MAPPING OF KEY HIV SERVICES, ASSESSMENT OF THEIR QUALITY, AND ANALYSIS OF GAPS AND NEEDS OF MOST-AT-RISK POPULATIONS IN CHUI OBLAST AND BISHKEK CITY, KYRGYZSTAN

AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

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AIDSTAR-One
John Snow, Inc.
1616 Fort Myer Drive, 11th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
E-mail: info@aidstar-one.com
Internet: aidstar-one.com

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ACRONYMS

ART	antiretroviral therapy
ARV	antiretroviral
CAR	Central Asia Regional Mission
CBC	complete blood count
CSW	commercial sex worker
DST	drug susceptibility testing
ELISA	enzyme-linked immunosorbent assay
FC	friendly clinic
FGD	focus group discussion
FHC	family health center
GFATM	Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria
GP	general practitioner
HOP	Health Outreach Project
IDU	injecting drug user
IEC	information, education, and communication
MARP	most-at-risk population
MAT	medication-assisted therapy
MOH	Ministry of Health
MOU	memorandum of understanding
MSM	men who have sex with men
NGO	nongovernmental organization
NSE	needle and syringe exchange
OI	opportunistic infection
OST	opioid substitution therapy
PHC	primary health care
PLWH	people living with HIV
PMTCT	prevention of mother-to-child transmission
PSI	Population Services International
SES	sanitary epidemiological station

STI	sexually transmitted infection
TB	tuberculosis
UNODC	U.N. Office on Drugs and Crime
USAID	U.S. Agency for International Development
VCT	voluntary counseling and testing

EXECUTIVE SUMMARY AND RECOMMENDATIONS

An increasing awareness of the HIV epidemic in Central Asia requires a solid understanding of the services available and the gaps in program delivery. In order to develop a deeper understanding of the current status of HIV services for most-at-risk populations (MARPs), access to and quality of the services provided, service delivery gaps, and capacity building needs, the U.S. Agency for International Development has commissioned this survey.

Qualitative research methodologies, namely semi-structured interviews and focus group discussions, were conducted among different groups of respondents in Chui Oblast and Bishkek, Kyrgyzstan.

Key findings show that Kyrgyzstan is successfully moving toward integration of previously vertical HIV services into the primary health care (PHC) system. Family health centers (FHCs) play an important role in ensuring easier access of MARPs to various services, including antiretroviral therapy (ART), prevention of mother-to-child transmission (PMTCT), medication-assisted therapy, and basic harm reduction services. Implementation of those components largely depends on the external funding provided through the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM). Access to ART is low, mostly due to people living with HIV (PLWH) not being able to receive CD4 cell counts. A standardized system to assess the quality of services provided at governmental medical institutions is limited to the periodic review and analysis of data that comes from official statistics. None of the facilities conduct client satisfaction surveys or involve clients in their programming. Low motivation of medical personnel remains a key obstacle to improving services provided to MARPs. Collaboration between nongovernmental organizations (NGOs) and governmental medical facilities is most effective when medical facility staff receive financial incentives from an NGO. To ensure access to services, many NGOs hire key medical personnel from government facilities to work part-time on projects.

Increasing the level of knowledge among MARPs regarding services that should be available triggers increased demands for more comprehensive services. Programs need to move away from provision of basic harm reduction services and target complex programs that are tailored to each individual group of MARPs and which can subsequently be tailored to the individual. A system of co-payments required by the government that requires a person to be employed, to have an identification document, to have a place of residence, as well as funds to cover 50 percent of the fees is a key obstacle that prevents injecting drug users (IDUs), former prisoners, and PLWH from accessing services. Stigma and discrimination among society in general and among medical personnel in particular are decreasing but are still barriers for PLWH to access public health care or even participate in NGO activities.

RECOMMENDATIONS

1. Kyrgyzstan has made significant progress integrating HIV services into the PHC system, and FHCs play an important role in ensuring easier access of MARPs to various medical services,

including ART, PMTCT, and opioid substitution therapy (OST). The country has also put significant effort into better integrating tuberculosis (TB) and HIV services. Though there are continuous challenges, mostly related to funding mechanisms and human resource capacities of this integration, positive results are noticeable for providers and patients. There is very little integration between HIV and narcology, and between HIV and STI services. Integration between HIV and maternal and child health services can also be improved. This is an area of focus that should be a priority, given the varied expressed needs of the clients.

2. The current situation, depending solely on GFATM funding to ensure integration, is not sustainable. Implementation of the most important prevention and treatment components of an HIV national program (ART, OST, needle exchange, condoms, TB treatment) largely depends on external funding provided through GFATM. This poses a serious threat to long-term planning and implementation of those components. In the coming years, significant focus will be required to determine national and local sources of funding to ensure that government services are offered seamlessly.

3. The system to assess the quality of services provided at governmental medical institutions is limited to the periodic review and analysis of data that comes from official statistics. None of the governmental medical facilities conduct client satisfaction surveys or involve clients in their programming. In order to provide the highest quality of services and continuously monitor quality, quantitative and qualitative approaches of data collection should be supported. The development and support of multidisciplinary teams working to routinely measure and address quality issues is critical, both in government facilities and NGO programs.

4. Low motivation of medical personnel remains the most serious challenge to effective provision of HIV-related services in the public sector. Low salaries of medical personnel, poor working conditions, and outdated buildings and equipment result in suboptimal level of services provided by government medical institutions to the population in general and MARPs specifically. As part of the efforts to address sustainability, issues of compensation should be addressed. Also, a systematic review of infrastructure and strategic support for essential equipment and materials should be considered.

5. Staff of government medical facilities are overloaded with paper-based reporting and other tasks and are not able to deal with many psychosocial problems of MARPs, especially IDUs and PLWH. They often face difficulties working with these groups and are not able to provide sufficient counseling to ensure adherence to treatment (HIV treatment, TB treatment, substance use treatment, STI treatment); therefore, it would be beneficial to have social workers or counselors as full staff of medical facility services that could help physicians and serve as a focal point for socially vulnerable groups. Considering the low level of funding of government health facilities, NGOs could use project money to send social workers to governmental medical facilities. This would improve collaboration between NGOs and the government health sector, improve the quality of services provided, and improve access of MARPs to medical services.

6. Collaboration between NGOs and governmental medical facilities is most effective when medical staff from facilities receive financial incentives from an NGO. To ensure access to services, many NGOs hire key medical personnel from governmental facilities to work part-time on projects. This measure works well in the short-term, but long-term strategies are needed to ensure effective collaboration of NGOs and governmental medical facilities, especially considering that as of now, everyone understands the need and the added value of such

collaboration. Joint planning of activities, including implementation of joint quality improvement activities, should be encouraged and supported.

7. NGOs and their clients feel the demand for more comprehensive and client-centered HIV programs that are not limited to basic harm reduction services. Provision of legal, social, and psychological support, as well as temporary housing solutions, are the top needs of almost all groups of MARPs. Technical assistance partners should be encouraged to expand the scope of technical expertise provided to meet these needs. Emphasis should be placed on how to integrate a more complete set of services into existing packages.
8. When planning and budgeting for harm reduction services, implementers need to ensure that the quality of individual protection materials (condoms, lubricant, syringes/needles) provided to MARPs is of the highest standard, as the poor quality of some of these materials unavoidably leads to misuse, low motivation to use, and low demand. Also, there is a need to establish rational and realistic standards for outreach work (e.g., a number of clients reached by one outreach worker per month) to prevent false reporting and ineffective outreach. Included in this needs to be a system for continuous supportive supervision systems that reward excellent performance and address challenges without punishing outreach workers.
9. Development and implementation of a non-judgmental system of providing PLWH with medical insurance regardless of their residence and employment status could improve access to medical services and increase continuity of care. The out-of-pocket cost of services (even if minimal) remains a significant obstacle for those PLWH who do not have any permanent income.
10. With the growing number of PLWH, FHC personnel, including "narrow" specialists, such as gynecologists, STI specialists, and dentists, need to be trained and retrained on HIV and provided with materials related to specific needs of PLWH. This HIV training can be incorporated into other types of trainings (e.g., PMTCT courses as part of the safe motherhood training). Once trained, supportive supervision and clinical updates are essential.

INTRODUCTION

An increasing awareness of the HIV epidemic in Central Asia and appropriate responsiveness of government and nongovernmental organizations (NGOs) requires a solid understanding of the services available and the gaps in program delivery. The U.S. Agency for International Development (USAID)/Central Asia Regional Mission (CAR) is tasked with scaling up its response to the epidemic and to this end has been implementing the Health Outreach Project (HOP). In the near future, it will also start implementation of the Quality Health Care Project, which will focus on facility-based services for HIV and other public health services, linking them to outreach programs such as HOP. In order to inform both of these projects, USAID/CAR is interested in developing a deeper understanding of the current status of HIV services to most-at-risk populations (MARPs), access to those services, and the quality of the services provided. In addition, CAR is interested in service delivery gaps and the capacity building required to address some of those gaps. This project, implemented by AIDSTAR-One, aims to provide this information and recommendations to USAID/CAR.

BACKGROUND AND OBJECTIVES

EPIDEMIOLOGICAL SITUATION

The HIV epidemic in Eastern Europe and Central Asia is escalating and is one of the fastest growing in the world. Driven by injecting drug use, high rates of HIV prevalence can be observed among high-risk groups along the drug trafficking routes that run from Afghanistan through Tajikistan, Uzbekistan, Kyrgyzstan, and Kazakhstan.

According to official statistics, the HIV prevalence rate in 2009 was 12.8 per 100,000 people in the Kyrgyz Republic. The majority (59 percent) of people living with HIV (PLWH) are 20 to 39 years old. Although the epidemic is still dominated by injecting drug use (62 percent), recent data indicate a steady increase in a share of HIV transmission through unprotected sex from 3 percent in 2001 to 25 percent in 2009. The percentage of PLWH who are women has tripled over the last six years: from 9.5 percent in 2001 to 25.5 percent in 2009. The majority of these women were infected by sexual partners who are injecting drug users (IDUs). As of October 1, 2010, 3,149 PLWH were cumulatively registered in Kyrgyzstan (Country Multisectoral Coordination Committee 2010), while the estimated number of PLWH is believed to be almost 9,000 people (Country Multisectoral Coordination Committee and Ministry of Health [MOH] of the Kyrgyz Republic 2010).

According to the country's latest sentinel surveillance results, HIV prevalence in 2009 was 14.3 percent among IDUs, 1.6 percent among female sex workers, and 7 percent among prisoners. High prevalence rates of viral hepatitis C among IDUs (53.6 percent in 2009) and prisoners (39.3 percent in 2009) indicates that unsafe injection practices are pervasive among key populations at higher risk for acquiring HIV. Prevalence of syphilis in 2009 was 33.8 percent among sex workers, 15.3 percent among prisoners, and 12.6 percent among IDUs; this illustrates high rates of unsafe sexual practices.

HIV-RELATED SERVICES

According to the latest UNGASS Country Progress Report, the total budget for the HIV program in Kyrgyzstan (2009) was approximately U.S.$10 million, out of which approximately U.S.$8 million came from external donors. Most of the funds (approximately U.S.$6.4 million) were spent on HIV prevention, including support provided by the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM)-funded project for outreach activities targeting MARPs and vulnerable youth. These programs provide HIV prevention services that include harm reduction counseling, products (syringes and needles; condoms; lubricants; and information, education, and communication [IEC] materials), and psychosocial support for MARPs. Services are provided by a limited network of trust points (safe venues where individuals can receive client centered services without fear of being reported to law enforcement authorities) and specially trained staff at government clinics. According to Law of the Kyrgyz Republic "About HIV/AIDS in the Kyrgyz Republic" adopted on June 27, 2005, voluntary counseling and testing (VCT) is available through anonymous VCT services at AIDS centers, family health centers (FHCs), and any other government health facility in the country.

However, most testing is being done among low-risk people (mostly pregnant women), and only 10 percent of all individuals tested for HIV can be classified as MARPs in Kyrgyzstan.

In 2008, there were 50 governmental settings for drug dependence treatment in Kyrgyzstan (U.N. Office on Drugs and Crime [UNODC] 2010). Medication-assisted therapy (MAT) using methadone is also supported by GFATM and is implemented through narcology services in all the oblasts of the country and in three penitentiary facilities. "Friendly clinics" were opened in the country to provide free sexually transmitted infection (STI) diagnosing and treatment to MARPs. Roughly U.S.$800,000 was spent in 2009 on HIV treatment, care, and support services. As of October 1, 2010, 311 PLWH in Kyrgyzstan are receiving antiretrovirals (ARVs). All ARVs including pediatric formulations, prevention of mother-to-child transmission (PMTCT), and post-exposure prophylaxis drugs are provided with the support of GFATM. During this period, significant efforts have been expended by national leaders and development partners to establish integrated tuberculosis (TB) and HIV services in order to ensure effective management of dual TB/HIV infection (both for prevention and treatment).

