place
- Establish a priority list and quantification of single use instruments to be procured by the UNDP for project implementation purposes.

In addition, the consultant was asked to adapt the priority list to the available budget of the Global Fund[41]. This had been reduced to allow additional funds to be allocated to purchase an increased quantity of antiretroviral drugs. Although the report is available in both a full and summarised version[42], this does not seem to contain a concise strategy or set of recommendations to avoid HIV transmission in hospital settings. For example, the summary appears to highlight the need for hepatitis B vaccination among health staff but does not seem to explicitly endorse strategies to avoid unnecessary blood transfusions and medical injections. Procurement of syringes and gloves has been excluded. However, the reason for this is not clear.

The element of the task related to quantifying the need for single use instruments was hampered by lack of consumption data. Indeed the report recommended a follow-up mission to collect and analyse such data. The figures included in the report were initially calculated based on data related to international norms[43] but were then revised downward[44] to

[41] The Bonnel executive summary is not completely clear exactly what budget is available for procurement of single use instruments from the Global Fund. In one place, it refers to the sum of $1.3m and in another to $1.4m. The total cost of the revised list is stated as $1.466m in the summary report and $1.4292m in the complete report. According to the programme budget, funds available for this purpose in year 1 are $803,200 plus $150,000 for five incinerators, i.e. $953,200. If the amount specified for laboratory supplies ($453,400) is also available, this brings the total to $1,406,600.

[42] There are some inconsistencies between these versions, for example, in the tables of lists of single use instruments. In the table that shows reduced amounts to fit the Global Fund budget, the number of peripheral venous catheters for adults in the summary version is 250,000 but 190,000 in the complete report. Similarly, the number of Foley catheters required is 50,000 in the summary but only 30,000 in the complete report.

[43] A narrative covering each item to be procured is included as section 10.6 of the complete report (pp 51-54). Although this explains how quantities have been calculated for some items, such as lancets, intravenous administration sets and Foley catheters, some items cross reference to other sections of the report, e.g. section 8.2.2 for blood collection bags and section 8.2.3 for central venous catheters. Other sections, e.g. on epidural anaesthesia sets and spinal needles are largely descriptive of what an item is and how it might be used without any details of how quantities were derived.

[44] Reductions were only made on some items. The number of lancets was reduced 94% from 5,400,000 to 300,000; central venous catheters were reduced 20% from 50,000 to 40,000; peripheral venous catheters for children were reduced 17% from 48,000 to 40,000; both epidural anaesthesia sets and spinal needles for anaesthesia were each reduced 23% from 13,000 to 10,000; 5 litre rectangular biohazard waste bags were reduced 50% from 200,000 to 100,000 and quantities of each of five items (dialyzers; arterial lines; venous lines; arterial fistula needles and venous fistula needles) were each reduced 54% from 43,500 to 20,000. Quantities for a number of items were unchanged. These included intravenous administration sets; infusion sets for children; suture threads; single use instruments for blood centres; pipettes and pipette tips; medical waste incinerators; and double lumen catheters for use in haemodialysis units. Figures for peripheral venous catheters in adults were unclear. According to the complete report, these were reduced from 210,000 to 190,000 but in the summary report, they increased to 250,000. Similarly, according to the complete report, the number of Foley catheters was reduced from 50,000 to 30,000 but

accommodate the Global Fund budget. The basis for these reductions is unclear. Some items were not reduced at all. In some cases, the scale of reduction was very large. For example, the number of lancets was reduced 94% from 1 to 1.2m per oblast[45] to only 300,000 for all five oblasts.

A preliminary procurement of single use instruments is underway based on the figures in the Bonnel report[46]. Items have not yet been received in Uzbekistan.

It appears that the figures in the tables relate to annual need and that there is the intention to provide single use instruments over a two year period. However, it is unclear how robust the figures are. In several places, the report states that the figures calculated are likely to reflect minimum need only. Yet, these amounts have been very substantially reduced to fit within the funds available. Efforts are now being made to obtain guarantees from government that they will meet any shortfall in provision of single use instruments in the five pilot[47] regions. Although such assurances may be given, it may be difficult for government to deliver on such a commitment, particularly if there is need to coordinate procurement and delivery of commodities with those being provided through Global Fund.

Given all these issues, the review team concludes that consideration should be given to scaling down the size of this pilot both in terms of number of pilot regions and the time frame of the pilot. It seems unlikely that the resources provided by the Global Fund will be sufficient to procure sufficient single use instruments to meet all the need in five regions over two years. The government may step in to procure additional supplies. Although this would be a highly appropriate and necessary approach to ensure sustainability and scale-up of this approach, it would increase the risks of the pilot. It might be better for the Global Fund to fully finance a one year pilot in one region ensuring that the pilot is fully funded, not only in terms of procuring single use instruments but also in supporting the implementation of an overall strategy to avoid HIV transmission in healthcare settings and in ensuring a thorough review/evaluation of lessons learned from the pilot. The review team recommends this in section 7 (p52).

Under this objective, some support has also been provided to enhance blood safety. This has included the development of software for registering blood donors[48]; procurement of equipment for blood safety laboratories and provision of sub-grants to the Red Crescent Society for work to increase the recruitment of volunteer blood donors.

HIV prevention

The implementation of programme activities started with some delay as a result of the transition in principal recipients for the grants. A particular challenge was posed by the fact that services for people who inject drugs and MSM were interrupted for several months after the Round 3 programme ended. Services for sex workers continued during this period through support from other donors. Despite this challenge of having to restart services that had been interrupted and the associated loss of clients, programme components for all

according to the summary report, the figure was unchanged.

[45] Which is described in the narrative of the main report as a minimum

[46] There appear to be some discrepancies between the numbers in the PSM plan and in the Bonnel report. Direct comparisons are hampered by use of different terminology and different ordering of items. However, the number of peripheral venous catheters ordered appears to be 290,000. This would correspond to the figures in the Bonnel summary of 250,000 for adults and 40,000 for children. It conflicts with the number in the complete Bonnel report of 190,000 for adults and 40,000 for children. Conversely, the number of Foley catheters ordered of 30,000 corresponds with the number in the complete Bonnel report and conflicts with the number of 50,000 in the Bonnel summary.

[47] Although provision of single use instruments through the programme is described as a pilot, it was unclear to the review team the extent to which this is the case. For example, will implementation and outcomes be systematically monitored and evaluated? Or is the programme simply providing commodities on a large scale without a clear overall strategy for preventing HIV transmission in hospitals and not clear government commitment or vision as to how it will maintain supply of these commodities in the future?

[48] However, it is reported that this is not yet introduced.

beneficiaries have subsequently been implemented as intended. Actual utilisation of these services has exceeded the targets that were set.

HIV prevention among people who inject drugs

The main focus of Global Fund support under this section is on HIV prevention activities for people who inject drugs. In Uzbekistan, these activities are delivered through a network of more than 230 trust points. Of these, 114 are supported directly with Global Fund finances. These funds have been used to pay trust point assistants, outreach workers and to install the electronic MIS in those trust points. In addition, Global Fund finances have been used to procure needles, syringes, condoms and other equipment which are reported to have been supplied to all trust points. Table 3 shows relative levels of activity of trust points supported and not supported by the Global Fund in four regions of Uzbekistan over a one year period in 2012.

Table 3: Reported levels of activity in Global Fund and non-Global Fund supported trust points: Bukhara, Fergana, Samarkand and Tashkent: 2012[49]

	Bukhara	Fergana	Samarkand	Tashkent	Total
Global Fund-supported trust points					
Number	8	9	12	9	**38**
Number of clients	950	1,159	4,211	3,659	**9,979**
Number of visits	21,491	12,297	45,366	32,616	**111,770**
Number of syringes distributed	122,247	169,292	398,890	445,650	**1,136,079**
Number of condoms distributed	62,214	119,742	259,770	140,244	**581,970**
Clients per trust point	119	129	351	407	**263**
Visits per trust point	2,686	1,366	3,781	3,624	**2,941**
Visits per client	23	11	11	9	**11**
Syringes per client	129	146	95	122	**114**
Syringes per visit	6	14	9	14	**10**
Condoms per client	65	103	62	38	**58**
Condoms per visit	3	10	6	4	**5**
Other trust points					
Number	8	12	12	4	**36**
Number of clients	378	210	1,061	1,554	**3,203**
Number of visits	13,439	5,821	4,942	42,968	**67,170**
Number of syringes distributed	75,266	21,694	72,379	181,917	**351,256**
Number of condoms distributed	37,322	14,288	48,624	29,436	**129,670**
Clients per trust point	47	18	88	389	**89**
Visits per trust point	1,680	485	412	10,742	**1,866**
Visits per client	36	28	5	28	**21**
Syringes per client	199	103	68	117	**110**
Syringes per visit	6	4	15	4	**5**
Condoms per client	99	68	46	19	**40**
Condoms per visit	3	2	10	1	**2**

Across the four regions, the total number of trust points supported by the Global Fund is 38. There are 36 other trust points. In total, the 74 trust points have over 13,000 clients. Overall:

- The total number of clients in those trust points supported by the Global Fund is more than three times those supported in other trust points

- The total number of visits to those trust points supported by the Global Fund is almost double those supported to other trust points

[49] The aggregated figures reported by UNDP are higher than these figures. For example, the total number of clients reported was 12,809 and the total number of syringes distributed was 1,439,056

- The number of syringes distributed through those trust points supported by the Global Fund is more than three times those distributed through other trust points

- The number of condoms distributed through those trust points supported by the Global Fund is more than four times those distributed through other trust points

On average, trust points supported by the Global Fund have more clients per trust point (263 compared to 89) and more visits per trust point (2,941 as compared to 1,866). The number of syringes distributed per client is very similar for those trust points supported by the Global Fund (114) and other trust points (110). However, the number of syringes given per visit is higher in trust points supported by the Global Fund (10) than in other trust points (5). This may explain why the number of visits per client is lower in trust points supported by the Global Fund (11) than in other trust points (21). Overall, the number of condoms distributed is lower than the number of syringes. These figures are averages across the four regions. There is considerable variation across regions (see Table 3).

These figures could be explained in a number of different ways. It could be that Global Fund support has resulted in greater utilisation of particular trust points but it could also be that the programme targeted Global Fund support to larger, busier trust points. Baseline data was not provided to the review team but this would shed light on this issue. Further data on utilisation of services is provided in the section on programme coverage (p39).

Many respondents commented on the very important work being conducted by outreach workers from trust points. Many clients prefer to receive syringes from the outreach workers rather than attending the trust points themselves. But, there is reported to have been high turnover of outreach workers. Levels of remuneration are very low. Outreach workers report lacking identification cards/badges, bags for their supplies and funds to cover transport costs. Until 2011, some narcologists used to work as trust point assistants but this is no longer the case. Additional services which people who inject drugs would like to see include provision of food and clothes; discounts on medical treatment; income generating activities and drop-in centres.

HIV prevention among sex workers

In addition, NGOs are also providing services to female sex workers, including condoms, counselling and referral to medical services including for HIV testing. Services are provided by working with peer educators and, so-called, “mamarosas” (female pimps, often older, former sex workers). Younger sex workers often work for these “mamarosas”, while more-experienced, older sex workers may operate on their own or in small groups of friends. Sex workers would like to see services expanded to include provision of incentive packages and expanded medical services. Members of key populations, particularly sex workers, are able to receive anonymous, syndromic treatment of STIs through a network of 30 friendly cabinets. These are overseen by the Republican Centre of Dermatology and Venereology. 15 cabinets are located within Dermatology/Venereology services, 14 in AIDS centres and one in a narcological dispensary. The costs of these cabinets to the Global Fund have been relatively modest, less than $100,000 over two years. Most of the cost is for pharmaceuticals. The Republican Centre of Dermatology and Venereology has:

- Produced an order and clinical guidelines for the syndromic management of STIs
- Provided training on the syndromic management of STIs
- Conducted three monitoring visits in the first year

In 2012, there were more than 16,000 visits to these clinics. The Republican Centre of Dermatology and Venereology would like to establish four more clinics and would like to see more equipment, more training and additional remuneration for staff working in the clinics.

The dermatology/venereology services also have anonymous cabinets for STI treatment. Friendly cabinets differ from these in that they provide treatment free of charge and services are targeted to members of key populations.

HIV prevention among men who have sex with men

The scale of services for MSM is very limited. Only one NGO is providing these services. Although HIV prevention services for other key populations are available in all 14 regions of Uzbekistan, services for MSM are only provided in seven currently. There are no services specifically provided to male sex workers currently. Not only is it illegal for men to have sex with men in Uzbekistan, but there are also strong cultural taboos in this area. Overall, relatively low priority is given to working with male sex workers. In some cases, people deny the existence of MSM in Uzbekistan. As a result, it is particularly difficult to reach MSM with services, due to the particularly negative attitudes to MSM in society, which render MSM a largely hidden group. MSM services in different regions show mixed approaches and results, for example in Tashkent city MSM clients mainly include young unmarried men, while clients in Andijan region include men selling sex to men and older, married men. A better understanding of MSM subpopulations, sexual networks and behavioural dynamics is needed to reach this group more successfully, i.e. both younger and older MSM, married and unmarried, as well as male sex workers. While service targets are met, it is very difficult to identify whether the MSM population is adequately covered by the existing services. Furthermore, the review concludes that services should be expanded to other regions that are currently not covered, mainly due to the perceived "absence of MSM" by local stakeholders. Detailed recommendations related to possible expansion of HIV prevention services for key affected populations are contained in section 7 (p52).

