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CASE STUDY: THE DIALOGUE ON HIV AND TUBERCULOSIS PROJECT, KAZAKHASTAN

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The Health Finance and Governance Project

USAID's Health Finance and Governance (HFG) project helps to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. The five-year, \$209 million global project is intended to increase the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG supports countries as they navigate the economic transitions needed to achieve universal health care.

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ACRONYMS

CFIR	Consolidated Framework for Implementation Research
HFG	Health Finance and Governance Project
HSS	Health system strengthening
HTC	HIV testing and counseling
IDU	Injection Drug Users
IEC	Information, Education, Communication (Materials)
IOM	International Organization of Migration
KP	Key populations
MDT	Multidisciplinary team approach
MoH	Ministry of Health
MSM	Men who have sex with men
PLHIV	People living with HIV/AIDS
PSI	Population Services International
PWID	People who inject drugs
QHPC	Quality Health Care Project
REP	Replicating Effective Programs
SW	Sex workers
TAG	Technical Advisory Group
TB	Tuberculosis
TRaC	Tracking Results Continuously
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

USAID's Health Finance and Governance project (HFG) contributes to USAID's assistance to countries to deliver key health services and builds the evidence base around health systems strengthening (HSS). Under HFG's research portfolio, a series of retrospective, qualitative case studies were undertaken to understand the dynamics of successful HSS interventions by focusing on how HSS projects were implemented. This report presents the results for one of the five cases: Dialogue Project on HIV/AIDS and TB in Kazakhstan (2009-2015).

Dialogue was led by Population Services International (PSI) with support with support from AIDS Foundation East-West, Project HOPE, and the Kazakh Association for People Living with HIV/AIDS. In addition to this, nine different local NGOs were awarded sub-grants to implement various components of the project. Dialogue conducted trainings with local government officials, journalists, pharmacists, and medical providers on service delivery issues for key populations (KPs) as well as addressing persistent social problems such as gender-based violence. Importantly, Dialogue was part of a bifurcated strategy to address escalating HIV and TB epidemics through USAID's Central Asian Mission. The other project, Quality Health Care Project (QHCP), was an important partner, with an explicit focus on health systems strengthening. Though they were not identified in the case study selection process, their interaction with the more service-delivery-oriented Dialogue project was seen as crucial to sustainable implementation. While this case study was not analytically equipped to disentangle the effects of QHCP vs. Dialogue, it is important to note that this nuanced approach to regional planning was likely a key aspect of effective health systems strengthening.

Though Dialogue was implemented as regional project in five Central Asian countries, this case study focuses specifically on Kazakhstan, which represented approximately 20% of the overall project cost. This included an initial funding of \$3.04 million of the \$14.8 million regional project and received a total obligation of \$3.8 million out of \$19.8 million by the end of the project. While declines in funding for Kazakhstan were reported during the project, these were accommodated by the increased financial presence of the Global Fund Round 10. Despite this, actors seemed to think that the level of funding was adequate for implementation of the full package of outreach and support services delivered by the project.

Dialogue focused on reducing the spread of HIV and TB epidemics in Central Asia by improving health behaviors among KPs (i.e. people who inject drugs, sex workers, men who have sex with men, prisoners, people living with HIV/AIDS, and migrants). This was accomplished by focusing on three broad areas, including supported outreach to KPs, improved evidence-based decision-making, and improvements to the continuum of care. The backbone of this approach was delivery of a targeted package of services to KPs, through one of six different outreach models. Some of the services included in these outreach efforts were 1) information on HIV, 2) oral presentations on TB preventative methods (individual or group counseling, sessions/ mini-sessions), 3) referral of KPs for HIV and TB testing and counseling, 4) referral to drug treatment, 5) distribution of information, education, and communication material 6) condom distribution, 7) motivational interviewing, 8) case management for adherence to treatment, 9) TB community adherence support. While the project centered on service delivery, one of

the themes that emerged from the analysis was that effective implementation touches on other aspects of health systems that can lead to sustainable improvements.

Implementation of the Dialogue Project was facilitated by a number of important factors related primarily to project design and the complex dynamics among actors. First, there existed reliable epidemiological data with which to accurately diagnose the problem of growing HIV and TB epidemics in Central Asia, and implementing partners were intimately acquainted with evidence-based models for delivering outreach services to KPs. Second, the prior lack of political priority for addressing the needs of KPs created ample space for USAID to develop a sizable program of work to be implemented by partners that were familiar with each other. Third, Dialogue focused on generating high-level political support from a wide array of entities throughout its lifespan. While some of this is attributable to the strategic vision of USAID's regional mission, Dialogue used technical working groups and regional committees to monitor and respond to changes in implementation, which created a degree of ownership for the portfolio across government, civil society, and other community stakeholders. Fourth, while the focus of implementation was on the delivery of outreach services to KPs, the project worked through multidisciplinary teams, 9 sub-grantees NGOs, multiple implementing partners, the Department of Health, and republican AIDS Centers to strengthen the working dynamics among partners. Not only was the capacity of local NGOs strengthened, but several of the project tools were reportedly adopted by republican AIDS centers and are now included in national treatment protocols. Furthermore, the capacity of health professionals and the media to accommodate and understand the challenges faced by KPs in seeking treatment were reported to have effects that extended beyond the life of the project. By planning for sustainability and implementing effectively, the project was able to report on the multiple ways in which it served to strengthen the health system.

Despite these facilitators, a number of challenges, primarily with the enabling environment and implementation climate, were present throughout project implementation. Some of these challenges included stigma towards KPs, vertical service delivery systems, funding changes, and coordination/cooperation amongst multiple implementing partners. In addition to these broad challenges, project staff identified a number of smaller operational issues, such as branding requirements by USAID, difficulties in recruiting local implementing NGOs in some regions, bureaucratic services to migrants, staff turnover, and language difficulties. These problems were all seen as surmountable and did not interfere with the ability of the project to achieve its objectives.

Dialogue achieved a number of positive outcomes. The project reached a total of 34,810 KPs from 2009-2015. Over the life of the project, 5,050 KPs were referred to HIV testing and counseling (HTC) services and now know their HIV status. A total of 4,499 KPs were referred to diagnostics over this time period as well. Another key achievement was the training of KPs as outreach peer educators, of which 527 were trained to provide outreach services in "hot zones". There were also important behavioral health impacts of the project amongst KPs in Kazakhstan. For example, people who inject drugs had a significantly higher proportion of HIV testing and counseling utilization (87.4% vs. 48.1%, Odds Ratio (OR)=7.3, $p<.001$). Similarly, those involved with the project were more likely to use condoms with regular partners (47.9% vs. 27.6%, OR=2.0, $p<.05$) and seek TB testing (87.1% vs. 73.8%, OR=2.1, $p<.05$). Sex workers who participated in the project were also more likely to utilize HIV testing and counseling than other sex workers (88% vs. 74%, $p<.01$). Also, men who have sex with men and were project participants reported safer sexual behavior than other men who have sex with men (84.4% vs. 11.5%, $p<.001$). The multidisciplinary team approach conducted at three project sites resulted in 82% of TB patients continuing antiretroviral treatment. These statistics demonstrate that participation in the project had a strong effect on improving reported health behaviors among KPs.

While it remains debatable whether Dialogue can be classified as a true health systems strengthening project, this research demonstrates two important features of effective health systems strengthening.



First, the combination of Dialogue Project with QHCP as financed through USAID's Central Asia Mission is an example of how seemingly intractable problems can be tackled through coherent project design and nimble project coordination. Second, the experience of Dialogue Project demonstrates that excellence in implementation, including actor engagement and adaptability, necessarily generates positive effects that serve to strengthen other dimensions of health systems. In this way, the Dialogue Project was a strong example of how a shared vision, through effective collaboration, can be transformed into measurable behavioral health outcomes and improved health systems performance.

I. INTRODUCTION

USAID’s Health Finance and Governance (HFG) project helps to improve health in developing countries by expanding people’s access to health care. The project team works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. HFG’s research portfolio enhances the ability of USAID to assist countries in delivering priority health services while simultaneously contributing to the global pool of knowledge on health systems strengthening (HSS).¹

Under this research portfolio, the “Understanding the Dynamics of Successful Health System Strengthening Interventions” study seeks to bring into better balance our focus on “what works” in HSS with “how HSS works” to improve the performance of future HSS efforts. Our aim is to examine the dynamics of HSS project implementation, not to examine the cases as models for HSS interventions. We are pursuing this goal by initially conducting a set of six qualitative, retrospective case studies of successful USAID-supported HSS interventions and then producing a cross-case analysis to draw common patterns across cases.

The aim of this study to address four key questions:

1. How were a range of successful HSS interventions implemented in different countries?
2. What factors facilitated and constrained the successful implementation and documented outcomes of the interventions?
3. What were important factors about implementation that emerged across the different cases?
4. What are the implications of this study for future of implementing HSS interventions?

We chose six cases to examine a small sample of successful HSS initiatives in different places under different conditions and with different features in an attempt to tease out some of the policy setting, adoption, and implementation factors and processes that matter. While we remain attentive to the range of complex factors that affect success, we seek to distinguish those factors that decision-makers and implementers can control or influence. In so doing, we hope to develop and provide recommendations for adapting and sustaining HSS reforms in low-income countries.