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT RESPONSE

USAID initiated HOP in September 2009 to provide technical assistance, training and direct outreach services to increase access to quality HIV prevention and TB prevention and treatment interventions among MARPs. HOP will work in four countries in the region: Kazakhstan, Kyrgyzstan, Tajikistan, and Uzbekistan (pending approval by the Government of Uzbekistan).

The Quality Health Care Project will provide technical assistance, training, equipment and commodities to assist the Central Asian republics to improve the quality, scope, and coordination of a broad range of health services, including HIV. By incorporating modern quality improvement techniques and evidence-based international standards into ongoing reforms of health systems, this program will assist Central Asian countries to improve their management, financing, and implementation of medical services provided for TB, HIV, maternal and child health, and primary health care (PHC). USAID envisions that the project will work in the same geographical areas with HOP.

OBJECTIVES

The main objectives of this research were to:

1. Identify HIV services being provided to the five HOP MARP target groups (men who have sex with men [MSM], sex workers, IDUs, former prisoners, and PLWH) in Chui Oblast and Bishkek to assess the following:[1]
    - Service provision and geographic coverage
    - Fees
    - Referral processes
    - Best/promising practices

[1] Owing to civil unrest and the general disruption of health services at the time of the survey, Osh and Jalalabad oblasts were dropped from the survey. It is hoped that the survey can be conducted there at a later date as survey results might be different than results from Bishkek City and Chui Oblast.

- Perceived challenges and barriers
- Informed consent procedures.

2. Identify perceived quality of services and service gaps among MARP target groups that are users and nonusers of HIV services in the previously mentioned sites.
3. Develop recommendations for improving access to and the quality of services provided by the facilities.

METHODOLOGY

Qualitative research methodologies, namely semi-structured interviews and focus group discussions, were conducted among different groups of respondents in Chui Oblast and Bishkek (see Appendix 1 for a list of respondents).

Semi-structured interviews, supported by a mapping tool interview guide (see Appendix 2), were conducted with representatives and selected staff of government facilities that provide HIV, TB, STI, methadone, needle exchange, and other related services to target key MARP groups. These facilities included:

1. National AIDS center
2. Chui Oblast AIDS center
3. Bishkek city AIDS center
4. Chui Oblast TB center
5. National dermatovenerology center
6. National narcology center
7. MAT point in Tokmak
8. Chui Oblast Family Medicine Center
9. Zhayil district Family Medicine Center in Karabalta.

In addition, semi-structured interviews using a separate tailored tool (see Appendix 3) was conducted with key staff from HOP NGOs (Antistigma, Pravo na zhizn, Rans Plus). The objective of the interviews with NGOs was to assess the range and coverage of services provided by them in relation to the size of the key MARP groups they serve.

In addition to these two sets of semi-structured interviews, a series of focus group discussions (FGD) and individual in-depth interviews with IDUs, PLWH, sex workers, and former prisoners were conducted. The purpose of these FGDs and individual interviews was to identify the perceived quality of services provided by government facilities, NGOs, and the private sector as well as service gaps, unmet needs, and challenges these MARP groups have encountered when accessing needed services.

LIMITATIONS

There are several factors that could introduce a bias into results of this rapid assessment:

- This study was conducted in the form of a qualitative rapid assessment that does not allow drawing any conclusions about the actual (statistical) prevalence of specific concerns, attitudes, or beliefs among service providers or clients (MARPs).
- The study focused only on Chui Oblast and Bishkek City and as such is not necessarily representative of the overall situation in the country.
- Collection of statistical information about the number of MARPs served by a medical facility (other than friendly clinic or trust point) during a certain period of time was not possible due to the fact that medical facilities do not keep their attendance records by specific groups of people, only by gender, age, and the reason for referral (disease).
- MARP representatives who participated in FGDs or individual interviews were recruited through NGO representatives (outreach workers) and thus only included clients of HIV-related services. No hidden subgroups of MARPs were interviewed. In addition, the number of FGD participants was too small to be representative of the population. Focus groups or interviews with 8 to 10 members of each target group, when each target group measures in the hundreds to thousands, could not meet the statistical assumptions to extrapolate accurately or reliably to the overall MARP group.
- FGD participants could have expressed views that are consistent with social standards in order to not present themselves negatively. This social desirability bias may have lead respondents to self-censor their actual views, especially when asked questions in a group setting. To partially control this bias, in-depth interviews with individual clients from each of the MARPs were conducted in addition to the FGDs.
- Many of the respondents from governmental medical facilities were also employed by different NGOs for project support, therefore some of the services provided by them were actually provided by them from within their NGO's scopes of work and would not be normally provided by the staff of the facility. In such situations, respondents were asked to specify in which capacity they were providing services to MARPs.

DETAILED FINDINGS

FINDINGS FROM THE MAPPING ASSESSMENT WITH GOVERNMENT FACILITIES

The structure of HIV-related medical services in Kyrgyzstan is complicated and crosses several national programs and vertical systems, including the following:

- *National- and oblast-level AIDS centers,* which are mostly responsible for HIV surveillance, including sentinel surveillance, oversight, and implementation of HIV prevention and specialized care and support to PLWH; as well as provision of organizational and technical support to different health facilities on HIV-related services, including FHC infectious disease specialists.
- *National- and oblast-level TB centers,* which are responsible for coordination of TB activities, TB surveillance, oversight and implementation of TB prevention and treatment programs, and provision of organizational and technical support to different health facilities on TB-related services, including FHC TB specialists.
- *The National Dermatovenerelogy Center and its branches in the south,* which are responsible for prevention, diagnosis, and treatment of STIs, and organizational and technical support to different health facilities on STI-related issues, including FHC dermatovenerologists.
- *The National Narcology Center and its branches in the south,* which are responsible for coordination of curative and preventive assistance to patients with addiction to psychoactive substances and organizational and technical support to different health facilities on addiction-related issues, including FHC narcologists.

All of these facilities serve as points of reference for other medical facilities in regard to their respective diseases.

Aside from clinical institutions, sanitary and epidemiological stations (SESs) are responsible for registration of HIV-positive cases, epidemiological surveillance, collection of information on HIV-related morbidity, and oversight of prevention activities in health facilities. The National Health Promotion Center and its branches at the oblast level are mandated to organize HIV education among the general population, with an emphasis on youth.

Government facilities included in the rapid assessment provide different levels of services related to HIV and MARPs (more details on each service can be found in the subsequent section):

1. FHCs located at the rayon level provide a wide range of services related to HIV prevention and awareness raising among the general population and MARPs, distribution of condoms and syringes, HIV testing and counseling, very basic STI testing, opioid substitution therapy (OST), and antiretroviral therapy (ART).

2. Local AIDS centers provide more technical assistance to the infectious disease specialists at the PHC level, provide HIV testing and counseling, ART, and implementation of HIV prevention among MARPs.
3. Specialized tertiary-level medical facilities with inpatient capacities such as the National Center of Narcology, the National STI Center, and the oblast level TB centers are focusing on testing and treatment of their respective diseases. For PLWH, specialized facilities either invite FHC or HIV center specialists to participate in the management of patients or manage the person the same as the other patients regardless of HIV status.

Health financing in government medical facilities in Kyrgyzstan utilizes a system of co-payments (medical insurance), which means that a fee (50 percent of the cost) is charged for virtually all medical services provided to clients by government medical facilities.[2] Some groups of populations are exempt from paying any co-payment fees (people older than 65 years, children younger than 5 years, disabled persons); discounts are applied for those who are considered officially unemployed or poor (based on family size and income). To be eligible for and receive services based on a co-financing system, a person needs to have identification, be registered at his/her place of residence and a local FHC, and be enrolled in the medical insurance fund (for which one must be officially employed). Those who are not working but are not officially registered as unemployed so do not have documents confirming their poverty status as well as those who do not have identification and are not registered with any of the FHCs (most of the time because they do not have a registered place of residence) have to cover 100 percent of costs. Anonymous services and services provided by private medical facilities do not require any registration or personal identification but cost significantly more than those provided through a co-payment system at government medical facilities. The range and the quality of services provided is the same for patients on a co-payment system and those who themselves fully cover the costs of the services themselves. No costs are charged for HIV-related services and supplies provided by different projects, funded by external donors (GFATM, UNODC, U.N. Population Fund, USAID, etc.).

Working hours for outpatient services at government facilities are from 8:00 a.m. until 5:00 p.m. (sometimes 4:00 p.m.), and also apply to trust points, friendly clinics and OST sites opened within GFATM-funded projects.

All facilities visited have some sort of a system in place to assess the quality of services provided. However, this system is limited to the periodic review and analysis of data that comes from official statistics. None of the facilities conduct client satisfaction surveys or involve clients in their programming.

Key challenges in implementation of quality HIV prevention, treatment, care, and support services from the side of health facilities include the following:

- Low motivation of service providers due to low salaries
- Lack of staff and inability of facilities to attract young specialists
- Low staff retention rates
- Poor condition of buildings

[2] A visit to the general practitioner, complete blood count, general urine test, and electrocardiogram provided at the FHC level are free of charge for all those enrolled in a co-financing system.

- Limited and outdated equipment or inability of staff to operate the existing high-technology equipment or lack of supplies for it
- Limited access to updated medical resources and literature.

The biggest client challenge reported by providers, especially when working with IDUs, is to develop health-seeking behaviors and a responsible attitude toward their health status.

Based on discussions with staff, increased salaries or additional payments are the only real motivation for health service providers working at the government facilities. Improved working conditions (e.g., renovated buildings and modern equipment) and an opportunity to receive additional trainings and high-quality professional literature are additional motivation that is welcomed by the staff; however, these motivational tools would not suffice in lieu of additional compensation.

Cooperation of government medical facilities (the local AIDS centers, FHCs, and STI centers) with NGOs is mostly based on the fact that some of the physicians are hired by NGOs to implement project activities and receive additional payments. Government medical facilities often do not consider NGOs as equal partners that are able to help them in improving the quality of services provided to the population, especially to MARPs, and therefore do not include NGOs in any formal planning of health services for MARPs.

Only two facilities (the Family Medicine Center of Dzhail Rayon and the National Dermatovenerology Center) have had a chance to participate in the system of vouchers started by HOP that were implemented as referral tools to support client use of multiple essential services. Because there are no services available only to clients referred by HOP, service providers think that vouchers are only useful for HOP internal monitoring purposes and thus do not feel responsible for filling them in or making sure they are not lost.

HIV PREVENTION AND AWARENESS RAISING

Among governmental medical facilities, FHCs and local AIDS centers are generally responsible for HIV prevention and awareness raising among the general population and MARPs.

HIV awareness activities conducted by FHCs through the network of general practitioners (GPs) are limited to implementation of short educational lectures to organized groups (such as in educational facilities or at a workplace), as well as nonsystematic HIV-related discussions with those clients of GPs who are known to practice risky behaviors (e.g., IDUs). Topics of those discussions usually include provision of basic information about HIV and its modes of transmission. Rayon-level narcologists who are located at the FHCs are also responsible for HIV prevention and awareness raising among IDUs (both clients of OST programs and other IDUs using narcology services at the PHC level). Distribution of IEC materials, most often developed within the GFTAM-funded project or other projects are distributed to clients of the trust points and friendly STI clinics.

Needle and syringe exchange (NSE) is available through trust points located at FHCs and local AIDS centers. The range of services provided at trust points includes distribution of clean needles and syringes, distribution of IEC materials, referral for HIV testing, and OST. Working hours of trust points located at government facilities are from 8:00 a.m. until 5:00 p.m.; they are closed on Saturdays and Sundays. All trust points located within governmental medical facilities are staffed by a nurse, a social worker, and several outreach workers. All needles and syringes are provided for clients free of charge as part of the GFATM-funded project. There is anecdotal evidence that

syringes/needles are sold to IDUs by outreach workers or by drug dealers at *yamas*.[3] At the time of interviews, none of the facilities had operational mobile trust points.

HIV COUNSELING AND TESTING

According to the National HIV Law of the Kyrgyz Republic, any person can undergo HIV VCT at any medical facility. Based on the data from laboratories of the Chui Oblast AIDS center and Bishkek city AIDS center, the vast majority of tests are provider-initiated (mostly for pregnant women) or for immigration purposes when client-initiated (see Table 1).

Table 1. Number of tests performed in August by code in all rayons of Chui Oblast.*

Reason for Testing/Code	PITC or VCT	Number of Tests	Percentage of the Total Number of Tests Performed
Pregnant women/109	PITC	838	66%
Clinical reasons/113	PITC	157, including 30 for TB patients	12%
Contacts of PLWH (during epidemiological investigation)/115	PITC	138	11%
Prisoners/112	PITC	59	5%
Medical staff/118	VCT	42	3%
IDUs/102	VCT or PITC	29	2%
Sex workers/104	VCT or PITC	29	2%
Migrants/106	VCT	20	1.6%
Anonymous/114	VCT	6	0.5%

PITC, provider-initiated testing and counseling; VCT, voluntary counseling and testing
*Data of the Chui Oblast AIDS Center obtained during an interview at the facility.