Operational research is being planned to produce recommendations on improving the quality and service delivery system of harm reduction among key populations in Uzbekistan.

HIV prevention among young people in general

The programme finances some peer education among young people through Kamolot, the public youth movement in the country. Kamolot's peer educators have provided general HIV information to a total of 34,110 young people through educational mini-sessions. However, it is the review team concludes that these activities are too general to have meaningful impact on HIV transmission in Uzbekistan. The team's recommendation that consideration should be given to discontinuing support to these activities is presented in section 7 (p52). If Kamolot and the government decide that these activities should continue, the review team concludes that the peer educators trained in phase 1 of the programme would be able to do this as part of Kamolot's ongoing activities through Kamolot's extensive network in all regions of the country. There are no major factors inhibiting HIV peer education for young people in Uzbekistan.

Factors facilitating HIV prevention activities

The following factors have facilitated the successful delivery and actual utilisation of HIV prevention services for key populations:

- Mapping of key populations and client needs assessments prior to programme implementation

- Systematic capacity building of programme staff and peer volunteers, which has resulted in committed and motivated staff and volunteers at most facilities and organisations visited

- Client-oriented, low-threshold services based on identified needs and provided by trained staff and volunteers. Client-friendliness and trust have been key in attracting clients

- Extensive outreach has been a key element for providing services to members of key populations. Outreach is carried out by teams of professional staff and trained peer outreach workers and volunteers, with adequate supervision and support

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- Service packages comprising a range of services responding to client needs. These include STI services through friendly cabinets; harm-reduction services for people who inject drugs through trust points; peer outreach work; HIV education; and referral to HIV testing and counselling and other services

- Good collaboration, partnerships and referral between government institutions and civil society organisations at national, regional and local levels. The approach of combining service provision through government facilities (AIDS centres, polyclinics, trust points, STI clinics and friendly cabinets) with outreach and peer-driven interventions by civil society organisations has proved particularly effective for reaching clients and attracting them to use these services. Partnerships between NGOs from different regions have allowed scaling up services to other regions and rapid transfer of expertise to less-experienced local NGOs

- Effective monitoring of services and availability of programmatic data at local and national level, for example through the computerised management information system (MIS) and assessments of client satisfaction

Sub-populations that may require particular attention

The review team concludes that further attention may be needed to ensure that particular sub-groups of sub-populations are able to access services. These include:

- Women who inject drugs. Currently, services are provided to both men and women who inject drugs, through involving peer outreach workers of both sexes. However, women may not be reached effectively through programmes reaching mainly men

- Young people who inject drugs. Most people who inject drugs that currently access services are reported to be within the age group 30-45 with small numbers of young drug users, especially below the age of 20. This reflects a reported trend of declining injecting drug use among young people in the last few years. Nevertheless, it is unclear if young people who are injecting drugs are reached with services

- Male sex workers. Currently, services for sex workers only reach women.

The review team's recommendations on these matters are presented in Section 7 (p52).

Quality of prevention services

Quality of services is determined by the degree to which services meet established professional standards and client expectations. It comprises a number of dimensions:

- Security and safety

- Accessibility - overall, accessibility of services has improved primarily as a result of the establishment of low threshold services for key populations in combination with extensive outreach work

- Technical competence and compliance with professional standards - systematic capacity building of staff and (peer) volunteers has contributed to competent staff and compliance with professional standards

- Responsiveness of services to client needs and expectations - responsiveness to client needs has improved as a result of initial needs assessments; effective monitoring of service delivery, which allows rapidly responses to emerging issues; and the active involvement of clients through peer outreach workers.

- Relation between service provider and client, including trust, confidentiality and respect - capacity building of staff and volunteers, the involvement of peer outreach workers, and the establishment of low-threshold confidential service outlets, e.g. trust points and friendly cabinets, have also contributed to strengthening trust, confidentiality and respectful relations between clients and service providers

- Client/community participation/involvement - the recruitment of peer outreach workers for all MARP groups has been an important way to strengthen the active involvement of clients.

- Continuity of services without interruptions

- Effective referral and collaboration with other service providers - referral mechanisms and collaboration among government and civil society organisation service providers ensure better access to a wider range of services, and better meeting clients' needs

- Effective monitoring of services and their utilisation - M&E systems have been particularly strengthened through the introduction of a standardised MIS that allows systematic data collection on key aspects of service delivery. M&E data is not only available at management levels, but trained M&E staff at local levels can use the data for making informed programmatic decisions

Challenges to the delivery of HIV prevention services

Although the factors described above have contributed to effective delivery of HIV prevention services to key population, albeit with some delay due to external factors, a number of factors still challenge and hamper more effective delivery of services. These include:

- Decreasing priority given to HIV prevention among key populations. As mentioned earlier (p7), HIV in Uzbekistan continues to be concentrated among key affected populations, particularly people who inject drugs and their sexual partners. Other sub-populations, such as sex workers and MSM remain particularly vulnerable to HIV. Despite this, there is a perception among some that the epidemic is shifting to the general population. This misperception constitutes a challenge for the continued prioritisation of HIV prevention among key populations. The review team concludes that the second phase of the grant should maintain and further intensify the prevention focus on key populations. A recommendation along these lines is included in section 7 (p52).

- Ineffectiveness of some referrals between civil society organisations and governmental service providers. Although, overall, the referral mechanisms between different service providers are in place and facilitate access of clients from key populations to services, such as STI treatment, ART, and HIV testing and counselling, referrals do not always lead to actual uptake of services. While outreach workers already play a key role in this regard by accompanying clients on referrals to other services, the review team concludes that their role needs to be further strengthened. In section 7 (p52), the team recommends that one way of doing this would be through financing associated transport

costs. Particular difficulties were reported for clients of harm reduction services who wish to access drug treatment services, e.g. at narcology centres. One reason for the lack of collaboration and referral links between harm reduction services and narcology services is different views on harm reduction, and the importance of low-threshold, client-friendly services.

- Limited success in promoting HIV testing and counselling among key populations. Despite the availability of trained staff and good collaboration between government and civil society organisation service providers, actual uptake of HIV testing services by key populations remains low. Therefore, HIV testing and counselling services need to be more accessible for key populations. An important step to achieving this would be to introduce rapid HIV testing in low-threshold services, such as at trust points and friendly cabinets. The team recommends this in section 7 (p52).

- Limited range of services for key populations. The currently limited package of HIV prevention services may hamper the further increase of coverage and service use. Clients and service providers express a need to include additional services to better meet the needs of clients. Additional services for people who inject drugs, mentioned by service providers and clients, include referral to free legal support; hepatitis B and C testing and treatment; OST; vocational training and income-generating activities; food packages; and more practical educational materials to promote safer injection use. Service providers for female sex workers express additional service needs such as voucher programmes for free-of-charge gynaecological services; pap smears; ultrasound; and tests for syphilis. Expressed service needs for MSM include drop-in centres that offer a confidential place for meetings and education sessions; psychological counselling; and water-based lubricants.

- Unfavourable climate for new pilot or introduction of OST. The results of a previous OST pilot were received with mixed opinions by narcologists and other experts. As a result of the lack of consensus, no follow-up OST programmes have been planned to date. However, OST is internationally acknowledged as a key harm reduction service for people who inject drugs, which also facilitates access and adherence to ART programmes.

- Commodities do not always meet client expectations. While current services pay attention to most aspects of service quality, there is still room for improvement. Commodities such as syringes do not always meet client expectations and needs, which may change over time. For example, in some regions, as a result of changing patterns of drug use, clients report a preference for 10ml syringes in preference to the 2ml and 5ml syringes currently supplied. Similarly, MSM may require extra-strong condoms and lubricants.

- Limited in-depth research and understanding of sexual networks and behavioural risks, especially for MSM. While behavioural dynamics and sexual networks among key populations are often well understood by project staff, more in-depth qualitative research may be needed to thoroughly understand HIV risks among specific subpopulations. For example, current services for MSM in Tashkent mainly reach young MSM, while transgender men, male sex workers and their clients, such as married men, may not be covered. Similarly, more knowledge may be needed on women and young people who inject drugs, as well as on young women engaging in transactional sex without being considered sex workers. A recommendation on how the planned review of harm-reduction services could begin to generate this understanding is presented in section 7 (p52).

- Insufficient attention to, and limited coverage of, services for MSM. As mentioned above, services for MSM are currently limited to seven regions. While service targets for MSM are being met, the absolute number of clients reached countrywide (1,455) remains relatively low. The low priority and limited budget assigned to MSM services may be associated with the particularly strong stigma and discrimination towards MSM, as well as the criminalisation by law. Unlike sex work, which is dealt with as an administrative offense, sex between men sex is considered a criminal offence and prosecuted as such. Therefore, the results from the planned operational research among MSM, and other key populations, should be used to better target MSM with services. Particular attention should be given to identifying better ways of reaching MSM, if the existing HIV prevention interventions are not be sufficient to attract MSM to these services. Detailed recommendations are made in Section 7 (see p52).

- Restrictions regarding working conditions and associated turnover of staff and peer volunteers. Outreach work by social workers and peer volunteers is key to successfully reaching members of key populations. However, turnover of staff and volunteers, as a result of unfavourable working conditions, means loss of investments in terms of staff recruitment, capacity building, and the associated financial costs. In addition, once staff and volunteers are 'lost', it becomes increasingly more difficult to replace them with other staff and volunteers, as the pool of adequate people for working with key populations is limited, especially in smaller regions and communities. Therefore, small additional investments for improving work conditions may lead to considerable gains in coverage cost-effectiveness of services, and actually save money rather than lead to increased costs. Recommendations of what this might include are made in Section 7 (p52).

- Civil society capacity and government regulations limiting involvement of civil society organisations. Service delivery to key populations is hampered by the limited number of civil society organisation/NGOs in Uzbekistan with the capacity and experience of working in this field. This is largely due to the difficulties for registering NGOs at national and local levels, as well as government procedures regarding the approval of transfers of funds to NGOs. Structural delays in the transfer of funds result in interruption of services, non-payment of staff salaries or incentives for volunteers, and affect the service delivery to clients. Furthermore, existing rules and regulations hamper the institutional and organisational development of civil society organisations, affecting the quality and continuity of their services. Most NGOs focus on survival rather than a long-term vision and strategies. Technical expertise developed in previous programmes is often lost as a result of abrupt interruption of funding and programmes.

- Existing legislation reinforces stigma, discrimination and criminalisation of key populations. As a result, these populations are often considered 'hidden' by those seeking to provide them with services. Although positive amendments to laws have been made in the past regarding legal action against sex workers and people who inject drugs, for example, quantity of drugs and criminal prosecution; and sex work as an administrative not a criminal offence, existing restrictions still drive key populations "underground" and make it more difficult to deliver services to them. This is particularly the case for MSM. In this regard, ongoing advocacy and lobbying is needed to create further space for service delivery to key populations. In addition, increased collaboration, capacity building and formal and informal agreements with national and local authorities are needed to create enabling environments.

- Stigma and discrimination by communities, health-care workers, and law enforcement agencies hamper access to and utilisation of services. Many potential clients from key populations are reluctant to use services, particularly HIV testing, for fear of being identified as belonging to a particular sub-population as this may result in stigma, discrimination, legal action, arrest etc.

Integration

According to the programme grant agreement, one of the programme's objectives is to facilitate decentralisation and integration of services for sustained outreach and improved access. However, a fundamental problem with these terms is that they are very broad and can be used in widely differing ways by different stakeholders. For example, when asked about these areas, some stakeholders talked about decentralising ART provision from national to regional AIDS centres. Others talked about coordination and integration of different vertical services, such as those for HIV and TB. An example of the latter approach is the provision of STI services through friendly cabinets at AIDS centres.

A key problem in this area is that there does not currently appear to be a clear, shared understanding of precisely what is meant by decentralisation and integration in the context of this programme. What services are expected to be decentralised from where to where? Which services are to be integrated together?

From the activities described in the grant agreement and the programme budget, it appears that the intention of this objective is to bring health workers involved in delivering primary health care services into the provision of HIV-related services. Precisely how this would be done and with what expected results appears unclear. However, it would seem to involve:

- Primary healthcare staff referring PLHIV for relevant services, such as treatment of opportunistic infections and STIs

- Some primary health care staff, e.g. patronage nurses, carrying out some HIV-related duties, such as educating families on HIV and preparing them for home-based care

Mention is also made of engaging civil society organisations and mahalla committees in community-based monitoring and feedback for sustained improvement in quality. According to the programme budget, a number of activities relating to M&E are included under this objective. These include introduction of the MIS and this mid-term review. It appears that this objective is a bit of a 'catch all' for items that appear difficult to fit into other parts of the programme's design.

The review team concludes that the biggest and most significant problem with this objective is that expected results have not been clearly defined. This is of critical importance. Is it that more referrals would be made from primary health care to HIV-related services? Is it that primary health care staff are expected to integrate certain HIV-related services into their activities? Unless this is done, there is a significant risk that substantial resources could be expended on training primary health care staff in various ways without tangible benefit.

This risk is particularly high because the only result defined for this objective relates to training, namely the number of health staff trained to deliver services (see Figure 5, p43). According to UNDP's report to the Global Fund for the first six months of 2012, 784 health care providers, mainly family practitioners, have been trained on HIV in the context of integrated management of childhood illnesses. The report stated that this had resulted in increasing knowledge regarding HIV prevention. The considerable investment in training primary healthcare staff envisaged under the programme is unlikely to be justified if the only result is increased HIV knowledge of those health staff.