This report presents one of the six case studies – on the Dialogue Project on HIV/AIDS and Tuberculosis in Kazakhstan. In Section 2, we describe the study methods. In Section 3, we present the contours of the context in which the intervention was implemented, basic information on the intervention, how it was designed, and its outcomes. In Section 4, we describe implementation process for the intervention, including implement groundwork, key features of implementation process, and how

¹ As defined by the World Health Organization, we define HSS interventions as those that implement “changes in policy and practice in a country’s health system” and improve “one or more of the functions of the health system and that leads to better health through improvements in access, coverage, quality, or efficiency” (WHO 2011: 9). HSS interventions are horizontal approaches that can address the root causes of health system constraints and impact multiple issues, rather than vertical service- or disease-specific interventions like health system support programs (Travis et al. 2004: 903).



the intervention was sustained and disseminated. Finally, in Section 5, we present our synthesis of the primary factors that influenced the intervention's implementation and contributed to its success.

2. METHODS

The study, comprised of six case studies and cross-case analysis, was conducted in several phases, each of which is briefly described in turn. For a more detailed explanation of our case selection process and methods, please see (Conrad et al. 2016).

2.1 Design and implementation

In the first phase of the study (October 2015-March 2016), we finalized the design and began implementation, which involved engaging USAID and selecting the case studies.

2.1.1 Design

The aim of this study was to address four key questions:

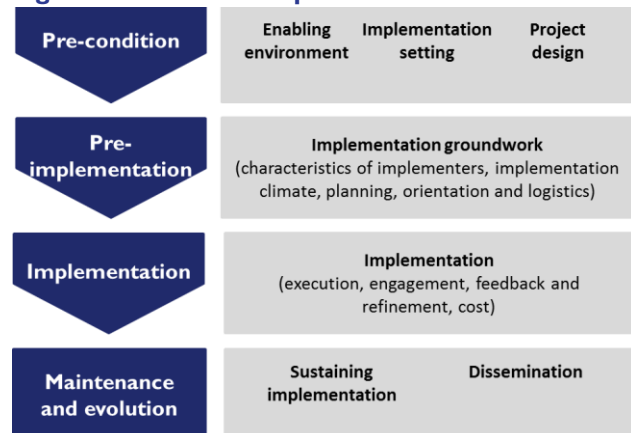
1. How were a range of successful HSS interventions implemented in different countries?
2. What factors facilitated and constrained the successful implementation and documented outcomes of the interventions?
3. What were important factors about implementation that emerged across the different cases?
4. What are the implications of this study for future of implementing HSS interventions?

To answer these questions, we designed a protocol to conduct retrospective, qualitative case studies. We used an implementation framework to guide the case studies. Our primary aim for applying the implementation framework was to determine which factors influence implementation that we needed to collect data on and consider during analysis. We combined two implementation frameworks to apply in this study – the Consolidated Framework for Implementation Research (CFIR) (Damschroder et al. 2009) and the Replicating Effective Programs (REP) framework (Kilbourne et al. 2007). Both CFIR and REP are based on implementation theories and empirical evidence of what affects the successful implementation of health interventions. We used CFIR to more broadly frame the intervention and we used REP as a framework that focuses on project implementation process. Figure 1 outlines the combined framework. See Annex A for detail.

As we assessed each implementation domain and factor, we also explored:

1. Decision-making processes associated with design and adoption of the intervention;
2. How the intervention was implemented, including how potential challenges or obstacles were addressed;
3. Expected and unexpected outcomes of the intervention, both positive and negative; and

Figure 1 Combined Implementation Framework



4. Prospects for sustainability of the intervention, such as the degree to which the project activities have been institutionalized in the country.

Before we finalized the design, the team submitted the study design and data collection instruments to Abt’s Internal Review Board (IRB) and JHSPH’s IRB for review. Abt’s and JHSPH’s IRB exempted the study from review.

2.1.2 Implementation

To ensure that the case studies were of practical relevance, we set up a Technical Advisory Group (TAG) composed of experts and representatives from inside and outside USAID Bureau of Global Health to consult with on the study and provide expertise.

This case was selected for study from USAID’s 2014 Global Call for Health System Strengthening Cases using a defined set of criteria and a systematic review and sampling process that we developed. The case was purposively selected from the available pool and the case is not representative or necessarily the most successful HSS project implemented in the region. Our objective in the case selection was to purposively select 6 cases from the 143 cases submitted to USAID’s 2014 Global Call for Health System Strengthening Cases that are successful, robust examples of health system strengthening interventions.

The reviewers engaged in a multi-stage sampling process consisting of four sequential selection rounds that excluded cases that did not meet the specified criteria in each round using the identified available data and the predetermined review method. The 4 selection rounds were as follows:

1. **Round 1:** Reviewers considered only those interventions that were fully implemented before the start of the selection process.
2. **Round 2:** Reviewers accepted the submitter’s self-reported definition of health systems strengthening, labeled the intervention “provisional,” and sought a determination of an “effective” intervention.
3. **Round 3:** Reviewers applied criteria to determine whether a provisional, effective health system strengthening intervention could be confirmed as health system strengthening.
4. **Round 4:** Reviewers applied criteria to determine whether a confirmed, effective health system strengthening intervention was robust (see Figure 2).

Figure 2 Dialogue Project Qualifying HSS Criteria

Round	Criteria	Inclusion criteria	How met criteria
1 (implementation period)	Implementation completed	Submission states implementation period was completed by 10/2015	2015, March
2 (impact and evidence)	Effective intervention	One of 13 identified types of interventions referenced	Health worker training to improve service delivery; Service integration; Strengthening health services at the community level; Voucher programs
	Health systems outcome	One of 4 health systems	Uptake of healthy

		outcomes referenced	behavior
	Health impact	Health impact referenced	Reduced morbidity and mortality
	Both health system outcome and health impact	At least one health system outcome and health impact referenced	Yes
	Verification of health impact and health system outcome achieved	One type of documentation is referenced for at least one health impact or health system outcome	Project M&E data
3 (HSS)	Multiple primary disease targets	At least 2 diseases targeted referenced	HIV, TB
4 (robust HSS)	Multiple health system functions and sub-systems targeted	At least 2 HSS WHO building blocks targeted and at least 2 sub-systems functions targeted	Building blocks: Service delivery, Human resources for health Sub-systems: Human resources for health, Service delivery, Governance, Information
	Verification that intervention was successful HSS intervention	Intervention had health system outcome, health impact and targeted multiple diseases and health system functions	Yes
	Category D for HSS intervention type	Based on typology of HSS we developed, case addresses at least 2 health system functions and at least 3 sub-systems	Yes
	Category E for HSS intervention type (not inclusive of D)	Based on typology of HSS we developed, case addresses at least 2 health system functions and at least 4 sub-systems	Yes

2.2 Data collection and analysis

In the second phase, we conducted the case study research. We divided the case studies among our team members so that no team members conducted research on a project that their organization implemented. The case teams collected both primary and secondary data on retrospective (features 1-3 above) and prospective (feature 4 above) data that are described in more detail below. As applicable, we collected primary and/or secondary data on each implementation factor and domain.

For primary data collection, we conducted individual interviews with key informants who possessed in-depth knowledge of the history and workings of the HSS intervention. We followed a common semi-structured interview guide for the interviews, but adjusted the questions posed as applicable for the respondent and their role in the project (see Annex B for the interview guide). We documented each interview through verbatim notes and audio recordings. We interviewed 7 key informants for this case

study. Six interviews were conducted in English and one was conducted in Russian. Informants included representatives of USAID’s implementing partners who sponsored the intervention, and USAID mission staff with knowledge of the intervention.

The research team imported the interview notes into NVivo 11, qualitative data analysis software package, for coding and analysis. Analysts applied a single codebook developed prior to beginning the coding process and refined by coding a small sample of interview notes from several cases. The codes were informed by *a priori* concepts based on the domains and factors from the combined CFIR and REP implementation frameworks. To accommodate unexpected or context-bound themes and concepts emerging from the data, the codebook included a ‘family’ for each case to allow for inductive coding as needed for each specific country or intervention. We applied this common codebook for the purposes of reliability, quality control, and comparison across interview respondents and eventually across case and country contexts.

Once coding was complete, the analysts conducted iterative, exploratory analysis in NVivo using text analysis techniques (e.g., repetition, similarities and differences, word frequency, word co-occurrence, semantic network analysis, etc.) to explore themes, patterns, outliers, and trends, and conflicts between and among data sources.

We reviewed secondary data capture different features of the intervention and contextualize the intervention. We conducted document review of the relevant published and unpublished documents about the intervention that we were able to obtain. To review the documentation on each case, we filled out a common document abstraction template (in an Excel spreadsheet) to systematically review the documents and synthesize salient data. Abstraction categories reflected domains from our combined CFIR and REP frameworks. We also conducted a focused literature review to identify the key contextual factors (e.g. socio-cultural, political, economic, etc.) relevant to the case and existing evidence about barriers to and success of health system strengthening and reform in the country. We used the literature and document reviews to build on and verify the interview data where possible and applicable (bearing in mind that written documentation represents the official record). We analyzed the findings from the literature and document reviews in conjunction with analysis of the primary data. We uploaded the document abstraction forms in NVivo for coding and analysis with the interview data.

The research team ensured the reliability and validity (both external and internal) of our qualitative research in a several ways. We revised our semi-structured interview guide and record review forms based initial use. We used experienced researchers and held team meetings to ensure that all team members had a consistent and thorough understanding of the research goals and intent behind each question and probe. We further used consistent data documentation procedures and structured, systematic analysis techniques using qualitative analysis software (e.g., NVivo) to ensure reliability, quality control, and cross case comparisons. Further, we triangulated primary qualitative data with secondary data to improve the validity of findings from primary data. Finally, we conducted member checking by asking a key informant, usually the project’s Chief of Party, to review and comment on the case narratives regarding coherence and validity. We also had a TAG member review each case narrative to provide further expert review. We then finalized the case narratives based on this feedback.