Provider-initiated testing is done is accordance with the *prikaz* #445 dated December 11, 2007. According to this *prikaz*, written consent of a person tested is required for any type of HIV testing. Testing and counseling is free of charge, except for the situation when a certificate regarding HIV status is needed for immigration or other purposes. In this case, express test (results within four hours) costs 150 soms (U.S.$3), while cost of a normal test (results in one to three days) is 100 soms (U.S.$2).

All facilities (AIDS centers, FHCs, TB dispensaries, STI dispensaries, narcology centers) provide HIV testing and counseling. The actual testing is done at the AIDS centers (enzyme-linked immunosorbent assay [ELISA] at local AIDS centers and Western Blot at the National AIDS Center). Every facility has a technician who is specifically assigned to provide VCT, and all staff are trained. If the result is negative, post-test counseling is done at the facility where the blood was drawn; there are instances when negative test results are provided by phone without counseling. If the result is positive, post-test counseling is conducted by staff of the local AIDS center. No system to assess the quality of counseling provided to clients exists.

[3] *Yamas* are sites where drugs are being sold and sometimes injected.

Client-initiated testing can be done anonymously (using a code or any name the patient provides for reference). If the first test is positive, the AIDS center contacts the medical facility that sent the blood for testing and asks for a second blood sample. This sometimes creates a problem if the person was tested anonymously and did not leave any contact details (this most often happens with MARPs referred by outreach workers). In this case, medical facilities either ask the NGO that referred the client to find him/her or tries to find the client themselves.

On average, it takes three to five days for a person to receive a negative result and up to three weeks for a positive result. Positive results are given in verbal form only; no written documentation is provided. At the time of notification and at a following psychological counseling session at the AIDS center, a person who has tested positive is provided with information about existing care and treatment services and NGOs that work with PLWH. At the time the patient is informed about the positive HIV test result, the results are sent as an urgent notification to the local SES that is responsible for the follow-up epidemiological investigation as well as to an infectious disease specialist at the FHC near the person's place of residence. Partner notification support is provided on the client's request either by an SES epidemiologist during the epidemiological investigation or later by an FHC infectious disease specialist or personnel of the AIDS center.

TREATMENT SERVICES FOR PEOPLE LIVING WITH HIV

ART was launched in Kyrgyzstan in 2005. ART is decentralized and integrated into PHC services. ARV drugs are provided by the network of local AIDS centers as well as family medicine centers. As of October 1, 2010, 311 PLWH were receiving ART. ART drugs are provided free of charge for patients and are fully funded by the GFATM grant. According to the current clinical protocol (updated in 2007), PLWH are put on ARVs when their CD4 cell count is 350 or lower. A perceived ability of a person to adhere to treatment is also considered for ART initiation in addition to the CD4 count. Therefore, active drug users not on MAT are not started on treatment regardless of their CD4 counts.

A majority of doctors responsible for ART at all levels have received special training organized either by the National AIDS Center or different projects. Updated clinical protocols and *prikazy* are sent by the National AIDS Center to all local AIDS centers and oblast FHCs to be further distributed among infectious disease specialists from the FHCs. ARVs are distributed by the National AIDS Center. At rayon-level FHCs, the infectious disease specialist receives ARVs for patients and stores them at the FHC. There are no proper pharmacy conditions to store even small amounts of ARVs at the Bishkek city AIDS center, so patients from that center are referred to obtain their drugs at the National AIDS Center. PLWH receive ARVs for one to three weeks at a time, depending on their adherence. During the last 12 months, there were no stockouts of drugs.

Clinical monitoring of PLWH is done once every six months based on clinical symptoms and CD4 counts. For Chui Oblast, CD4 counts are run at the Republican AIDS Center, where all FHCs and other AIDS centers send blood samples for testing. Currently, there is no opportunity to do viral load (no supplies and no trained specialists). CD4 count is also not always available due to shortage of supplies (last stockout of tests was in 2010 and lasted for six months). As a result, PLWH are not able to start ART. For example, out of 183 PLWH registered in Dzhail rayon as of December 1, 2010, only 2 receive ART. When questioned about the reason for such low numbers, most respondents, including PLWH themselves, said that this is due to the absence of CD4 counts.

Depending on the specific needs, PLWH are also being referred by the FHC or AIDS center specialists to different specialized services or other specialists within the FHC (e.g., TB specialists, narcologists, gynecologists, STI specialists).

Treatment of opportunistic infections (OI), excluding TB (see subsequent section on TB), is provided either by FHC infectious disease specialists or staff at the AIDS centers. Some drugs for OI treatment (antifungal, broad spectrum of antibiotics, antivirals) are provided by the GFATM grant. Drugs not provided by the GFATM or unavailable have to be procured by the patient in retail pharmacies. During the past 12 months, there was a 6-month break in supply of drugs for OIs, which led to stockout of some drugs in all oblasts of Kyrgyzstan, including Chui and Bishkek city. Generally, proper diagnosing, especially if it requires laboratory confirmation, remains challenging due to the low qualification of laboratory specialists and little experience managing OIs.

Hepatitis C testing and treatment can be done for those PLWH who can pay for it. Some projects for PLWH have included hepatitis C testing in the past, but commonly patients need to pay themselves. The cost of ELISA testing for hepatitis C markers is around U.S.$5, while the polymerase chain reaction test costs around U.S.$27. Hepatitis C treatment remains extremely expensive and is not covered by any insurance. Moreover, there are only a few specialists in the country that have experience treating hepatitis C. Due to these concerns, hepatitis C treatment is considered inaccessible.

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION

Kyrgyzstan updated its clinical protocol for PMTCT in 2009 (*prikaz* #917 dated April 25, 2009). PMTCT services are provided free of charge at FHCs and maternities. The National AIDS Center, in collaboration with different international organizations, is responsible for organizing training on PMTCT for medical professionals.

The Kyrgyzstan MOH issued a *prikaz* for universal HIV testing of pregnant women in November 2007 to be performed by doctors at FHCs for antenatal clients. Maternity hospitals conduct intrapartum testing for women with undocumented HIV status. All maternities have rapid tests available on site. Antenatal ARV prophylaxis for mothers and ARV prophylaxis for their infants to prevent vertical transmission is done at the FHC (lamivudine and zidovudine [Combivir]). In the case of late HIV testing and a need for intrapartum prophylaxis, a single dose of zidovudine is given to a mother during delivery. There were no stockouts of drugs during the last 12 months.

Infant feeding counseling is done by the pediatrician at the FHC level. Free distribution of baby formula for children born to mothers living with HIV is guaranteed by the state in Kyrgyzstan; however, due to procurement issues, FHCs face problems in providing it to women.

Family planning counseling is done by gynecologists at the FHC level. However, no specific training was organized and no information was provided to specialists on family planning and reproductive health issues in relation to HIV. Thus, FHC gynecologists do not always feel confident in discussing this topic with PLWH.

COMMUNITY- AND HOME-BASED CARE AND SUPPORT FOR PEOPLE LIVING WITH HIV

No support services for PLWH are provided at the FHC level. AIDS centers are the only facilities that provide support to PLWH, but mostly in the frame of different projects and in close collaboration with NGOs. The range of services includes referral for legal counseling, psychological

counseling, adherence counseling and support, support in obtaining permanent disability status or getting personal identification documents, food packages, and provision of other humanitarian aid. Psychologists working at the AIDS centers are paid from the GFATM grant. AIDS centers try to attract family members of PLWH to work as outreach workers and help with adherence. Considering their high work load, absence of permanent social workers on staff, and low motivation of personnel, government facilities prefer to refer PLWH for support services to different NGOs working in the area.

Provision of home-based care through governmental medical facilities surveyed is limited to bringing methadone to MAT clients temporarily on bed care. In such cases, although extremely rare, a nurse of the MAT point is responsible for delivering methadone to patients. Other than that, no home-based care is provided to PLWH or other groups of clients. Occasionally, patients and their family members are referred to different religious organizations or Red Crescent branches to seek home-based care services, but those referrals are not systematic.

TUBERCULOSIS DIAGNOSIS AND TREATMENT

Kyrgyzstan has made substantial progress toward integrated TB service delivery. TB detection is primarily passive, and PHC providers are responsible for identification of TB suspects (done by sputum microscopy, fluorography, or chest radiography; skin test for people younger than 18 years) and referral of those who are TB-positive for services (to either the oblast TB dispensary in Lebedinovka or the inter-regional TB clinic in Karabalta).

Screening for TB at the PHC level can be done in one day, but patients are usually asked to come back for results the next day. Sputum smear microscopy is done at the FHC free of charge for all patients. Each PHC has a laboratory specialist specifically assigned and trained to do sputum microscopy. For a person with insurance, the cost of fluorography regardless of their HIV status is 20 soms (U.S.$0.50) and the cost of x-ray is 49 soms (U.S.$1). Cost of services doubles if a person has no insurance. An oblast TB dispensary has a mobile unit equipped with x-ray capability that is intended for TB screening in rural locations where no TB screening is available. During the past 12 months, however, this unit was not used by the oblast TB dispensary due to the shortage of supplies, including gasoline, and of staff willing to travel.

TB diagnosis and treatment is done at specialized TB service centers. Referral by an FHC specialist is required for free of charge hospitalization. In the case of self-referrals, a patient has to pay for a complete blood count (CBC), chest x-ray, and an electrocardiogram. Culture and drug susceptibility testing (DST) is done at the National TB Center. For the last several months, the National TB Center was not able to do any DST due to a shortage of supplies. The intensive phase of treatment for smear-positive TB patients is provided on an inpatient basis free of charge. Smear-negative TB patients, especially PLWH, can opt to be treated at the FHC level on an outpatient basis at the FHC. The continuation phase of Directly Observed Treatment Short-course (DOTS) for TB. multidrug-resistant TB DOTS, and DOTS+ are also provided at the FHC level. Most of the TB drugs, including first- and second-line drugs, are provided by the GFATM grant and are received by the oblast TB dispensary from the National TB Center. During the last 12 months, there was a short (two-month) break in supply of pyrazinamide; this break, however, did not lead to treatment interruptions because the oblast TB dispensaries were able to buy the necessary volume of this drug using their own budgets.

Oblast TB dispensaries do not have equipment necessary to implement any additional medical tests and investigations for hospitalized patients (for example, hepatitis B or C tests, ultrasound, etc.).

Doctors of the TB dispensary have to take their patients to other medical facilities (either to the FHC or other third-level facilities) if there is a need to do any additional testing. In such cases, the cost of additional tests and investigations is covered by the patient.

Management of patients with dual TB and HIV co-infection is done in collaboration with staff of the AIDS center (either the city or oblast AIDS center) or an FHC infectious disease specialist (depending on where the patient is normally being treated for HIV) based on the clinical protocol approved by the MOH *prikaz* #178 dated April 25, 2008. An oblast TB dispensary does not have co-trimoxazole on site, but when there is dual TB/HIV co-infection, either the AIDS center or the FHC sends the necessary amount of the drug. ARVs are also supplied by the FHCs or the AIDS centers. Patients with dual infections often receive additional food packages and the necessary supply of drugs from NGOs. Sometimes, this causes conflicts with other TB patients who are not HIV-positive as they do not receive support from NGOs.

Provision of clean needles, syringes, and condoms for those TB patients who inject drugs is done by NGOs at the request (by phone) of the oblast TB dispensary. There is no trust point or regular needle exchange services at the site.

Quality control is limited to the periodic review and analysis of data that comes from official statistics. None of the TB facilities surveyed conduct client satisfaction surveys or involve clients in their programming. The oblast TB dispensary is responsible for the supervisory monitoring of all TB specialists and laboratories working in Chui Oblast. Transportation expenses for monitoring visits are included in the budget but are not funded, therefore, in 2010 staff of the oblast TB dispensary were not able to do any monitoring visits.

TB dispensaries are located in very old buildings, some dating back to the 1930s (originally intended for no more than 20 years of use). Low salaries of staff; aging personnel and high rates of staff turnover, especially among laboratory workers; old and unsuitable buildings for TB wards; and poor infection control measures are among other challenges of the oblast TB dispensary. Sometimes, masks, respirators, and uniforms are provided to staff by projects, but normally all staff members are expected to buy those themselves.

SUBSTANCE USE SERVICES

Substance use treatment services are provided by narcologists at FHCs and the National Center of Narcology in Bishkek. At FHCs, all services are outpatient, while the National Center in Bishkek provides both outpatient and inpatient services. The range of services provided at FHCs include counseling, withdrawal treatment (drug-assisted detoxification), provision of MAT (OST with methadone), limited harm reduction services (mostly NSE and distribution of IEC materials), and naloxone for overdose prevention in nonmethadone IDUs (piloted in 2009 and restarted on a limited scale using UNODC funding in October 2010). Inpatient withdrawal treatment with methadone and rehabilitation for up to one month are also available at the National Center of Narcology. Wound management for post-injection complications is provided at the surgery department of FHCs, oblast hospital, or city hospitals in Bishkek.