The review team concludes that this area of the programme needs fundamental review and reconsideration. This approach might be appropriate for a country where HIV is spreading primarily and extensively through the general population. Its relevance to Uzbekistan, where the epidemic is primarily concentrated among key populations is unclear. Are primary healthcare staff well-placed to identify and refer members of key populations? Would other

people, e.g. outreach workers and staff of NGOs be better placed? There is clearly a need to decentralise certain HIV services, such as provision of HIV testing for members of key populations. But, the review team concludes that the current approach is not optimal. Recommendations on these points are made in Section 7 (see p52).

Supply chain management

A very large proportion of the programme's overall budget goes towards procurement of equipment and medical supplies. This includes procuring ARVs, laboratory equipment and supplies, and single use instruments. As a result, it is of crucial importance for the programme that there is an effective supply chain for these products.

According to the grant agreement, the objective in this area is to strengthen systems for PSM of necessary health products and consumables for HIV prevention, diagnosis and treatment. The activities described are focused mostly on antiretroviral medicines and include:

- Strengthening ART forecasting and stock management
- Strengthening four interregional warehouses for ARV storage and onward distribution

Relatively little progress has been made in this area. UNDP's Programme Management Unit have been working with UNDP's Procurement Support Office and have identified a consultant who will conduct a review of the system for supply management. A major challenge for UNDP is that this system is affected by many major issues, such as availability of transport. UNDP's ability and capacity to influence these systems is quite limited. To date, the approach has been very focused on procuring and delivering particular medical supplies, such as ARVs. For example, the expected result of this area of the programme would be a reduction in the percentage of health facilities dispensing ART that experienced a stock-out of at least one required antiretroviral drug in the last 12 months. The programme reported that, as of June 2012, this percentage had reduced from the baseline figure of 58.8% in 2011 to 25% in June 2012. Although encouraging, it is still of concern that one quarter of health facilities experienced a stock-out of at least one antiretroviral drug during this period. Stock-outs are a fairly crude method of measuring supply of medicines. Significant shortages may be occurring in the absence of actual stock-outs if health facilities adopt measures to avoid stock-outs, such as restricting provision of medicines that are in short supply.

Given the resources available to the programme, it is probably appropriate for the programme to focus narrowly on strengthening systems for delivery of ARVs. Strengthening the supply management system more broadly is likely to require considerably more resources than currently available to the programme.

Health systems strengthening

The programme has a specific objective focused on health systems strengthening. However, it is clear that many other parts of the programme could be considered as strengthening Uzbekistan's health system. For example, systems for PSM and logistics are an essential part of a functioning health system. In addition, the Global Fund recognises community systems as part of the overall health system. With this in mind, the work done by the programme in supporting and developing the capacity of NGOs providing social support services and promoting effective linkages between these NGOs and government services is a key element of building a robust health system.

In the context of the programme, this objective has a more limited focus. According to the description in the grant agreement, expected activities are mostly focused on strengthening health information systems, including, for example, Uzbekistan's system of sentinel HIV surveillance. There are also expected to be activities related to setting standards for medical

care in Uzbekistan. The budget provides for a variety of activities including different types of training[50]; participation in international conferences; development of a new national AIDS programme; development of a national M&E plan; and strengthening of the system of HIV sentinel surveillance.

When asked about progress in strengthening the health system, Project Management Unit (PMU) staff describe a range of activities under other objectives, including development of a register for blood donors; development of a referral system for PLHIV; and strengthening the system for procurement of single use instruments.

The review team concludes that consideration should be given, in phase 2 of the programme, to merging a number of these smaller objectives into one objective. This could perhaps be characterised as strengthening health and community systems. It would be essential to ensure that this is focused on activities which will maximise benefits for those most affected by HIV in Uzbekistan. A recommendation based on these conclusions is included in Section 7 (p52).

Enabling environment

According to the programme grant agreement, another of the programme's objectives is to create an enabling environment for effective scale-up of HIV prevention, treatment, care and support services. This covers a number of activities. However, review team concludes that this objective lacks clear focus, a coherent strategy and clear targets. As a result, this element is weak.

The budget divides activities into a small part ($6k) focused on engaging policy makers and a larger part focused on addressing stigma and discrimination. Tackling stigma and discrimination is likely to be an important part of an effective response to HIV in Uzbekistan. This is likely to require addressing not only stigma and discrimination experienced by PLHIV as a result of their HIV status, but also importantly the stigma experienced by particular key populations, such as people who inject drugs, sex workers, and particularly MSM.

The review team received relatively little information about the programme's approach and activities to addressing stigma and discrimination. The budget describes a wide range of 'sensitisation' activities with different groups of society, including women and uniformed personnel. It may be useful to review the effectiveness or otherwise of this approach. This is an area where perhaps a national network of PLHIV could be supported to be more active.

Programme management

UNDP is acting as the sole PR for the grant. This was not the original intention. Uzbekistan proposed to the RCC for the Round 3 grant that there should be two PRs – the Republican AIDS Centre and the National Association of Non-governmental, Non-profit Organisations of Uzbekistan. However, following a capacity assessment by the LFA, it was decided that alternative arrangements would be made and UNDP was appointed as overall PR.

Overall, UNDP has managed the programme well. According to the latest Grant Performance Report on the Global Fund website, the grant has an overall rating of A2. This means that the grant is currently assessed as meeting expectations.

There have been some delays in funds being transferred to sub-recipients, particularly NGOs. However, the reasons for this are largely beyond the control of UNDP[51]. In Uzbekistan, such transfers are scrutinised by a Bank Commission. It is reported that this can

[50] Categorised as workforce strengthening
[51] Although UNDP's own internal procurement and management systems may contribute to delays

delay the release of funds to a sub-recipient by one to two months. This is particularly problematic for small NGOs that have no other sources of funding and no financial reserves.

There were some initial problems for UNDP largely because it had not been involved in programme design. As a result, there were some differences between the project proposal and UNDP norms, e.g. on travel. As a result, UNDP had to develop a specific standard operating procedure for the programme. UNDP has also modified the M&E arrangements for the programme, including introducing more in-field data verification. UNDP headquarters are currently considering the possibility of providing sub-recipient with 'buffer' funds to use in situations where disbursements are delayed for the reasons outlined above. The review team concludes that introducing such a system could be extremely helpful for the smooth operation of the programme. A recommendation based on this conclusion is included in Section 7 (p52).

Overall, the capacity of sub-recipients to manage a large and complex programme of this nature is quite limited in a number of areas, including procurement, financial management, M&E, and quality control. In particular, some of the newer NGOs have very limited capacity relying on intermittent, project-based funding for their activities.

Discussions are underway as to how the programme might be managed in phase 2, particularly whether or not there should be a transition of PR from UNDP to a government agency, such as the Republican AIDS Centre. In principle, such a transition is a good idea to ensure and further strengthen national ownership of the programme and its contribution to the overall national response to HIV. The team's recommendations for a transition plan are included in Section 7 (p52). In the end, any transition plan would be subject to existing Global Fund procedures, for example, further capacity assessments of prospective principal recipients by the LFA.

A key function of effective programme management is sharing and communicating knowledge, data and information that is relevant to the programme's operation. This is particularly relevant to the context of Uzbekistan. Although availability of HIV-related data is improving, publication and broad discussion of such data, e.g. annual reviews, is not yet standard practice. There is a golden opportunity for the Global Fund and UNDP to model open and transparent data management. Some progress has been made in this area but more could be done. The team's recommendations based on these conclusions are included in Section 7 (p52).

Monitoring and evaluation

One of the special terms and conditions of the SSF agreement was the establishment of a fully-functional electronic monitoring system for recording, analysis and reporting on the periodic result for indicators on MARPs reached with HIV prevention services financed under the grant agreement. This MIS[52] has been established with considerable investment from the Global Fund, in terms of provision of computers and Internet access. The system provides national aggregated data on the number of clients and the types of service provided. It is based on a national system of unique identifiers based on parents' initials, sex and date of birth.

Data from each client visit is recorded at the trust point or by the outreach worker. This is done manually on a form provided for this purpose. Data is then uploaded periodically to the electronic MIS by a specified staff member. The MIS data interface does not match the layout of the manual form. As a result, errors in data entry occur and have been identified by cross checking manual records with those in MIS. The review team observed MIS in action in

[52] The system was originally developed under the DFID-funded Central Asia Regional HIV/AIDS Project

a variety of locations visited. Quite variable levels of competency in using MIS were observed.

PMU reports that there was a 'reset' of MIS data at the beginning of 2013 in order to allow reporting on number of clients seen within 2013, i.e. excluding those seen previously but not returning for services in 2013. As a result, some sites report that they can no longer access their data prior to 2012. However, not all sites seem to be affected by this. The precise reason and nature of this 'reset' is unclear because the way the MIS is set up would enable the data required to be provided without any 'reset'.

Although the MIS is largely used for reporting to the national level, some organisations report that they use the aggregated data for their own local management purposes.

6.3 Programme coverage

The programme is reaching its targets

In general, the programme is meeting its quantitative targets. For example, Annex 5 (p72) presents data from the latest Grant Performance Report, available on the Global Fund website. This is based on UNDP's report for the period January to June 2012. Overall, almost all targets have been met or largely met. Data is available across the range of programme services. For example, the number of members of key populations reached with prevention services were 17,173 people who inject drugs (target 17,000), 5,991 sex workers (target 8,000) and 1,409 MSM (target 1,200). In addition, 5,005 STI treatment courses were provided through friendly cabinets (target 5,000).

However, there are some concerns that the targets are largely just being met. This raises the question as to whether the targets are stretching enough and whether they may actually be limiting performance in some cases. For example, this could be the case if funds are only available to achieve a particular level of service.

Although it is important to ensure that all people who need a service receive it, it is also important to ensure that the services provided respond to client needs and are of sufficient quality to be effective.

Are levels of coverage sufficient to make a difference?

Although meeting programme targets is important in terms of the effectiveness of programme management and implementation, a larger question is whether or not they are being delivered at sufficient scale to make a difference. This issue is examined here mainly for prevention services for people who inject drugs.

According to UNAIDS guidelines for Global AIDS Response Progress reporting[53], coverage of needle and syringe programmes can be assessed by measuring the number of syringes distributed per person who injects drugs per year. For this indicator, the denominator is the number of people who inject drugs in the country, not only those who access services. Coverage is said to be:

- Low if less than 100 syringes are distributed per person per year
- Moderate if the number of syringes distributed per person per year is between 100 and 200
- High if greater than 200 syringes are distributed per person per year

[53] See http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/JC2215_Global_AIDS_Response_Progress_Reporting_en.pdf

According to Uzbekistan's 2012 UNGASS report, the country distributed 173 syringes per person in 2011. As a result, the coverage could be characterised as 'moderate'. However, no details of how this number was calculated are provided. It is known that trust points overall distributed 2.6 million syringes in 2011. If this figure has been used to calculate this number, the total number of people who inject drugs would be 15,029. It is unclear if this is the number of people accessing the trust points in 2011. It is not likely to be the total number of people who inject drugs in the country because it is too low and there is no officially agreed estimate for this figure.

According to data for trust points from 2012 in the four regions visited by the review team, the average number of syringes distributed per person attending the trust points was 110[54] in trust points not supported by the Global Fund and 114 in those supported by the Global Fund (see Table 3, p28). Across the four regions, the range was 95-146 in those trust points supported by the Global Fund and 68-199 in other trust points. As this figure is for those who attend the trust points only, the true coverage is likely to be much lower.

Given that there is currently no agreed estimate of the number of people who inject drugs in Uzbekistan, it would be reasonable for the Global Fund to use, for indicative purposes, estimates previously provided in the country's applications, i.e. 80-100,000. If these figures were applied to the number of syringes distributed nationally through the trust points in 2011 (2.6m), the coverage would be between 26 and 33 syringes per person per year.

The review team were concerned to hear reports from service users and service providers that the number of syringes and condoms that could be provided on one visit was restricted. Service users, in particular, commented that this number did not correspond fully to their need for syringes. It appears that this may relate to an order of the Ministry of Health which is said to restrict the number of needles and syringes that can be distributed to an individual.

There are similar issues in calculating the coverage of ART. There is currently no agreed estimate of people who need treatment. However, there are indications that not everyone who needs treatment is yet receiving it because people who inject drugs find it difficult to adhere to ART in the absence of OST, the majority of members of key populations were not tested for HIV in 2011 and, also in 2011, almost one third of those who were diagnosed with HIV were diagnosed late, i.e. with a CD 4 of <350.

6.4 Programme outcomes and impact

Programme contribution to HIV strategy

There is a significant degree of alignment between the Global Fund's support provided under the SSF grant agreement and Uzbekistan's national HIV strategy for 2013 to 2017. The national strategy has two goals. These are to ensure a reduction on the spread of HIV in Uzbekistan by 2017 and to achieve universal access to comprehensive HIV prevention, treatment, care and support by the same year.

The national AIDS strategy outlines eight key principles on which the national response to HIV is based (see Box 3). Funding from the Global Fund is supporting the Government of Uzbekistan to implement the national HIV response according to these principles. For example, the significant amount of funding provided by the Global Fund to support ART has allowed the government to provide treatment of patients with HIV free of charge (#5). In addition, the Global Fund and UNDP have provided financial and technical resources to enhance cooperation between government agencies and civil society (#8).