2.3 Cross-case analysis

In the third phase of the study, we analyzed this and the other five descriptive case study narratives from Phase 2 to help generate explanations for successful HSS interventions. The cross-narrative analysis of Phase 3 sought to build or strengthen the evidence base for the “how” and “why” of what works in HSS by determining which implementation domains and factors from the implementation framework

influenced the success of the interventions. We looked for common and divergent factors that were present or absent across cases and contexts, and we tried to determine the relationships between the implementation factors and domains based on our findings. As an exploratory study, we hope these findings can provide some comment on the factors that may be associated with successful HSS implementation and inform future studies of HSS interventions.

3. FINDINGS

The findings presented here concern implementation of the Dialogue Project on HIV/AIDS and Tuberculosis in Central Asia, supported by USAID. This project was overseen by the Central Asia Regional Mission. The study team chose to focus specifically on the experience of a single country within the Dialogue Project: Kazakhstan. This distinction was somewhat blurred in the following analysis as many interview participants referred to multiple countries in their views on the Dialogue Project. In addition, some interview participants referenced interactions with the concurrent USAID Quality Health Care Project as a critical partner in health system strengthening. While the lessons on health systems strengthening transcend these distinctions, they are nonetheless important to note before proceeding.

In this Section, first we outline the relevant features of the context within which the intervention was implemented, including key features of the socio-economic context, political system, and health system. Second, we first describe the basic features of the intervention, including its primary goals, activities, design, and timeline. Third, we outline the main outcomes and impacts of the project. Fourth, we describe the implementation process, beginning with the implementation groundwork, implementation itself, and then how the project was sustained and disseminated.

3.1 Pre-conditions

3.1.1 Problem definition

The Dialogue project was designed as a regional program to address the high incidence of HIV/AIDS and Tuberculosis (TB) in Central Asia. In 2011, for example, Kazakhstan had the second highest percentage of Multiple Drug Resistant-TB cases among incident TB cases (30% vs. the global average of 3.7%) (Hermosilla et al., 2015). Despite recent advances in HIV/AIDS treatment, Central Asia faces one of the fastest growing HIV/AIDS epidemics in the world (Ancker & Rechel, 2015). Both epidemics are highly associated with risky behaviors in key populations (KPs), such as injection drug users (IDUs). Kazakhstan has one of the world's highest rates of IDU, with estimates as high as 10% of the population in some regions (Hermosilla et al., 2015). Furthermore, despite its relative wealth, research has shown that lifestyle decisions in Kazakhstan contribute to poorer health status than in neighboring countries, such as Kyrgyzstan (Cockerham, Hinote, Abbott, & Haerpfner, 2004). In this epidemiological context, donors such as the US government, found significant scope for leveraging existing partnerships to address HIV/AIDS and TB in the communities driving the epidemics.

Interview respondents were somewhat mixed in their views of whether or not epidemiological evidence was used to define the problem. As one implementer (Kazakhstan 01) commented, *“I don't think there was evidence. It was just well recognized. We did baseline research within the program. It is a problem in our Central Asia countries.”* Another implementer (Kazakhstan 04) thought that the Dialogue Project operated from a clear problem informed by evidence: *“This came from epidemiological situation from the study results that were conducted by [International Organization of Migration] and other researchers. Because relating to HIV, the problem that for example according to IOM studies, nearly 30% of migrant workers have risky sexual behaviors in the host country.”* A USAID employee (Kazakhstan 06) speculated further, *“I don't know because that started before me, I assume because the HIV rates are high among key populations and usually government doesn't want to prioritize that since it's usually injecting drug users, so I assume USAID was*

trying to fill a gap in the HIV prevention services at the time.” Regardless of whether or not evidence was used in defining the problem, there seemed to be consensus, at least among the donor community, that the growing burden of HIV/AIDS and TB in Central Asia required immediate attention.

3.1.2 Enabling environment

The Dialogue Project was heavily influenced by the enabling environment, including socio-economic context, the political system, and the health system in Kazakhstan as well as other Central Asian countries.

Interview respondents frequently mentioned the persistent challenge of working with marginalized communities in states with strong authoritarian legacies in Kazakhstan and in other Central Asian countries. As one implementer (Kazakhstan 02) explained, “I think the major challenge in each country was the legislation and the general population attitude, all the stigma and discrimination in the society.” Others suggested that the fragmented system of care under the former Soviet Union played a role in distancing decision-makers and government officials from the needs of the less fortunate:

“[...] this terrible politics between countries where you have former Soviet stigma carry over, the bureaucracy, the ‘put them in prison mentality’, the angry advocates versus the political elites who would be happy to let everybody die. This is a terrible challenge.” (Kazakhstan 05 Implementer)

Implementers, in particular, faced significant challenges in garnering support from local officials on account of the pervasive influence of stigma for the KPs the Dialogue Project was designed to accommodate. One implementer described how the tacit support they received to implement the Dialogue Project was incentivized by the project’s funding rather than support for the KPs.

“Sex workers, drug users, prisoners, MSM – all these people, not just marginalized, they’re just deleted from daily life in these countries. They’re nowhere. You can’t hear any official report or presentation that they address these people or that these people even exist. They do not exist, they are invisible. Suddenly Dialogue project started working with these unwanted, let’s say dirty, invisible people. Of course, [...] they support the project because of course it’s a lot of money invested in their countries and of course it’s the US government [...] You can feel it in daily implementation. You can feel the barriers.” (Kazakhstan 02 Implementer)

Others argued that Kazakhstan is somewhat different on account of geography, economic wealth, and position within Central Asia. According to one implementer Kazakhstan is “more open and secular” than the rest of Central Asia.

“It’s just different dynamics[...] As you’re moving into middle income status and it’s not overpopulated, it’s largely urban, it’s got fairly open press, the family planning rates are higher, it’s a more open society.” (Kazakhstan 05 Implementer)

Another key feature of the enabling environment for Dialogue Project in Kazakhstan was the external politics of aid coordination and the internal politics of the health system. In this respect, Dialogue Project was developed as a component of a bifurcated strategy by USAID’s Central Asian (regional) Mission to address the growing HIV and TB epidemics. It seems clear that one project, the Quality Health Care Project (QHPC) was specifically designed as a health systems strengthening project and the Dialogue Project was to remove the barriers to entry for marginalized populations to access care within the system. Though QHPC was not identified in the case study selection process, the strategy, and its strong emphasis on sustainable health systems strengthening, was reflected in the role Dialogue Project ultimately fulfilled.

“[We] understood for HIV prevention in Central Asia, you needed a front line. You can call it outreach or whatever. We called it a front line. It didn’t exist because there wasn’t a lot of civil society[...]But the other part of the deal is Dialogue was good on this and understanding that the regular army has got to come up. Or just like in a military comparison, you’re going to get overrun on this front line, it’s not sustainable. You’re just out there. It’s very risky to be out there with no system support and no money except for donors, and everything else. We understood those dynamics and we even had a model we discussed between us, it really became more QHCP’s strategy, but we worked closely with Dialogue.”
(Kazakhstan 05 Implementer)

In addition to this, both projects entered Kazakhstan, as well as other Central Asian countries at a time when there was considerable dysfunction among stakeholders in the health system. In this respect, these projects were designed to implicitly address coordination and mistrust in the health sector.

“[...] there was an enormous problem to create and support NGOs. The dynamics were miserable; in Central Asia they were probably worse than most because there was a system there. We have to understand that the system, including HIV centers, hated INGOs because they’re paid a lot more, they’re flexible, they can float around and do their thing.” (Kazakhstan 05 Implementer)

Thus the environment in which Dialogue Project operated, including stigma for its beneficiaries, regional variation in systems functioning, and dynamics amongst actors, had a sizable bearing on both the tone and implementation of the project.

3.1.3 Implementation setting

Related to the broader enabling environment in which Dialogue Project operated were particular contextual features of the implementation setting, including characteristics of the government employees as well as the implementation climate that influenced the set of interventions to be delivered.

While several respondents reported that the government was not supportive of the project’s target populations, not all respondents felt that cooperation with government officials was negative. On the contrary, one implementer was able to provide a specific example of the ways in which a government employee enthusiastically contributed to the project’s outreach efforts.

“First I found high level of commitment of the head of [one of the] TB Control hospitals and he was very committed to working among migrants. He had deep knowledge of link between migration and TB and understood importance of working with migrants on TB and providing treatment in Kazakhstan. ... We found by his own initiative, he organized, with the health authorities, health fairs in markets where majority of traders were foreigners from Uzbekistan, from Kyrgyzstan and they joined this initiative conducted and outreach work and informational sessions. Some cases of TB were detected during this campaign. It was very useful and effective cooperation.” (Kazakhstan 03 Implementer)

Another interview participant also pointed out that the “legacy of Lenin” in the former Soviet Union favorably affected the project’s implementation because there were relatively strong health information systems and reporting structures in place. While these systems were helpful, however, the influence of stigma at times undermined activities, as one implementer (Kazakhstan 05) explained, “The stigma came from the system, a little in Kazakhstan, a little more in Kyrgyzstan, and a lot in Tajikistan. You can’t integrate into a system that is the major purveyor stigma.”