Virtually all substance use treatment services provided at the National Narcology Center, except those funded using external sources (OST, NSE, and naloxone), require payment from clients (either through 50 percent co-payments or full payments if noninsured). Payments received from patients and the Medical Insurance Fund are not sufficient to cover the costs of operating the facility; therefore, the center is not motivated to provide additional services. For example, previously, all inpatient IDU clients were screened for hepatitis B and C, but this practice was stopped due to the

high costs for the facility (blood samples are being sent to SES for testing). Only patients with symptoms of active hepatitis are being examined by facility staff and medical consultants, screened for hepatitis B and C, and treated by basic detoxification, therapeutic nutrition, and hepatoprotectors.

The cost of inpatient 10-day detoxification varies from 830 soms (approximately U.S.$18) if a person has insurance, a personal identification document, and was referred to the center by the FHC; 1480 soms (U.S.$32) if a person does not have insurance, has identification, and was referred by the FHC; to 2400 soms (U.S.$51) if a person has no identification, no referral, and no insurance. All costs mentioned apply only if a person agrees to be registered as a drug user. Anonymous services require no registration and the cost for a 10-day drug-assisted withdrawal therapy is around 4800 soms (over U.S.$100). Based on physician feedback, the quality of detoxification services provided as part of the medical insurance scheme is poor because of the limited spectrum of drugs available. The quality of anonymous detoxification is better because it allows using more effective drugs and other services, such as psychotherapy, which address underlying mental health issues.

OST with methadone is provided within the framework of the GFATM-funded project. The *Clinical Protocol on Substitution Methadone Maintenance Therapy* was developed and adopted by the MOH in April 2008 (MOH and Ministry of Justice 2008). The usual working hours for drug treatment service centers are from 8:00 a.m. until 1:00 p.m. seven days a week, which allows patients to pick up their medication either before working hours or during a lunch break. Previously, OST services in specialized and drug treatment centers based at FHCs employed a team of specialists that included narcologists, nurses, social workers, and psychologists or psychotherapists. Currently, the position of psychotherapist has been dropped and not all the centers have social workers. Therefore, the quality and the outcome of OST vastly depends on the qualification of the narcologist and their ability and desire to provide effective individual and group counseling to clients. Most often, narcologists initiate psychological counseling with clients only if the urine test for drugs comes out "dirty," indicating current use of drugs. With more clients on OST and availability of only one narcologist and one nurse who fulfill the roles of general narcology services within FHCs, monitor and implement the OST program, and monitor and implement NSE, there is a risk that the existing OST sites may turn into methadone distribution points with no psychotherapy available to IDUs, thus limiting the broader health impact of OST services.

SEXUALLY TRANSMITTED INFECTION SERVICES

Despite efforts to fully integrate STI services into the PHC system, most patients with STI symptoms are either referred to specialized STI dispensaries or private clinics. Most FHCs have an STI specialist at the site, but the range of services provided to clients is limited to smear tests and Wassermann's reaction for syphilis, and general consultations. If a patient is diagnosed with an STI, treatment can also be prescribed at the FHC (laboratory confirmation of an STI is required). In the case of outpatient STI treatment, all drugs have to be procured by the patient. As an example, at the time of the survey, the range of costs for some drugs used for treatment of different STIs were as follows (prices for drugs vary depending on the pharmacy and the brand):[4]

- Benzathine benzylpenicillin (2.4 million IU) in 5-mL vial—U.S.$2.50 to 4
- Ceftriaxone 1 g (as sodium salt) in vial—U.S.$1 to 2

[4] Data from a pharmacy in Kara-Balta, Chui Oblast and pharmacy hotline in Bishkek (+996312 910026).

- Azithromycin 250 mg—U.S.$4 to 6
- Ciprofloxacin 500 mg (as hydrochloride)—U.S.$1 to 2
- Doxycycline 100 mg (hydrochloride)—U.S.$0.30 to 1
- Fluconazole (in capsule: 50 mg)—U.S.$1.30 to 2.20
- Acyclovir 200 mg (in tablets)—U.S.$0.70 to 1
- Metronidazole (suppository: 500 mg, 10 pack)—U.S.$0.70 to 2
- Clotrimazole 100 mg (in vaginal tablets, 10 per pack)—U.S.$0.70 to 1.

The oblast dermatovenerology dispensary (oblast STI dispensary) located in Bishkek provides outpatient and inpatient STI services for patients from Bishkek or Chui Oblast. A wide range of laboratory and treatment outpatient services for the general population is provided at the anonymous STI office. All services provided at the anonymous STI cabinet have to be paid by the patient.

One of the STI friendly clinics (FCs) funded by the GFATM grant is also located at the dispensary; another is located at the Bishkek city AIDS center. These clinics mostly serve MARPs (primarily sex workers and drug users) referred by different projects. All services provided at these sites are free of charge for the patient. Provision of anonymous STI services at any qualified medical facility is implemented based on the MOH *prikaz* #270 dated May 21, 2010; no separate *prikaz* exists for the friendly STI clinics.

Staff of the FCs include a doctor and a nurse. With GFATM funding, the FC at the oblast STI dispensary is able to provide a wide range of diagnostic services, including smear, culture test, and blood test for the most common STIs. This particular FC is able to conduct laboratory testing for STIs. Upon initial consultation a syndromic approach to STI treatment is used, and a doctor prescribes appropriate treatment based upon symptoms and adjusts the treatment strategies based on laboratory results. Results are normally ready on the next day. The FC located at the Bishkek city AIDS center cannot perform laboratory testing at the site; its STI treatment strategy for a suspected STI infection is either to refer patients to the STI dispensary (if a patient agrees) or use a syndromic approach. None of the FCs provides written results of any tests to patients. All documentation remains with the FC. When an STI is diagnosed, the FC can either refer a client for hospitalization (highly recommended in cases of syphilis in pregnancy and complicated or recurrent cases of an STI) or prescribe outpatient treatment. Drugs prescribed to FC clients for STI treatment are free of charge and are provided by the GFATM project. Clients can also be tested for HIV at the FC (for FCs at the STI dispensary, FC draws the blood and sends it to the AIDS center for testing). FCs also distribute free condoms and IEC materials to clients.

During the last six months, the GFATM project did not provide any funding/supplies to FCs. Without external funding, the FC located at the National Dermatovenerology Center was able to continue providing diagnostic and counseling services to clients using its own resources. However, clients are now being asked to buy all drugs themselves and, if needed, pay for additional testing. In the absence of funding, the FC located at the Bishkek city AIDS center has stopped most of its activities: as it does not have its own laboratory, only three sex workers were served for the first six months of 2010.

FINDINGS FROM SEMI-STRUCTURED INTERVIEWS WITH HEALTH OUTREACH PROJECT NONGOVERNMENT ORGANIZATION STAFF

The NGOs surveyed serve different groups of MARPs and implement several projects, which helps to ensure sustainability of their work and organizations, as well as provide a diverse array of services to clients. All of the services provided by NGOs are free of charge. No NGOs surveyed implement activities other than those funded through grants.

All NGOs have a system to measure the quality of services they provide. Quality of services is informally discussed during FGDs or in unofficial conversations with clients. NGOs also conduct periodic surveys among clients to assess service satisfaction and to determine needs. Also, NGOs have routine monitoring systems to track the number of clients reached by each of the outreach workers and the number/type of services and supplies provided. Outreach coordinators conduct periodic field visits to monitor the work of outreach workers.

With the aim to ensure effective functioning referral systems within different projects, all NGOs have signed formal memorandums of understanding (MOUs) with various governmental medical facilities. The MOUs are mostly needed for NGOs to show donors proof of support and collaboration with governmental institutions. The MOUs also function as a means to keep government facilities informed about activities and projects implemented by NGOs. The real collaboration and support from governmental medical facilities in ensuring client-friendly and accessible services to MARPs is provided mostly when staff of government medical facilities are employed by NGOs for projects. All NGOs surveyed had several staff that were also staff of governmental medical facilities. When working with PLWH, having personnel of government medical facilities (FHC infectious disease specialists and AIDS center staff) on staff not only ensures easier access to services for clients, but also provides the target group with access to NGOs.

NGOs have highlighted a number of commonly expressed needs and challenges faced by target populations, as follows:

IDUs and former prisoners:

- Problems with law enforcement structures, even when a person does not violate any laws. For example, if a person who is registered as an IDU and/or former prisoner is stopped by the police while carrying clean syringes/needles, they will often be questioned, searched, and taken to a police station for further questioning.
- Absence of work and income.
- No place to live.
- Health problems, especially post-injection complications and hepatitis B and C.
- Lack of money to access medical services (transportation costs, service fees, cost of medicines).

PLWH:

- Challenges related to accessing health services, especially among those clients who come from rural areas (transportation costs to Bishkek and fear of being seen by neighbors or relatives if they use local services).

- Disrupted availability to CD4 counts due to shortages of supplies at the laboratory in Bishkek or inability to arrange sending blood for testing from the rayon level to Bishkek via FHCs.
- High level of HIV-related stigma in society, especially in rural areas, and high level of self-stigmatization among PLWH and their family members.
- OIs and their treatment (doctors at FHCs do not always know how to manage and do not have appropriate drugs).
- Access to social support, including medical insurance and disability pension.
- Food packages and other humanitarian aid.

Sex workers:

- Problems with law enforcement structures. Women are regularly arrested by the police without any charges and let go after paying bribes.
- Supply of quality condoms and lubricants.
- Access to STI screening and treatment services.
- Abortions for unwanted pregnancies, including abortions after 12 weeks of pregnancy.
- Day care, presents, food/hygiene packages for children.

In the opinion of most NGOs, an ideal HIV service delivery system for MARPs would be based on a client-centered approach with individual tailored packages that draw on a wide range of social, legal, and psychological services. The ideal project would also include a temporary housing solution (drop-in center, community center)—a place where clients could spend time, socialize, and learn new income-generating skills. In order to provide services in a drop-in center, NGOs would prefer to have an opportunity to buy premises using grant funds rather than renting different locations and spending the same and even more funds without ever being able to obtain a permanent place.

As a target for a single outreach worker, 35 to 50 clients with at least two contacts with each client per month should not be exceeded; otherwise, the work is not effective, and it is not possible to verify results achieved. Considering very low salaries and the high workload of medical staff of governmental organizations in Kyrgyzstan, provision of financial motivation is needed to ensure access of MARPs to friendly services is provided at governmental institutions.

Vouchers are useful for NGOs to monitor use of referrals; however, their successful implementation is only possible when social workers or outreach workers escort clients to the medical facilities and keep the vouchers, or when the medical provider is employed by the project and has a vested interest in completing a voucher and then returning it back to the project.

Financial sustainability due to dependency on external grants remains a key issue for all NGOs. The NGOs surveyed are good at writing project proposals and looking for external funding, but with some of the donors closing their grant components (Central Asia AIDS Control Project, Central Asia Regional HIV/AIDS Programme) and the GFATM providing funding for a limited spectrum of harm reduction services, funding opportunities for comprehensive services are very limited.

In terms of management systems and strengthening needs, NGOs need support in strategic planning and management, human resources management, and overall programmatic and operational management of their organizations. Target groups have growing demands for services

and organizations can no longer limit their menus to provision of minimal harm reduction services. Implementation of a comprehensive package of educational, social, and legal services requires qualified staff. Currently, NGOs face problems finding properly trained social workers, psychologists, or lawyers who are willing and able to work with target groups. Finding training opportunities and technical literature for those specialists in the country is also challenging. Organizations also need more information about best practices in the region. All of them have expressed the desire to visit other organizations that have made progress in working with MARPs and see their work in real time (study tours).

FINDINGS FROM FOCUS GROUP DISCUSSIONS

FOCUS GROUP DISCUSSION WITH PEOPLE LIVING WITH HIV

This FGD was conducted in Kant at the office of the NGO Antistigma. A total of six PLWH participated, including two women. FGD participants came from different sites around Kant. The FGD lasted for approximately 80 minutes.

All of the FGD participants received HIV-related services at governmental facilities more than once over the previous 12 months. These services included PMTCT, MAT, monitoring of ART, and TB diagnosis and treatment. The quality of services provided mainly depended on the individual doctor who worked with the participant. For example, all the FGD participants liked the infectious disease specialist working at the FHC (also employed by the HOP subproject), and they thought that services (ART monitoring, management of OIs) provided at the FHC are accessible and friendly. The GPs/family practitioners of three out of six FGD participants were told about the client's HIV status, and there were no stigma problems. In everyone's opinion, stigma and discrimination of PLWH by medical specialists has been reduced significantly over the last three years. Still, random instances of discrimination occur and a few doctors working at the FHC continue to show a negative attitude toward PLWH. For example, there was a case where a person was refused surgical assistance to address local inflammation on her hand after announcing to the doctor that she was HIV-positive. Also, aside from irregular negative attitudes about HIV, there are some situations where FHC doctors do not have sufficient knowledge and information about HIV to provide the full range of services that are needed. For example, a gynecologist at the FHC did not have information and was not able to provide proper counseling to a woman living with HIV who wanted to get pregnant but was afraid because of her HIV status. The woman was finally provided with some information (only information about the possibility of having a healthy baby, no information about potential risks and procedures) by other women living with HIV at the NGO. Now 10 weeks pregnant, this woman is not on ARVs, has not yet told the infectious disease specialist about her pregnancy, and has not yet been counseled about PMTCT.