[54] According to aggregated data provided by UNDP, the total number of syringes distributed in the supported trust points in the four regions was 1.44m among 12,809 clients, i.e. 112 per client.

Box 3: Summary of key principles in the national HIV strategy for Uzbekistan 2013 to 2017

1. Actions on issues related to HIV are carried out in accordance with the legislation of Uzbekistan, which is improving in line with international recommendations.
2. Interventions to prevent HIV and STIs allow for the traditions and culture of the people of Uzbekistan, including the provision of HIV prevention information in the languages of the peoples of Uzbekistan.
3. Action for the prevention and treatment of HIV and STIs are conducted on the basis of the experience of Uzbekistan with the advice of WHO and UNAIDS and relevant examples of international best practice.
4. Uzbek citizens, regardless of their HIV status, health status or occupation, have equal right of access to skilled services for the prevention, treatment, care and support of HIV. Access to skilled services is also provided to groups with special status, such as refugees and stateless persons.
5. Treatment of patients with HIV is free of charge.
6. Services are provided to meet the needs of target groups on the principles of confidentiality, friendliness, counseling and informed consent.
7. The needs of women and children are taken into account in both the design and implementation of HIV prevention and treatment programmes.
8. Programmes of HIV and STI prevention, treatment and care are implemented in close cooperation between government and civil society.

The national HIV strategy for 2013 to 2017 contains six priority actions (see Box 4). The objectives of the SSF programme with the largest funding align very clearly with these main actions, namely the focus on HIV treatment, care and support (priority action #6), control of hospital transmission of HIV (priority action #3) and HIV prevention among key populations (priority action #2). Global Fund support is also supporting other areas identified in the national HIV strategy including strategic programme management through support and involvement with the Interdepartmental Expert Council/CCM. In addition, Global Fund support has been pivotal in strengthening national systems for HIV data collection and use.

The national HIV strategy notes that HIV prevention programmes for MSM are only provided by one organisation, the NGO Istikbolli Avlod. It also notes that there is a significant level of stigma and discrimination by society and law enforcement agencies towards vulnerable groups, including MSM, making it difficult to conduct prevention work among this target group. Given this context, Global Fund support to this particular aspect of prevention work is especially important.

Box 4: Priority actions in the national HIV strategy 2013-2017

1. Improvement of the legal framework in order to ensure universal access.
2. Preventing HIV infection among high-risk groups, particularly people who inject drugs, sex workers and MSM
3. Prevention of HIV transmission in health care settings
4. Prevention of mother to child transmission (PMTCT)
5. HIV and STI prevention in the general population
6. Ensuring universal access to diagnosis and treatment of HIV and STIs

The national HIV strategy for 2013 to 2017 notes that the purchase of ARV drugs and PCR reagents had, to date, been carried out almost entirely with Global Fund support. Although this has undoubtedly been of crucial value to the national response to HIV and has contributed almost entirely to the scale up of ART in Uzbekistan, the strategy notes that reliance on one external source of funding for such a critical service is undesirable and places the provision of HIV treatment in a vulnerable position.

Causation and contribution of Global Fund financing across the results chain

One of the objectives of the mid-term review is to conduct analysis of causation and the contribution of the Global Fund and other explanations along the programme results chain from inputs to outcomes. There are a number of challenges with this. First, the programme does not have a results chain explicitly defined, for example in a theory of change. It could be argued that such a chain is implied within the indicators specified for programme monitoring.

Figure 5 attempts to make that results chain more explicit. The size of the 'input' boxes are proportional to the financial size of the relevant objectives. The four smaller objectives[55] have been merged into one box.

Some of the indicators are weak and would not meet agreed international standards for indicators[56]. For example:

- Some indicators are difficult to interpret, for example the indicator on the number of people receiving treatment for opportunistic infections. As coverage with ART increases, it is likely that the number of opportunistic infections would fall resulting in the number of opportunistic infections treated falling. This indicator would not distinguish between a fall because the number of opportunistic infections had fallen and a fall because opportunistic infections needing treatment were not getting treated. As a result, it will be difficult to interpret this indicator.

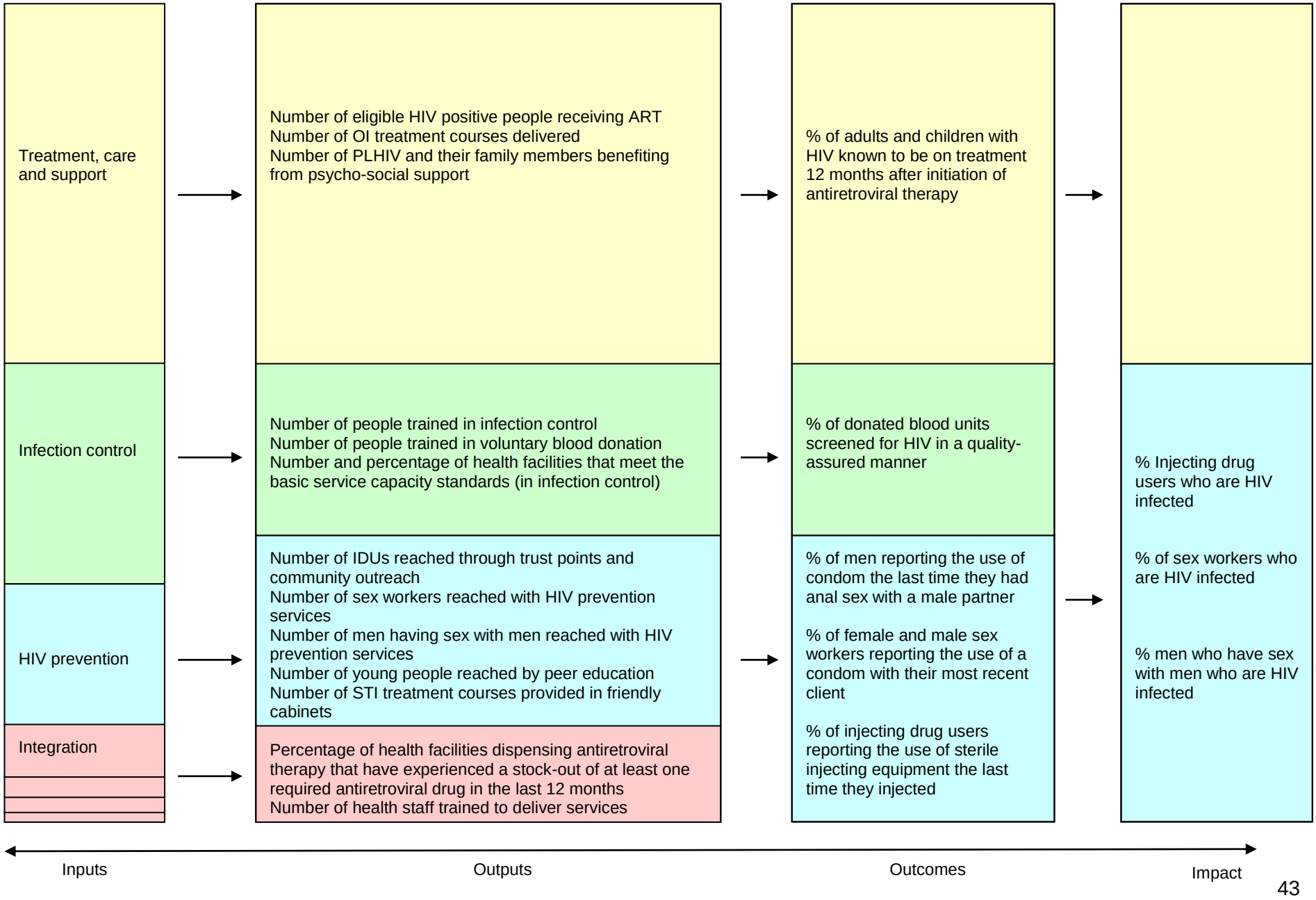
- Some indicators have a very poor track record, e.g. the former UNGASS indicator on blood safety. There was a tendency for all countries to report this as 100%. As a result, it was dropped from Global AIDS Response Progress reporting. This is also the case for indicators measuring the coverage of services for key populations. It has proved very difficult to agree a definition of number reached[57]. At least for services for people who inject drugs, this measure has been superseded by the number of syringes/needles distributed per person[58].

In addition, some parts of the results chain are incomplete. For example, the funding for integration and decentralisation appears to be focused on producing more people trained as an 'output' but is it unclear what outcome this might lead/contribute to? Without clarity on this, there is a serious risk of just conducting a large number of trainings with no clearly-agreed outcome.

There are difficulties in determining rigorously the causal link between inputs and outputs and any observed changes in outcomes and impact. This is because we will not know what would have happened in the absence of the intervention, i.e. the counterfactual. This may be less of an issue where the intervention is large, where the existence of other contributory or causal factors is minimal and where the observed change is close to the programme action. For example, it is likely to be both credible and plausible to argue that the observed increase in number of PLHIV receiving ART in Uzbekistan is causally linked to the financial inputs provided by the Global Fund for this purpose. It is, however, more difficult to argue that observed reductions in HIV prevalence among people who inject drugs has been caused by HIV prevention activities among people who inject drugs. Certainly, some local stakeholders believe this to be the case and this is a plausible explanation. However, to do this rigorously requires at least demonstrating that these services had been delivered on significant scale and that there had been demonstrated changes in relevant behavioural indicators such as reported use of sterile injecting equipment and condoms. These issues are explored in this section.

[55] In terms of financial size
[56] See http://www.unaids.org/en/media/unaids/contentassets/documents/document/2010/4_3_MERG_Indicator_Standards.pdf
[57] For example, is it the number of people ever reached, the number reached during a particular period or the number reached at an agreed level of intensity.
[58] See http://www.ncbi.nlm.nih.gov/pubmed/20189638 and http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/JC2215_Global_AIDS_Response_Progress_Reporting_en.pdf

Figure 5: Proposed results chain for Global Fund support to HIV response in Uzbekistan



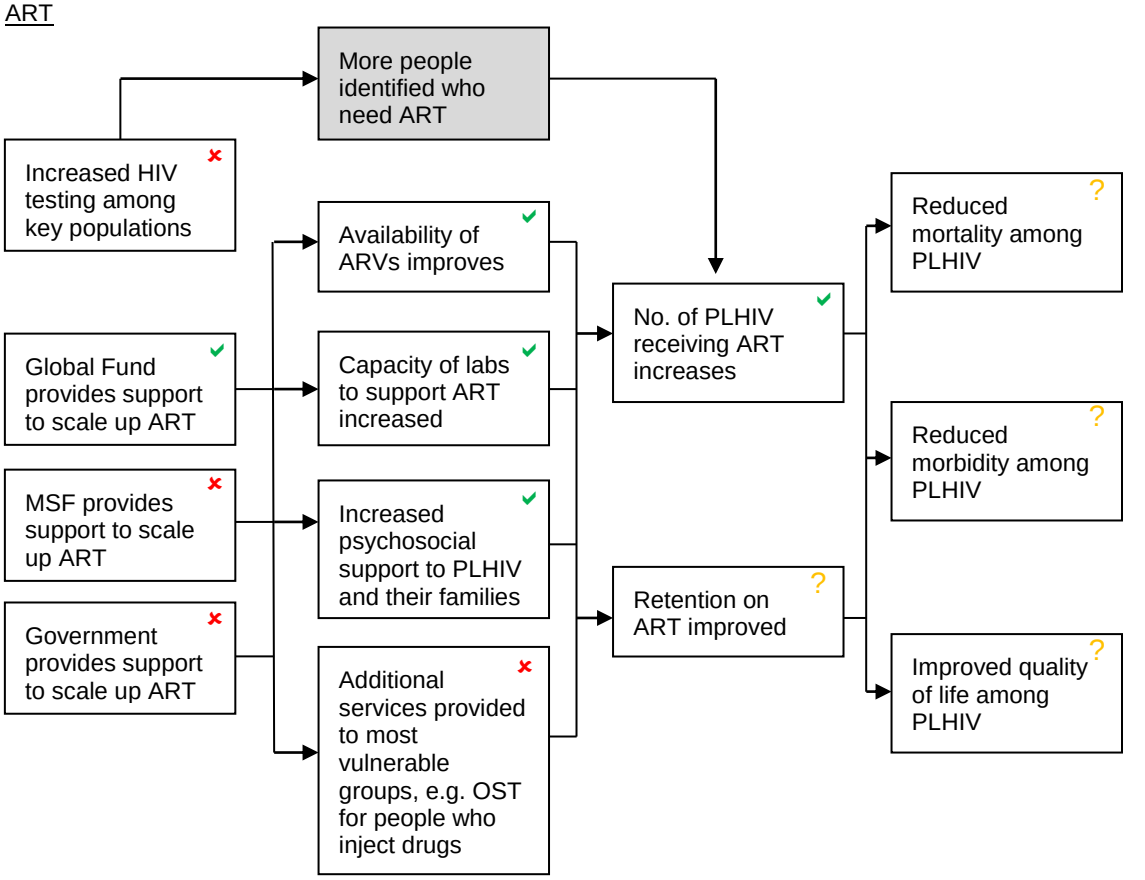
The approach we will take in this report is to explore these issues, in an illustrative way, in the two areas mentioned above, i.e. the provision of ART for PLHIV and the provision of HIV prevention services for people who inject drugs (see Figure 6). Elements are marked as follows:

- Green ticks – review team considers that there is evidence that these elements have been or are being achieved
- Amber question marks – review team considers that there is insufficient evidence to determine whether or not these elements have been or are being achieved
- Red crosses – review team considers that there is evidence that these elements have not yet been or are not being achieved
- Grey boxes indicate those elements that cannot be assessed as preceding elements are not in place

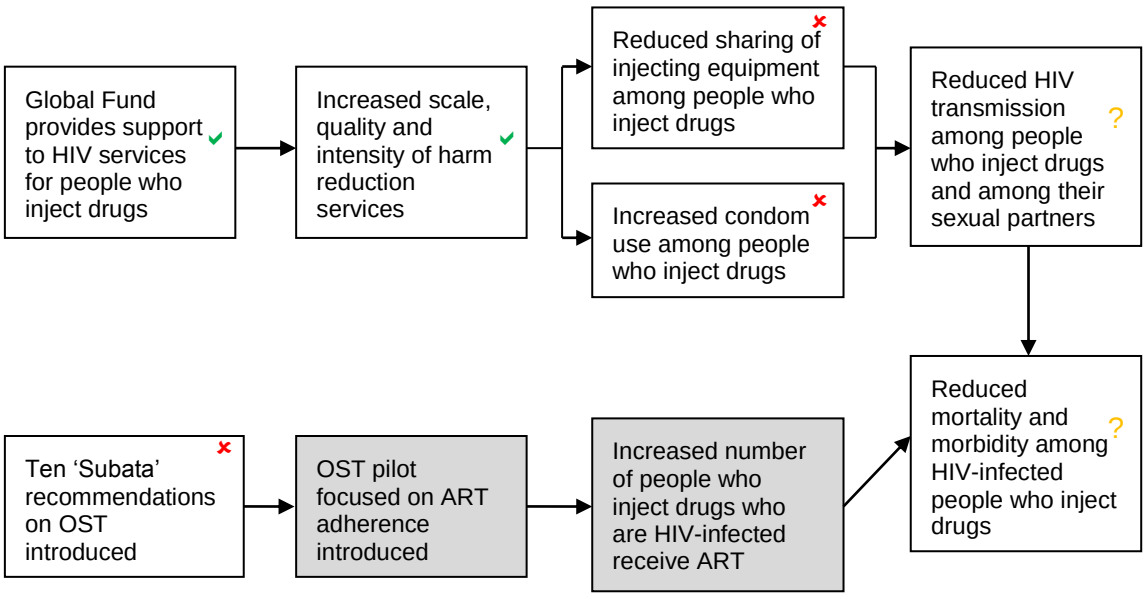
The next four sections of the report describe how these assessments have been made. They proceed in turn from inputs to outputs to outcomes and to impact. They focus mainly on the two areas of work illustrated in Figure 6, that is, treatment for PLHIV and programmes among people who inject drugs. Some reference is made to other parts of the programme work where appropriate.

Figure 6: Illustrative results chain for provision of ART and HIV services for people who inject drugs

ART



HIV services for people who inject drugs



Programme inputs

The Global Fund has made a significant financial contribution to Uzbekistan's national response to HIV. According to official statistics[59], the Global Fund was the most significant external funder of the HIV response in Uzbekistan in 2011[60] contributing $6.4m, approximately one third of total funding to the national HIV response.

According to disbursement requests[61] submitted to the Global Fund, during the first six months of 2012, UNDP's reported cash outflow was $4.4m of an available budget of $7.2m. Reasons given for this variance included:

- An expansion of the budget for antiretroviral medicines which were not purchased during this period
- Reported delays in the Global Fund approving the PSM plan
- Time taken to establish and sign agreements with sub-recipients

Sub-recipients have now received their funds. However, it is a time-consuming and complex process to receive these funds. For example, it takes one to two months to obtain clearance from the Bank Commission for NGO sub-recipients to use these funds after UNDP has deposited these into the organisation's bank account. Given that some of the NGOs have no other sources of funds and no financial reserves, these delays are extremely problematic. UNDP is currently exploring the possibility of providing NGOs with buffer funds which should help overcome this problem.

UNDP has demonstrated persistence, hard work and resourcefulness in finding ways of providing funds to NGOs which comply with Uzbekistan's regulatory environment. This has, for example, involved collaborating with three NGOs (Intilish, Ishonch va Hayot and Istikbolli Avlod) who are currently registered only to work in Tashkent. They are currently seeking registration to work on the national level and UNDP has been supporting this application. In the meantime, UNDP has been financing activities directly that, in time, will be taken on by these organisations.

One of the specific questions in the review's terms of reference (see Annex 1, p57) was "are Global Fund HIV investments allocatively efficient?" Allocative efficiency is an economics concept that has been used in the context of HIV[62] to ensure that scarce resources flow to the programmes that are most likely to produce the best results. This issue is extremely relevant to both the Global Fund and the Government of Uzbekistan. Resources available to respond to HIV are unlikely to continue to grow as they have over the past decade. It is therefore essential that the difficult decisions are taken to ensure that these resources are used to fund programmes that are most likely to produce the best results. These issues have been explored in some detail in the section of this report on programme design (see p17. However, the main points and conclusions on this issue are summarised here. Recommendations arising from these conclusions are presented in Section 7 (see p52).

- Spending on expanding access to ART is highly appropriate and it is understandable that UNDP/the Global Fund took the decision to allocate additional funds in this area to cover unmet need. However, it is inappropriate and unsustainable for all the costs of

[59] In Uzbekistan's report to Global AIDS Response Progress Reporting 2012
[60] The year prior to the start of SSF
[61] The last report available to the review team was for activities financed in semester 1, i.e. from January to June 2012.
[62] E.g. by the World Bank – see http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/EXTHIVAIDS/0,,contentMDK:23053804~menuPK:4896254~pagePK:210058~piPK:210062~theSitePK:376471,00.html

ARV provision to be met by the Global Fund. The decisions of MSF and, in particular, the Government of Uzbekistan, to provide finances for ARVs are particularly welcome. The review team concludes that the Global Fund's contribution to ARV procurement taper off in phase 2 as the government takes on more responsibility for this provision.

- Some key support services essential for ART adherence, such as OST for people who inject drugs, are absent in Uzbekistan. The review team concludes that allocating resources to support the introduction of these should be a high priority for the Global Fund in phase 2. The ten recommendations in the Subata report provide a sound basis on which to proceed. In principle, agreement to these recommendations from the Government of Uzbekistan will be needed before proceeding on this basis to phase 2.

- Although it is highly appropriate to use Global Fund finances to support HIV testing in Uzbekistan, the current focus of HIV testing on low risk groups, such as labour migrants, pregnant women, blood donors and people planning to marry is not allocatively efficient. The low rate of HIV testing among key populations means that a significant number of HIV infections are likely to be undiagnosed or diagnosed late. If Uzbekistan's HIV testing policy remains unchanged, the Global Fund might consider allocating these funds elsewhere. The review team concludes that initiatives to maximise testing among key populations, such as rapid testing in trust points, would merit support from the Global Fund.

- While recognising the importance of preventing nosocomial infections and acknowledging that some HIV infections in Uzbekistan have occurred in hospital settings, the review team concludes that the absolute number of these is relatively small and the amount of Global Fund resources allocated in this area is disproportionate to the number of HIV infections that would be prevented by enhancing infection control in hospitals. Given that the intention of this approach is to pilot and demonstrate how infection control can be strengthened in hospital settings, the review team concludes that it would be appropriate to scale down the size of the pilot to perhaps one region and to expect that Global Fund support to this area would taper down in phase 2 as the government takes on responsibility for funding in this area.

- Given that the HIV epidemic in Uzbekistan is mainly spreading among key populations, such as people who inject drugs and their sexual partners, it is highly appropriate that most of the programme's prevention resources are focused on these groups. The review team concludes that it would be appropriate to further intensify support to HIV prevention programmes among these groups, particularly people who inject drugs, sex workers and MSM.

- HIV prevention activities among members of the general population, such as young people and women are unlikely to be allocatively efficient. The review team concludes that funds for these activities should be allocated to prevention activities among key populations.

- Funds spent on general, unfocused training, e.g. of primary care staff, is unlikely to be extremely allocatively inefficient given that the purpose and expected results of this initiative seem poorly defined. The review team concludes that resources for this purpose should be allocated elsewhere.

- Funds spent on building NGO capacity and promoting cooperation between government and NGOs is likely to be very allocatively efficient. NGOs can often provide services that are difficult for government to provide and can also support the provision of services, such as ART, by government agencies. Overall, costs of local NGOs are low. However,

the review team concludes that better results may be achieved if key additional investments are made, e.g. by increasing the remuneration package available to outreach workers.

Programme outputs

Data relating to programme coverage is considered elsewhere in this report (see p39). It is clear that as a result of Global Fund financing more people with HIV are receiving ART and more members of key populations are receiving HIV prevention services. Programme targets are being met. However, there is evidence that coverage of needle and syringe programmes is low to moderate. There is also evidence that some people who would benefit from ART are not currently receiving it, because they have not yet been tested for HIV or because they cannot access supportive treatment for their opiate drug use.

Programme outcomes

This review is a mid-term review of phase 1 activities implemented with Global Fund support from 2011. As a result, it is probably premature to be assessing the outcomes and impact of this work. For example, programme reports to the Global Fund emphasise that sentinel surveillance data for 2011 will be taken as a baseline for the programme. However, Global Fund support to Uzbekistan's response to HIV did not only commence in 2011. Support under the original Round 3 agreement started in December 2004. As a result, Uzbekistan has benefited from almost a decade of Global Fund support. This section therefore looks more broadly at the possible outcomes of that support.

Data on HIV-related knowledge and behaviour of key populations at risk of HIV infection is available from sentinel surveillance studies. These have been carried out, in Uzbekistan, among people who inject drugs, sex workers and MSM every two years since 2005. Relevant data is summarised in Table 4. Although these figures appear to show some positive trends, e.g. in levels of knowledge among key populations, caution is needed in interpreting these figures, particularly for MSM where the sample size was small and limited to Tashkent. In addition, there are unexplained variations between some of the figures for 2011 sentinel surveillance and official figures for the same data reported to the Global AIDS Response Progress reporting in 2012. These have been noted as footnotes to Table 4[63]. The figures in UNDP reports to the Global Fund[64] correspond to the figures reported to be available from sentinel surveillance.

Overall, rates of annual HIV testing among key populations remains low. It is particularly low among people who inject drugs - <30% in 2011. Condom use by sex workers at last sex with a client is reported to be high (86% in 2011). However, condom use by people who inject drugs at last sex is reported to be low (38% in 2011). Relatively low condom use by people who inject drugs has been reported in all rounds of sentinel surveillance since 2007. Although reported use of sterile injecting equipment among people who inject drugs is relatively high (81% at last injection in 2011), this percentage has not risen since 2007. In fact, it fell slightly from 84% in 2007.

Given (i) the lack of evidence of a rise in reported use of sterile injecting equipment among people who inject drugs; (ii) evidence of low condom use between people who inject drugs and their sexual partners; and (iii) the continued absence of some key HIV-related services for people who inject drugs[65], the review team concludes that there is insufficient, evidence to determine conclusively that the reported decline in the number of new HIV diagnoses and HIV prevalence among people who inject drugs has occurred as a result of the HIV

[63] Discrepancies of 1% have been discounted.
[64] For example, for condom use among MSM
[65] I.e. OST

prevention programmes initiated among this group. Clearly, some local stakeholders believe this to be the case and this is a plausible explanation. It is certainly likely that these efforts have contributed to preventing a significant number of HIV infections. However, the epidemic is not yet under control. Efforts need to be redoubled and focused where they can make most difference.

Table 4: Knowledge and behaviour among key populations: Data from sentinel surveillance: 2007-2011

	2007	2009	2011
People who inject drugs			
Percentage who both correctly identify ways of preventing the sexual transmission of HIV and who know how HIV is transmitted	32%	57%	61%
Percentage reporting the use of sterile injecting equipment at last injection	84%	83%	81%
Percentage reporting the use of a condom during last sexual intercourse	36%	43%	38%[66]
Percentage reached with HIV prevention services[67]	40%	20%	55%
Percentage who had an HIV test in the last 12 months and know the results	19%	25%	21%[68]
Sex workers			
Percentage who both correctly identify ways of preventing the sexual transmission of HIV and who know how HIV is transmitted	28%	37%	42%
Percentage reporting the use of a condom during last sexual intercourse with client	76%	84%	85%
Percentage reached with HIV prevention services[67]	75%	71%	76%[69]
Percentage who had an HIV test in the last 12 months and know the results	30%	35%	40%
MSM			
Percentage who both correctly identify ways of preventing the sexual transmission of HIV and who know how HIV is transmitted	41%	48%	59%
Percentage reporting the use of a condom during last anal sex with a male partner	62%	84%	90%[70]
Percentage reached with HIV prevention services[67]	31%	53%	53%[71]
Percentage who had an HIV test in the last 12 months and know the results	30%	51%	31%

Programme impact

Data on these issues has been presented earlier in this report (see p7). Overall, the number of new HIV diagnoses reported nationally has fallen over the last three years, the proportion of new infections reported to be due to injecting drug use has fallen and HIV prevalence among people who inject drugs detected through sentinel surveillance fell from 2007 to 2009 and again from 2009 to 2011 (see Table 1, p7).