One challenge frequently identified was the ability of the project to work with local officials to integrate care for migrants specifically. “Countries were very supportive. I don’t remember very big challenges. The referral system didn’t work enough in all countries. [...] Like government budgeting mechanisms and budgeting treatment for people without IDs. It’s mostly about migrants [...]” (Kazakhstan 07 Implementer). Another respondent further elaborated on addressing this challenge:

“At the same time we faced structural barriers. Like when I approached Almaty AIDS Control Center and I asked for condoms for migrants they said they can’t distribute among foreign citizens. They also had problems working with sex workers who are also often from foreign countries. It’s the point we discussed with them, like working with sex workers, they agree to provide HIV diagnostic without indicating any names or place of birth. I remember sex workers and other vulnerable groups, they used voucher to have access to HIV diagnostic and treatment. Even foreigners had access to treatment (Kazakhstan 03 Implementer)

Finally, the implementation setting was also influenced by the nature of the work and the challenges program staff faced on a daily basis. These included the personal emotional and physical toll of HIV/AIDS on the lives of outreach workers, the challenge of reaching KPs, and the difficulty of stepping back from outreach to work on broader health system strengthening. As one respondent soberly explained:

“Even the nature of the NGOs and their dynamics. Not so much their sustainability but there’s a lot of personal tragedy in why people started these NGOs. There’s a lot of really tragic stories so it’s tough to make your way through that and focus on the bigger point[...]It doesn’t cloud their judgement but it makes it harder. It’s like you have a training but people are in the hospital or they died, or people won’t come to certain places and show their face. To get people out of hiding literally was very difficult. It isn’t easy to step back and do this broader health systems strengthening. You’re really on the front lines and you dig in and try to hold on. It’d hard to find the energy for that when you’re working with NGOs and are on the front lines emotionally if I can put it that way. [...] We did training on just how to communicate with people, you were just always struggling to get people to come and you’re just dealing with the underworld basically.” (Kazakhstan 05 Implementer)

3.1.4 Project features and design

The project’s goal was to reduce the spread of HIV and TB epidemics through improvement of health behaviors among key populations (KPs) throughout Central Asia in Kazakhstan, Kyrgyzstan, Tajikistan, Uzbekistan, and Turkmenistan. KPs most at risk of contracting HIV and TB were targeted, which included people who inject drugs (PWID), sex workers (SWs), men who have sex with men (MSM), prisoners, people living with HIV/AIDS (PLHIV), and migrants.

A PSI-led consortium implemented the project from 2009 to 2015 (see Figure 4). Project implementation in Kazakhstan occurred at six key sites: Almaty city, Almaty Oblast, Karaganda, Temirtau, South Kazakhstan and East Kazakhstan (Ust-Kamenogorsk) (see Figure 6). From year four, target sites were reduced from six to two on account of changes in funding for Kazakhstan, which we address below.

Project Profile

Title: Dialogue Project on HIV/AIDS and TB

Period: 10/2009 – 8/2015

Funding: USAID

Budget: \$3.04 million (Kazakhstan), \$14.8 million (project)

Prime contractor: Population Services International (PSI)

Sub-contractors: AIDS Foundation East-West, Project HOPE, Kazakh Association for people living with HIV/AIDS

Local implementers: 9 different local NGOs

Focus: Treatment and support for HIV/AIDS and TB in key populations



Figure 3 Implementer Roles in Kazakhstan. Source: (PSI, 2009)

Organization	Technical Role
PSI	<ul style="list-style-type: none"> • Technical lead on HIV outreach and continuum of care • Conduct TRaC surveys • Build capacity to use data effectively among local partners • Build capacity of local NGOs in outreach to MSM, SWs, IDUs and migrants
Project HOPE	<ul style="list-style-type: none"> • Technical lead on TB outreach and continuum of care • Build capacity of all partners to integrate TB messages into HIV outreach • Participate in IEC/BCC TWGs to coordinate between HOP and NCSs • Work with health providers to better meet the needs of KPs • Train community leaders to support TB case detection and treatment adherence
AFEW	<ul style="list-style-type: none"> • Implement outreach to prison populations • Build capacity of local NGOs reaching PLWH in social support services • Train project partners in integration of client management model into outreach
Kazakh Association of PLWH	<ul style="list-style-type: none"> • Coordinate and monitor outreach activities to PLWH in Kazakhstan • Provide technical assistance to local NGOs reaching PLWH in improving continuum of care services

Figure 4 Dialogue Project Intervention Timeline in Kazakhstan

Year	Event
2009	Pilot studies, NGOs identified, awarded grants, trained
2010	Full implementation
2011	Full Project implementation
2012	Funding decreased for Kazakhstan, sites reduced and covered by The Global Fund Round 10; IOM begins migrant outreach work
2013	Activities in Kazakhstan close or are institutionalized through local support

The primary objectives of the project were:

- HIV transmission risk behavior reduction
- Increased use of evidence-based HIV prevention
- Increased TB treatment service use by KPs
- Improved TB case detection among selected KPs
- Improved adherence to, and decreased default rate from, TB treatment among KPs

This was achieved by focusing on three broad domains:

- Supported outreach to vulnerable groups
- Improved evidence based decision making
- Continuum of care improvements

This was achieved largely through the delivery of a targeted outreach package of services to KPs. This package was used different models to reach different types of KPs (see Figures 2). Some of the services included in these outreach efforts were 1) information on HIV, 2) an oral presentation on TB preventative methods (individual or group counseling, sessions/ mini-sessions), 3) referral of KPs for HIV and TB testing and counseling, 4) referral to drug treatment, 5) IEC material distribution, 6) condom distribution, 7) motivational interviewing, 8) case management for adherence to treatment, 9) TB community adherence support. For more information on the outreach models, please see Figure 5 below.

The project conducted outreach with KPs and engaged in capacity building with multiple stakeholder groups. The project reached a total of 34,810 KPs during this time period. Over the life of the project, 5,050 KPs were referred to HIV testing and counseling (HTC) services and now know their HIV status. A total of 4,499 KPs were referred to diagnostics over this time period as well. Another key achievement was the training of KPs as outreach peer educators, of which 527 were trained to provide outreach services in “hot zones”. All nine sub-grantee NGOs were trained in programmatic, financial, and administrative management. In addition to strengthened management capacities, the relationship between these NGOs and the local government was reportedly strengthened through the Dialogue Project’s work in Kazakhstan. Journalists (n=38) participated in workshops hosted by the project to receive accurate and non-stigmatizing information on HIV and TB. Similarly, 70 pharmacists were trained to recognize TB symptoms in clients and refer them to appropriate testing facilities instead of simply selling anti-TB medications without prescriptions. A total of 360 medical providers were trained in city polyclinics, tuberculosis dispensaries, and AIDS centers at target sites in Kazakhstan. This training included HIV and TB stigma and discrimination, interpersonal communication, the voucher referral system, and interpersonal counseling skills. Finally, 65 individuals were trained to conduct gender-based violence (GBV) prevention activities, which reached 1,563 participants over the course of the project in Kazakhstan.

Figure 5 Outreach Model by KP in Kazakhstan. Adapted from: (PSI, 2015)

Key Population	Model	Description
People Who Inject Drugs (PWID)	“Break the Cycle” (BTC)	This HIV prevention model aimed at people who are injecting drugs, the model encourages PWID to abstain from injecting in front of non-injectors, lessen discussion about injection with those who are at risk of trying it, refrain from teaching non-injectors to inject. The BTC model was updated to increase uptake of HIV testing (HTC) and TB testing, drug treatment services among PWID. During the project implementation the Model was expanded by adding a new component on overdose prevention (OD) and use of Naloxone. Also the PWID with TB received community based adherence support while on TB treatment.
Sex Workers	“ADARA”	HIV prevention model to decrease risky behavior, improve the uptake of health and social services for HIV, STI, TB, and drug use prevention, and increase uptake of HTC and STI testing, and drug treatment services among SWs. Adara prevents

Key Population	Model	Description
		initiating injecting drug use among SWs, decreases risk behaviors among DU-SWs, and increases SW use of health and social services.
Men who have sex with men (MSM)	LaSky-“ <i>Trusting each other</i> ”	This HIV prevention model is targeting MSM and aimed at advocating for safer sexual behaviors by increasing HIV/STI knowledge and uptake of medical services for HTC and STI testing and treatment and mobilizing the MSM community to openly and actively support HIV prevention efforts within MSM communities
Prisoners	“START Plus”	An HIV and TB risk reduction program for formerly incarcerated individuals that promotes increasing HIV and TB knowledge and uptake of medical and social services for testing, treatment, and adherence, improving prisons’ skills for reintegration into society, and reducing risky sexual behavior.
People Living with HIV (PLHIV)	“UNISON”: Multidisciplinary approach to improving TB treatment adherence among PLHIV	Implemented to increase the uptake of friendly medical services for PLHIV (especially those also infected with TB), such as TB testing and treatment and sexual and reproductive health (SRH) and family planning (FP) services. Also aimed at reducing risky sexual behaviors to prevent secondary HIV transmission, improving early TB case detection, and lessening treatment default rates.
Migrants	“Safety Route”	Aimed at increasing TB, TB/HIV co-infection knowledge amongst migrant populations who returned to their country of origin in the last two years, potential migrants, and internal migrants. Also intended to increase uptake of friendly medical services for TB testing, prevention, and treatment by migrant populations. The Project successfully implemented the activities among migrants where community leaders, primary health care facilities, the migration service, transportation workers, and local NGOs jointly conducted TB prevention interventions: information campaign, identifying potential TB cases, referral, TB detection and providing services on TB treatment adherence support.