Another key concern that all PLWH have voiced is the absence of routinely available CD4 counts. With the increasing awareness among PLWH about the need to monitor their immune status, more and more PLWH are keen to know their CD4 counts in order to make informed decisions about ART.

Aside from making personal complaints, which most PLWH prefer not to do for fear that their HIV status be disclosed, there is no way PLWH can give their opinions about services to providers. As a way to express their satisfaction or dissatisfaction, PLWH discuss doctors and quality of services with NGOs or during peer-support group discussions. However, in the opinion of FGD participants, aside from paying fees to service providers to ensure friendly and quality services, NGOs have no real power to change anything on a structural level.

Services that are directly related to HIV are free of charge (provision of ART, CD4 count and other basic medical investigations, such as CBC, as well as MAT). In 2009, more drugs were available at the FHC, and PLWH were receiving all of them for free, even vitamins. However, one of the FGD participants had an onset of oral candidiasis two months ago and had to buy all the drugs prescribed by the FHC doctor, which were expensive. In addition, a chest x-ray for TB costs around 50 soms (U.S.$1). Even if services are free of charge, there are transportation costs to go from a rayon to the oblast AIDS center in Tokmak or Bishkek, which is not affordable for many PLWH. The need to go to other sites in the presence of integrated HIV care at the FHC level was explained by the high level of stigma and discrimination, especially in rural areas. Most PLWH prefer to receive services (ARVs, OI treatment, and other counseling) in Bishkek because they are afraid to be seen by neighbors or relatives when visiting an infectious disease specialist at the FHC. There are also concerns about confidentiality when using local FHC services.

Fear of having their HIV status revealed to others also prevents some PLWH from using NGO services. All of the FGD participants were regular clients of the project, but they all know other PLWH who refuse to come to an NGO that works with MARPs and participate in peer-support groups because they do not want others to know about their status (even if others are also PLWH). Those who use services of NGOs find them very helpful and useful, especially in terms of providing information, social support, and improving access to medical services through the network of affiliated doctors.

When asked about design and implementation of a service delivery system most responsive to the needs of their community, PLWH said that the current service provision system is adequate, but more work is needed to decrease stigma and discrimination of PLWH among the general population and medical professionals. It would also be helpful to introduce a medical insurance scheme that would allow PLWH to receive services at FHCs based on a co-payment system. This would especially help those PLWH who are unemployed and also avoid problems of possible stigma when being referred by an AIDS center or an NGO known to work with PLWH.

FOCUS GROUP DISCUSSION WITH SEX WORKERS

Two separate small group discussions (two to four participants) took place in two different saunas in Sokoluk rayon. The third discussion (four participants) took place at the home of one of the HOP outreach workers in Shopokovo. In total, 10 women were interviewed. Discussions lasted from 40 minutes to an hour.

HIV testing was the only service that sex workers surveyed used at governmental medical facilities during the past 12 months. Some sex workers were referred for HIV testing by outreach workers and were tested for free (mostly within the framework of the sentinel surveillance surveys), while others needed an HIV certificate to present to a sauna's administrators.

None of the sex workers interviewed used governmental services for STI screening or gynecological assistance during the last 12 months, preferring instead to go to private clinics. The reasons for not using governmental services included not wanting to wait in lines at the FHC, inconvenient working hours of facilities, low quality of services and low trust in qualifications of FHC staff, absence of registration/insurance, and fear of discrimination if someone finds out their occupation. Also, sex workers from remote rayons do not want to go to Bishkek to use FCs because they do not want to spend time getting to Bishkek. In addition, they are often required to produce written confirmation that they do not have any STIs or that STIs were successfully treated, which is not provided at the FC. Some of the women that recently started sex work did not undergo STI screening, but said that if they had symptoms they would most probably go to the private clinic near the sauna.

All but two sex workers were previously contacted by different outreach workers from NGOs, mostly when providing condoms and lubricants. Many times, sex workers are able to get condoms from outreach workers for free only if they personally know outreach workers and have an ability to meet outreach workers outside of the sauna's premises. When outreach workers come to the sauna and leave condoms with the sauna's administrators, the latter often sell the GFATM-funded condoms to sex workers.

When asked about design and implementation of a service delivery system most responsive to the needs of their community, sex workers said that mobile clinics that could come to the sauna in the evening before working hours and provide a wide range of medical services at the site (STI screening, gynecological assistance, and HIV testing), as well as regular provision of quality condoms would be ideal.

FOCUS GROUP DISCUSSION WITH INJECTING DRUG USERS, INCLUDING FORMER PRISONERS

There were two FGDs: one that took place at the office of the NGO RANS Plus in Bishkek and one at the NGO Antistigma in Kant. Ten people, including two women, participated in the first FGD, and 11 people including three women participated in the second group. Both FGDs lasted for about 80 minutes and included IDUs that were former prisoners and MAT clients.

Most of the FGD participants used HIV-related services at governmental medical facilities over the previous 12 months. The range of services included MAT, trust points, and HIV testing at the AIDS center (as part of the sentinel surveillance survey). A few respondents were recently released from prison and had chest x-rays for TB done there.

Those who were on MAT were satisfied with the services and the program. The MAT point is open every day, and the morning working hours are generally acceptable for everyone. However, if a person in Bishkek is not able to get to the MAT point before 12:30 p.m., they will need to get special permission from the Director of the Narcology Center in order to receive services, which usually means waiting for a long time and having an unpleasant conversation with the Director or the Deputy. Speaking about the MAT program, FGD participants noted that they thought provision of methadone prevents people from injecting drugs; without additional social and psychological support, though, it does not allow people to stop using drugs or prevent people from wanting to use drugs. Because IDUs enrolled in MAT do not need to go and look for money to buy drugs, they have a lot of free time; however, because they are unemployed and have nothing to do, they get bored and go back to injecting drugs.

Money and the absence of documents is a general obstacle for IDUs and former prisoners to use any kind of medical services. Because many of FGD participants and other IDUs they know are unemployed or without documents, they are not able to access medical services at governmental organizations through the co-financing system; therefore, self-treatment or no treatment is the usual health-seeking behavior even in serious conditions.

Visits to government- or NGO-based trust points are not common because IDUs are afraid to be caught by police when picking up clean needles and syringes; therefore, it is very common for one person from a group to go to the trust point or meet the outreach worker and take supplies for the whole group. FGD participants stated low quality of needles/syringes provided by the GFATM. They also said that needles/syringes that should be provided for free are being sold by law enforcement personnel in prisons, temporary detention centers, and by drug dealers and distributors

at *yamas*. Two people were in a situation where a guard sold them an already used syringe while in the temporary detention center. Drugs prescribed for TB treatment or other conditions (including ARVs) are often taken away from detainees when being admitted to temporary detention centers. This leads to discontinuation of treatment.

HIV testing can be a challenge for experienced IDUs because nurses are often not able to easily draw blood from IDUs, and because IDUs "treasure" their veins, they prefer not to be tested. In the opinion of FGD participants, currently the most valuable contribution made by NGOs is related to their assistance to IDUs and former prisoners (most of which are IDUs) in helping with documentation. Another valuable contribution is that NGOs can refer clients to medical personnel affiliated with NGOs. Referrals and help in accessing surgical services for post-injection complications are especially welcome.

An ideal service delivery system for IDUs and former prisoners includes provision of more comprehensive services that include legal and psychological support and some income-generation support. FGD participants had an idea to organize a small business (furniture shop, construction team, etc.) for those on MAT and former prisoners who are not IDUs to keep them busy and employed. For active IDUs, narcology services should include distribution of naloxone and an opportunity to get free detoxification. Ideally, distribution of free syringes and needles to IDUs should include distribution through a network of private pharmacies that are accessible all the time and are located in all residential areas.

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APPENDIX I

LIST OF KEY RESPONDENTS

Name	Organization, Position	Contact Information
Adamkaly Kozhamkulov	Sanitary and Epidemiological Station of Dazhail Rayon in Karabalta Epidemiologist	
Aibar Sultangaziev	NGO Pravo na Zhizn Chairman of the Board of Directors	3 Dzerzhinskogo str., apt. 29, Shokoloko +996 313448023 Pravo-jizn@rambler.ru
Aida Karagulova	Bishkek City AIDS Center Epidemiologist	+996 312486617
Aigul Ismailova	National AIDS Center Deputy General Director	+996 312 623823, rospid@mail.ru
Anna Storozhkova	Chui Oblast TB Dispensary Deputy Director	+996 312 603353
Asel Isaeva	Family Medicine Center of Dzhail Rayon Narcologist	
Baktygul Mamytova	Chui Oblast Family Health Center Reproductive Health Coordinator	1 Lenina str., Lebedinovka +996 312333104
Balkabek Israilov	NGO Antistigma Director	+996 772518347 antistigma@mail.ru
Bubina Alyshpaeva	Chui Oblast AIDS Center Head of the Laboratory	
Dinara Yusupova	National Center of Dermatovenerology Director	
Docturbek Beishebaev	Chui Oblast TB Dispensary Director	79 Pobedi str., Lebedinovka +996 778288295
Ekaterina Novikova	NGO Pravo na zhizn Executive Director/Program Coordinator	Katrin8080@mail.ru
Elmira Dzhorabaeva	Chui Oblast AIDS Center Doctor of the Outpatient Department	
Elmira Kalieva	National Center of Narcology Coordinator for Trust Points	
Kanatbek Ozubekov	PSI, outreach workers	+996 551451612
Kudaiberu Kulbaev	Family Medicine Center of Dzhail Rayon Infectious Disease Specialist	

Maria Kistel	NGO Antistigma Outreach Coordinator	
Mavludakhan Raimzhanova	Family Health Center in Tokmok Nurse of the OST/Trust Point	
Rano Gazamova	Bishkek City AIDS Center Assistant Epidemiologist, Manager/STI specialists of the friendly clinic	
Ruslan Tokubaev	National Center of Narcology Director	
Sayora Muzurupkhanova	Family Medicine Center of Dzhail Rayon Deputy Director	Karabalata
Svetlana Gulyanina	Family Medicine Center of Dzhail Rayon Nurse of the OST/Trust Point	
Tatyana	NGO RANS Plus Assistant Coordinator	
Tatyana Borisova	National Center of Narcology Deputy Director	+996 551451612
Ulukbek Bekturganov	Chui Oblast AIDS Center Director	+996 3138 62788
Valentina Kirichenko	National Center of Dermatovenerology Head of the Monitoring and Evaluation Department	+996 312595211
Vladimir Chudaikin	Family Health Center in Tokmok Narcologist	+996 313 820595 Delta57@mail.ru

APPENDIX 2

INTERVIEWER'S GUIDE: GOVERNMENT FACILITY STAFF

QUESTIONNAIRE FOR HIV MAPPING ACTIVITY

GOVERNMENT FACILITY LEVEL INTERVIEWS

CENTRAL ASIA

General Comments

- Two sets of interviews should be held at each facility, over the course of a half day:
  1. Center directors and physicians
  2. Nurses and auxiliary health workers (counselors, case managers, pharmacists, laboratory staff).

  The entire interview should be administered to both groups. Each section of the interview tool covers a specific technical service that may or may not be offered by the facility. If a specific service is not offered, say HIV treatment, then the interviewer will skip to the questions in that section that ask about referrals.
- AIDSTAR-One and AIDSTAR-Two will work with Population Services International (PSI) to set appointments at each of the centers.
- Priority centers for interviews are: 1) oblast AIDS center; 2) TB centers; 3) venerology centers; and 4) narcology. If HIV services are provided in PHC settings or private pharmacy, they may be included. To be discussed and determined with PSI and the Mission.

Introductory Remarks by Interviewer

AIDSTAR-One and AIDSTAR-Two have been commissioned to conduct a rapid mapping of the service delivery responses to HIV epidemics in Kyrgyzstan in order to guide future programs that USAID is planning to support.

The objectives of this mapping are the following:

- Identify the spectrum and scale of services provided in selected oblasts of Kazakhstan, Tajikistan, and Kyrgyzstan to five population groups most at risk of HIV infection. We will be looking at the coverage of services, their affordability, level of integration of different services and functionality of referral systems, effective practice of service delivery, as well as any challenges and other obstacles that prevent vulnerable people from accessing services.
- Define whether these services are sufficiently responsive to the essential needs of the target populations and are in line with international recommendations relevant to Central Asia. Identify any significant quality issues and gaps in the required continuum of services.
- Develop recommendations for improving accessibility and quality of services available to MARPs in selected sites.