Is this evidence that Uzbekistan's programmes among people who inject drugs have been effective in stemming the transmission of HIV among people who inject drugs? This is certainly the view of some local stakeholders and it is one possible, plausible explanation.

[66] This figure differs from the figure reported in Uzbekistan's report to the Global AIDS Response Progress reporting process which was 43%. This corresponds to the figure from 2009 sentinel surveillance.
[67] Based on the information provided to the review team, the precise nature of this data is not defined. However, it has been assumed that this relates to the UNGASS definition of coverage, i.e. having received a condom (and in the case of people who inject drugs – a syringe) in the last year and knowing where to get an HIV test.
[68] This figure differs from the figure reported in Uzbekistan's report to the Global AIDS Response Progress reporting process which was 29%.
[69] This figure differs from the figure reported in Uzbekistan's report to the Global AIDS Response Progress reporting process which was 64%.
[70] This figure differs from the figure reported in Uzbekistan's report to the Global AIDS Response Progress reporting process which was 57%.
[71] This figure differs from the figure reported in Uzbekistan's report to the Global AIDS Response Progress reporting process which was 45%.

However, for the review team to conclude that this explanation is the most credible and plausible explanation would require demonstrating that alternative explanations are less credible/less plausible. There are a number of alternate explanations for the observed epidemiological data:

- The reduction in reported new HIV cases could be an artefact of a change in testing policy. This is hard to disprove. It is certainly true that there has been a significant increase in testing among populations with low HIV prevalence. It is also true that reported rates of HIV testing among key populations are relatively low and rates of late diagnosis are relatively high. Therefore, it is difficult to be sure that the HIV case reporting data reflects an accurate picture of HIV incidence in Uzbekistan. In addition, the absolute rate of new diagnoses remains high. At best, there may have been some diminution in the rate of HIV transmission. It would definitely be premature to conclude that the epidemic is being brought under control.

- The reported reduction in HIV transmission through injecting drug use could be simply the natural progression of the epidemic. As most/all of the people who inject drugs within a particular network become HIV infected the rate of HIV transmission through injecting drug use will fall and the rate of sexual transmission will rise as their sex partners become infected.

- However, it is possible that absolute number of people who inject drugs being infected annually currently is higher than at the start of the epidemic even though the percentage of new infections among people who inject drugs has fallen. This is because the absolute number of new infections per year remains high. To understand this issue, it is helpful to look at absolute numbers of new infections among people who inject drugs year on year. The team requested absolute figures for new HIV diagnoses by year since the epidemic began[72]. These were not made available.

- The number of people infected through injecting drug use may be underreported. This is likely to be the case given that injecting drug use is both illegal and socially undesirable. There is risk of desirability bias among both people diagnosed and health staff responsible for reporting data.

- Falls in HIV prevalence in sentinel surveillance studies among people who inject drugs may be due to migration or death of HIV-infected people who inject drugs. It is extremely likely that this is at least part of the explanation for the decline because without this it would be expected that HIV prevalence would stabilise and plateau as HIV transmission among people who inject drugs is controlled.

On balance, there are a number of equally, and possibly more, plausible ways of explaining the observed data among people who inject drugs rather than this being an intervention effect.

Overall, there is strong evidence that Global Fund inputs have produced concrete outputs both in terms of more people receiving ART and in terms of more people who inject drugs benefiting from HIV prevention services. However, the review team concludes that it is not yet clear the extent to which these outputs are producing specific outcomes/impact, such as reduced mortality and morbidity among PLHIV and reduced transmission of HIV among people who inject drugs (see Figure 6, p44).

[72] Disaggregated by sex and route of transmission

Availability of quality data

One of the questions the review team was asked to address was whether there was sufficient quality data available to detect the effect of increasing service coverage and quality on disease burden.

Overall, it is the view of the review team that there is sufficient epidemiological data available to accurately understand and to respond effectively to the HIV epidemic in Uzbekistan (see p7). But, there are limitations. Information is largely restricted to officially-sanctioned data only. It is likely that there could be significant desirability bias within official data. There are some apparent inconsistencies within different presentations of the same data[73]. Reasons for this are unclear. There is very limited availability of other sources of data, such as from NGOs or academic studies, which could be used to confirm and/or refine official data.

There are limited opportunities to engage in critical discussion and dialogue about data. For example, Uzbekistan's report to the Global AIDS Response Progress reporting process in 2012 commented that the country has not yet introduced a broad discussion and publication of annual reviews of the spread of HIV.

Some key data elements, e.g. population size estimates, are not available and this restricts the ability to accurately calculate programme coverage. It may be possible to suggest plausible ranges for this and to narrow the extent of these ranges as more data on the sizes of relevant sub-populations becomes available. Sentinel surveillance data is not available for some key sub-populations, such as prisoners and the sexual partners of people who inject drugs. Currently, there is no data available on the quality of services provided, e.g. through user surveys, or on improvements in the quality of life of PLHIV. Ultimately, it is difficult to assess rigorously the effect of Global Fund programmes in Uzbekistan on disease burden because of the lack of robust evidence of what would have happened in their absence, i.e. there is no counterfactual data.

[73] For example between behavioural data in reports on sentinel surveillance and reports to the Global AIDS Response Progress reporting process (see Table 4, p38).

7. RECOMMENDATIONS

These recommendations are focused strongly on planning for phase 2 of the grant.

1. Given the nature of the HIV epidemic in Uzbekistan, there is a need in phase 2 to **increase the focus of programme's activities on those areas where it can make the most difference, in particular, promoting HIV prevention among key populations**. This would involve further scaling up the existing prevention services for key populations, with special attention on accessibility and quality of services. In this regard, special attention should be given to strengthening client-orientation and to developing innovative approaches, especially for population sub-groups that may not be currently reached by services, such as women and young people who inject drugs, male sex workers and married MSM. It will also involve reducing/stopping activities in some areas, e.g. HIV prevention among young people, in general, and unfocused, ad hoc training activities.

2. **HIV prevention activities among key populations could be strengthened by expanding services in ways identified by clients and service providers, and further strengthening outreach work by increasing the financial and other incentives provided to outreach workers**. There is a particular need to expand services for MSM. Detailed suggestions as to how this might be done are presented in Box 5. There is also a need for expanded services for sub-groups of key populations that find it difficult to access services, such as:

   - Women who inject drugs. Outreach services specifically targeting women who inject drugs could be further expanded, especially for those who also engage in sex work, as this represents a particularly vulnerable group

   - Young people who inject drugs. Special efforts are needed to ensure that those young people who are injecting drugs are reached with services. This may require recruiting more young ,peer outreach workers and targeting them through specific approaches

   - Male sex workers. Specific efforts are needed to reach male sex workers and men who engage in selling/transacting sex to/with other men. Such men are likely to be particularly vulnerable to HIV, especially as currently no services are provided to them. Options for reaching this group include expanding sex workers programmes to include all sex workers and/or using the existing networks and contacts that have been established among the MSM community

   To do this, more knowledge may be needed on women and young people who inject drugs, as well as on young women engaging in transactional sex without being considered sex workers. In this regard, the review of harm-reduction services that is planned to take place shortly, should not only focus on assessing the utilisation and quality of services, but explicitly look at specific subpopulations that may not be reached by existing services.

   In order to recognise and reward the essential contribution made by professional staff and outreach workers in the provision of HIV prevention services for key populations, the review team recommends that the following are considered in phase 2:

   - Small increases in salaries of professional staff

- Improved financial and in-kind incentives for outreach workers and peer volunteers, e.g. reimbursement of transport expenses; food and other incentive packages. Outreach workers could also be provided with bicycles or motorbikes to facilitate their work

- Training and certificates which will increase people's professional status

- Provision of transport to outreach workers and peer volunteers to maximise their work efficiency

Box 5: Detailed suggestions for expanding HIV prevention activities among MSM in phase 2

Given perceptions that it may be difficult and/or unnecessary to expand HIV prevention services for MSM in phase 2 of the Global Fund programme, the review team highlight here why these services are considered so important and then suggest ways in which this work could be expanded in phase 2.

Globally, men who have sex with men have been particularly vulnerable to HIV infection. In many countries, HIV has spread predominantly through sex between men. Data from sentinel surveillance in Uzbekistan among MSM in 2007 and 2009 showed high rates of HIV prevalence among some MSM in the country. The lower prevalence in 2011 is unlikely to reflect a real reduction in prevalence among MSM. It is more likely to be an artefact of the small sample size.

To date, the programme, and especially the NGO Istiqbolli Avlod, has been doing a relatively good job in finding MSM and providing services, The main issue is to build on these existing experiences, identify what works and what does not, and implement programmes systematically in all regions.

The review team suggests that in phase 2 activities for MSM should focus on:

- Using the upcoming operational research to focus on identifying different subpopulations of MSM, looking at issues such as age, marital status, and involvement in selling or buying sex. An accurate picture of sexual networks and behavioural dynamics among MSM will allow better targeting of programmes and services for different MSM groups. Lessons can be learned from the fact that in some regions they have been able to identify older, married MSM, as well as a small number of male sex workers catering to a male clientele.

- The results of this operational research should be used to guide interventions in regions with existing programmes for MSM, particularly in Tashkent. In addition, it should inform the establishment of additional MSM programmes in other oblasts.

- Special attention should be given to identifying the service needs of MSM, not only regarding condoms or HIV prevention, but also in terms of psychosocial counselling, legal support, lubricants, more targeted HIV education, and effective referral mechanisms.

- The focus of these services should not be primarily led by "wanting to attain the targets set", but should be based on client-oriented services that meet the needs of a diverse group of MSM. Service providers should not be satisfied once they reach a certain numerical target, but should primarily look at the specific HIV risks of particular groups at risk, such as men selling sex to other men. This is a particularly important group to cover, while they seem to be largely overlooked, or their existence denied for various reasons.

- Implementing NGOs should conduct ongoing, very basic "operational research" through regular focus group discussions, observations, interviews with key informants etc. to ensure they thoroughly understand the situation of MSM and any changes, i.e. risk behaviours, networks, prevention and other service needs etc. This will help identify more effective strategies for working with MSM.

3. There is need to **<u>further increase the capacity of NGOs to provide social services for members of key populations</u>**. NGOs are critical to the provision of such services not only in Uzbekistan but also in other countries. Effective links between NGOs and government services have been developed and these need to be strengthened and developed. The proposal, currently being considered by UNDP headquarters, of

providing sub-recipient with 'buffer' funds to use in situations where disbursements are delayed, is strongly endorsed and recommended by the review team.

4. The Ministry of Interior, in general, and its health staff, in particular, should be invited to participate in planning for phase 2 with a view to **identifying any areas related to HIV in prisons which could be incorporated into the programme**. It may be possible to identify some ways of supporting the Ministry of Interior and its health staff to provide HIV services in the prison. For example, there may be some specific training needs of prison health staff related to the care and treatment of PLHIV.

5. Plans need to be made to ensure the sustainability of activities commenced with Global Fund financing. During phase 2, **the Global Fund should taper off its funding to ART and infection control as these areas are increasingly financed by government**. There are clearly many practical and logistical arrangements relating to ART provision which need to be made on an ongoing basis. It may be helpful for the government to establish a working group involving itself, MSF and UNDP to ensure that these matters and discussed and decided so that ART can be provided to all who need it.

6. Efforts should be made to **reduce late HIV diagnosis by expanding HIV testing among key populations**, e.g. by supporting introduction of rapid HIV testing in low threshold services, such as trust points and friendly cabinets.

7. **People who inject drugs should be given maximal support to adhere to ART**. This should involve reintroducing opioid substitution therapy along the lines recommended by Emilis Subata. Key first steps would be for the CCM and Ministry of Health to endorse this report and to establish a working group on OST.

8. Given the reduction in budget for procurement of single use instruments and the problems in generating robust estimates of the quantities needed, **consideration should be given to reducing the scale and length of this pilot of measures to control HIV transmission in hospital settings**, for example, to one region over one year rather than in five regions over two years. This would allow procurement and provision of single use instruments to be done as part of an overall package of measures to reduce HIV transmission in hospital settings rather than as a poorly-planned, stand-alone measure. It would also allow prompt and thorough review/evaluation of lessons learned, as would be expected from a pilot project.

9. Consideration should be given to **integrate the four smallest objectives (integration; health systems strengthening; supply chain management and enabling environment) into one objective**. This could perhaps be characterised as strengthening health and community systems. It could be streamlined in order to allow more resources to be focused on prevention among the most affected populations. The review team recommends that resources are, in particular, reallocated away from unfocused and untargeted training of primary health care staff. There should be clarity over the expected results under this objective and a clear strategy through which these will be achieved.

10. Given that there are currently limited opportunities to engage in critical discussion and dialogue about HIV-related data in Uzbekistan, there is **an opportunity for the Global Fund and UNDP to model transparent and open sharing of data, knowledge and information related to the programme**. This is already beginning to happen in some areas. However, more could be done. There is a specific opportunity to engage stakeholders in discussion and dialogue about the findings, conclusions and recommendations of this review as part of the planning process for phase 2 of the

programme. Important first steps would be for UNDP to develop a communications strategy and to assign clearly the responsibility for delivering this strategy within PMU.