Tracking Results Continuously (TRaC) evaluations demonstrated the behavioral health impact of the project amongst KPs in Kazakhstan (PSI, 2014a, 2014b). PWIDs had significantly higher proportions of HTC utilization (87.4% vs. 48.1%, Odds Ratio (OR)=7.3, $p < .001$). Similarly PWIDs involved with the

Figure 6 Dialogue Project Intervention Sites in Kazakhstan. Source: (PSI, 2015)



project were more likely to use condoms with regular partners (47.9% vs. 27.6%, $OR=2.0$, $p < .05$) and seek TB testing (87.1% vs. 73.8%, $OR=2.1$, $p < .05$). SWs who participated in the project were more likely to utilize HTC than other SWs (88% vs. 74%, $p < .01$). Also, MSM project participants reported safer sexual behavior than other MSMs (84.4% vs. 11.5%, $p < .001$). The multidisciplinary team approach (MDT) conducted at three project sites resulted in 82% of TB patients continuing antiretroviral treatment. These statistics demonstrate that participation in the project had a strong effect on improving reported health behaviors among KPs.

Project documentation and interview respondents identified a number of sustainable approaches adopted by Dialogue Project that contributed to the ability of the health system to respond to the threat of emerging HIV and TB epidemics among KPs. This included the signing of multiple Memoranda of Understanding (MoUs) between medical institutions affiliated with the project and the referral voucher system institutionalized by the MoH of Kazakhstan. The MDT approach was incorporated into the MoH's Clinical Protocol on testing and treatment of HIV among adults and youth. This approach was also adopted by some AIDS Centers and funded through government, and was included in the National Proposal of Kazakhstan to fund the TB component through the Global Fund for AIDS, Tuberculosis and Malaria (GFATM). Capacity of health workers was strengthened at multiple tiers of service delivery within the health system to accommodate the special needs and health demands of KPs. The national client databases, developed by the project, including unique identification code for participants, was incorporated in the HIV prevention programs of Republican AIDS Centers. Finally, as a result of participation in the project the sub-awarded NGOs were reportedly not only better able to independently implement outreach activities, but also to more effectively collaborate with government partners to design, monitor/evaluate, and implement HIV/AIDS and TB programs in Kazakhstan.

The Kazakhstan portion of the Dialogue Project was approximately 20% of the overall cost. This included \$3.04 million of the \$14.8 million for the regional project, which eventually reached \$3.8 million out of \$19.8 million by the end of the project. In general, study participants seemed to think that the

level of funding was adequate for implementation of the full package of outreach and support services delivered by the project. There were reported declines in funding from the regional USAID mission in the final two years of the project for Kazakhstan. This was due to the relative economic wealth of Kazakhstan compared to neighboring project countries as well as the decision to cover part of this work in The Global Fund round 10 portfolio as opposed to PEPFAR. Views on how these financial changes impacted the study were mixed and are discussed later.

3.2 Pre-implementation

3.2.1 Implementation groundwork

Respondents frequently cited pre-implementation characteristics, such as the identity of the prime and the implementation climate as key features that enabled successful implementation. Many thought PSI was a good fit to be awarded the contract based on their experience in the region and their commitment to working with marginalized communities. As one implementer explained:

“PSI was leading and PSI always works that way. They always do this grassroots outreach and social marketing. For sure if it as a different lead organization it would have been designed differently and implemented differently. [...] If it was another prime, it would have been designed like hundreds of conferences, millions of useless manuals, trainings for thousands of people. Like many projects, it’s very useless really. ‘It’s just money to the earth.’ PSI works differently. We’ve worked with them for many years. They addressing the real needs of people and they design any project, not just dialogue, very close to the people’s needs. [...] They’ve worked historically with small grassroots NGOs, they are in constant contact with them and they know these needs. It’s very interesting, PSI is, how do you say, they’re very folksy in a good way. They feel the trend and the needs and see what’s really needed to be implemented in a good way. They implement that way in their projects.” (Kazakhstan 02 Implementer)

Though this attitude was generally well supported by other respondents, PSI themselves were very quick to point out that the entire project was designed to leverage the strengths of a variety of actors across multiple dimensions of HIV and TB outreach. The collaborative ethos of the project was nicely described by a project leader using the following analogy:

“If you can organize 3 people you can organize thousands of people. It’s having good partners. If everyone in consortium move together in one direction the boat will move. If they work in different directions then both will stay in same place as the beginning.” (Kazakhstan 07 Implementer)

This commitment to collaboration and support was reflected in the views of others with respect to effective leaders within PSI, particularly the leadership team of Dialogue. As one implementer commented, *“They have a regional director who can, how do you say, motivate and energize people”* (Kazakhstan 02 Implementer). Another echoed these sentiments, *“I think they have professional staff and have clear understanding of what it means to work in a consortium. Unfortunately not all organizations have this understanding. [...] Maybe it’s personality but it’s good to have all these good personalities in one team”* (Kazakhstan 04 Implementer). While these explanations emphasize individual behavior and agency in producing positive outcomes, it seems clear that USAID’s choice to award PSI the contract, given their experience and understanding of partners, was important.

Finally, some respondents identified trust in the prime as a key aspect of effective community engagement as well as generating a favorable implementation climate for partners. One implementer explained,

“In Almaty, the organizations, we’re all like a big family. We know each other. We know who is who, who is doing what. Each organization has their reputation. PSI has a very good reputation, that they’re doing very good quality projects and products. If PSI approaches me to be involved in a new initiative, I would always say yes because I know they’re very good partners, very fair, very frank partners and they always produce good projects. Compared to another organization on the same level, I might say that I’ll just think about it. With the current structure, PSI is very good and very professional. This leads to the result that people really trust them and the interventions they suggest. The most important is the management team and how they perform and what kind of reputation they have.” (Kazakhstan 02 Implementer)

This commitment to collaboration was evident in the management and reporting structure of the Dialogue Project. This included the establishment of technical working groups and committees to monitor project performance and address issues as they arose.

“We did it together. For example we had regional oversight committee and key stakeholders, international organizations and local NGOs, we got together and analyzed the situation in the countries, we analyzed results for example 1st year and 2nd year of project. This committee decided how to implement the project, what can be changed and what can be improved. Also technical working groups and committees established in the project in each country – like establishing decision groups that decided how to implement. I don’t remember how many, around 10 people in regional oversight committees” (Kazakhstan 01 Implementer).

3.3 Implementation

3.3.1 Execution

The implementation process for Dialogue Project was transparent and sensitive to the needs of the local communities in each project site. Sites were chosen based on multiple criteria, as one implementer explained, the “priority was situation of HIV and TB. Epidemiological situation, where most HIV and TB cases is, where biggest than other sites and also where NGOs working [...] We got data from Republican AIDS Centers. In each country the Republican AIDS Center is the facility that gives these statistics” (Kazakhstan 01). The majority of activities were implemented simultaneously across all sites. Furthermore, implementation was seen as the joint responsibility of multiple stakeholders.

The activities revolved around outreach to KPs. All activities, with the exception of outreach to migrants were implemented in all sites simultaneously. The nine sub-awarded NGOs were recruited based on their geographic reach, relationship to specific segments of the target KPs, and their ability to implement the outreach models at a grassroots level. This approach was seen as coherent and appropriate in the context of twin HIV and TB epidemics.

“The most important activities I think it was outreach work focused on people, on key populations. This practical activity for the people implemented by the people, by peer educators and outreach workers. This I think was the main the most important approach. Because like trainings, conferences, working with the government, working with high officials, it’s already implemented by many other organizations. From my point of view, the real people, the ordinary people are always forgotten you know. The Dialogue payed a lot of attention to the grassroots level let’s say.” (Kazakhstan 02 Implementer)

Project participants were proud of the structure of the activities and the unique assemblage of outreach models. In addition to this, the use of multidisciplinary teams consisting of a doctor, social worker, and peer educator were seen as effective ways to reach and retain patients. These models, the multidisciplinary team approach, and many of the training materials were seen as sustainable deliverables

in that implementers thought would continue to be used beyond the life of the project. Similarly, the health literacy gained by project participants as well as local health officials was seen as yielding strong returns on investment. The reliance on vouchers was seen as beneficial because health workers could accept the vouchers and provide services without knowing the identity of the patient. This also facilitated trans-border TB referral for migrants. Many of the core activities led to other psycho-social interventions that the project was able to accommodate for KPs.

3.3.2 Actor Engagement and Dynamics

Actors generally agreed that there existed a strong sense of consensus in designing and implementing project activities. This seemed to be attributable to the legacy of PSI in implementing other projects in the region, their ability to convene a wide variety of stakeholders, and generate consensus through a process of deliberation about problematic features of implementation. This was evident from the onset of project implementation.

“PSI was very prepared for implementing this project. They provided us with all reporting templates. And methodology that we just updated for migrants. We discussed all interventions and we had joint vision and strategy relating to migrants. It was very good collaboration between the project.” (Kazakhstan 04 Implementer)

In the early stages of implementation, actor engagement was difficult due to the vertical nature of systems designed to address TB and HIV in isolation. The Dialogue Project devoted attention to strengthening collaboration between the two reporting and referral systems so that, for example, *“HIV system should not say this is not my patient its TB patient. There was debate but we tried to find consensus and finally yes, it was achieved” (Kazakhstan 01 Implementer)*. Some saw this as symptomatic of the Soviet approach where medical facilities report to MOH, but primary care facilities report to departments of health, which are governed by local officials. In Kazakhstan, the project sought to build consensus on a regional basis through departments of health.

Implementers generally agreed with the approach to engagement. This included signing MOUs with health officials in the each region in the first year of a project. Also, as one implementer (Kazakhstan 03) commented, *“Community knows what is needed, so should include them in all levels of project.”* Formal arrangements were made between implementers through MOUs, partnership agreements, and in some cases simply letters of contribution. Also, project leaders involved the police, Ministry of Justice, and municipalities, which they found very helpful.