The mapping will be conducted by a group of experienced consultants supported by international experts in concentrated HIV epidemics.

You are invited to participate in the interviews as a government service provider. Your knowledge of the needs of at-risk populations as well as of the services available in your area is very important for this assessment. The interview will take about an hour or hour and a half. We will not use your personal data in the assessment report or in any other way.

Please feel free to ask any questions before we start.

We can now proceed with the questions.

Name of Interviewer: Date of Interview:

ORGANIZATION/FACILITY DETAILS

1. Name of facility:
2. Country:
3. Oblast:
4. Rayon:
5. Address:
6. Telephone number:
7. Fax Number:
8. Email address:
9. Director:
10. Staff interviewed (with positions)

Name	Position	Contact Information

11. Facility/program operating hours/days (24-hour clock):
12. Is there a means by which clients can contact a provider during nonoperating hours? Please describe:
13. In your opinion, what does the ideal HIV service delivery system look like? What prevention, treatment, care, and support services should be provided?
14. Can you describe one or two best and promising practices of HIV prevention, treatment, care, and support work that you implement that you would like to share with others doing similar work?
15. What are the three most significant challenges (other than funding) for which you need assistance to implement quality HIV prevention, treatment, care, and support services?

GENERAL HIV PROGRAM

1. How many people are working in this program? This includes employees as well as volunteers.

Worker Category	Employees	Volunteers
Physician		
Nurse		
Counselors		
Peer Educators		
Outreach Workers		
Social Workers		
Laboratory Technicians		
Trained Pharmacist		
Administration/Finance		
Other (specify)		
Other (specify)		
Other (specify)		

2. Do you partner with any NGOs who place staff within your facility to provide services (such as NGO peer educators)?
   a. Yes. If yes, identify the NGOs.
   b. No
3. Have any staff received training between October 2009 and September 2010 in the any of the following cross-cutting issues?

Training Topics	Yes/No	Cadre of Staff Trained (List All)
Counseling, including disclosure		
Stigma and discrimination		

Gender		
Sexual orientation		
Confidentiality		
Program management		
Quality improvement/quality assurance		
Supportive supervision		
HIV counseling and testing		
STI treatment		
HIV clinical care		
HIV treatment (ART)		
TB screening and care		
TB/HIV coordinated care		
MAT		
Overdose management		
Other (specify)		
Other (specify)		

4. Which of the following services does this facility provide? Check all that apply for both direct and referral.

	On-site	**Referral**
Education/awareness training or counseling		
Prevention: sexual (including condom distribution)		
Prevention: IDU (including needle/syringe exchange)		
Counseling and testing		
Laboratory testing		
Prevention with positives		
STI		
Post-exposure prophylaxis		
PMTCT		
Needle exchange		
MAT		
Home-based care		
HIV care, non-ART		
HIV care, ART		
General medicine/clinical care		

Obstetrics and gynecology		
TB		
Hepatitis C		
Other (specify)		
Other (specify)		

5. In which settings are your services provided? (please check all that apply)

Clinic (outpatient)	
Hospital	
Nonclinical facility/NGO	
Mobile	
Community	
Workplace	
Other (specify)	

6. What are the target groups for your program? Please order them from largest/most significant (1) to smallest/least significant (7). If you do not provide services to a specific population, report not applicable (N/A).

	Rank Order	**Number Served (Oct. 2009 to Sept. 2010)**
IDUs		
MSM		
Sex workers		
Former prisoners		
PLWH		
Family of PLWH		
TB/HIV patients		
Migrant workers		
Truckers		
Community at-large/general population		
Other (specify)		
Other (specify)		

7. Do you face challenges working with these populations? (please describe)
8. What practical strategies and interventions (if any) are you using to reduce stigma?
9. What support could be provided to assist you in better serving these populations?

10. What is the geographic coverage of your program?
    a. Oblast(s) (specify)
    b. Rayon(s) (specify)
    c. Village(s)/town(s) (specify)
11. Do you have a system in place for ensuring client confidentiality? Please describe.

A. HIV PREVENTION AND AWARENESS RAISING

1. Do you provide any HIV prevention activities?
    a. Yes
    b. No (if no, skip to Section B)
2. Are there any systems in place to assess the quality of services?
    a. Yes (check all that apply)
        i. Routine review of data
        ii. Client satisfaction surveys
        iii. Other (specify)
    b. No
3. Which of the following areas are included in your HIV awareness/community mobilization programs? Check all that apply.

General HIV information	
Sexual prevention education	
VCT	
STI	
Stigma/discrimination reduction	
Condom promotion	
Condom negotiation	
MAT	
Safe injection	
Overdose management	
Drug demand reduction	
Other (specify)	

4. What type of material do you use to communicate HIV messages? Check all that apply.

Printed documents, pamphlets, posters, billboards	
Audiovisual, video	
Media, television spots, radio spots	
Other (specify)	

5. Do you develop your own education materials?
    a. Yes
    b. No
6. Do you use education materials developed by others?
    a. Yes (If developed by others, by which organization?)
    b. No
7. Do you provide condoms? Check all that apply.

Male condoms	
Female condoms	
Lubricant	

8. Do clients have to pay for condoms or lubricant?
    a. Yes (specify amount)
    b. No
9. Do you provide any of the following supplies and/or drugs to IDUs? Check the appropriate column.

	Yes?	**No?**
Bleach and cleaning materials		
Clean needles and syringes		
MAT		
Other (specify)		

10. Do clients have to pay for bleach, cleaning materials, or syringes?
    a. Yes (specify amount)
    b. No
11. Do you train any peer educators?
    a. Yes
    b. No (if no, skip to skip to Section B)
12. If the organization trains peer educators, how many were trained between October 2009 and September 2010?

	Number Trained	**Number Still Active**
IDU		
MSM		
Sex workers		
Former prisoners		
PLWH		

Family of PLWH		
TB/HIV patients		
Migrant workers		
Truckers		
Community at-large/general population		
Other (specify)		

13. Briefly describe how peer educators are supervised.

B. HIV COUNSELING AND TESTING

1. Do you provide HIV counseling and drawing blood for testing?
   a. Yes
   b. No (if no, skip to Question 20 in this section)
2. Do you charge any fees for HIV counseling and testing?
   a. Yes (specify amount)
   b. No
3. Briefly describe how counseling staff are trained and supervised.
4. Are there any systems in place to assess the quality of services?
   a. Yes (check all that apply)
      i. Routine review of data
      ii. Client satisfaction surveys
      iii. Other
   b. No
5. Which, if any, of the following are available and used routinely to guide HIV counseling and testing (check all that apply)? Obtain copies of all that are available.

	Treatment Protocols	**Treatment Guidelines**	**Government Prikazs**
Available			
Used routinely			

6. How are staff informed of and trained in changes in any treatment protocols, guidelines, or *prikazs*?

7. How many clients were tested in August 2010? (provide information for all that apply)

	Counseled	Blood drawn	Number who received results	Number who tested positive
IDU				
MSM				
Sex workers				
Former prisoners				
PLWH				
Family of PLWH				
TB/HIV patients				
Migrant workers				
Truckers				
Community at-large/general population				
Other (specify)				
Total				

8. For each of the periods in the table below, what is the number of clients who returned for services?

	July to Sept. 2010	June to April 2010	Jan. to March 2010	Oct. to Nov. 2009
Number of returned clients				

9. In a typical week, approximately how many clients do you see? (where possible, verify with patient logs)
10. What is the average amount of time spent with a client? (where possible, verify with patient logs)
    a. Fifteen minutes or less
    b. Fifteen to thirty minutes
    c. Thirty to forty-five minutes
    d. Forty-five minutes to one hour
    e. More than an hour
11. Between April 2010 and August 2010, how many HOP vouchers did you accept?
12. Do you have recommendations on how the voucher system could be improved?

13. In which settings are your HIV testing services provided? (please check all that apply)

	ELISA/Western Blot	Rapid Test
Clinic		
Hospital		
Nonclinical facility		
Mobile		
Community		
Workplace		
Other (specify)		

14. How do clients receive information about receiving results, including when to return for results, why it is important, and where to go?
    a. Printed materials
    b. Counseling
    c. Printed materials and counseling
    d. Other (specify)
15. On average, how long does a client have to wait to receive results?
16. What information do clients need to provide in order to obtain test results?
    a. Name or other personally identifying information
    b. Unique identifier code
17. Does this program provide partner notification support for those who test positive for HIV?
    a. Yes
    b. No
18. What test kits are used for HIV testing?
19. During the past six months, have there been any stockouts of test kits? (Specify which test kits have experienced stockout.)

GO TO SECTION C

20. If you do not provide counseling and testing, do you refer?
    a. Yes
    b. No (if no, skip to Section C)
21. Where do you refer clients for counseling and testing?

22. How is the referral made? (Check all that apply)
    a. Information given
    b. Appointment booked
    c. Health navigator/peer support
    d. Other (specify)
23. Is there a system in place to determine if a referral was used?
    a. Yes (describe)
    b. No

C. SEXUALLY TRANSMITTED INFECTIONS

1. Do you provide screening and treatment for STIs?
    a. Yes
    b. No (if no, skip to Question 20 in this section)
2. Does the program charge any fee for STI services?
    a. Yes (specify amount)
    b. No
3. Briefly describe how staff are trained and supervised.
4. Are there any systems in place to assess the quality of services?
    a. Yes (check all that apply)
        i. Routine review of data
        ii. Client satisfaction surveys
        iii. Other
    b. No
5. Which, if any, of the following are available and used routinely to guide STI screening and treatment (check all that apply)? Obtain copies of all that are available.

	Treatment Protocols	Treatment Guidelines	Government Prikazs
Available			
Used routinely			

6. How are staff informed of and trained in changes in any treatment protocols, guidelines, or *prikazs*?

7. How many clients were treated for STIs in August 2010?

	Treated for STI	Provided or referred for counseling and testing	Tested for HIV	Tested positive
Male				
Female				

8. For each of the periods in the table below, what is the number of clients who returned to receive test results?

	July to Sept. 2010	June to April 2010	Jan. to March 2010	Oct. to Nov. 2009
Number of returned clients				

9. In a typical week, approximately how many clients do you see? (where possible, verify with patient logs)
10. What is the average amount of time spent with a client? (where possible, verify with patient logs)
    a. Fifteen minutes or less
    b. Fifteen to thirty minutes
    c. Thirty to forty-five minutes
    d. Forty-five minutes to one hour
    e. More than an hour
11. Between April 2010 and August 2010, how many HOP vouchers did you accept?
12. Do you have recommendations on how the voucher system could be improved?
13. Does this program provide counseling about STI prevention and treatment?
    a. Yes
    b. No
14. How do clients receive information about receiving results, including when to return for results, why it is important, and where to go?
    a. Printed materials
    b. Counseling
    c. Printed materials and counseling
    d. Other (specify)
15. On average, how long does a client have to wait to receive results?

16. What information do clients need to provide in order to obtain test results?
    a. Name or other personally identifying information
    b. Unique identifier code
17. Does this program provide partner notification support for people treated for an STI?
    a. Yes
    b. No
18. What laboratory supplies and treatment drugs are supplied for the STI program?
19. During the past six months, have there been any stockouts of laboratory supplies or drugs? (specify which products have experienced stockout)

GO TO SECTION D

20. If you do not provide STI services, do you refer?
    a. Yes
    b. No (if no, skip to Section D)
21. Where do you refer clients for STI services?
22. How is the referral made? Check all that apply.
    a. Information given
    b. Appointment booked
    c. Health navigator/peer support
    d. Other (specify)
23. Is there a system in place to determine if a referral was used?
    a. Yes (describe)
    b. No

D. PREVENTION OF MOTHER-TO-CHILD TRANSMISSION (THIS SECTION MAY BE OPTIONAL)

1. Do you provide PMTCT counseling at site?
    a. Yes
    b. No (if no, skip to Question 16 in this section)
2. Do you charge any fee for PMTCT services?
    a. Yes (specify amount)
    b. No

3. Briefly describe how staff are trained and supervised.
4. Are there any systems in place to assess the quality of services?
    a. Yes (check all that apply)
        i. Routine review of service delivery data
        ii. Client satisfaction survey
        iii. Other (specify)
    b. No
5. Which, if any, of the following are available and used routinely to guide PMTCT services (check all that apply)? Obtain copies of all that are available.

	Treatment Protocols	**Treatment Guidelines**	**Government Prikazs**
Available			
Used routinely			

6. How are staff informed of and trained in changes in any treatment protocols, guidelines, or *prikazs*?
7. What services are provided as part of comprehensive PMTCT? Check all that apply.