In addition, the review team makes **one management recommendation** which is that the CCM, UNDP, the Republican AIDS Centre and others should develop a detailed transition plan as to when and how the role of PR could be transferred from UNDP back to the Government of Uzbekistan. This would need to cover:

- Capacities that need to be developed prior to transition and how these would be assessed
- The expected timeline
- Any provision for staggering the transition. This might involve first handing on responsibility for management of government sub-recipients with responsibility for NGO sub-recipients being transitioned at a later stage

8. LESSONS LEARNED

A number of key lessons have been learned by the programme. These could perhaps be discussed, documented and disseminated under an expanded communications strategy for the programme. These lessons include:

- The critical importance of outreach workers in delivering HIV prevention activities for key populations, such as people who inject drugs, sex workers and MSM

- The great value of NGOs in providing social support services to key populations, particularly when linked with relevant government services, such as trust points and friendly cabinets.

- A number of lessons learned regarding the provision of ART. These include the value of the working group on treatment that was established under the CCM, in gaining government financial support for ART provision. It also includes the valuable role of multidisciplinary teams in providing psychological and social support to PLHIV and of groups of doctors in making treatment decisions.

ANNEX 1: TERMS OF REFERENCE

1. Introduction

In 2010 and 2011 Uzbekistan has been awarded two grants of The Global Fund to fight AIDS, tuberculosis and malaria - HIV Round 3 Rolling Continuation Channel (RCC) and Round 10 grants. The RCC grant is expected to further strengthen prevention, care and treatment services with a focus on MARPs as well as facilitate Community Systems strengthening and creation of an enabling environment. With necessary support from the RCC grants the National programme aims to achieve the National Strategic Plan goal of stabilizing the epidemic at the concentrated stage by means of ensuring Universal Access to HIV prevention, treatment, care and support, with specific focus on vulnerable populations. Round 10 grant proposal is a complementary proposal to the current R 3 RCC HIV grant and to the national response. It will cover three broad areas: infection control for prevention of HIV transmission; procurement and management of necessary health products and consumables for HIV prevention, diagnosis and treatment; integration and decentralization for sustained outreach and improved access. Round 10 grant will be implemented in 5 regions: Andijan, Namangan, Fergana, Samarkand and Tashkent.

UNDP is a key partner to the Global Fund to fight AIDS, Tuberculosis and Malaria and works in a number of countries as a PR. A decision by the Multispectral Expert Council selected UNDP as the PR for the implementation grants. In accordance with Global Fund Policy the grants have been consolidated in a Single Stream of Funding. The consolidated project is implemented by UNDP in close cooperation with governmental and non-government organizations.

The main goal of the project is to prevent the spread of HIV into the general population by reducing its impact on at most vulnerable populations and to strengthen health systems and national capacity for universal access to HIV prevention, diagnosis, treatment and care in Uzbekistan.

Objectives:
1. To scale up coverage and increase quality and comprehensiveness of HIV prevention services for most-at-risk populations (MARP)
2. To scale up treatment, care and support for PLHIV
3. To strengthen health system in Uzbekistan
4. To create an enabling environment for effective scale up of HIV prevention, treatment, care and support services
5. To strengthen infection control for prevention of HIV transmission
6. To strengthen systems for procurement, supply and management of necessary health products and consumables for HIV prevention, diagnosis and treatment
7. To facilitate decentralization and integration of services for sustained outreach and improved access

The project activities to implement objectives from 1-5 were started from July 2011. The work on the remaining objectives, i.e. 6, 7, had started from 2012.

As per approved SSF budget and work plan, external assessment to evaluate phase 1 (2011-2012) by independent experts or companies is planned. It should be noted that the assessment results should be submitted to GF by March 2013.

The purpose of this research is to conduct independent mid-term review of implementation of the first phase of GFTAM's project (HIV component) in Uzbekistan (2011-2012). The overview should be focused on mid-term outcomes and mid-term achievements of the

program and should include in-depth analyses of data on project achievements against the results framework agreed with GFTAM.

2. Goal and objectives

Goal - to conduct mid-term evaluation of the first phase of implementation of GFTAM's project (HIV component) in Uzbekistan. The evaluation should be built on (a) the results of National program evaluation which include impact and outcome data, and outline key analyses of epidemiological and financial data related to HIV programming in Uzbekistan (b) assessment of the overall impact on the burden of cases and deaths and on the assessment of causation and the contribution of the Global Fund and other explanations along the results chain from inputs to outcomes

Objectives:

- **To conduct project evaluation which combines four following components:**

1. Assess the relevance of program design to the HIV epidemic;
2. Assess the efficiency and effectiveness of programme implementation, its major achievements (or lack therefore);
3. Identify major problems and constraints faced by the grants' implementation at all levels;
4. To assess availability, accessibility, uptake and quality of prevention activities among Most-at-risk Populations, HIV counselling and testing, HIV case follow-up, ART, OI prophylaxis, PMTCT, and ART for those who are in need and identify gaps and opportunities among different services.
5. To evaluate results and achievements of the first year implementation the Project components:
   a. To strengthen infection control for prevention of HIV transmission
   b. To strengthen systems for procurement, supply and management of necessary health products and consumables for HIV prevention, diagnosis and treatment
   c. To facilitate decentralization and integration of services for sustained outreach and improved access
6. To assess adequacy of the Project's contribution into the implementation of the National strategy and provide recommendations on Project restructuring if needed
7. To conduct analysis of causation and the contribution of the Global Fund and other explanations along the programme results chain from inputs to outcomes.

3. Evaluation questions

The programme evaluation will seek to address the following evaluation questions:

1. **Programme design**

• Is the Global Fund investment – for HIV prevention services for most-at-risk populations (MARP), infection control for HIV transmission, strengthening systems for procurement, supply management and decentralization/integration of services allocated efficiently?

- Financing level allocated for HIV prevention services for most-at-risk populations (MARP), infection control for HIV transmission, strengthening systems for procurement, supply management and decentralization/integration of services;
- Resource allocation for HIV prevention services for most-at-risk populations (MARP), infection control for HIV transmission, strengthening systems for procurement, supply management, and decentralization/integration of services disaggregated by the key interventions;

- The mix of interventions provided as compared to the set of interventions proven to be effective for HIV prevention services for most-at-risk populations (MARP), infection control for HIV transmission, strengthening systems for procurement, supply management and decentralization/integration of services;
- The mix of interventions as compared with the health needs of the populations; number of IDUs, SWs, MSM, size of IDUs, SWs, MSM;

- Are the service delivery models evidence-based and adapted to local context?
- preventive intervention packages
- documented evidence for adopting these packages
- service delivery model and programme design facilitate availability of key interventions
- service delivery model and programme design support increase of accessibility and acceptance of key interventions

2. **Programme implementation**
- Are the interventions implemented as intended? Are these services actually used (uptake, utilisation) by intended target?
- Are the designed service packages delivered to reach intended targets?
- Has access by age, sex, equity and quality of key intervention services improved?
- Are there any structural, legal and cultural factors inhibiting or facilitating the delivery of service packages?

3. **Coverage with interventions - Achievement of targets**
- Has there been an increase in coverage of key intervention services, and has these reached targets?
- Is the targeting, coverage and utilization of interventions equitable across and within targets?
- What is the degree of integration of these services with services provided by the national health care system? HIV counselling and testing, HIV treatment, TB services, referral to specialized health services

4. Impact assessment
- Has there been a change in disease mortality/morbidity and/or incidence and prevalence, positive or negative?
- Has there been a change in outcomes and behaviours, positive or negative?
- Has there been an increase in coverage of key intervention services, and has these reached groups at risk?
- Have finances been disbursed for key services and contributors?
- Were there sufficient quality data to detect the effect of increase in service coverage and quality on disease burden? What were sources of bias?
- What was GF contribution in scale up of resources, increase of coverage of key intervention services, improvement of service quality and outcome? What were the other competing explanations and hypotheses of changes in outcomes and impacts, positive and negative?
- Are Global Fund HIV investments allocatively efficient?
- How can contributions of the Global Fund be improved to better contribute to outcomes and impact? What are the management recommendations?

4. Requirements for design of the evaluation

The evaluation should be based on assessing positive and negative impacts and outcomes. The evaluation should include investment in rigorous analysis, disaggregation of data by time, person and place including comparison groups where feasible, and using

mixed methods approaches. Analysis should assess explicitly competing explanations and sources of bias.
The evaluation should be designed to use qualitative and quantitative research methodologies including but not be limited to some of the following:

Desk review - Programmatic data, i.e., number and kind of services provided; size of population, people reached by the programme, by SW, IDU and MSM and geographic areas; facility data on services utilisation
- Financing data, i.e., committed budget, disbursement and expenditure against disease burden, by service delivery areas and geographic areas;
- Existing surveys and surveillances, and studies including peer-reviewed journal articles in English, Russian, Uzbek
- Population size by FSW, IDU and MSM and geographic areas, known factors facilitating and inhibiting the programme implementation; best practices from national programme and other international programmes.

- Based on the results of the analysis, develop an Action plan for in-country activities and additional data collection.

- Additional semi-structured interview
  - Define the type and quantity of data/information to be collected
  - Define the number and type of programme staff to be interviewed
  - Define the number and type of representatives of target populations/ groups to be interviewed
  - Define the number and type of relevant stakeholders to be interviewed
  - Develop the interview questions and train the interviewees on the purpose and process of interview.
  - Select the programme sites to be visited

- Data/information analysis:
  - Develop analytical plan for data and information collected
  - Conduct the data collection and analysis in accordance with the plan
  - Develop recommendations to increase effectiveness and achieve greater impact

- Report preparation and finalization, dissemination.
  - Draft the report and circulate for comments
  - Finalise the report
  - Abstract the key messages for target audiences: Ministry of Health – National HIV Programme, Country Coordinating Mechanism, Global Fund Secretariat, PR, Local Fund Agent, country partners

- Interviews with key stakeholders and staff involved in programme implementation including sub-recipients (programme implementation parties, community stakeholders and partners);

- Interviews with target populations and beneficiaries

This evaluation should be designed to cover 4 administrative locations (oblasts) in Uzbekistan (Tashkent city, Samarkand, Fergana and Khorezm oblast[74]).

[74] Proposed 4 oblasts have been selected by the UNDP based on the socio-geographical criteria and to ensure that all administrative sub-regions of the country are covered. Proposed oblasts can be changed by the evaluation team subject for UNDP agreement/approval based on the justifications provided by the consulting team.

A multidisciplinary team of consultants will carry out the above mentioned activities. All team members must be fluent in English or Russian. The team will be made of staff with expertise of:

- Advanced degree in public health, social science, development studies, gender or other field relevant to the topic;
- At least 5 years of experience in research and analysis of HIV prevention programmes, health projects or design and implementation of MARPs related programmes;
- HIV programme design and implementation;
- Extensive experience in health programme evaluations;
- Extensive experience in the field of HIV prevention, treatment, care, support, PMTCT, and HIV
- Experience in conducting surveys/interview;
- Familiarity with the Global Fund business model and ability to understand and interpret country basic macroeconomic data and indicators, particularly those related to government budgeting, including sources of financing for government expenditures.

Data collection activities should be carried in December-January, the first draft of analytical report should be submitted on January 30th, 2013.

The results of the evaluation should be summarised in a written report in English and Russian. A full, written summary report will be developed by the research team. The research team will present the report findings to UNDP Uzbekistan.

5. Deliverables

Deadlines for deliverables:

Inception report:	13 January 2013
Field visits and draft report:	06 February 2013
Final report:	17 February 2013

The evaluation reports in Russian and English will be submitted to the PR, Global Fund and the CCM. The report will contain:

- Title and opening pages
- Table of contents
- List of acronyms and abbreviations
- Executive summary
- Introduction
- Description of the intervention
- Evaluation scope and objectives
- Evaluation approach and methods
- Data analysis
- Findings and conclusions
- Recommendations
- Lessons learned
- Report Annex

ANNEX 2: BIBLIOGRAPHY / BACKGROUND DOCUMENTS

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Other documents and/or materials in Russian:

Medical questionnaire before blood donation (in Russian, in Uzbek Cyrillic and Latin)

Guideline on syndrome diagnostics and treatment (in Russian language).

MOH order No. 129 About expansion of operations to fight HIV-infection with focus to vulnerable groups and strengthening the work of Friendly cabinets. (In Uzbek and in Russian languages).

Leaflet about blood donation (publication in Uzbek language; From Fergana oblast Blood Bank Centre).