One feature of the project conducive to effective implementation was the establishment of technical working groups. These groups were composed of high-level stakeholders from the departments of health, NGOs, and the key community members. These technical working groups provided a regular forum to discuss design features of implementation, adjustments to current protocol or target groups, and an important venue for generating consensus for project activities. This level of coordination was seen as one of the ways in which the project was keenly aware of the different structural challenges in providing outreach to KPs and proactively sought effective means of addressing them.

Actor dynamics were characterized by the strong leadership of the prime, which sensitively addressed the needs of other partners throughout implementation. This was particularly important given the large number of implementers involved in Kazakhstan. The dynamics and the deep commitment to collaboration was vividly captured by the following description by one of the project’s implementers:

“We found we were respected as an organization with capacity on migration and they respected our work and had very good communication skills. Even if it was a critique it was in a constructive way and they were always supportive...Not all principle recipients don’t behave like this, because sometimes you

do a lot but the principle recipient tries not to mention your achievements, they always try to mention your issues maybe. But in Dialogue, in terms of PSI, it's a different way. They're friendly and we felt part of a team, it was good team work I'd say. Like when we developed educational materials, they provided comments but finally they expressed high evaluation of our job and it was very encouraging. So it encouraged us to do something else. Not in all consortium you face this kind of attitude" (Kazakhstan 04 Implementer).

The commitment to building a collaborative team spirit was also evident by the number of regular venues in which partners were engaged to identify issues with implementation and monitor progress. This included monthly meetings, national working groups, regional groups, and various technical committees. The level of engagement amongst actors was relatively constant throughout the implementation process, as one implementer (Kazakhstan 03) commented, *"Didn't seem that monthly meetings or committees changed over first two years of project. But monthly meetings became less important once the team members started to talk to each other regularly informally."*

Another feature of implementation that fostered an effect working dynamics amongst actors was the development of a management and communication plan. An implementer explained,

"First we developed management and communication manual in the first year. Then based on this manual, we developed management and communication plan. We combined efforts of everyone in consortium. In every country we established technical groups, HIV and TB technical groups and all our consortium partners belonged to these technical groups. So we designed a paper where we described how we should work and this manual was developed based on efforts from all consortium members. At beginning it was Project HOPE, and Kazakh Organization of People Living with HIV, and AFEW. Then IOM and Red Cross joined and we made some amendments to manual in year 3." (Kazakhstan 07 Implementer)

There were also less tangible, but some saw as equally salient, management features of implementation that strengthened the dynamics amongst actors. This was perhaps reflected in the project's ethos which had a strong commitment to serving marginalized KPs who were dying from treatable illness. Project leaders saw it as their job to remind each other of this common goal in no uncertain terms throughout implementation.

"The people's inspiration, excitement, if they believe or don't believe in what they're doing at level of civil society, you should share part of your soul with them. You should show how this project will improve the life of one person who is sitting in the corner of a room and dying. [...] Sometimes when people are very busy with their work, they can forget about the people for whom this project was designed. So every time you remember it's about the quality of life of people who will die from diseases, it will work. I've been here for 15 years. I was program coordinator, COP, program manager I know every corner of this process and what is important not to forget." (Kazakhstan 07 Implementer)

Cooperation amongst stakeholders was particularly important because of the diverse funding streams as well as the two-pronged approach from the Regional Mission in implementing both the Quality Health Care Project as well as the Dialogue Project. In this way consensus was held relatively constant throughout.

"Yes, because we did it all together. It wasn't just PSI that implemented this program. We implemented in partnership with different government authorities, with local NGOs, with international organizations. For the last 2 years we worked with Quality project in last year, also funded by USAID, its' aimed at strengthening health system in Central Asian countries they implemented community advisory board, who worked closely with our Dialogue multidisciplinary teams. We tried to do it all together all the time. Like our closing ceremony was joint with Quality project where we presented joint results. We had

regular partner meetings every month, we invited all partners who implement projects like Global Fund and USAID projects. (Kazakhstan 01 Implementer)

The role of the major HIV/AIDS funders in the region (USAID and The Global Fund) and coordination between them seemed to play a large role in facilitating implementation. According to one implementer (Kazakhstan 07), “These two donors actively communicated under the Dialogue project and we even had joint meetings and monitoring... and joint plans.”

As one implementer noted, the entire project was designed to facilitate this type of collaboration for outreach and support. This is in essence why the project was called The “Dialogue” Project in the first place.

“It’s establishment of dialogue between state and civil society, between all types of donors, between national programs of 5 countries which are linked to each other though migration. It’s establishment of regional oversight committees, of regional dialogue to fight HIV and TB in the region. So it’s like a big umbrella. [...] But umbrella impression is establishment of good dialogue between all the sectors of this sphere which belongs to HIV and TB. It’s the only way to improve quality of life of people at risk, it’s establishment of fruitful and effective dialogue approach, and this worked from my opinion.” (Kazakhstan 07 Implementer)

3.3.3 Changes

While all activities were implemented across all sites, respondents noted that some ended earlier on account of the aforementioned funding changes in Kazakhstan. One implementer explained,

“In Kazakhstan we stopped early because of financial issues. It was not our decisions, it was a USAID decision I think. It was because of a shortage of money for Kazakhstan because it became an upper-middle income country [...]. So money and activities were less. By the end, it was completely removed from Kazakhstan. It was like a trend to decrease financing for Kazakhstan and by the end they just completely stopped.” (Kazakhstan 02 Implementer)

This change in funding was confirmed by a respondent at USAID, although the respondent was unsure of the effects of this change on project implementation:

“So there was a real push from OGAC a couple years ago up until today to decrease the amount of support going to Kazakhstan and to focus more on Kyrgyzstan and Tajikistan mainly because of the economic situations in each country. Kazakhstan being ranked higher than the other countries, OGAC had a clear point of view that we shouldn’t be spending as much money in Kazakhstan and that we should be spending more in Tajikistan and Kyrgyzstan. I can’t remember when that started but it really had had more to do with economic climate than anything else. I don’t think it even had to do with HIV prevalence. I don’t remember when that shift started and how that played out at the project level.” (Kazakhstan 06 USAID)

Yet, when described by the project leadership, this was downplayed as a misunderstanding by implementing partners.

“Global Fund Round 10 came to the region.... I can’t say activities were broken or sites were deleted from the list. Such sites were moved from one donor to another, it was mutual agreement. How to not replicate activities of two main donors. We worked hard to not replicate activities and make sure the approaches from USAID and Global Fund were cost effective, program effective, people effective. That’s why we weren’t able to work in Karaganda and spend money for same NGOs spending money of USAID and Global Fund... It was a decision made at very top levels, by USAID, Global Fund, and Ministry of Health of Kazakhstan and Republican AID Center. (Kazakhstan 07 Implementer)

Regardless of how much the change in financing disrupted program activities, a change did occur. It seems possible that the project leadership devoted significant attention to ensuring that implementation was sustained in the absence, or shifting, of funding away from target sites. It also seems as though the change was unavoidable for project staff that were not in a position to influence decision-making at a diplomatic level.

In addition to the funding change, several smaller changes were routinely made to adjust features of implementation throughout the life of the project. The project's flexibility was seen as a positive feature of an effective service delivery apparatus. This is in keeping with the project's desire to be sensitive to the needs of the target population as well as the implementers on the ground. An implementer describes how the project made routine adjustments:

"It depended on the budget. If the budget was decreased we had to decrease coverage. Activities changed depending on decisions from regional oversight committees, like if we needed to change the site or make more efforts on people who inject drugs and less on MSM because more HIV among drug injectors." (Kazakhstan 01 Implementer)

In addition, the respondent stated that they documented the changes made, *"we provided working plans and summarized these changes and analysis we made helped us to decide what to change. USAID had to approve of changes and if they did we moved forward"* (Kazakhstan 01 Implementer).

Finally, positive feedback and refinement of project activities was facilitated by evidence which was provided to project staff. First, the TRaC studies to measure and monitor health behaviors for KPs were conducted to monitor and target specific behavioral health outcomes. Second, Project Hope conducted key qualitative research on TB that informed service delivery. Third, Dialogue Project developed a health management information system that was consistently refined, updated, and used to make planning decisions. In general, it appears as though Dialogue Project made good and consistent use of routine data for monitoring and evaluation purposes.

3.3.4 Challenges

Many of the large challenges identified by interview respondents were addressed in the early Section 3.1 on pre-conditions. Some of these challenges included stigma towards KPs, vertical service delivery systems, funding changes, and coordination/cooperation amongst multiple implementing partners. In addition to these broad challenges, project staff identified a number of smaller operational issues, such as branding requirements by USAID, difficulties in recruiting local implementing NGOs in some regions, bureaucratic services to migrants, staff turnover, and language difficulties. These problems were all seen as surmountable and did not interfere with the ability of the project to achieve its objectives.

3.4 Maintenance and evolution

3.4.1 Sustaining implementation

Interview participants frequently pointed to the many ways in which the project's activities were sustainable. This included the strengthened capacity of local NGOs to secure funding and deliver services, coordination among multiple segments of the health system, reduced stigma, and the adoption of some program materials, such as the management information system, into government health programs. As one implementer noted, *"A lot of the project received funds from government, are still operating even in Karaganda and continuing the activities. That's why we have Flagship project to deliver success of Kazakhstan to other countries"* (Kazakhstan 07).

The Flagship project is the successor to the Dialogue Project, which has been awarded to PSI to extend the work of Dialogue Project in Central Asia. This is seen as an endorsement of both the Dialogue Project and the relative priority of delivering outreach services to KPs.