Antenatal HIV testing and counseling	
Provision of ART to mother	
Provision of ART to baby	
Safer delivery practices or caesarean section	
Infant feeding counseling	
Infant feeding supplies	
Family planning counseling	
Other (specify)	

8. For each of the periods in the table below, what is the number of clients who returned for services?

	July to Sept. 2010	**June to April 2010**	**Jan. to March 2010**	**Oct. to Nov. 2009**
Number of returned clients				

9. In a typical week, approximately how many clients do you see? (where possible, verify with patient logs)

10. What is the average amount of time spent with a client? (where possible, verify with patient logs)
    a. Fifteen minutes or less
    b. Fifteen to thirty minutes
    c. Thirty to forty-five minutes
    d. Forty-five minutes to one hour
    e. More than an hour
11. Between April 2010 and August 2010, how many HOP vouchers did you accept?
12. Do you have recommendations on how the voucher system could be improved?
13. How many women were enrolled in PMTCT from October 2009 to September 2010?
14. What ARVs are supplied for PMTCT?
15. During the past six months, have there been any stockouts of ARVs? (specify which ARVs have experienced stockout)

GO TO SECTION E

16. If you do not provide PMTCT, do you refer for PMTCT services?
    a. Yes
    b. No (if no, skip to Section E)
17. Where do you refer pregnant women living with HIV for PMTCT?
18. How is the referral made? Check all that apply.
    a. Information given
    b. Appointment booked
    c. Health navigator/peer support
    d. Other (specify)
19. Is there a system in place to determine if a referral was used?
    a. Yes (describe)
    b. No

E. TUBERCULOSIS

1. Do you conduct TB screening at this site?
    a. Yes
    b. No (if no, skip to Question 21 in this section)

2. Do you charge any fees for TB services?
    a. Yes (specify amount)
    b. No
3. Briefly describe how staff are trained and supervised.
4. Are there any systems in place to assess the quality of services?
    a. Yes (check all that apply)
        i. Routine review of service delivery data
        ii. Client satisfaction survey
        iii. Other (specify)
    b. No
5. Do you provide treatment for TB on site?
    a. Yes
    b. No (if no, skip to Question 7 in this section)
6. Which, if any, of the following are available and used routinely to guide TB treatment (check all that apply)? Obtain copies of all that are available.

	Treatment Protocols	Treatment Guidelines	Government Prikazs
Available			
Used routinely			

7. How are staff informed of and trained in changes in any treatment protocols, guidelines, or *prikazs*?
8. How are patients screened for TB? Check all that apply.
    a. Skin test
    b. Chest x-ray
    c. Sputum sample
    d. Other
9. How many clients were treated for TB for the first time in August 2010?

	New TB cases	TB clients screened for or referred for counseling and testing	TB clients tested for HIV	TB clients tested as HIV-positive	Number of clients who received their HIV results
Male					
Female					

10. For each of the periods in the table below, what is the number of clients who returned for TB follow-up services?

	July to Sept. 2010	**June to April 2010**	**Jan. to March 2010**	**Oct. to Nov. 2009**
Number of returned clients				

11. In a typical week, approximately how many clients do you see? (where possible, verify with patient logs)
12. What is the average amount of time spent with a client? (where possible, verify with patient logs)
    a. Fifteen minutes or less
    b. Fifteen to thirty minutes
    c. Thirty to forty-five minutes
    d. Forty-five minutes to one hour
    e. More than an hour
13. What drugs are supplied for treatment and prevention of TB?
14. During the past six months, have there been any stockouts of TB drugs? (specify which drugs have experienced stockout)
15. Between April 2010 and August 2010, how many HOP vouchers did you accept?
16. Do you have recommendations on how the voucher system could be improved?
17. Does this program provide counseling about TB prevention and treatment?
    a. Yes
    b. No
18. How do clients receive information about receiving results, including when to return for results, why it is important, and where to go?
    a. Printed materials
    b. Counseling
    c. Printed materials and counseling
    d. Other (specify)
19. On average, how long does a client have to wait to receive results?
20. What information do clients need to provide in order to obtain test results?
    a. Name or other personally identifying information
    b. Unique identifier code

GO TO SECTION F

21. If you do not provide TB services, do you refer clients?
    a. Yes
    b. No
22. Where do you refer clients for TB services?
23. How is the referral made? (check all that apply)
    a. Information given
    b. Appointment booked
    c. Health navigator/peer support
    d. Other (specify)
24. Is there a system in place to determine if a referral was used?
    a. Yes (describe)
    b. No

F. SUBSTANCE USE SERVICES

1. Do you provide services to address substance use, particularly injection drug use?
    a. Yes
    b. No (if no, skip to Question 16 in this section)
2. What services do you provide? (Check all that apply)
    a. Harm reduction/prevention
    b. NSE
    c. Wound management
    d. MAT (including counseling support)
    e. Other (specify)
3. Do you charge fees for any of these services
    a. Yes (specify amount and for which service)
    b. No
4. Briefly describe how staff are trained and supervised.
5. Are there any systems in place to assess the quality of services?
    a. Yes (check all that apply)
        i. Routine review of data
        ii. Client satisfaction surveys
        iii. Other
    b. No

6. Which, if any, of the following are available and used routinely to guide HIV treatment (check all that apply)? Obtain copies of all that are available.

	Treatment Protocols	Treatment Guidelines	Government Prikazs
Available			
Used routinely			

7. How are staff informed of and trained in changes in any treatment protocols, guidelines, or *prikazs*?
8. How many clients were provided services in August 2010? Provide information for all that apply.

	Harm Reduction/ Prevention	NSE	Wound Management	MAT	Other (specify)
Male					
Female					
Total					

9. For each of the periods in the table below, what is the number of clients who returned for services?

	July to Sept. 2010	June to April 2010	Jan. to March 2010	Oct. to Nov. 2009
Number of returned clients				

10. In a typical week, approximately how many clients do you see? (where possible, verify with patient logs)
11. What is the average amount of time spent with a client? (where possible, verify with patient logs)
    a. Fifteen minutes or less
    b. Fifteen to thirty minutes
    c. Thirty to forty-five minutes
    d. Forty-five minutes to one hour
    e. More than an hour
12. Between April 2010 and August 2010, how many clients have been referred to you by the HOP?
13. Do you have any recommendation on how the voucher system can be improved?
14. What drugs and supplies are distributed as part of this program?
15. During the past six months, have there been any stockouts of these supplies? (specify which supplies have experienced stockout)

GO TO SECTION G

16. If you do not provide services for substance use, do you refer?
    a. Yes
    b. No (if no, skip to Section G)
17. Where do you refer clients for substance use services, including MAT?
18. How is the referral made? (Check all that apply)
    a. Information given
    b. Appointment booked
    c. Health navigator/peer support
    d. Other (specify)
19. Is there a system in place to determine if a referral was used?
    a. Yes (describe)
    b. No

G. HIV CARE AND TREATMENT

1. Do you provide clinical treatment for HIV on site?
    a. Yes
    b. No (if no, skip to Question 19 in this section)
2. Does the program charge any fee for HIV clinical care services?
    a. Yes (specify amount and for what services)
    b. No
3. Briefly describe how staff are trained and supervised.
4. Are there any systems in place to assess the quality of services?
    a. Yes (check all that apply)
        i. Routine review of service delivery data
        ii. Client satisfaction survey
        iii. Other (specify)
    b. No
5. Which, if any, of the following are available and used routinely to guide HIV treatment (check all that apply)? Obtain copies of all that are available.

	Treatment Protocols	Treatment Guidelines	Government Prikazs
Available			
Used routinely			

6. How are staff informed of and trained in changes in any treatment protocols, guidelines, or *prikazs*?
7. How many clients were treated for HIV for the first time in August 2010?

Gender	New HIV Case	HIV Care, no ART	HIV Care and ART
Male			
Female			

8. For each of the periods in the table below, what is the number of clients who returned for services?

	July to Sept. 2010	June to April 2010	Jan. to March. 2010	Oct. to Nov. 2009
Number of returned clients				

9. In a typical week, approximately how many clients do you see? (where possible, verify with patient logs)
10. What is the average amount of time spent with a client? (where possible, verify with patient logs)
    a. Fifteen minutes or less
    b. Fifteen to thirty minutes
    c. Thirty to forty-five minutes
    d. Forty-five minutes to one hour
    e. More than an hour
11. Do you provide adherence counseling and support, including side-effect management?
    a. Yes
    b. No
12. Between April 2010 and August 2010, how many HOP vouchers did you accept?
13. Do you have recommendations on how the voucher system could be improved?
14. Does the facility include routine laboratory tests (CD4 and viral load)? Check all that apply.
    a. CD4
    b. Viral load
    c. Other (specify)
15. Are pharmacy services for distribution of opportunistic illness drugs and ARVs available on site?
    a. Yes
    b. No (if no, skip to Question 18)
16. What ARVs and drugs to manage OIs are supplied for treatment of HIV?

17. During the past six months, have there been any stockouts of these drugs? (specify which drugs have experienced stockout)
18. Does the clinic provide other health services? Check all that apply.
    a. PHC
    b. Obstetrics and gynecology
    c. Other (specify)
    d. Other (specify)

GO TO SECTION H

19. If you do not provide HIV treatment services, do you refer clients for treatment?
    a. Yes
    b. No (if no, skip to Section H)
20. For each of the periods in the table below, how many clients were referred for HIV treatment services?

	July to Sept. 2010	**June to April 2010**	**Jan. to March 2010**	**Oct. to Nov. 2009**
Number of referred clients				

21. How is the referral made? (Check all that apply)
    a. Information given
    b. Health navigator/peer support
    c. Other (specify)
22. Is there a system in place to determine if a referral was used?
    a. Yes (describe)
    b. No

H. COMMUNITY- AND HOME-BASED CARE

1. Do you provide community- and home-based care for PLWH?
    a. Yes
    b. No (if no, skip to Question 16 in this section)
2. Does the program charge any fee for community- or home-based services?
    a. Yes (specify amount)
    b. No

3. Briefly describe how staff are trained and supervised.
4. Are there any systems in place to assess the quality of services?
    a. Yes (check all that apply)
        i. Routine review of service delivery data
        ii. Client satisfaction survey
        iii. Other (specify)
    b. No
5. Which, if any, of the following are available and used routinely to guide HIV treatment (check all that apply)? Obtain copies of all that are available.

	Treatment Protocols	**Treatment Guidelines**	**Government Prikazs**
Available			
Used routinely			

6. How are staff informed of and trained in changes in any treatment protocols, guidelines, or *prikazs*?
7. Which of the following activities are provided as part of community- or home-based care? (check all that apply)

Physical care of PLWH	
Client counseling	
Family counseling	
Support for the caregivers	
Social and legal services	
Other (specify)	

8. How does the community- and home-based care program recruit clients? (check all that apply)

Self-referrals	
Family	
Community and religious leaders	
Clinics	
Outreach workers	
Other (specify)	

9. For each of the periods in the table below, what is the number of clients who returned for services?

	July to Sept. 2010	June to April 2010	Jan. to March 2010	Oct. to Nov. 2009
Number of returned clients				

10. In a typical week, approximately how many clients do you see? (where possible, verify with patient logs)
11. What is the average amount of time spent with a client? (where possible, verify with patient logs)
    a. Fifteen minutes or less
    b. Fifteen to thirty minutes
    c. Thirty to forty-five minutes
    d. Forty-five minutes to one hour
    e. More than an hour
12. Between April 2010 and August 2010, how many HOP vouchers did you accept?
13. Do you have recommendations on how the voucher system could be improved?
14. What supplies are provided as part of community- and home-based care?
15. During the past six months, have there been any stockouts of these supplies? (specify which supplies have experienced stockout)

GO TO SECTION I

16. If you do not provide community- or home-based care services, do you refer clients for these services?
    a. Yes
    b. No (if no, go to Section I)
17. How is the referral made?
    a. Information given
    b. Appointment booked
    c. Health navigator/peer support
    d. Other (specify)
18. Is there a system in place to determine if a referral was used?
    a. Yes (describe)
    b. No

I. SUPPORT FOR PEOPLE LIVING WITH HIV

1. Do you provide support to PLWH?
   a. Yes
   b. No (if no, skip to Question 12 in this section)
2. Does the program charge any fee for PLWH support services?
   a. Yes (specify amount)
   b. No
3. Briefly describe how staff are trained and supervised.
4. Are there any systems in place to assess the quality of services?
   a. Yes (check all that apply)
      i. Routine review of service delivery data
      ii. Client satisfaction survey
      iii. Other (specify)
   b. No
5. Which of the following activities are provided as part of PLWH support? Check all that apply.