ANNEX 3: PEOPLE INTERVIEWED[75]

T A S H K E N T

UNDP / PMU

- Mr. Stefan Priesner, UNDP Resident Representative in Uzbekistan
- Mr. Jaco Cilliers, Deputy Resident Representative; UNDP
- Ms. Gayane Tovmasyan, Chief Technical Adviser; UNDP/PMU
- Mr. Zakir Kadirov Program Manager, UNDP/PMU
- Ms. Rakhima Nazarova, Prevention Coordinator; UNDP/PMU
- Mr. Alisher Makhkamov, Capacity Development Coordinator; UNDP/PMU
- Mr. Akmal Makhamatov, M&E Coordinator; UNDP/PMU
- Ms. Nadira Muratova, Public Health Coordinator; UNDP/PMU
- Ms. Olga Kim, Treatment Coordinator; UNDP/PMU
- Mr. Shakhruh Hushmuradov- Senior Procurement Specialist

MOH
Komil Mukhammedov- Head of Epidemiological Department, MOH

REPUBLICAN AIDS CENTRE / CCM

- Prof. Nurmat S. Atabekov, Director; Ministry of Health, Republican Centre to Fight AIDS & CCM (“MEC”) Chair
- Ms. Guzal Akramova, Manager; Secretary Multisectoral Expert Council (MEC)

UNFPA

Dilyafruz Khudaykulova, National Program Officer on HIV

UNODC

Nazokat Kasimova, National Program Officer
Borikhan Shaumarov- National Program Officer

GIZ
Ernesto Rabello - Program Manager
Dildora Azimova - National Program Officer

CDC

Shakhida Karamatova Country Team Leader

MOH / PIU

- Mr. Zabikhulla I. Inogamov, Manager, Programme Implementation Unit GFATM at Ministry of Health, Republican Centre to Fight AIDS
- Ms. Dildora Mustafayeva, Treatment Specialist; Programme Implementation Unit GFATM at Ministry of Health, Republican Centre to Fight AIDS
- Mr. Sergey Kargin, M&E Specialist Programme Implementation Unit GFATM at Ministry of Health, Republican Centre to Fight AIDS

[75] Last names of some people, e.g. outreach workers, have not been given to protect confidentiality

- Ms. Tursunoy Usmanova, National Expert on Monitoring and Evaluation Programme Implementation Unit GFATM at Ministry of Health, Republican Centre to Fight AIDS

STI INSTITUTES & CLINICS

- Dr. Alisher A. Abidov, Chief Venereologist; Ministry of Health, Republican Specialised Scientific-Practical Medical Centre of Dermatology and Venereology
- Ms. Olga Izvekova, Ministry of Health, Republican Specialised Scientific-Practical Medical Centre of Dermatology and Venereology
- Dr. Shakhida Djalilova, City's Chief Medical Specialist; Ministry of Health, Tashkent City Dermatology and Venereology Clinic *(meeting at a Friendly Cabinet in outskirts of Tashkent City)*

CENTRAL ASIA REGIONAL TRAINING CENTRE ON HIV/AIDS CARE AND TREATMENT

- Ms. Guzal Giyasova, Director of Centre

UNAIDS / UNICEF

- Mr. Denis Haveaux, UNAIDS Country Coordinator; *UNAIDS*
- Dr. Komiljon M. Akhmedov, National Programme Officer; *UNAIDS*
- Dr. Komiljon Karimov, HIV Specialist; *UNICEF*

PRICEWATERHOUSECOOPERS

- Mr. Davronbek Abdukarimov, Assistant Manager Assurance & Advisory; *PricewaterhouseCoopers*

MSF

- Dr. Ramesh Dahal, Project Coordinator/MD

ISTIQBOLLI AVLOD – MAIN OFFICE IN TASHKENT

- Ms. Mavjuda Ibragimova, Sub-project Coordinator; Istiqbolli Avlod
- Ms. Dildora Kaseva, Financial Expert; Istiqbolli Avlod
- Ms. Luisa Alijanova, M&E Specialist; Istiqbolli Avlod
- Mr. Almohamad Ibragimov, Coordinator Tashkent Oblast; Istiqbolli Avlod

TRUST POINT IN TASHKENT AIDS CENTRE

- *Not all names of those present could be recorded (approx. 8 people)*
- Mr. Boris Shelepov, Mental Diseases Doctor, Narcologist
- Mr. Ildar Ayupov, Outreach Worker
- Mr. Sergey, PLHIV Volunteer
- Ms. Elena Devyatova, Medical Doctor at Trust point
- Mr. Sergey K., PWID client
- Two outreach workers from NGO Intillish

NGO ISHONCH VA HAYOT OFFICE IN TASHKENT

- Ms. Victoria Ashirova, Project coordinator
- Mr. Vladimir Petrov, M&E Coordinator at Ishonch va Hayot
- Mr. Marat X, Social Worker at Ishonch va Hayot

- Ms Nadira X, Social worker at Ishonch va Hayot
- Ms. Nastya X, Social worker at Ishonch va Hayot
- Mahbuba, Social worker at Ishonch va Hayot

F E R G A N A

FERGANA REGIONAL (OBLAST) AIDS CENTRE

- Dr. Botir Kadirov, Head Doctor of Fergana Regional AIDS Centre

Fergana Red Crescent

- Albert Mustaev Director of the Blood Center, Fergana City
- Hursanoy Islamova, Fergana Oblast Red Crescent
- Ilhombek Yunusbekov Director, Red Crescent

KAMOLOT

- Sherzod Rakhimov, Head of Kamolot in Fergana
- Davlat Ruziev Program Coordinator, Kamolot
- Yoquthon Yarmatova, Trainer, Kamolot
- Mahmudali Kadirov, Trainer, Kamolot
- Meeting with 20 Kamolot volunteers

OFFICES OF NGOs OILA / ISTIKBOLLI AVLOD (partners)

- Akhunova Zulfiya, Coordinator
- Muminova Shahlo, MIS Operator
- Boltayev Bahadir, Outreach Worker
- Mamatova Arofat, Outreach Worker
- Jivih Olga, Outreach Worker
- Seven clients of outreach workers

UZBEK ASSOCIATION FOR REPRODUCTIVE HEALTH (UARH) & NGO INTILISH

- Kalandarova Nargiza Muhtarovna – Director of UARH
- Abdillaev Sharof, Regional Coordinator
- Shakhlo Muminova, M&E Specialist
- Mamadov Mahmud, Outreach Worker
- Jivih Nataliya, Outreach Worker, NGO Intilish, Fergana City
- Boltayev Bahadir- Outreach-worker of UARH

B U K H A R A

BUKHARA REGIONAL (OBLAST) AIDS CENTRE

- Dr. Nabiv Sharif, Head Doctor AIDS of Bukhara Regional AIDS Centre
- Mr. Rakhmonkul Bekmurodov, Coordinator Bukhara Region; Bukhara Regional AIDS Centre
- Mr. Suleiman Gadoyev, M&E Coordinator; Bukhara Regional AIDS Centre

MULTIDISCIPLINARY GROUP BUKHARA AIDS CENTRE

- Ms. Naderjda Vokhidova - Outreach Worker
- Ms. Gulmira Gubaidulina
- Dr. Sadiv R., Deputy Head of AIDS Centre
- Mr. Andrei Rakhmatov – Outreach Worker

ISTIQBOLLI AVLOD OFFICE BUKHARA

- Ms. Huseinova Abira Amanova - Coordinator
- Ms. Favzia Halmuradova Iliazova - Outreach Worker
- Ms. Feruza Halilova – Operator of MIS
- Ms. Mukhabat Kadirova - Outreach Worker
- Mr. Islom Sadulayev - Outreach Worker
- Mr. Alisher Rajabov -- Outreach Worker
- Ms. Marhabo Zahidova - Outreach Worker
- Ms. Lola Karimova - Outreach Worker

NGO MADAT (office) / INTILISH BUKHARA

- Mr. Bakhtior Samadov, Project Coordinator; NGO Madat
- Ms. Dilafruz Satorova, M&E Specialist; NGO Madat
- Mr. Bobir Sharipov, Outreach Worker at Trust Point
- Mr Alisher Mirhanov, Outreach Worker at Trust Point

MEETING AT TRUST POINT IN POLYCLINIC IN BUKHARA

- Mr. Alisher Rajabov, STI doctor (also met at Istiqbolli Avlod Office day before)
- Three people who inject drugs (anonymous)

SAMARQAND

SAMARQAND REGIONAL (OBLAST) AIDS CENTRE

- Ismatulla Djumaev, Head of AIDS Centre, Samarkand
- Zakir Umurzakov, Trust Point Assistant
- Meeting with three doctors at the AIDS Centre

NGO Istiqbolli Avlod

- Laziz Ikramov, Director of Samarqand NGO
- Muborak Kasimova, Coordinator
- Zarukh, Operator of MIS
- Ravshan Mamatov, Outreach Worker
- Ruslan Nasirov, Outreach Worker
- Alina Outreach Worker
- Soniya, Volunteer

NGO UARH/Intilish

Zamira- Director
Gulirano- Coordinator
Askar- MIS Specialist
Elmiyo- Narcologist

Ruslan, Outreach Worker
Artur, Outreach Worker
Meeting with 24 outreach workers

ANNEX 4: LIST OF GRANT SUBRECIPIENTS: 2012

	SR/Organization	Total Budget	Tranches (sum) 1st	2nd	3rd
Governmental Organisations					
1	Republican AIDS Center	525548[76]	118,078.73	127,073.00	152,637.00
2	SES	151,114	52,846.00	60,067.87	38,200.13
3	Institute of Dermatovenerology	26838	19,938.00	3,450.00	3,450.00
4	Institute of Haematology	62286	52,270.00	7,766.00	2,250.00
5	Institute Virology	20468	15,070.00	1,800.00	3,598.00
6	Central Asia ToT Center	184092	96,792.00	44,281.00	43,019.00
7	Republican Nurse training Center	81852	35,334.00	32,070.00	14,448.00
NGOs					
1	Intilish	443 558[77]	3,900.0	4,650.0	4,650.0
2	Ishonch va Hayot	71,256	13,166.0	13,920.0	13,170.0
3	Istikbolli Avlod SW	188,505	3,060.0	-	-
3	Istikbolli Avlod MSM	53,205			
4	Kamolot	99,062	40,435.0	22,650.0	35,977.0
5	Red Crescent Society	107,942	60,138.0	23,902.0	23,902.0
6	Anticancer Society	26,005	10,346.7	7,693.3	7,965.0
7	Women Committee	39,779	15,575.0	15,690.0	8,514.0
			536,949.4	365,013.2	351,780.1

[76] Out of 127 759,27 USD was administered by UNDP
[77] Transfer to SR Bank account 13200

ANNEX 5: PERFORMANCE AGAINST QUANTITATIVE TARGETS

From Grant Performance Report dated January 2013

Objective 1	To scale up Coverage and Increase Quality and Comprehensiveness of HIV prevention Services for Most-at-risk Populations (MARP)
SDA	Prevention: Behavioral Change Communication - Community Outreach

Indicator 1.1 - Number of IDUs reached through trust points and community outreach

	Target		Result		
	Period	Value	Period	Value	
Level 3-People reached	1	17,000	1	17,173	101%

Indicator 1.2 - Number of SW reached with HIV prevention services

	Target		Result		
	Period	Value	Period	Value	
Level 3-People reached	1	8,000	1	5,991	75%

Indicator 1.3 - Number of MSM reached with HIV prevention services

	Target		Result		
	Period	Value	Period	Value	
Level 3-People reached	1	1,200	1	1,409	117%

Indicator 1.4 - Number of young people reached by peer education

	Target		Result		
	Period	Value	Period	Value	
No Level	1	10,000	1	14,001	120%

Indicator 1.5 - Number of STI treatment courses provided in friendly cabinets

	Target		Result		
	Period	Value	Period	Value	
No Level	1	5,000	1	5,005	100%

Objective 2	To Scale up Treatment, Care and Support for People Living with HIV
SDA	Treatment: Antiretroviral treatment (ARV) and monitoring

Indicator 2.1 - Number of eligible HIV positive people receiving ART

	Target		Result		
	Period	Value	Period	Value	
Level 3-People reached	1	4,000	1	3,992	100%

Indicator 2.2 - Number of Opportunistic Infections (OI) treatment courses delivered

	Target		Result		
	Period	Value	Period	Value	
No Level	1	2,000	1	4,312	120%

Indicator 2.3 - Number of PLWHA and their family members benefiting from psycho-social support

	Target		Result		
	Period	Value	Period	Value	
Level 3-People reached	1	2,000	1	3,245	120%

Indicator 2.4 - Number and percentage of HIV positive pregnant women who have received ARV prophylaxis to reduce MTCT in accordance with nationally approved treatment protocol

	Target		Result		
	Period	Value	Period	Value	
Level 3-People reached	1	N: 500 D: 520 P: 96.2 %	1	N: 281 D: 281 P: 100 %	104%

Indicator 2.5 - Number and percentage of infants born to HIV positive mothers who received ART prophylaxis					
	Target		Result		0% 30% 60% 90% 100%
	Period	Value	Period	Value	
Level 3-People reached	1	N: 500 D: 532 P: 94 %	1	N: 279 D: 281 P: 99.3 %	106%

Objective 5	Enhancing capacities and systems on infection control for prevention of transmission, procurement, supply and management of health products and consumables for HIV prevention, diagnosis and treatment
SDA	HSS: Health Workforce

Indicator 5.1 - Number of people trained in infection control					
	Target		Result		0% 30% 60% 90% 100%
	Period	Value	Period	Value	
Level 1-People trained	1	80	1	95	119%

Indicator 5.2 - Number of people trained in voluntary blood donations					
	Target		Result		0% 30% 60% 90% 100%
	Period	Value	Period	Value	
No Level	N/A		N/A	Not Found	Cannot Calculate

Indicator 5.3 - Number and percentage of health facilities that meet the basic service capacity standards (in infection control)					
	Target		Result		0% 30% 60% 90% 100%
	Period	Value	Period	Value	
No Level	N/A		N/A	Not Found	Cannot Calculate

Indicator 5.4 - Number of health staff trained to deliver services					
	Target		Result		0% 30% 60% 90% 100%
	Period	Value	Period	Value	
Level 1-People trained	N/A		N/A	Not Found	Cannot Calculate

Indicator 5.5 - Percentage of health facilities dispensing antiretroviral therapy that have experienced a stock-out of at least one required antiretroviral drug in the last 12 months					
	Target		Result		0% 30% 60% 90% 100%
	Period	Value	Period	Value	
Level 2-Service Points supported	N/A		N/A	Not Found	Cannot Calculate