“With Flagship project we’re also targeting capacity building of NGO but now it’s extended like improvement of access to HIV services and our aim is to improve prevention to treatment and rapid case detection. Work to motivate people to start treatment and adhere to treatment and work with their close injecting and sexual partners. We try to get them to be tested and know their HIV status. What we do in the project is to advocate NGOs to make rapid HIV testing in NGOs. Now HIV testing is only in AIDS centers and medical facilities, but not by NGOs, now we want to pilot rapid testing by NGOs and civil society. It’s a kind of a continuation but I think it will be more on treatment adhering and case detection.” (Kazakhstan 01 Implementer)

According to one interview participant, the Flagship Project will integrate some of the activities from both the Dialogue Project as well as the Quality Health Care Project. *“This project is different from Dialogue but it’s a continuation of Dialogue and Quality and others” (Kazakhstan 07 Implementer)*. In this way, at the very least, Dialogue Project has sustained the attention of donors to fund outreach to KPs in Central Asia.

While this new line of funding bodes well for the ability of Dialogue’s work to sustain project achievements, the new direction of the Flagship project presents some challenges for implementers. These challenges amount to the demanding nature of PEPFAR’s strategic priorities, which has somewhat shifted since the Dialogue Project was implemented. A USAID representative explained,

“It’s the same design but the focus is more on increasing the number of HIV positive people getting treatment. They use different terms, but broadly the same approach of reaching key populations to identify people who are HIV positive and get them on HIV treatment. Now there is a big focus on adherence and it’s creating support groups at the community level to help them stay on treatment. [...] The big focus now is getting this community based testing going and then getting people into treatment and keeping them on treatment. It’s really ambitious considering before was just focused on linkage to testing and now we’re looking across the whole thing. It’s the direction PEPFAR has moved in, it’s the expectation now. You can’t just do prevention, but it’s all about viral suppression and only way to get viral suppression is to get people on treatment and adhere to treatment. For this region in particular it is very hard with injecting drug users. A lot of pressure now to reach new people. They’ve been asking PSI to set up this new network model to go after partners or friends of drug users to go into their networks to get new people. There will be a lot of pressure on them. (Kazakhstan 06 USAID)

3.4.2 Dissemination

It is not entirely clear how the project achievements were disseminated. Some respondents remembered participating in a conference at the end of the project. Others reported that PSI made use of a quarterly bulletin. Some suggested that the roundtables and regional oversight committees were regular venues for dissemination of project updates and achievements. If there was a focused dissemination strategy beyond deliverables submitted to the client, it remains unclear what it included.

4. DISCUSSION AND SYNTHESIS

In this section we discuss our results and synthesize the key factors that led to the successful implementation of the project.

4.1 Synthesis and lessons learned

Implementation of the Dialogue Project was facilitated by a number of important factors related primarily to project design and the complex dynamics among actors. First, there existed reliable epidemiological data with which to accurately diagnose the problem of growing HIV and TB epidemics in Central Asia. In addition to this, the prime as well as other implementing partners, were intimately acquainted with evidence-based models for delivering outreach services to KPs. Thus, the project design, with strong evidence for both problems and solutions, was appropriate, despite the many challenges presented by the difficult implementing environment.

Second, the prior lack of political priority for addressing the needs of KPs created ample space for USAID to develop a sizable program of work to be implemented by partners that were familiar with each other. The Dialogue Project and QHCP were established as a means to link KPs to much needed services, while reducing stigma in the process. Implementing partners were well connected before, and maintained active lines of communication throughout, the design and implementation of both projects. This enabled the shared vision to be incorporated into a coherent and robust program of implementation.

Third, the project incisively focused on generating high-level political support from a wide array of entities throughout its lifespan. This was aided by the strong support demonstrated by the USAID regional mission, which actively promoted the project's achievements. By creating technical working groups and regional committees to monitor and respond to changes in implementation, respondents suggested that a degree of ownership was created for the portfolio across government, NGOs, and community stakeholders as well. This had a synergistic effect with the aforementioned shared vision among implementers.

Fourth, while the focus of implementation was on the delivery of outreach services to KPs, the project was sensitive to the need to generate far-reaching sustainable achievements that strengthened the health system in Kazakhstan. By working with multidisciplinary teams, 9 sub-grantees NGOs, multiple implementing partners, the Department of Health, and republican AIDS Centers, the dynamics, which were reportedly 'horrible' before, were vastly improved. Not only was the capacity of local NGOs strengthened, but many of the tools developed to support the outreach models demonstrated the effectiveness of addressing the growing burden of HIV and TB. Many of these tools were reported adopted by AIDS centers and are now including in national treatment protocols. Furthermore, the capacity of health professionals and the media to accommodate and understand the challenges faced by KPs in seeking treatment were reported to have effects that extended beyond the life of the project. By planning for sustainability and implementing effectively, the project was able to report on the multiple ways in which it served to strengthen the health system

Despite these facilitators, a number of challenges, primarily with the enabling environment and implementation climate, were present throughout project implementation. These barriers included the pervasive stigma and social exclusion of KPs in Kazakhstan. In a political environment marked by a

legacy of authoritarian rule, many respondents reported the difficulty in addressing the needs of communities without adequate legal protection or recognition of human rights. The project intentionally tried to bring 'invisible' KPs into mainstream treatment and care, which required patience and persistence on the part of implementing partners. In the same way that trust was an important facilitator of success among the team of implementing partners, trust was a barrier between KPs and the health system.

In addition to this, a sizable degree of dysfunction within the health system was noted. This included parallel and disorganized vertical service delivery mechanisms for TB and HIV. The project devoted attention to this through the voucher referral program and client database. They also worked to engage the Department of Health to integrate these services into mainstream clinical settings for KPs. While it was likely beyond the scope of the project to fully address the vertical nature of service delivery country-wide, in project sites, respondents reported that this was somewhat improved by the consistent engagement of multiple stakeholders to ensure that project activities were executed appropriately. Also, by relying on a multidisciplinary team of health professionals, the needs of KPs were more effectively accommodated.

Another challenge frequently identified was adapting to changes beyond the control of the project itself. This included the changing priorities of development partners with respect to Kazakhstan given its relative wealth in the region. Views were mixed on how the project was affected by shifting some project sites from USAID funding to The Global Fund - round 10, in the last two years of project implementation. While Kazakhstan became less of a priority in the region, some respondents felt that the activities of Dialogue Project remained unaffected. Regardless, of the nature of these financial changes, they surfaced frequently throughout interviews and their effects were difficult to determine from project documentation.

Analysis of these facilitators and barriers to implementation allows for a closer examination of the health systems strengthening dimensions of the Dialogue Project. On the one hand, the project achieved sustainable success across multiple dimensions of the health system. This is particularly notable given the difficult implementation climate and urgency of the rising TB and HIV epidemics in Kazakhstan. On the other hand, the project was designed to move beyond a broke system and deliver services out on the 'frontlines'. As one respondent commented,

“To fully put them in health system strengthening with some obligation for sustainability, I think it’s a stretch. To be honest, I think it undermines a little Dialogue’s strengths and the creativity they showed out there on the frontlines. They weren’t supposed to be the ones with the obligations to make that sustainable, they were supposed to be on the frontline.” (Kazakhstan 05 Implementer)

Regardless of whether or not the Dialogue Project can be classified as a true health systems strengthening project, this research demonstrates two important features of effective health systems strengthening. First, the combination of Dialogue Project with QHCP as financed through USAID’s Central Asia Mission is an example of how seemingly intractable problems can be tackled through coherent project design and nimble project coordination. Second, the experience of Dialogue Project demonstrates that excellence in implementation, including actor engagement and adaptability, necessarily generates positive effects that serve to strengthen other dimensions of health systems. In this way, the Dialogue Project was a strong example of how a shared vision, through effective collaboration, can be transformed into measurable health outcomes and improved health systems performance.

4.2 Conclusion

The Dialogue on TB and HIV Project helped to reduce the spread of TB and HIV epidemics through improvement of health behaviors among key populations (KPs) in Kazakhstan from 2009-2013. By remaining sensitive to the needs of project beneficiaries and sharing a deep commitment to collaboration, project staff were able to implement with excellence. This translated into several sustainable outputs that strengthened multiple dimensions of the health system in Kazakhstan. In so doing, the Dialogue Project generated an effective dialogue between civil society and the government of Kazakhstan around the previously neglected epidemics of HIV and TB in marginalized communities. In this way, the project helped to ensure that the health and dignity of vulnerable members of society are better protected by a more responsive and fair health system in Kazakhstan.

ANNEX A: COMBINED IMPLEMENTATION FRAMEWORK

Phase	Domain	Factor	Description	Unit of analysis
I Pre-condition	Enabling environment	Wider environment	Economic, political, social, and health system context within which intervention ² is implemented	National/regional context
		External policies and incentives	Strategies to spread intervention – policy, regulations (not directly implemented by project but (pre)existing) Policies that constrained implementation Other donor led initiatives that complement intervention	National/regional context
		Characteristics of organization	Structural characteristics of organization such as social architecture, age, maturity, and size of organization Culture of organization such as norms, values, basic assumptions of organization	Change target/larger host organization ³ (identify for each case; e.g. MOH)
	Implementation setting	Implementation climate	Climate within organization, including relative priority of project, readiness for implementation, learning climate, and policies, procedures, and reward systems that inhibit or facilitate implementation	Change target/larger host organization (identify for each case; e.g. MOH)
		Intervention source	Stakeholder perception if intervention internally or externally developed	As applicable for each case (e.g. MOH, local partners, change target)
	Project design	Identification of effective intervention	Process for deciding intervention approach and activities	As applicable for each case (e.g. MOH, local partners, change target)
			Stakeholder perception of quality and validity of evidence that intervention will	

² The total package of activities that is implemented by the project.