Individual counseling	
Income-generation/skills training	
Home-based care	
Legal services	
Nutritional support	
Family planning counseling	
Drug demand reduction	
Referral to other medical services (reproductive health; management of complications due to drug use; PMTCT; ART adherence support and counseling; etc.)	
Other (specify)	

6. How many PLWH are in this program as of August 2010?

	Less than 1	1 to 5	5 to 15	15 to 25	25 to 35	35 to 45	45 or more
Male							
Female							

7. For each of the periods in the table below, what is the number of clients who returned for services?

	July to Sept. 2010	June to April 2010	Jan. to March 2010	Oct. to Nov. 2009
Number of returned clients				

8. In a typical week, approximately how many clients do you see? (where possible, verify with patient logs)
9. What is the average amount of time spent with a client? (where possible, verify with patient logs)
    a. Fifteen minutes or less
    b. Fifteen to thirty minutes
    c. Thirty to forty-five minutes
    d. Forty-five minutes to one hour
    e. More than an hour
10. Between April 2010 and August 2010, how many HOP vouchers did you accept?
11. Do you have recommendations on how the voucher system could be improved?

GO TO SECTION J

12. If you do not provide PLWH support services, do you refer clients for these services?
    a. Yes
    b. No (if no, go to Section J)
13. How is the referral made? (check all that apply)
    a. Information given
    b. Appointment booked
    c. Health navigator/peer support
    d. Other (specify)
14. Is there a system in place to determine if a referral was used?
    a. Yes (describe)
    b. No

J. FAMILY SUPPORT SERVICES

1. Do you provide support to family of PLWH?
   a. Yes
   b. No (if no, go to Question 8 in this section)
2. Does the program charge any fee for family support services?
   a. Yes (specify amount)
   b. No
3. Briefly describe how staff are trained and supervised.
4. Are there any systems in place to assess the quality of services?
   a. Yes (Check all that apply)
      i. Routine review of service delivery data
      ii. Client satisfaction survey
      iii. Other (specify)
   b. No
5. Which of the following activities are provided for family support? (check all that apply)

Individual counseling	
Income generation/skills training	
Home-based care	
Legal services	
Nutritional support	
Other (specify)	

6. Between April 2010 and August 2010, how many HOP vouchers did you accept?
7. Do you have recommendations on how the voucher system could be improved?

GO TO SECTION K

8. If you do not provide family support services, do you refer clients?
   a. Yes
   b. No (if no, skip to Section K)

9. How is the referral made? (check all that apply)
    a. Information given
    b. Appointment booked
    c. Health navigator/peer support
    d. Other (specify)
10. Is there a system in place to determine if a referral was used?
    a. Yes (describe)
    b. No

K. CLOSING QUESTIONS

1. Are there services which your clients need that you feel this site could add? Please specify.
2. What are your top priority areas/needs that would improve your motivation and job satisfaction? Rank the responses with 1 being the most beneficial and 5 being the least.
    a. Training
    b. Routine supportive supervision
    c. Materials and supplies
    d. Appropriately trained
    e. Client education materials and support
    f. Greater NGO involvement
    g. Incentives (identify other than money)

APPENDIX 3

INTERVIEWER GUIDE: HEALTH OUTREACH PROJECT–FUNDED NONGOVERNMENTAL ORGANIZATION STAFF

SEMI-STRUCTURED INTERVIEW GUIDE

INTERVIEWS WITH HOP GRANTEES (NGOS PROVIDING SERVICES TO MARPS IN SELECTED SITES)

CENTRAL ASIA

General Notes

NGOs are key service providers for various MARP groups in Kazakhstan, Tajikistan, and Kyrgyzstan. The purpose of this short, structured NGO interview is to obtain information and, especially, their perspectives on service gaps, coverage, quality, and best practices. Some additional general notes are as follows:

- NGOs will be interviewed as part of oblast interviews.
- NGOs may be grouped by MARPs that they serve. For example, if there are two NGOs that serve only IDUs, they may be interviewed together. This will allow to obtain more representative data at oblast level within the restricted timeframe.
- A wide range of staff should be included. This should include program managers as well as frontline staff, including counselors, trainers, and outreach workers. As a general rule, not less than half of all interviewees should be selected out of frontline workers.
- We will work with PSI to set up appointments with each of the NGO groups. The interview schedule is subject to changes during the interview process itself based on the preliminary analysis of the first completed interviews.

- The interviews will be administered and documented in Russian, providing explicit consent of interviewees.

Introductory Remarks by Interviewer

The USAID-funded project AIDSTAR-Two (or AIDSTAR-One) has been commissioned to conduct a rapid mapping of the service delivery responses to HIV epidemics in Kazakhstan and Tajikistan in order to guide the future programs that USAID is planning to support. The objectives of this mapping are as following:

- Identify the spectrum and scale of services provided in selected oblasts of Kazakhstan, Tajikistan, and Kyrgyzstan to five population groups most at risk of HIV infection. We will be looking at the coverage of services, their affordability, level of integration of different services and functionality of referral systems, effective practice of service delivery, as well as any challenges and other obstacles that prevent vulnerable people from accessing services.
- Define whether these services are sufficiently responsive to the essential needs of the target populations and are in line with international recommendations relevant to Central Asia. Identify any significant quality issues and gaps in the required continuum of services.
- Develop recommendations for improving accessibility and quality of services available to MARPs in selected sites.

The mapping will be conducted by a group of experienced consultants supported by international experts in concentrated HIV epidemics.

You are invited to participate in the interviews as a nongovernmental service provider. Your knowledge of the needs of at-risk populations as well as of the services available in your area is very important for this assessment. The interview will take about an hour. We will not use your personal data in the assessment report or in any other way.

Please feel free to ask any questions before we start.

We can now proceed with the questions.

Name of Interviewer: Date of Interview:

NGO ORGANIZATION/FACILITY DETAILS

1. Name of organization:
2. Country and city:
3. Address:
4. Telephone number:
5. Fax number:
6. Email address:
7. Director:

8. Staff participating in the interview (with positions):

Name	Position	Contact Information

1. What HIV/STI services do you currently offer?
2. What oblasts do you work in?
3. Which oblasts and/or rayons do you reach?
4. What are the target populations you serve?
   Probe for MSM, commercial sex workers (CSWs), IDUs, former prisoners, migrants, PLWH.
5. How many people (specify MARP group) did you serve in August 2010?

MARP Group	Number of Population Served

6. How many were served from October 2009 through September 2010?

MARP Group	Number of Population Served

7. What are the most sought after services by each of the MARP groups you serve?
8. What is your estimate of unmet demand for services? How many people are there in the MARP group(s) you serve that do not access your services?
9. How is your program staffed? Describe the roles of paid staff as well as volunteers/peers.

Role	Paid Staff	Volunteers

10. Do you charge fees for any of your services? Which ones? If you do, how much is charged? Do you have a program to subsidize the costs for those that cannot pay?
11. What are the three most significant challenges (other than funding) for which you need assistance to implement quality HIV prevention, treatment, care, and support services?
12. Can you describe one to two best and promising practices of HIV prevention, treatment, care, and support work that you implement that you would like to share with others doing similar work?
13. What are you aiming to achieve by working with these populations? What is the mission and goals of your organization?
14. What are the most commonly expressed needs and challenges/difficulties faced by your target population? Please prioritize needs by assigning numbers with 1 being the most essential and 5 being the least essential.
15. What systems do you have in place to measure the quality of the services you provide? How often do you assess the quality of your services?
16. If you could design and implement the ideal HIV service delivery system for the MARPs you service, what would it look like?
17. Please comment on the level of integration of the services you provide with other government and NGO services in your area. Is the integration effective? What makes it effective? If it is not effective, what are the reasons for this?
18. What are the most significant and important organization and management systems strengthening needs (name three to five)?

APPENDIX 4

MODERATOR GUIDE: FOCUS GROUP DISCUSSIONS WITH CLIENTS OF HIV SERVICES AND VULNERABLE PEOPLE NOT ACCESSING SERVICES

General Comments

Some general comments are as follows:

- There will be at least five FGDs per country, and one per MARP (MSM, IDU, CSW, prisoner, PLWH).
- FGDs will be done at the oblast level, depending on the MARP to be served by HOP.
- Both users and nonusers of services should be included. Wherever possible, separate discussions will be organized with these two segments of the participants.
- AIDSTAR-One and AIDSTAR-Two will work with PSI and NGOs to set up FGDs.

The main objective of the FGDs is to ensure that the perspective of the existing and prospective service users are sufficiently taken into account in the analysis of the current status of services. Data obtained from the discussion participants will allow verification and triangulation of information collected through other assessment instruments. Most importantly, FGDs identify the needs of MARPs in their own words and their prioritization of those needs. FGDs will include the beneficiary's assessment of the spectrum of services, obstacles and shortcomings, service gaps, ideas for service improvement, characteristics and qualifications of service providers, as well as clients' identification of exemplary services and practices that can be replicated.

Target population	MSM IDUs CSWs Former prisoners PLWH

Number of FDG sessions to conduct	There will be at least five focus groups per country. One per MARP subgroup: MSM, IDUs, CSWs, former prisoners, and PLWH. They will be done at the oblast level, depending on the MARP to be served by HOP NGOs.
Number of participants per FGD session	Five to ten individuals. Both users and nonusers of HIV services should be included.
Approximate duration per FGD	Fifty to sixty minutes.
Informed consent	The moderator must get signed copies of the informed consent forms from each participant. For participants that do not know how to read or write, the moderator should read the consent form, ask if they would like to be part of the FGD, and ask them to mark an *X* in the space provided for their signature in the consent form. All participants should be provided an opportunity to ask any questions about the consent form prior to beginning the group discussion.
Introduction:	*Hello. My name is _____ and I have been asked by the AIDSTAR-Two/AIDSTAR-One project to conduct a series of FGDs to assess the HIV services available to you. The information you share with me will be used to guide future prevention, care, and treatment programs that are being planned in this country.* *It is important for me to hear your opinion about the services you currently receive and/or need and your impressions about the quality of these services. Feel free to make positive or negative comments about any of the things we'll be discussing today. This is a free flowing discussion and there is no right or wrong answers. I will not be offended in any way by anything you say so please feel free to speak your mind.*
General Notes:	Name of facilitator: Date of FGD:
FGD Facility Information	Name of facility: Name of person assisting with recruitment/logistics: Address: Country: Oblast: Telephone: Email:
Demographics of the group	MARP group: Number participating: Women: Men: Duration of FGD:

A. HIV-RELATED SERVICES ACCESSIBLE TO MARPS

1. What HIV-related services do you have access to?
   Probes: If not mentioned, ask for services such as VCT, needle exchange, MAT, ART, STI screening and treatment, psychosocial support, peer education, PMTCT, etc.

B. PERCEPTION OF GOVERNMENT FACILITY SERVICES

I would like us to focus on the services you have received at government facilities.

2. Could you please tell me what HIV-related services you received between September 2009 and August 2010 and where?
   Probe for names of government facilities.
3. Were you charged any fees these services? Which ones and how much?
4. What did you like about these services? What didn't you like?
5. If you are not pleased with a service at the [*name of government facility*], is there a way for you to give your opinions to providers?
   Probe: If there is a way, have you ever done it? What resulted from that?
6. How was your confidentiality protected?
7. Did you receive referrals for any services you wanted or needed but weren't provided by the government program? Where were you referred?
8. If you have the opportunity to improve the services provided by [*name of government facility*], what would you change?

C. PERCEPTION OF NGO SERVICES

Now, I would like us to focus on the services you have received at NGO sites.

9. Could you please tell me what services you received between September 2009 and August 2010 and where?
   Probe for names of NGOs.
10. Were you charged any fees these services? Which ones and how much?
11. What did you like about these services? What didn't you like?
12. If you are not pleased with a service at the [*name of NGO*], is there a way for you to give your opinions to providers?
    Probe: If there is a way, have you ever done it? What resulted from that?
13. How was your confidentiality protected?
14. Did you receive referrals for any services you wanted or needed but weren't provided by the NGO program? Where were you referred? Did you use the service?

15. If you have the opportunity to improve the services provided by [*name of NGO*], what would you change?
16. Of the services you have received in the past, which ones do you think should be expanded or replicated in other regions/oblasts/cities?

D. PERCEIVED BARRIERS AND CHALLENGES TO ACCESS HIV-RELATED SERVICES

17. What other HIV-related services that you need are not available to you?
    Probe: Why do you think they are not available?
18. What challenges or difficulties do you face in accessing HIV-related services?
19. For people who haven't used a government service between September 2009 and August 2010, what kept you from using the services?
20. For people who haven't used an NGO service between September 2009 and August 2010, what kept you from using the services?

E. INVOLVEMENT OF MARPS IN THE DESIGN AND/OR DELIVERY OF HIV-RELATED SERVICES

21. Describe how have you been involved in the design and/or delivery of HIV-related services in the past.
22. If you could design and implement a service delivery system most responsive to the needs of your community to prevent the spread of HIV, what would it look like?
    Probe: Please describe the services, how they would be offered (e.g., static facilities, mobile units, outreach) and the relationship between NGO, government, and clients.

For more information, please visit aidstar-one.com.

AIDSTAR-One
John Snow, Inc.
1616 Fort Myer Drive, 11th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
Email: info@aidstar-one.com
Internet: aidstar-one.com