³ Institution within which activities are being implemented; may be MOH or other local organization (will focus on larger organization like MOH rather than individual hospitals); depending on the case this organization may be more or less involved in the actual implementation.

Phase	Domain	Factor	Description	Unit of analysis	
			have desired effects		
			Perceived relative advantage and complexity/perceived difficulty of intervention		
		Adaptability	Degree to which intervention was adapted to local needs, including degree to which beneficiaries' needs were understood and design was adapted to meet their needs	Project implementers ⁴ (e.g. prime + subs)	
		Draft package	Perceived quality of how intervention is presented	As applicable for each case (e.g. MOH, local partners, change target)	
2	Pre-implementation	Implementation groundwork	Structural characteristics of implementing organization	Structural characteristics of implementing organization such as social architecture, age, maturity, and size of organization; culture of organization such as norms, values, basic assumptions of organization	Project implementers (e.g. prime + subs)
			Implementation climate	Climate within project including relative priority of project, readiness for implementation, learning climate, and policies, procedures, and reward systems that inhibit or facilitate implementation	Project implementers (e.g. prime + subs)
			Planning	Degree to which intervention is planned in advanced, quality of methods; refinement of draft package based on pilot testing, stakeholder feedback	Project activities
			Orientation and logistics	Quality of initial planning and execution of the project, including needs assessment, pilot testing, leadership engagement	Project activities ⁵
3	Implementation	Executing	Fidelity of implementation	Project activities	
		Engaging	How the project attracted and involved appropriate individuals throughout project: opinion leaders, formally-appointed internal implementation leaders, champions, external change agents	Project activities	

⁴ Prime contractor and sub-contractors (may include local subs) who implement the project. This does not include the change target organization.

⁵ Specific activities directly implemented by the project implementers. These may or may not align with other activities in the change target organizations. These individual activities make up the intervention as a whole.

Phase	Domain	Factor	Description	Unit of analysis
4 Maintenance and evolution		Feedback and refinement	Qualitative and quantitative feedback about progress and quality of implementation Refinement of activities based on feedback	Project activities
		Cost	Costs of total intervention - planned and actual	Intervention
	Sustaining implementation	Organizational, financial changes	Changes made to sustain the intervention	Project implementers (e.g. prime + subs); Project activities
		Re-customize delivery as need arises	Adapting the intervention delivery as circumstances change	Project implementers (e.g. prime + subs)
	Dissemination	National dissemination	Preparing refined package, training, and TA program for national dissemination; was project nationally disseminated	Project implementers (e.g. prime + subs); Change target

ANNEX B: KEY INFORMANT INTERVIEW GUIDE

Instructions

First complete informed consent to conduct interview and ask permission to record.

Ask as many of the primary questions as is feasible given the time constraints and as are appropriate for the respondent given their role in the project. Ask probe questions as applicable. Prioritize the most important questions if you do not have sufficient time to ask all applicable questions.

Respondent's role

1. Can you tell me about your involvement with [PROJECT]?
 - a. When were you involved with [PROJECT]?
2. Who were you working for during that time? (e.g. Implementing partner (specify); USAID Mission; USAID HQ; government counterpart; other—specify)
 - a. What was your position or title with [PROJECT]?
 - b. Did you change organizations or positions during your time on [PROJECT]?

Pre-condition

3. What problem(s) was the [PROJECT] trying to solve?
 - a. Who felt this was an issue of concern? (e.g. MOH, US Mission, other stakeholders?)
 - b. Why did they see it as a concern?

PROBE: What evidence was this based on?
 - c. Was there a country/government initiative or reform targeting this issue that the [PROJECT] was intended to support? Please describe briefly.
4. How did USAID decide to fund a project to address this problem? Who was involved in the decision?
 - a. What evidence was used to understand the issue?

PROBE: Evidence used by respondent or respondent's organization, other partners, local stakeholders, USG?
 - b. What approaches or activities did USAID specify in the RFA/RFP? (*Skip if can answer from documentation*)

PROBE: Did other stakeholders contribute to what was specified in the RFA/RFP?

- c. How did USAID decide what to include in the RFA/RFP? Did other stakeholders contribute?
5. How was this [PROJECT] selected to address [ISSUE]?
 - a. Who was involved in the selection?
 6. Can you briefly describe the [PROJECT's] approach and activities?
 - a. Which do you think were the most important activities?
 7. During the work planning process, how were the specific activities used in [PROJECT] selected?
 - a. Who contributed to these decisions?

PROBE: Prime or subcontractors, US Mission, MOH, hospitals, [PROJECT] participants, beneficiaries
 - b. What other information influenced the selection of the [PROJECT] interventions? (e.g. government priorities, new USAID/USG initiative, existing policies/regulations, new financing, etc.)
 - c. Were other interventions considered but not selected?
 - d. How much consensus was there between stakeholders about the design of the interventions?
 8. How were the intervention sites identified? (e.g. hospital, school of nursing, etc.)
 - a. Who contributed to these decisions?
 9. How were the activities designed to be appropriate for the local health system context?
 - a. How were planned activities piloted?
 - b. How were planned activities adapted to existing conditions during the [PROJECT]?

Pre-implementation

10. Were there any individuals or organizations who provided strong support for the [PROJECT]?
 - a. How did they promote [PROJECT] implementation?

PROBE: Did they promote implementation at individual sites or for particular activities?
 - b. What are the reasons they supported the [PROJECT]? (e.g. specific to [PROJECT] or supportive to larger country initiative?)
11. Were there any individuals or organizations who delayed or impeded implementation of [PROJECT]?
 - a. How did they impede [PROJECT] implementation?
 - b. What are the main reasons they impeded it?
12. Can you tell me about the dynamics of the individuals and organizations working on [PROJECT]?

- a. How did these evolve over time?

Implementation

13. How were [PROJECT] activities implemented?
 - a. Were all the activities implemented in all of the project sites? *(Skip if can answer from documentation)*
 - b. Were activities implemented in phases? *(If yes)* What were the phases? *(Skip if can answer from documentation)*
 - c. Did the [PROJECT] activities change over time? *(If yes)* Why? *(Skip if can answer from documentation)*
 - d. Were changes documented? *(If yes)* How? *(Skip if can answer from documentation)*
 - e. How did contextual factors affect implementation? (e.g. social, economic, political, technological, etc.)
14. Was there consensus among different partners and stakeholders about how the [PROJECT] was implemented?
15. Where did the resources for [PROJECT] implementation come from? (e.g. [PROJECT]/[PARTNER], USG, government, others) *(Skip if can answer from documentation)*
 - a. Was there enough funding and other resources to support [PROJECT] implementation?
PROBE: financial, technical, human, technological.
 - b. *(If there was a shortage of resources)* How was the shortage addressed?
16. What challenges were faced during day-to-day [PROJECT] implementation?
 - a. Were there any issues with policies or regulations?
 - b. How did [PROJECT] address these challenges?
17. How were [PROJECT] activities monitored and/or evaluated? *(Skip if can answer from documentation)*
 - a. Who was responsible for monitoring implementation progress? Was this part of standard implementing practices?
 - b. Was an evaluation conducted? By whom? Who requested it? Who paid for it?
 - c. How were findings from M&E incorporated into implementation?
 - d. What was the response to M&E findings?
18. What dissemination activities were undertaken during [PROJECT]? (e.g. small-scale meetings at [PROJECT] sites, national workshops presenting findings, feedback sessions to USG, etc.) *(Skip if can answer from documentation)*
 - a. How was feedback disseminated throughout [PROJECT]? (e.g. [PROJECT] participants, end-of-the-line beneficiaries and policymakers)

Maintenance and evolution

19. What was done during [PROJECT] to support continuation of activities after [PROJECT] ended?
 - a. What role did [PARTNER] or others have in helping to sustain the activities?
 - b. What role did others play in sustaining the activities? (e.g. US Mission, MOH, intervention sites, communities)
20. What is the current status of activities included in [PROJECT]?
 - a. Who has taken responsibility for sustaining the interventions? (e.g. financial, organizational, technical responsibility)
 - b. What are the long-term prospects of the interventions?
 - c. What, if any, are the plans to scale-up/expand the interventions from [PROJECT]? (e.g. same country, other settings)

Reflections

21. What do you think were the impacts of [PROJECT]? (e.g. changes in health status, improved service delivery, increased quality of services.)
22. Were there any consequences from [PROJECT] that were unintended or unexpected?
23. What were some challenges to the overall implementation of [PROJECT]?
 - a. How could have these been addressed during the implementation period?
 - b. Do these challenges remain an issue today? Why?
24. What were the key factors that led to the success of [PROJECT]?
25. What are some lessons learned from implementing this intervention that you would take forward on other projects of this nature?
26. Is there anything else we have not discussed that you would like to share about the implementation of [PROJECT]?
27. Do you have any questions for us?

ANNEX C: ACTIVITY TABLE

Activity type	Disease/health system target	Location/administrative level	No. of sub-activities
Targeted Outreach Package of Services to KPs	Service Delivery, HIV/TB	Community Outreach	Approximately 9
Capacity-building of NGOs	Human Resources for Health / Governance	NGOs	None
Training journalists, pharmacists, providers	Human Resources for Health / Governance	Civil Society	None
Developing National Client Database	Health Management Information Systems, Service Delivery	National	None
Integration of referral voucher program for TB	Financing, Service Delivery, TB	Primary care	None
Strengthening the Continuum of care through case management, multidisciplinary teams, and GBV prevention	Service Delivery	Primary care, community outreach	3

ANNEX D: BIBLIOGRAPHY

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